THE INCREDIBLE YEARS®
Parents, Teachers and Children Series

Basic Workshop Manual

3-day group leader workshop

(covers Incredible Years® Toddler, Preschool Basic and early School Age Basic Programs)

For Group Leaders of Parents of Children Ages 2-8

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**NOTE: This manual is for workshop purposes only. Full program set can be purchased from The Incredible Years®*

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Finally, check out our blog for information, tips and news for parents, teachers, and group leaders!

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The Incredible Years®
Parent Group Leader Workshop Agenda

Day 1

Morning

- Overview of the Webster-Stratton program
  - Family and child risk factors
  - Content of program
  - Research findings
  - Group leader roles
- Child-Directed Play Promotes Positive Relationships

Afternoon

- Descriptive Commenting, Academic & Persistence Coaching
- Emotional & Social Coaching
- Logistics: Getting your first group started (recruitment, location, leader preparation, child care, incentives)

Day 2

Morning

- Praise Program
- Tangible Rewards Program: (Routines & Rules, Limit Setting)

Afternoon

- Handling Misbehavior: Follow Through & Ignore
- Maximizing your results (partners, role playing, home assignments, buddy system, collaboration between home and school, "principle training," ensuring generalization, self-monitoring checklist, make-up sessions, ending the group)

Day 3

Morning

- Handling Misbehavior: Time Out to Calm Down
- Handling Misbehavior: Logical Consequences

Afternoon

- Problem Solving
- Weekly evaluations
- Self and peer evaluations
- Ongoing consultation
- Certification of group leaders

Using the Incredible Years® Copyrighted Materials and Trademarked Brand

All Incredible Years® programs and materials are copyright protected. Additionally "The Incredible Years®" Brand is trademark protected.

Because our materials are sold in such a way that some items may be photocopied and others may not, please review the following information to ensure proper use of materials. Please contact The Incredible Years® office with your questions - we are here to help!

Some General Guidelines:

- If your agency plans to implement an Incredible Years® Program, they must purchase the program set from The Incredible Years® office. A program set includes all the main components to run your groups. A leader's manual, DVD set with vignettes to show, and other "extra" items are included.
- In the leader's manual, you MAY photocopy the handouts and different evaluation forms for parents to use and fill out. You may keep the master copies in your leader's manual so that you can reuse them for each group.
- You may not make any alterations to these handouts, evaluations, or any of the other forms in the leader's manual. This includes removing copyright information, recreating materials without permission from The Incredible Years® and/or translating any of the materials without permission.
- You may not photocopy the entire leader's manual to create new manuals. If you need additional manuals, they can be purchased from The Incredible Years® office.
- You may access select materials from our website, in the "Group Leader Resources" section.
- The DVD set that comes with each program is copyright protected. Burning the dvd discs or making "back up" copies is not allowed. If a disc is lost or broken, replacements can be purchased from The Incredible Years® at a low cost. Full sets of the DVD are typically not sold separately from the full program set - if you require multiple DVD sets, we suggest purchasing multiple sets of the program, which qualifies you for discounting.
- Please refer to our website Terms and Conditions, here: http://incredibleyears.com/policy/
- If you or your agency would like to use any portion of The Incredible Years® Brand (i.e., logo for flyers, any information about your Incredible Years classes that will be posted on your website, etc.), contact The Incredible Years® office for information on our brand agreement.

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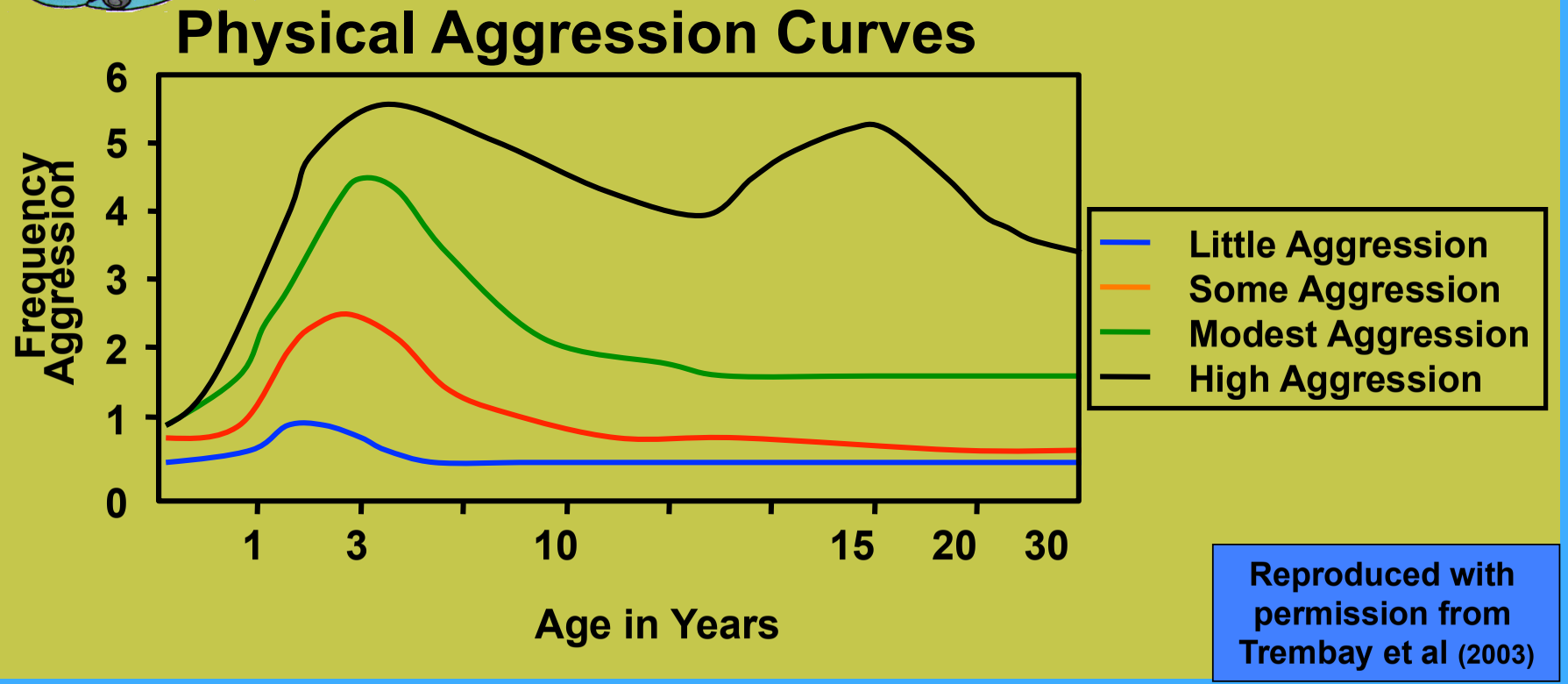
Child Dinosaur Classroom Prevention Program
Ages 3 to 8 years
Child Dinosaur Treatment Program
Ages 4 to 8 years
Autism Spectrum & Language Delays Teacher Program
Ages 3 to 5 years
Incredible Beginnings Teacher/Child Care Provider Program
Ages 1 to 5 years
Autism Spectrum & Language Delays Parent Program
Ages 2 to 5 years
Attentive Parenting® Universal Program
Ages 2 to 6 years
Advanced Parent Program
Ages 4 to 12 years
School Age BASIC Parent Program
Ages 6 to 12 years
Teacher Classroom Management Program
Ages 3 to 8 years
School Readiness Parent Program
Ages 2 to 4 years
Preschool BASIC Parent Program
Ages 3 to 6 years
Well-Baby Prevention Program
Ages 0 to 9 months
Toddler Basic Parent Program
Ages 1 to 3 years
Baby Parent Program
Ages 0 to 12 months

Trajectories of Physical Aggression



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IY Summary of Content of Incredible Years® Parent Programs

Content Components For IY Parent Programs	Basic Toddler Sessions	Basic Preschool Sessions	Basic School Age Sessions	Advance Sessions (post-Preschool & School Age)
Building Parent Support Networks	All	All	All	All
Child-directed Play, Positive Attention, Special Time – Building Positive Relationships	1, 2	1, 2	1, 2	
Promoting Language Development	2, 3	3, 4		
Pre-academic Coaching	3	3, 4		
Social and Emotional Coaching	4, 5	5, 6	3, 4	
Promoting Reading Skills and Parent School Involvement	3	3, 4	13, 16	
Academic and Persistence Coaching		3, 4	3, 4	
Art of Praise and Encouragement	6	7, 8	5	
Spontaneous and Planned Incentives	7	8, 9	6	
Managing Separations and Reunions	8	10		
Consistent Rules and Predictable Routines		10, 11	7	
Responsibilities and Household Chores		10, 11	7	
Clear Limit Setting	8	12, 13		
Positive Discipline: Distractions, Redirection, Ignoring	9, 10, 11, 12	12, 13	9	
Time Out to Calm Down, Logical Consequences		14, 15, 16	10, 11, 12	
Teaching Children and Parents Self-Regulation and Calm Down Skills		14, 15	9	
Talking about drugs, alcohol, and screen Time			7	
Teaching Children and Parents Problem Solving		17,18	12	
Parents Partnering with Teachers			16	
Coaching Children's Homework			14, 16	
Active Listening and Speaking Up				1, 2

Effective Communication to Self and Others				3
Giving and Getting Support				4
Adult Problem Solving Meetings (4-12 year olds)				5
Problem Solving with Teachers (4-12 year olds)				6
Teaching Children to Problem Solve (6-12 year olds)				7
Familly Meetings (8-12 year olds)				8, 9

NOTE: Numbers reflect session number protocols in different manuals. However, these session protocols may take more than one session to complete. The pacing of the amount of content covered depends on the educational background and risk level of the parents as well as the children's developmental difficulties and diagnoses.

Table 2: Content and Objectives of the Incredible Years® Parents and Toddlers Program			
Content	Objectives	Content	Objectives
Toddler Program: 1—3 Years			
Part 1: Child-Directed Play Promotes Positive Relationships	• Understanding the value of showing attention and appreciation as a way of increasing positive child behaviors • Understanding the importance of showing joy with toddlers through songs and games • Understanding how to promote imaginary and pretend play • Learning how to be child-directed and understanding its value for children • Learning how to end play successfully with toddlers • Learning about toddlers' developmental needs and milestones • Learning about the "modeling" principle • Balancing power between parents and children • Building children's self-esteem and creativity through child-directed play • Understanding the "attention rule"	**Part 2: Promoting Toddler's Language with Child-Directed Coaching**	• Understanding how to model and prompt language development • Learning how to coach preschool readiness skills • Learning about "descriptive commenting" and child-directed coaching • Learning about "persistence coaching" to build children's ability to be focused, calm and to persist with an activity • Learning about the "modeling principle" • Understanding how to promote pre-reading and pre-writing readiness skills • Appreciating normal differences in children's developmental abilities and temperament — completing temperament checklist
Part 3: Social and Emotion Coaching	• Understanding how to use emotion coaching to build children's emotional vocabulary and encourage their expression of feelings. • Understanding how to prompt social coaching to encourage children's social skills such as sharing, being respectful, waiting, asking, taking turns, etc. • Learning the "modeling principle"—by parents avoiding the use of critical statements and demands and substituting positive polite language, children learn more positive communication • Understanding how to coach sibling and peer play using modeling, prompting and praise to encourage social skills • Understanding developmental stages of play • Learning how to apply coaching principles in other settings such as mealtimes, bath time, and grocery store trips	**Part 4: The Art of Praise and Encouragement**	• Labeling praise • "Give to get" principle—for adults and children • Attending to learning "process," not only end results • Modeling self-praise • Resistance to praise—the difficulties giving and accepting praise • Promoting positive self-talk • Using specific encouraging statements versus nonspecific • Gaining and giving support through praise • Avoiding praising only perfection • Recognizing social and self-regulation skills that need praise • Building children's self-esteem through praise and encouragement

Table 2 Continued: Content and Objectives of the Incredible Years® Parents and Toddlers Program			
Content	Objectives	Content	Objectives
Toddler Program: 1—3 Years			
Part 5: Spontaneous Incentives for Toddlers	• Shaping behaviors in the direction you want—"small steps" • Clearly identifying positive behavior • Rewards are a temporary measure leading to child's learning a new behavior • What will reinforce one child will not necessarily reinforce another • Value of unexpected and spontaneous rewards • Recognizing the "first-then" principle • Designing programs that are realistic and developmentally appropriate • Understanding how to set up programs for problems such as not dressing, non-compliance, picky eating, difficulty going to bed, toilet training and rough animal care • Importance of reinforcing oneself, teachers, and others	**Part 6: Handling Separations and Reunions**	• Establishing clear and predictable routines for separating from children • Establishing routines for greeting children after being away from them • Understanding object and person permanence • Providing adequate monitoring at all times • Understanding how peek-a-boo games help children • Understanding how predictable routines for bedtime and schedules help children feel secure and safe • Completing the toddler-proofing home safety checklist
Part 7: Positive Discipline—Effective Limit Setting	• Reduce number of commands to only necessary commands • Learning about the importance of distractions and redirections • Understanding the value of giving children some choice • Politeness principle and modeling respect • Clear and predictable household rules offer children safety and reduce misbehaviors • "Monitoring Principle": Understanding the importance of constant monitoring & supervision for toddlers • All children will test rules—don't take it personally • Commands should be clear, brief, respectful, and action oriented • "When-then" commands can be effective • Distractible children need warnings and reminders	**Part 8: Positive Discipline—Handling Misbehavior**	• Understanding how to use distractions and redirections coupled with ignore • Parents maintaining self-control using calm-down strategies and positive self-talk • Repeated learning trials—negative behavior is a signal child needs some new learning • Using the ignore technique consistently and appropriately for selected behaviors such as whining, tantrums • Knowing how to help toddlers practice calming down • Know how to handle children who hit or bite • Understanding the importance of parents finding support

Table 3: Content and Objectives of the Incredible Years Early Childhood BASIC Parent Training Programs (Ages 3–6)			
Content	Objectives	Content	Objectives
Program One: Strengthening Children's Social Skills, Emotional Regulation and School Readiness Skills			
Part 1: Child-Directed Play	• Recognizing children's capabilities and needs • Adjusting to children's temperament and activity level • Building children's self-esteem and self-concept • Learning about normal developmental milestones • Avoiding the criticism trap • Understanding the importance of adult attention to promote positive child behaviors - "Attention Principle" • Building a positive relationship through child-directed play	**Part 2: Academic and Persistence Coaching**	• Descriptive commenting promotes children's language skills and builds children's self-confidence and frustration tolerance • Academic coaching increases children's school readiness • Using "persistence coaching" to strengthen children's ability to be focussed, calm and persist with an activity • Learning how to coach preschool reading skills • The "modeling principle"—by parents avoiding the use of critical statements and demands and substituting positive polite language, children model and learn more positive communication and to be respectful • Understanding children's developmental drive for independence
Part 3: Social and Emotion Coaching	• Using emotion coaching to promote children's emotional literacy • Combining persistence coaching with emotion coaching to strengthen child's self-regulation skills • Learning how to prompt and model emotion language • Social coaching, one-on-one, builds child's social skills (e.g., sharing, taking turns) • Knowing how to engage in fantasy play to promote social skills and perspective taking • Helping parents understand how they can coach several children in positive peer interactions • Understanding how to model, prompt, and praise social skills • Understanding developmental stages of play • Learning how to apply coaching principles in other settings (e.g., meal times, grocery store trips, bath times, etc.,)		

Table 3 Continued			
Content	Objectives	Content	Objectives
Program Two: Using Praise and Incentives to Encourage Cooperative Behavior			
Part 1: The Art of Effective Praise & Encouragement	• Labeling praise • Give to Get" principle—for adults and children • Modeling self-praise • Resistance to praise—the difficulties from self and others to accept praise • Promoting positive self-talk • Using specific encouraging statements versus nonspecific • Getting and giving support through praise • Avoiding praising only perfection • Recognizing social and academic behaviors that need praise • Building children's self-esteem through praise and encouragement • Understanding "proximal praise" and "differential attention"	**Part 2: Motivating Children Through Incentives**	• Understanding value of spontaneous rewards & celebrations • Understanding the difference between rewards and bribes • Recognizing when to use the "first-then" principle • Understanding how to "shape" behaviors • Providing ways to set up sticker and chart systems with children • Understanding how to develop incentive programs that are developmentally appropriate • Understanding ways to use tangible rewards for problems such as dawdling, not dressing, noncompliance, fighting with siblings, picky eating, messy rooms, not going to bed, and toilet training • Importance of reinforcing/refueling oneself and others
Program Three: Effective Limit Setting			
Part 1: Rules, Responsibilities and Routines	• Importance of routines and predictable schedules for children • Clear and predictable household rules offer children safety and reduce misbehaviors • Establishing clear and predictable routines for separating from children and greeting them, going to bed and morning routines • Starting children learning about family responsibilities • Helping children learn family household rules	**Part 2: Effective Limit Setting**	• Identifying important household rules • Understanding ways to give more effective commands • Avoiding unnecessary commands • Avoiding unclear, vague and negative commands • Providing children with positive alternatives/choices • Understanding when to use the "when-then" command • Recognizing the importance of warnings, reminders and redirection • When possible, give children transition time • "Politeness Principle" • Praise children's compliance to commands

Table 3 Continued			
Content	Objectives	Content	Objectives
Program Four: Handling Misbehavior			
Part 1: Limit Setting and Follow Through	• Understand the importance of distractions coupled with ignore • Understand the importance of consistency and follow through by parents • Maintain self-control and use calm down strategies • Understanding that testing is normal behavior • Use ignore technique consistently and avoid arguing about limits	**Part 2: Avoiding and Ignoring Misbehavior**	• Understanding how to effectively ignore • Understanding concept of "Selective Attention" and "Attention Principle" • Repeated learning trials—negative behavior is a sign child needs some new learning opportunities • Identifying appropriate behavior to ignore • Keep filling up bank account with play, coaching, praise and incentives • Practicing self-control and calm down strategies
Part 3: Time Out to Calm Down	• Learning how to teach children calm down strategies • Explaining Time Out to a preschool-age child • Using Time Out respectfully and selectively for destructive behavior or severely oppositional children • Following through when a child resists Time Out • Helping victim of aggressive act • Continuing to strengthen prosocial behaviors (positive opposite) • Parents practicing positive self-talk and anger management strategies	**Part 4: Other Consequences**	• Learning about developmentally appropriate logical consequences • Understanding the importance of new learning trials • Understanding the importance of brief, immediate consequences • Avoiding power struggles that reinforce misbehavior through lack of follow through • Determining age appropriate natural and logical consequences
Part 5: Teaching Children to Problems Solve Through Stories and Games	• Understanding that games and stories can be used to help children begin to learn problem-solving skills • Appreciating the developmental nature of children's ability to problem solve • Strengthening a child's beginning empathy skills or ability to understand a problem from another person's point of view • Recognizing why aggressive and shy children need to learn these skills • Learning how to help children think about the emotional and behavioral consequences to proposed solutions • Understanding the importance of validating children's feelings • Learning to model problem solving for children		

Table 6: Content and Objectives of the Incredible Years School-Age BASIC Parent Training Programs (Ages 6-12)			
Content	Objectives	Content	Objectives
Program Nine: Promoting Positive Behaviors in School-Age Children			
Part 1: The Importance of Parental Attention and Special Time	• Understanding how to build a positive relationship with children. • Helping children develop imaginative and creative play. • Building children's self-esteem and self-confidence through supportive parental attention. • Understanding the importance of adult attention for promoting positive child behaviors. • Understanding how lack of attention and interest can lead to child misbehaviors.	**Part 2: Social, Emotion, and Persistence Coaching**	• Understanding how to use academic and persistence coaching to encourage children's persistence and focus • Learning to use emotion coaching to build emotional literacy • Learning to use social coaching to encourage social skills such as being respectful, sharing, cooperating, and being a good team member.
Part 3: Effective Praise and Encouragement	• Knowing how to use praise more effectively. • Avoiding praising only perfection. • Recognizing common traps. • Knowing how to deal with children who reject praise. • Recognizing child behaviors that need praise. • Understanding the effects of social rewards on children. • Doubling the impact of praise. • Building children's self-esteem and self-concept.	**Part 4: Tangible Rewards**	• Understanding the difference between rewards and bribes. • Recognizing when to use the "first-then" rule. • Understanding how to set up star and point systems to motivate children. • Understanding how to design programs that are age-appropriate. • Understanding ways to use tangible rewards for problems such as dawdling, noncompliance, sibling fighting, messy room, not going to bed, and being home on time.

Table 6 Continued			
Content	Objectives	Content	Objectives
Program Ten: Reducing Inappropriate Behaviors in School-Age Children			
Part 1: Rules, Responsibilities, and Routines	• Politeness Principle • Understanding how to establish clear and predictable routines. • Strategies for encouraging children to be responsible. • Understanding the importance of household chores. • Making sure household rules are clear.	**Part 2: Clear and Respectful Limit Setting**	• The importance of household rules. • Guidelines for giving effective commands. • How to avoid using unnecessary commands. • Identifying unclear, vague, and negative commands. • Providing children with positive alternatives. • Using "when/then" commands effectively. • The importance of warnings, reminders, and giving choices.
Part 3: Ignoring Misbehavior	• Dealing effectively with children who test the limits. • Knowing when to divert and distract children. • Avoiding arguments and "why games." • Understanding why it is important to ignore children's inappropriate responses. • Following through with commands effectively. • Recognizing how to help children be more compliant.	**Part 4: Time Out Consequences**	• Guidelines for implementing Time Out for noncompliance, hitting and destructive behaviors. • How to explain Time Out to children. • Avoiding power struggles. • Techniques for dealing with children who refuse to go to Time Out or won't stay in Time Out. • Teaching children how to calm down. • Understanding the importance of strengthening positive behaviors.
Part 5: Logical and Natural Consequences	• Guidelines for avoiding power struggles. • Recognizing when to use logical consequences, privilege removal, or start up commands. • Understanding what to do when discipline doesn't seem to work. • Recognizing when to ignore children's inappropriate responses and how to avoid power struggles. • Understanding how natural and logical consequences increase children's sense of responsibility. • Understanding when to use work chores with children. • Understanding the importance of parental monitoring at all ages.		

Table 6 Continued			
Content	Objectives	Content	Objectives
Program Eight: How to Support Your Child's Education			
Part 1: Promoting Reading Skills	• Providing positive support for children's reading. • Building children's self-esteem and self-confidence in their learning ability. • Making reading enjoyable. • Fostering children's reading skills and story telling through "interactive dialogue," praise, and open-ended questions.	**Part 2: Dealing with Children's Discouragement**	• Helping children avoid a sense of failure when they can't do something. • Recognizing the importance of children learning according to their developmental ability and learning style. • Understanding how to build on children's strengths. • Knowing how to set up tangible reward programs to help motivate children in difficult areas. • Understanding how to motivate children through praise and encouragement.
Part 3: Fostering Good Learning Habits and Routines	• Setting up a predictable daily learning routine for academic activities. • Understanding how television and computer games interfere with learning. • Incorporating effective limit-setting regarding homework. • Understanding how to follow through with limits. • Understanding the importance of parental monitoring. • Avoiding the criticism trap.	**Part 4: Parents Showing Interest in School**	• Understanding the importance of parental attention, praise, and encouragement for what children learn in school. • Recognizing that every child learns different skills at different rates according to their developmental ability. • Understanding how to build on children's strengths. • Understanding how to show "active interest" in children's learning at home and at school. • Understanding the importance of working with your child's teacher. • Understanding the importance of parental advocacy for their children in school.

Getting Started with Learning the Incredible Years® Parent Programs

After you have completed your Agency Readiness Questionnaire, determined that you are ready to adopt the Incredible Years® Programs, and secured your funding, you can get started learning the programs. The following checklist will help group leaders/therapists know what to do to set up a self-study training regime for learning the program, either before accessing training or as a guide following training before you begin groups.

- **Agency administrators may contact IY to receive an administrator's packet.**

Materials Needed:

- Leader's Manual, book for parents, DVDs, and parent handouts for doing Basic Parent Program*
- Set of Sample Parent Group Session DVDs**
  Limit Setting, Ignoring, Problem Solving, and Time Out sample groups
- Download Articles from Web Site
- Collaborative Process Checklists (in manual)
- Incredible Years® Parent Training Workshop DVDs***

* Includes everything you need to deliver the programs (parent books ordered separately)
** These "how to" DVDs show therapists and group leaders actually delivering the parent groups. They are very helpful for self-study and learning the collaborative process of leading the groups.
*** DVD of therapeutic training workshop led by Dr. Webster-Stratton

Step #1: Schedule Training Workshops	Contact Incredible Years (IY) to plan your training needs. On-site workshops need to be planned 6-9 months in advance. Workshops in Seattle are offered 3+ times a year. IY staff will help answer questions and tailor the type of training according to your needs and the program you have chosen to implement.
Step #2: Obtain IY Materials and Start Self-directed Peer Group Study	As soon as you have the materials you can set up your self-study program. You do not need to wait for a workshop to get started learning these programs. In fact, if you have prepared ahead of time and are familiar with the materials you will get more out of the training workshop.

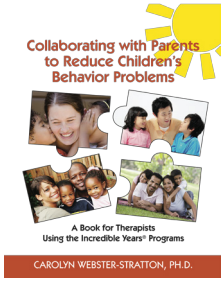
On-going Self-Study Peer Group Study involves the following:

_____ Set up weekly self-study meetings with co-leader and other staff who will be involved in delivering the IY parent program.

(continued on back)

____ Review the leader manual introductory materials and start planning for some of the logistics for how you will advertise your parent program, recruit families, arrange day care, and select a comfortable room for your groups. (See checklist in parent leader's manual.)

____ Read overview chapters
Parent Group Leaders read chapter 8 & 9 in *"Collaborating with Parents to Reduce Children's Behavior Problems"* book (available from IY)
Chapter 8 titled - "Working with Parents of Children who Have Conduct Disorders: A Collaborative Process using Theory Driven Principles", and
Chapter 9 titled: "Therapist Roles in Facilitating the Collaborative Learning Process."



____ View the sample DVDs (1 of 4) of actual parent group sessions in your self-study meeting (Limit Setting). This will give you an idea of how the group operates, the leader's role and how the video vignettes are used to trigger discussion, problem solving and practical exercises.
Note: Only view one of these DVDs at this point.

____ Start with the first program in the series "Play Part 1" and follow the leader manual with the accompanying DVDs. If you are doing this in a group, take turns leading the group (others pretend to be parents), showing the vignettes and asking questions.

____ At each meeting select the next program section to study.
Choosing a different person to be prepared to lead and present specified vignettes each week can be helpful.

____ To prepare for each meeting, read the accompanying chapter in *The Incredible Years* parent book. Eg., before reviewing "Play Part 1", read the chapter on Play in *The Incredible Years* parent book (or listen to it on CD).

____ At your self-study meetings practice being leader with others taking the role of parents to try out vignettes, questions and role plays practices. This will give you experience and more comfort with the materials.

Step #3: Start a Pilot Group

____ Begin a pilot parent group.
____ Continue to meet in your peer review group to consult with each other about progress and to get feedback on your group.
____ Video your parent group session for self-study. Use the *Collaborative Group Process Checklist* when you view your video.
____ Choose segment of your video of your group for peer review.

Step #4: View Sample Group Session DVDs

____ After you have done some of your own sessions, viewing the sample tapes will be helpful in giving you new ideas about group process, pulling out "principles," doing brainstorms and setting up play role practices.

____ It can be useful to view each of the following tapes prior to offering the related topic to your group:

- Limit Setting Sample Group DVD (Disc 1)
- Ignoring Sample DVD (Disc 2)
- Time Out Sample DVD (Disc 3)
- Problem Solving Sample DVD (Disc 4)

____ If you are working with interpreters and non-English speaking parents we recommend you view the following two DVDs:

- Play and Praise Sample Group DVD
- Incentives and Ignoring Sample DVD

Step #5: Attend Training

At some point during these steps you will attend your training. This may be delivered at your site or in Seattle. The more you understand the program ahead of time, the more you will get out of the training.

Note: IY Group Leader workshops must be delivered by accredited IY mentors or trainers.

Step #6: Obtain Consultation and Supervision

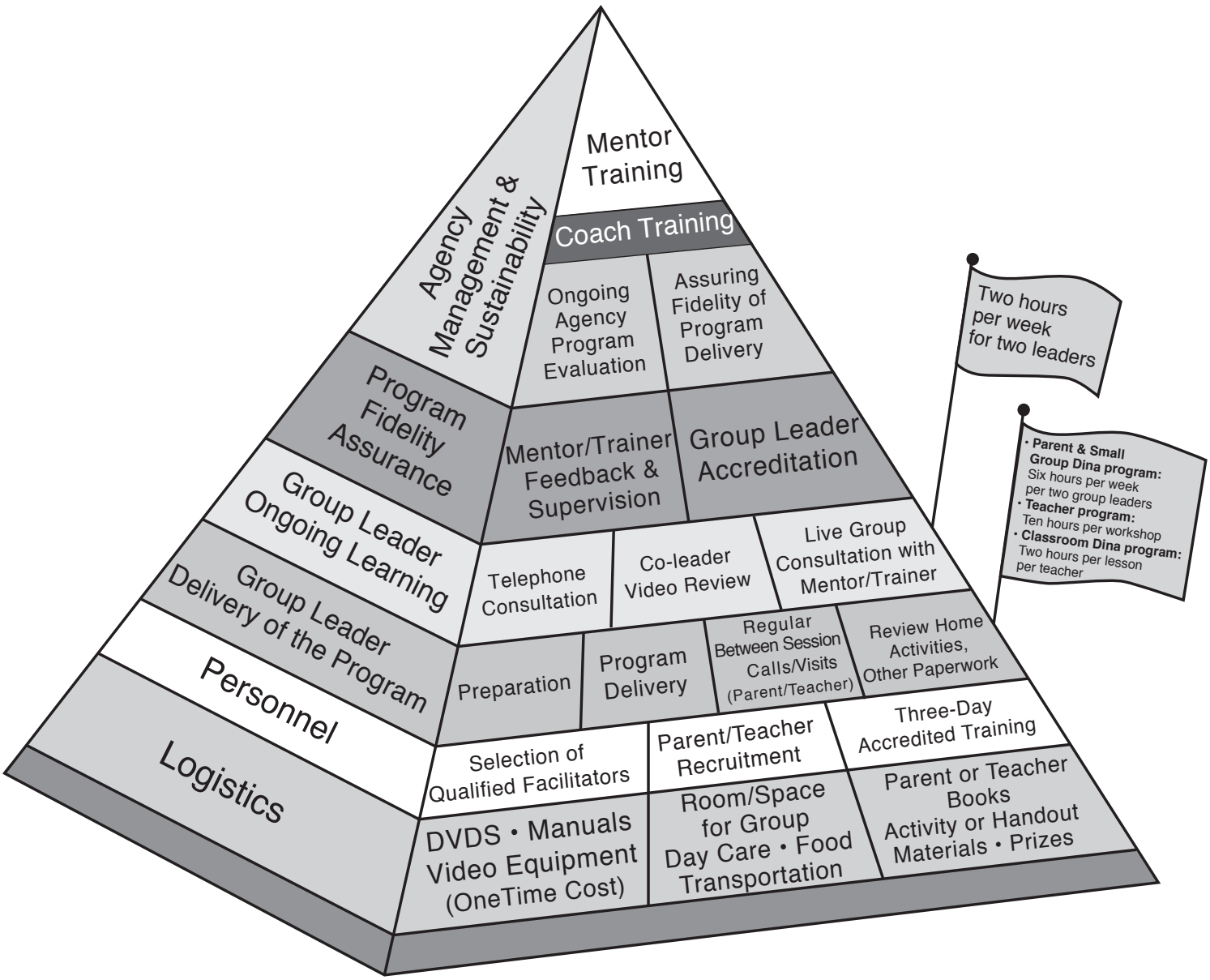
Once you have started doing groups and have done some self-evaluations of your group DVDs or video files using the *Collaborative Group Process Checklist,* you may request telephone consultation from an IY mentor or trainer. This consultation may include asking questions about your group's specific vision, planning & tailoring vignettes for parent's needs, how to set up role play practices, dealing with resistance, and feedback on one of your DVDs of your group.

Consultation Workshops given by IY trainers may be requested by your agency or may be obtained in Seattle. These involve small groups (10-14) of therapists sharing their DVDs for feedback and support.

Step #7: Review Training Workshop DVDs.

These 8 DVDs show Dr. Webster-Stratton delivering the BASIC parent leader training to new group leaders. These offer group leaders the opportunity to review their training and go back to view how the program developer models collaboration, mediates vignettes, uses coaching strategies, and sets up practices and buzzes.

Step #8: Become Certified/Accredited. See certification information on web site.



IY Implementation Pyramid:
Assuring Fidelity of Program Delivery

The Incredible Years®

A Note About the Use of Manual-Based Treatments

Critics of manual-based psychotherapies or treatments assume that manuals are rigid, inflexible, and offer little individual client or group leader variation. But just as a chef improvises and adapts recipes to create exciting, original meals, the experienced group leader will adapt a manualized intervention with sensitivity to the group's needs.

Although the Incredible Years® Parenting Program is a structured therapeutic program with detailed manuals, session protocols, home assignments, and handouts, its ultimate success is dependent on a skilled leader who tailors it to the families' individual needs. **Therapeutic principles can be manualized, but individualized, culturally sensitive, and empathic treatment cannot.** A high degree of clinical sophistication is a necessary requirement for successful delivery of this intervention. Attending certified training workshops, arranging ongoing supervision from IY mentors and trainers, and peer review and becoming certified/accredited as a group leader will enhance the leader's broader understanding of the treatment as a whole and how to implement it in a flexible, individual way.

A key element of this intervention is the collaborative leadership style of the group leader. This collaborative approach ensures that the parents "own" the material because the basic principles have been drawn from them by the skilled leader. See Parts 3 and 4 of the introduction for more information about the collaborative style as well as the book *Collaborating wtih Parents to Reduce Children's Behavior Problems* by Carolyn Webster-Stratton, Incredible Years Press (2012).

Tips About Using the Manual

Tip #1

Don't be too manual dependent by focusing on reading questions, thereby avoiding eye contact with parents when asking questions (glance down briefly). The questions are meant to be guides to facilitate group discussion about the vignettes and principles. In general, you can start with an open-ended question such as, "What do you think of that father's approach?" or, "How do you think the child (or father) felt in that instance?" Then listen carefully and try to follow the parents' lead and pull out key principles.

Tip #2

It is not necessary to ask all the questions in the manual. If the points raised in the questions have already been discussed with your first open-ended question or in a prior discussion of a vignette, move on to the next vignette or follow-up on a different important point that may have been initiated by a parent.

Tip #3

Each part in a media program is not meant to be covered in an entire two-hour session! In general 8-10 vignettes may be covered in a two-hour session. Pace yourself according to the parents' difficulty or familiarity with the material and the group's talkativeness. Sometimes a particular concept is new to a group (e.g. social and emotion coaching) and it may take three sessions to cover the material.

The checklists in Part 5 give suggestions for how to break up vignettes into 18 sessions for programs one through four. Sessions 19 and 20 are optional and are from the Advance Program. Those marked with an asterisk reflect vignettes that were used in study with children diagnosed with ADHD (ages 3–6). This does not mean you should omit the other vignettes with younger children because often they present key principles. Choose vignettes according to parents learning needs as well as vignettes which reflect the ethnicity of group members and nature of children's problems.

Tip #4

Do not change the order of the program. It is essential that programs one and two, Promoting Positive Behaviors, be covered first before programs three and four, Handling Misbehavior. Program 8, Supporting Your Child's Education, is shown after programs one through four. It is recommended that the Advance Program be offered next.

Tip #5

Do not try to do the entire BASIC series in fewer than 18, two-hour sessions for high risk populations and diagnosed children. If you need to cut down the number of sessions we suggest you just show programs one and two in an eight or nine session series. Later, the same parents could be offered programs three and four in another eight or nine session series (make completing programs one and two a prerequisite for attending programs three and four). A somewhat shorter prevention version of the program (14 sessions) may be used for lower risk populations. This would consist of omitting one of the academic and persistence coaching sessions and one of the social and emotional sessions. Additionally, the final three sessions on problem solving would be omitted. Whenever possible, try to follow the entire session series.

Tip #6

Tailor your handouts to the material you cover in a session. You may tailor the handouts by telling parents which aspects of the home activities need to be done that week and then the following week indicate the additional parts to be completed. Handouts with a Part A refers to the first handout given out in a topic and Part B to the second handout for the same topic given out at the subsequent session. A blank handout is provided in case you get behind and need to tailor the home activity according to material covered in that session.

Tip #7

Discuss and review home practice activities each week. Open each session with a discussion of how the week went and how parents managed the home practice activities. The comments and reactions of parents trying new strategies will lead to easy and relevant role plays and key discussions.

Tip #8

Use weekly parent evaluations to tailor therapeutic group methods and content to parents' needs on an ongoing basis. Whenever a parent indicates a neutral or negative rating on one of the evaluation scales (group discussion, leadership skills, content of program, or use of videotape), call the parent and talk about how you will address this issue to make the program more meaningful for them. Periodically talk to the entire group about how you are using the evaluations to tailor the program to everyone's learning needs.

Please Note:

If you are planning to use any of the Incredible Years® programs as part of a research grant we strongly recommend your leaders become certified as group leaders and that one of our certified trainers is involved in training your staff and providing ongoing consultation. We ask that you let us know about research projects and send us copies of the research results.

Part 1

Overview to Parents and Children Programs

1. Program History
2. Theoretical Assumptions
3. Ultimate Outcomes Expected and Short-term Objectives
4. Targeted Populations
5. Program Format and Content
6. Training Methods and Therapeutic Processes
7. Group Leaders
8. Program Evaluation

The Incredible Years®: Parents, Teachers and Children DVD Series

by Carolyn Webster-Stratton, Ph.D.

Program History and Rationale

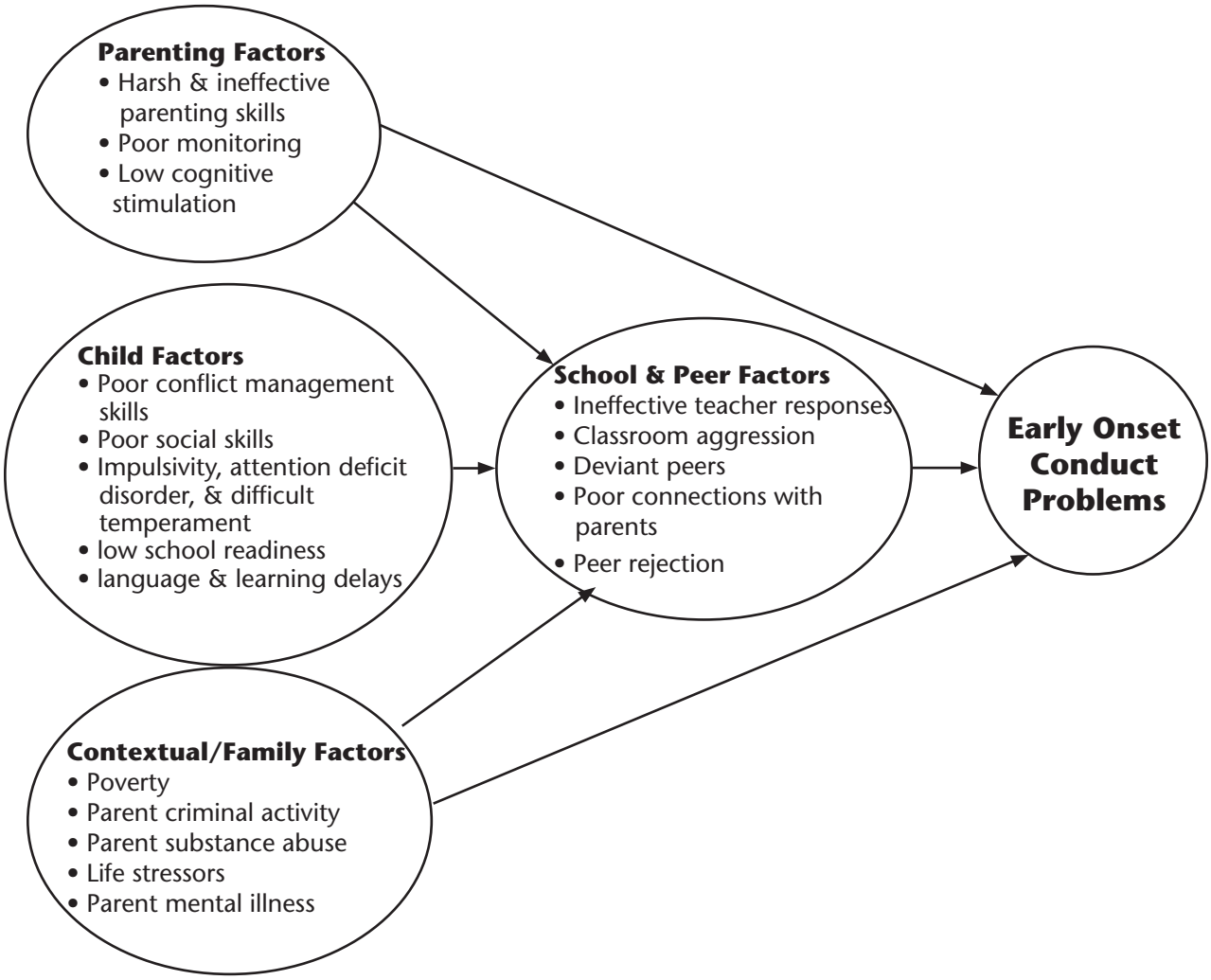
The Problem: The incidence of aggression in children is escalating—and at younger ages (Hawkins, Catalano, & Miller, 1992). Studies indicate that anywhere from 7-20 % of preschool and early school age children meet the diagnostic criteria for Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). These rates may be as high as 35% for very low-income families (Webster-Stratton, 1998; Webster-Stratton & Hammond, 1998). Research on the treatment and prevention of conduct disorders has been identified as one of the nation's highest priorities (NIMH, 1996). This agenda is vitally important because of the widespread occurrence of delinquency and escalating adolescent violence with its resulting high cost to society (Kazdin, 1985). Emergence of "early onset" ODD/CD in preschool children (in the form of high rates of oppositional defiance and aggressive and non-compliant behaviors) is stable over time and appears to be the single most important behavioral risk factor for antisocial behavior for boys and girls in adolescence (Loeber, 1991). Such behavior has repeatedly been found to predict the development of drug abuse in adolescence (Brook, Whiteman, Gordon, & Cohen, 1986; Dishion & Ray, 1991) as well as other problems such as juvenile delinquency, depression, violent behavior, and school dropout (Kazdin, 1985). Moreover, since conduct disorder becomes increasingly resistant to change over time, intervention that begins in the early school years is clearly a strategic way to prevent substance abuse, delinquency and mental illness in adolescence.

> **Unfortunately, recent projections suggest that fewer than 10% of the children who need mental health services for ODD/CD actually receive them (Hobbs, 1982). Less than half of those receive "empirically validated" interventions (Chambless & Hollon, 1998).**

Populations "At Risk": Children from low-income, low education, highly stressed or isolated families, single-parent families, and families where there is considerable discord, maternal depression, or drug abuse are at particularly high risk for developing conduct disorder (CD) (Webster-Stratton, 1990). Children whose parents' discipline approaches are inconsistent, physically abusive, or critical are also at high risk for CD (Ogbu, 1978) as are children whose parents are disengaged and uninvolved in their children's school experiences. Children whose teachers' classroom management strategies are critical, emotionally distant, and lacking in clear rules and teaching in social skills and conflict management are more likely to become aggressive. Moreover, children who are temperamentally more impulsive, inattentive, and hyperactive are more likely to receive less encouragement and support and more punishment from teachers and to experience more peer rejection and social isolation at school (Field, 1991; Rutter, Tizard, Yule, Graham, & Whitmore, 1976; Walker & Buckley, 1973). Such responses on the part of teachers and peers increase children's risk for developing conduct disorders. Furthermore, the risk of conduct disorder seems to increase exponentially with the child's exposure to each additional risk factor (Coie et al., 1993; Rutter, 1980).

In sum, there are multiple risk factors contributing to the development of CD in children and to the subsequent development of drug abuse. Nonetheless, it is evident from the research that there are no clear-cut causal links between single factors and the child's behavior. Most of these factors

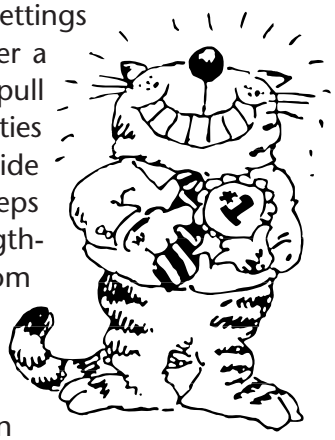
Risk Factors Related to Conduct Problems



are intertwined, synergistic, and cumulative. Multiple risk factors result in an unfolding cycle of events over time with cumulative effects on a child's vulnerability (Rutter, 1980). Consequently, prevention programs need to target multiple risk factors at strategic time points, particularly those that offer potential for change. Enhancing protective factors such as positive parenting and teaching skills, parent involvement with schools as well as other support systems and interventions that strengthen children's social competence and school readiness will help buffer against the development of conduct problems.

Rationale for School-Based Programs: There are three important reasons for including parents, teachers and schools as partners in developing early school-based intervention programs designed to prevent the development of conduct problems and eventual drug abuse. First, offering this training to parents in schools will be less stigmatizing than a clinic setting, and will make programs more available to parents of children from different cultural and socioeconomic backgrounds. Moreover, a related advantage is the sheer number of high-risk children and families that can be identified and offered additional support services in this non-stigmatizing setting. Schools hold the potential for providing one of the most efficient and effective service delivery methods for gaining access to large numbers of high risk families with children who can benefit from early intervention. Schools are ideally positioned to provide both parent and classroom interventions.

Secondly, interventions offered in schools that promote collaboration between teachers and parents offer a greater chance of increasing consistency of approaches across settings (from home to school) and the possibility of sustained effects. Moreover a classroom-wide intervention (teacher and child training) is preferable to "pull out" programs for high risk students because there are increased opportunities for more prosocial children to model appropriate social skills and to provide the entire classroom with a common vocabulary and problem-solving steps to use in resolving every day conflicts. Thus social competence is strengthened for the lower-risk as well as the aggressive children and the classroom environment generally fosters appropriate social skills on an ongoing basis. Additionally, with a classroom-based model, while formal social skills training may consist of two to three sessions each week, teachers can provide informal reinforcement of the key concepts throughout the day as children encounter real problems. Thus, the dosage of intervention is greatly magnified. We conclude that school-based interventions offer an opportunity for more accessible child, teacher and parent preventive interventions that coordinate the efforts of families and school personnel to help children who are at high risk for developing CD.



A third reason for emphasizing the importance of training teachers and school personnel (i.e., school psychologists and nurses) to deliver the parenting and classroom interventions is the variability in levels of training of staff and in the quality of parenting and classroom curriculums currently being offered. Many teachers and school counselors have had little formal training as parent educators or conducting groups or in parent counseling techniques. Classroom teachers often have little training in behavior management strategies and social skills curricula. The importance of teacher training is emphasized by the clear consensus among child development experts that the essence of successful early school years resides in the quality of the child-teacher relationship and the abilities of teachers to provide a positive, consistent and responsive environment. In a recent national survey, Phillips et al. (Phillips, Voran, Kisker, Howes, & Whitebrook, 1994) reported that teachers serving predominately low-income children used significantly more "harsh," "detached," and "insensitive" behaviors with children than teachers serving middle- and upper-income children. Sadly, consistent and positive classroom experiences may be the least available for the children who are most at risk. Training teachers and school personnel in the effective delivery of empirically validated parenting and classroom social skills programs will enhance the quality of services that teachers and school personnel deliver.

Finally, Gerald R. Patterson's theoretical work on childhood aggression strongly influenced the development of this series of parent and teacher training programs (Patterson, 1982). Patterson's social learning model emphasizes the importance of the family and teacher socialization processes, especially those affecting young children. His "coercion hypothesis" states that negative reinforcement develops and maintains children's deviant behaviors and the parents' and teachers' critical or coercive behaviors. The parents' or teachers' behaviors must therefore be changed so that the children's social interactions can be altered. If parents and teachers can learn to deal with children's misbehavior and to model positive and appropriate problem-solving and discipline strategies, the children can develop social competence and reduce aggressive behavior at home and at school.

Rationale for Parent Programs in Multiple Settings: The parenting programs may be offered in a variety of settings such as churches, mental health centers, pediatricians' offices, businesses, boys and girls clubs, sports clubs and health maintenance centers. In these settings parent groups can be supportive and ongoing, addressing the evolving challenges of parenting.

Theoretical Assumptions

The course is based on well-established behavioral/social-learning principles that describe how behaviors are learned and how they can be changed. At the core of this approach is the simple idea that people change as a result of the interactions they have on a daily basis with one another. One of the implications of this focus on interpersonal interactions is that, when children misbehave and families become disrupted, it is necessary to change the parents' behavior as well as the child's. This approach does not assume that the child is at fault (that is, he or she is a "bad egg"), or that the parent is inept. Rather, the emphasis is placed on helping parents' interactions with their children become more positive and on changing parents' responses to specific child behaviors.

The Incredible Years: Parent, Teacher & Child Training Series has been extensively researched and field-tested with over 2000 families, including normal children and children with conduct problems. The data from nine randomized studies involving clinic families (with children that have conduct problems) and non-clinic families indicate that parents who have taken the course are able to significantly reduce children's behavior problems and increase prosocial behaviors. Moreover, parents report that they feel more confident and comfortable about their parenting skills after completing the course. In addition, one- and three-year follow-up assessments have indicated that more than two-thirds of the clinic-referred families have continued to maintain positive parent-child interactions and normal child behavior. Thus, the cycle of aggression and abuse appears to have been halted for the majority of treated families whose children once exhibited conduct problems. The data from all the studies suggest that parent-training discussion groups that include the Parents and Children video vignettes are a highly effective and cost-efficient method for improving parent-child relationships and reducing young children's conduct problems.

Ultimate Outcomes Expected and Short-term Objectives

Longitudinal research has consistently shown that young aggressive or conduct-problem children are at high risk for mental illness, delinquency, depression, spouse and child abuse, adjustment problems and drug and alcohol abuse as adolescents and adults. In addition, their parents are at high risk for abusing these difficult children. The long-range goals of these programs are twofold:

First—to improve the poor long-term prognosis for children with conduct problems by identifying, intervening with and supporting families of young children with conduct problems;

Second—to develop a cost-effective prevention program which could be utilized by families of young children to prevent serious childhood conduct problems from developing in the first place.

The short-term goals of the series are to:

Promote child competencies:

- Increase children's social skills and emotional language.
- Increase children's problem-solving skills and effective anger management strategies.
- Decrease children's negative attributions and increase empathy skills.
- Decrease children's aggressive behavior and related conduct problems such as noncompliance, peer bullying and rejection, stealing and lying.
- Increase children's on-task school behaviors, reading skills and academic competence.

Promote parent competencies and strengthen families:

- Increase parents' positive relationships and bonding with their children through child-directed play and special time together.
- Increase parents' understanding of temperament, normal developmental landmarks and encourage developmentally appropriate expectations.
- Increase parents' positive communication skills, such as the use of coaching skills, praise and positive feedback to children, and reduce the use of criticism and unnecessary commands.
- Improve parents' limit-setting skills by replacing physical punishment with nonviolent discipline techniques and by promoting positive strategies such as ignoring the child's misbehavior, imposing logical consequences, providing redirection, and developing problem-solving and empathy skills.
- Improve parents' understanding of how to set up predictable routines, promote children's responsible behavior and successfully monitor their children's behavior.
- Improve parents' problem-solving skills and anger management.
- Increase family support networks and parents' involvement with schools.

Targeted Populations

The Preschool Basic Program is a practical and versatile program that can be used to teach effective child management skills to many different types of participants.

1. **All parents with children 3 to 6 years of age.** The series was originally designed to teach parents how to foster positive behaviors in their children and to give parents some effective techniques for dealing with common behavior problems. The series can be used as a preventive program that helps parents avoid behavior problems through early intervention.
2. **Parents of children with conduct problems and attention deficit disorder, 3 to 6 years of age.** The program has been extensively researched with over 2000 families with children with conduct problems. Our data indicate that the parents in these families were able to make significant improvements in their children's behavior after completing the course. The children in our studies displayed a wide variety of conduct problems including highly aggressive behaviors such as hitting and kicking; destructive acts; negative and defiant attitudes; whining, yelling, smart talk, and interrupting; and with high levels of noncompliance to parental requests. The program has not been researched with developmentally delayed, psychotic or autistic children. However, it is possible that the program could be adapted for use by parents of developmentally delayed children, and it may be reassuring for such parents to learn that all children, regardless of developmental status, exhibit similar aggressive and non-compliant behaviors at times.
3. **Parents at risk for abuse or neglect.** The program is suitable for parents who are at risk for abuse and neglect because of their own childhood abuse, or because of minimal social and economic support. It is also appropriate for parents who have been reported for child abuse. Parents of children who are highly aggressive and non-compliant have an increased risk of involvement with Child Protective Services for abuse or reporting feeling "out of control" when they discipline their children. Our research indicates that parents who participated in the BASIC parent training program were less likely to verbally attack or criticize their children and use physical punishment such as spanking and hitting compared with parents who did not participate in the program. The program was well received with over 85% of socioeconomically disadvanted parents attending greater than two-thirds of the sessions.
4. **Foster and adoptive parents.** The program is appropriate for foster and/or adoptive parents. Frequently these parents are caring for children who have behavior problems and who distrust adults. The program's focus on building a strong, positive relationship or bond between the parent and child is an important beginning step for these children to begin to trust their caregivers. In addition, the programs emphasis on predictable routines and positive discipline is especially relevant for the needs of these children.
5. **Teenagers taking baby-sitting classes or family life courses.** Parts of this program could be used to teach adolescents how to play and read with children and how to discipline appropriately. The program could also be an educational resource for groups of teenagers who are studying the normal growth and development of preschool children.
6. **Family therapists, social workers, child psychologists, teachers, nurses, physicians, Child Protective Service workers, and day care providers.** The program has been used to teach parenting skills to child care workers and other professionals who work with parents and children. It has also been used to illustrate play therapy skills as well as behavior management principles and cognitive problem-solving strategies in early childhood programs for teachers and psychology students.

The program has been researched and found effective with parents of all educational and socio-economic levels. The video vignettes show examples of mothers and fathers, who are of Caucasian, African American, Asian and Spanish cultural backgrounds.

Program Format and Content

The Preschool version of the BASIC parent training series is a 14–20 week program for parents, involving group discussion of a series of video vignettes. It is guided by cognitive social learning theory. The program teaches parents interactive play and reinforcement skills (Eyberg, Boggs, & Algina, 1995; Eyberg & Matarazzo, 1980; Hanf & Kling, 1973); nonviolent discipline techniques, including "time-out" and "ignore" (Forehand & McMahon, 1981; Patterson, 1982); logical and natural consequences; and problem-solving strategies (D'Zurilla & Nezu, 1982). The Advanced Parent Training Program that addresses other family risk factors such as depression, marital discord, poor coping skills, problem solving, and lack of support is recommended as a supplement to the BASIC program. It is recommended that the **School Readiness** or **Attentive Parenting** program also be shown in conjunction with the BASIC series if you want added emphasis on reading and school readiness skills. All of the training programs include video vignettes and parent group discussion facilitated by trained leaders.

Contents and Program Mechanics

The Preschool Basic parent training program materials include:

- **Nine DVDs** for the Preschool BASIC program.
- Comprehensive leader manuals for each program (consisting of over 800 pages of "how to" including leader questions for discussion, home activities, and interpretation of video vignettes).
- Parent weekly "refrigerator notes" (brief points to remember for the week).
- Parent assignments for home activities.
- Book for parents titled *The Incredible Years: A Trouble-Shooting Guide for Parents of Children Ages 2–8* (also available on CD in both English and Spanish).
- Refrigerator magnet.
- Parent Pyramid® poster. Pyramid shows how the programs build a positive foundation first with an emphasis on relationship skills before beginning to discuss discipline strategies.

The program uses multiple learning approaches: video modeling, group discussion and support, practice activities within sessions, home activities, reading assignments (or audio), self-monitoring checklists and goals, and leader teaching and support. The program is highly interactive, collaborative, and self-directed.

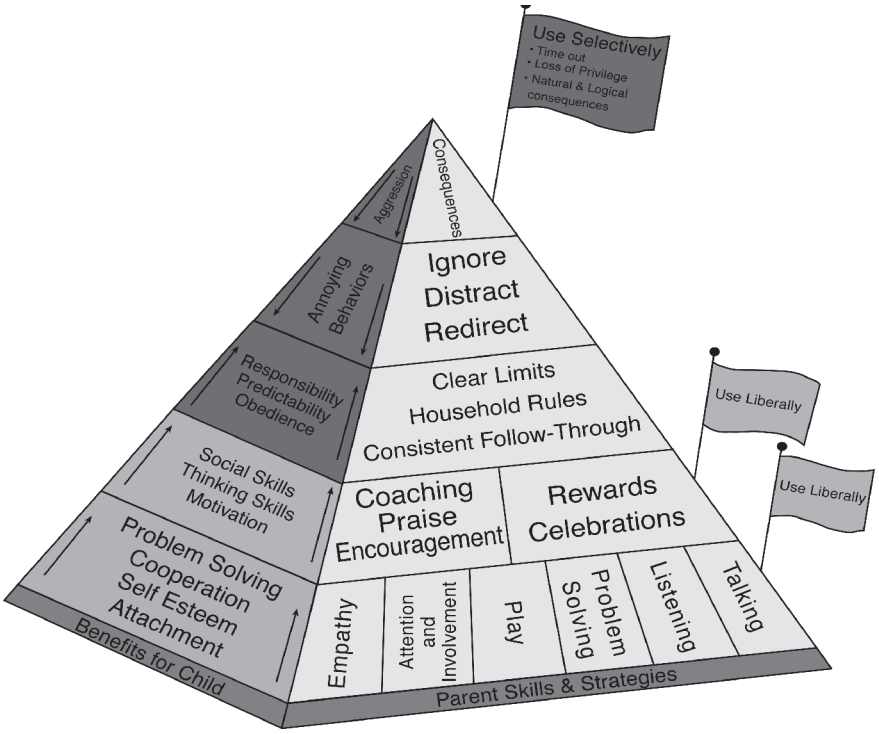
Note: There are also sample session "Experts in Action" DVDs showing group leaders facilitating active parent groups using this curriculum. These are very useful for group leaders' learning process.

There is also a home-based version of this program for parents who cannot attend the groups or who need additional coaching. See website for further details.

The Incredible Years®: Basic Preschool Parent Program (Program 1-4) (Ages 3-6)

Preschool Basic Parent Training Program. This program includes a leader's manual, participant's books, and nine DVDs divided into four programs/topics: Play, Praise and Rewards, Positive Discipline, and Handling Misbehavior. The leader's manual contains the video narration, an edited recap of each parent-child interaction, a concise statement of important points, discussion topics and questions, homework assignments, handouts, and a list of recommended readings. Brief video vignettes of parents interacting with children in family life situations illustrate child-rearing concepts. Group leaders use these scenes to facilitate group discussion and problem solving. Course participants quickly identify possible problems and learn effective alternatives by watching the examples. Participants discuss the principles of child-rearing and practice new skills through role-playing and home practice activities. The program can be offered for groups of 10 to 14 participants, and is covered in 14 to 20 two-hour sessions.

Each component within the full program builds on the previous one to ensure that participants learn the parent-child relationship skills outlined in the first two programs before moving to the cognitive behavior management approaches described later. Participants who have difficulty with



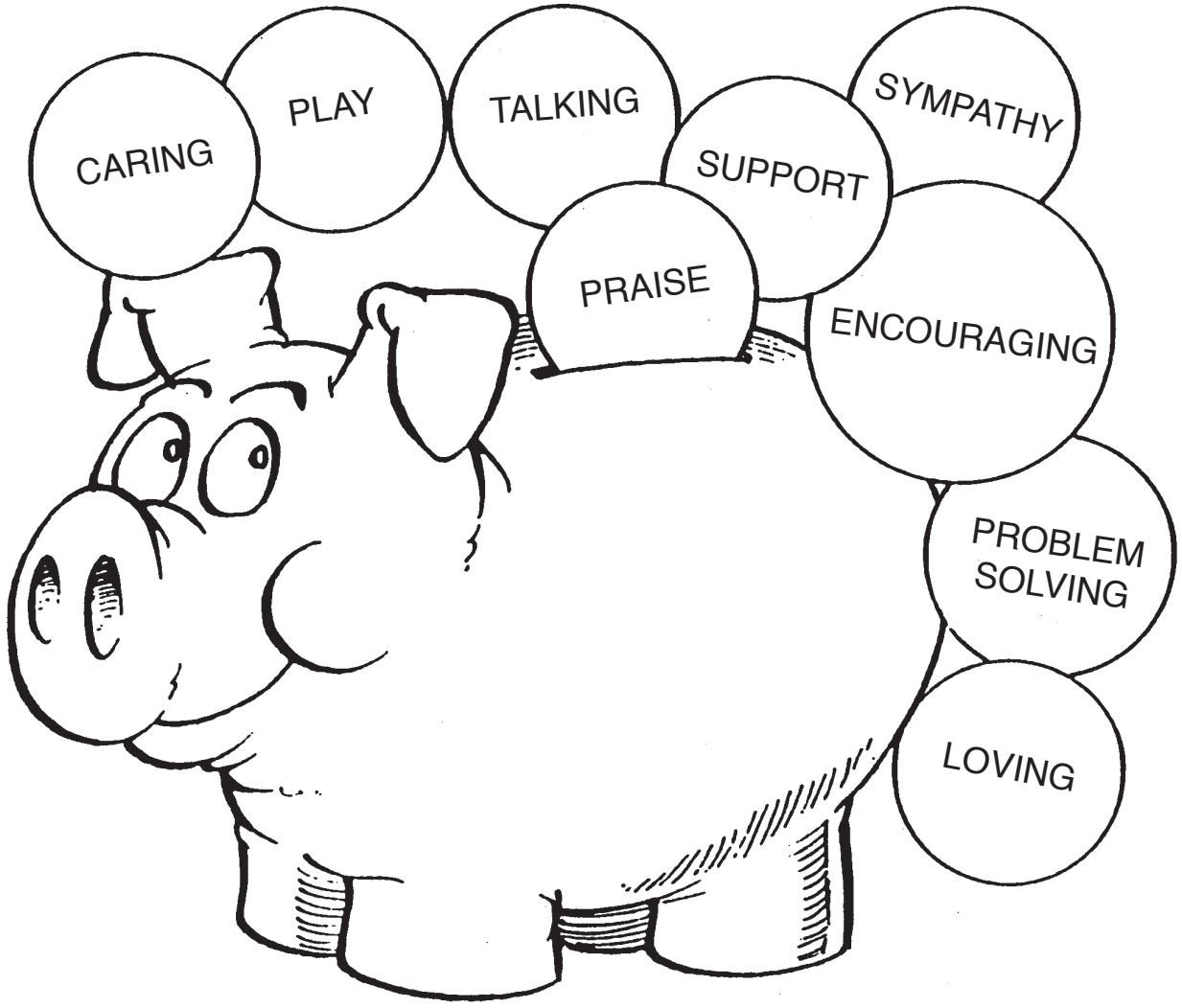
Parenting Pyramid®

material in a program can review additional vignettes and do more practice sessions before moving to subsequent programs. Although the content of this program is structured in presentation, the group leader should remain flexible in conducting the sessions. It usually takes nine two-hour sessions to complete the first two programs, but some groups may take longer. One group might discuss a vignette for 15 minutes, while another might spend little time with it. The group leader must therefore respond flexibly to the needs of the group. It is highly recommended that there be two leaders for each group, and even better to have a male and a female leader. On-site day care is provided for those parents who cannot arrange or afford baby-sitting.

It is critical to begin with the first two program topics: (1) Play and (2) Praise and Rewards. These programs show parents ways to play with children and to use praise and rewards to encourage cooperation, foster creativity, build self-esteem, and strengthen prosocial behavior. There are several advantages to beginning with these segments.

The first two program topics:

- Build positive attachment/bonding between the parents and children rather than focusing on behavior problems.
- Help parents understand how their child-directed play and coaching interactions with their children can promote prosocial behavior, self regulation and emotional literacy.



Remember to Build Up Your Bank Account

- Help parents and children feel good about their responses to each other.
- Help parents give children consistent attention, approval, and praise for good behavior rather than negative attention for misbehavior.
- Promote parents' empathy for their children and understanding of developmental and temperament differences.
- Promote group cohesion and trust in the group by starting with discussion of positive parenting concepts.

Often, when parents have completed the first two programs they already see positive increases in their children's prosocial behaviors. Once they have built up a "bank" of positive feelings and interactions with their child it becomes easier to draw on them when discipline is required. Moreover the positive behaviors which are being taught and encouraged serve to replace the inappropriate behaviors. After completing the first two components of the program, the leader progresses to (3) Positive Discipline and (4) Handling Misbehavior. Here the focus of the group is to decrease the inappropriate behaviors. (See appendix for content and objectives of BASIC Program.)

The Incredible Years®: School Readiness Series (Ages 3-5 years)

The School Readiness program consists of two programs. The first focuses on helping parents learn academic, social and emotional coaching through child-directed play. The second program helps parents understand how engaging in interactive and reading skills are effective ways of helping strengthen children's language skills, emotional regulation, social skills and pre-reading skills. The series may be shown as a stand-alone curriculum or in conjunction with Basic.

The Incredible Years®: School Age Basic Parent Program (Programs 9 and 10) (Ages 6-12 years)

The content of the School Age Basic Parent Training Program parallels the Preschool Basic programs except there is more emphasis on special time, responsibilities & chores, enforcing rules, after school monitoring and logical consequences. (See appendix for content and objectives.) Supporting Your Child's Education Program (below) is included in the leader's manual and can be offered following programs 9 and 10.

The Incredible Years®: Supporting Your Child's Education (Program 8) (Ages 6-12 years)

Academic performance has been implicated for children with behavior problems. Children with behavior problems often manifest low academic achievement and low intellectual functioning during the elementary grades and through high school. Reading disabilities in particular are associated with behavior problems. Despite the documented links between underachievement, language delays, reading disabilities, and conduct disorders, there have been few attempts to increase the effectiveness of parent training programs by adding an academic skills training component for parents. Parents

need to know how to help their children not only with their antisocial problems, but also with their academic difficulties (e.g., reading and writing). In addition, parents need to know how to work with teachers and schools in order to foster a supportive relationship between home and school settings. Such a coordinated effort between home and school regarding social and academic goals would offer the possibility of better generalization of child improvements across settings.

Supporting Your Child's Education offers parents strategies for reading and doing homework with their children, fostering supportive relationships with teachers, and setting up coordinated plans between home and school when necessary. This program follows the completion of the first two program topics covered in School Age program because it builds on the behavioral principles that were introduced and applies them to academic skills. This program can also be offered as a follow-up booster after the BASIC Preschool series is completed. (See appendix for the content and objectives of the academic skills training program.) This program is sold as part of the School Age Basic Program.

The Incredible Years®: Baby and Toddler Programs (Ages 0-3 years)

The baby and toddler programs are for parents of children ages 0–3 years. The method and process of delivering these programs is the same as for the preschool BASIC program. The content of the programs emphasize becoming a new parent, developmental milestones, temperament differences, safety proofing and parenting approaches that build a positive parent-child attachment (See tables appendices for content and objectives). Baby and Toddler programs can be purchased jointly or separately. There is a supplemental "Well-Baby" Program for group leaders who are working with Pediatricians. Information can be found on our website: www.incredibleyears.com.

The Incredible Years®: Advanced Parent Programs 5, 6 & 7 (Ages 4-12 years)

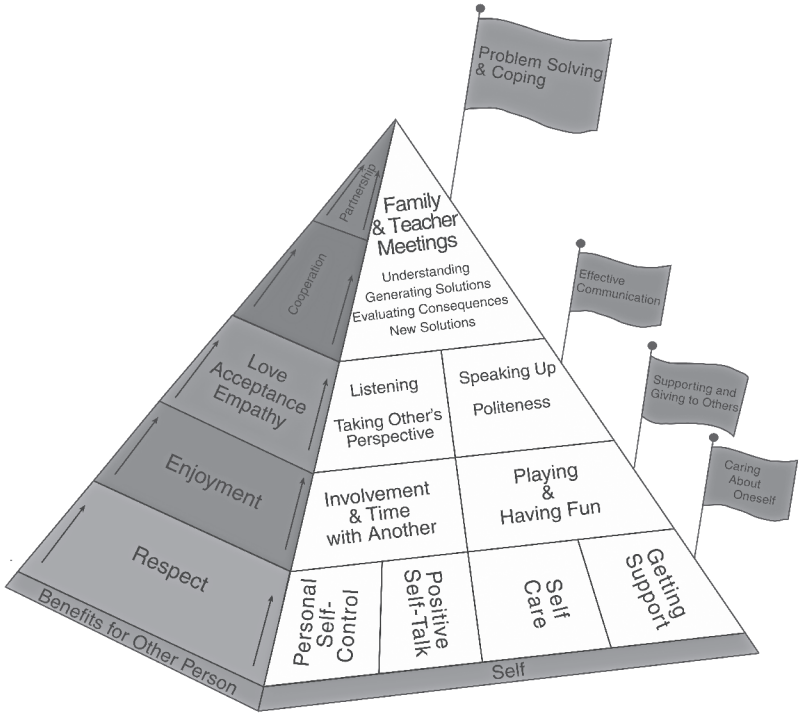
The Advanced Parent Training Program is a broader based family intervention, focused on more of the parents interpersonal issues and conflict manageent. It consists of a leader's manual and DVDs divided into four segments: Personal Self-Control and Effective Communication Strategies, Problem Solving Between Adults, Helping Children To Problem Solve, and Family Meetings. Offered to groups of parents who have completed the School Age Basic program, the Advanced program takes 9–10 two-hour sessions to complete. It reviews the material covered in the Basic program and helps parents understand how to apply the principles of communication and problem solving to other relationships. (See appendix for the content and objectives presented in the Advanced program.)

We have assessed the extent to which families maintain treatment effects and identified the characteristics of families who show treatment relapses or fail to show clinically significant effects. In several studies, we have shown that a family's ability to benefit from basic parent training is influenced by factors such as maternal and paternal depression, marital discord, single-parent status, negative life stressors, and socioeconomic status (Webster-Stratton, 1985a, 1990a, 1990b). These data point to the need to bolster the parent program for some parents by providing ongoing expanded therapy which focuses on parents' specific needs, including life crises management, depression management, problem-solving, and marital therapy, as well as on the child's needs for training in social skills, problem-solving and stress management. While therapy cannot pretend to alter a family's life stressors, it can help by teaching both parents and children how to cope more effectively in the face of stressful situations.

group leader (two leaders if resources permit). The group format fosters a sense of community support, reduces isolation, and normalizes parents' experiences and situations. This cost-effective approach also allows for diverse experiences with problem solving in a variety of family situations. Each parent is encouraged to have a partner or close friend participate in the program.

Video modeling. Because the extent of conduct problems has created a need for services that exceeds available personnel and resources, this intervention had to be cost-effective, widely applicable, and sustaining. Video modeling promised to be effective and cost-efficient. Modeling theories of learning suggest that parents can improve parenting skills by watching video examples of parents interacting with their children in ways that promote prosocial behaviors and decrease inappropriate behaviors (Bandura, 1977). This method of training is more accessible, especially to less verbally oriented parents, than other methods such as didactic instruction, written handouts, or a sole reliance on group or individual discussion. It promotes generalization and long-term maintenance of positive behaviors by portraying a variety of models in many situations. Furthermore, video modeling is cost-effective because it can be widely disseminated.

The programs show parents and children of different sexes, ages, cultures, socioeconomic backgrounds, and temperaments interacting with each other in common family situations, such as eating dinner, getting dressed in the morning, and playing. The leader uses these vignettes to trigger group discussion. Participants identify their mistakes by watching examples of interaction that are positive, negative, or neutral. By showing negative examples, the notion of "perfect parenting" is disproved, and parents are given the chance to learn from their mistakes. The video vignettes stimulate group discussion and problem solving, and the leader ensures that the discussion addresses the topic and is understood by all parents. After each vignette, the leader stops the video scene and asks open-ended questions about the interactions. Parents react to and discuss the episodes and develop alternatives.



Pyramid for Building Relationships®

Collaborative process. In this collaborative training model, the leader is not an "expert" who dispenses advice to parents. Meaning "to labor together," collaboration implies a reciprocal relationship that uses the leader's and parents' knowledge, strengths, and perspectives equally. In this nonblaming and nonhierarchical model, the leader promotes collaboration through reflection, summary of points made by parents, reframing, reinforcement, support and acceptance, humor and optimism, encouragement of each member's participation, teaching of important concepts, and role-playing exercises. By using a collaborative process the program becomes culturally sensitive as each individual's personal goals and values are respected and "connections" with the past are relevant to current perspectives and attitudes. Approximately 60 percent of a session is group discussion, problem solving, and support; 25 percent is video modeling (25 to 30 minutes of video); and 15 percent is teaching. More information about collaborative process can be found in the following books (Webster-Stratton & Hancock, 1998; Webster-Stratton & Herbert, 1994, Webster-Stratton, 2012).

Weekly homework practice activities. Every session also involves a home assignment or activity, which should be presented as an integral part of the learning process. The home activities help transfer the learning that takes place in group sessions to real life at home and stimulate discussion at later sessions. Home activities also convey the message that passive involvement in the group will not work magic; parents must work at home to make changes. Parents are provided with *The Incredible Years* and asked to read a chapter each week to prepare for the next session (Webster-Stratton, 2006). CDs are provided for those who cannot read or don't have the time to read. Parents are also asked to observe behaviors at home, record their thoughts and feelings, or try out a parenting strategy. At the start of each session, the leader asks parents to share their experiences with their home activities and reading. The leader can then assess whether parents are integrating the material into their daily lives. Parents are more likely to take the home activities seriously if they know the leader is going to review them each week.

Each week, when parents arrive at the group, they put the week's assignment in a folder, check off whether or not they were able to complete the assignment, and pick up the leader's comments on the previous week's assignment. These folders offer quiet group members another opportunity for communicating with the leader and provide a private place for questions and comments that parents do not want to share with the group. The checklists encourage parents to monitor themselves; parents often ask if they can get credit for a homework assignment turned in a week late. The leader's review of assignments often includes written feedback and stickers, sweets, cartoons, or cards to applaud the parents' achievement.

Weekly evaluations. Parents evaluate each group session by completing a brief weekly evaluation form, which gives the leader immediate feedback about participants' responses to the leader's style, the group discussions, and the content presented in the session. If a parent is dissatisfied or is having trouble with a concept, the leader may want to call that parent to resolve the issue. If the difficulty is shared by others, the leader can bring it up at the next session. (See Appendix for form.)

Resources needed: In order for parent groups to be well attended group leaders need to have available child care with qualified child care providers, transportation for those who need it, healthy food and a room large enough for a circle of 14–16 people. Evening meetings are necessary in order to make it possible for two parents to participate. TV monitors and DVD equipment and blackboards or flip charts are needed for training.

Program Features Leading to Ease of Replication/Independent Replications Studies

The media format of all these training programs increases the consistency, fidelity, and transportability of the program implementation, and makes it easier and less costly to implement and maintain in real-world settings. As can be seen above, all the programs include detailed leader manuals, handouts, books, and videos/DVDs and detailed information about the group process and activities which facilitates the replicability of the program. Four independent studies have already replicated our findings with the parent intervention program (Spaccarelli, Cotler, & Penman, 1992) with differing ethnic (Gross, Fogg, Webster-Stratton, & Grady, 1999) and cultural groups (Scott, 2001) and with both younger (Gross et al., 1999) and somewhat older children (Taylor, Schmidt, Pepler, & Hodgins, 1998). The collaborative process of working with parents and teachers lends itself to a culturally sensitive approach to training.

Training and Qualifications of Group Leaders

Group leaders may come from many disciplines, including nursing, psychology, counseling, social work, education, and psychiatry. It is optimal if the group leader can represent the dominant culture of the group. Even though the program materials are extensive and comprehensive, we find that the program has a greater chance of being disseminated successfully if the group leaders receive training first. In this training we model the collaborative teaching process and help leaders understand the importance of group processes such as: identifying participants' personal goals, weekly home activities, effective use of role plays, use of metaphors, buddy calls, self-talk training, weekly check-ins, values exercises and methods of responding to resistance.

Sample of Homework Activities

HOME ACTIVITIES FOR THE WEEK

To Do:

- **PLAY** with your child for a minimum of 10 to 15 minutes every day.
- **KEEP TRACK** of these special time periods on the Record Sheet: Special Times handout.

To Read:

- Handouts and Chapter One from The Incredible Years book.

OPTIONAL ACTIVITY:

- **FILL IN** the two checklists for evaluating play, and bring them to the next meeting.

Certification/Accreditation

Group Leader Certification: We highly recommend certification for the group leaders in order to enhance the quality and integrity of the programs. This certification requires participants to attend authorized training workshops that are offered regularly in Seattle. Certified trainers are also available to go on-site to train leaders if there are a minimum of 15 participants. Additionally certified group leaders may become certified to mentor new group leaders and offer introductory workshops (see below).

Group leader certification is required if the program is to be evaluated as part of a research program. This certification requires successful completion of:

- Application and background questionnaire.
- Three-day training from a certified trainer or three-day training and mentorship from a certified mentor.
- Completion of two 14- to 20-week parent groups; submission of session checklists.
- Peer review of groups by co-leader and feedback from certified mentor.
- Passing video review from certified trainer/mentor
- Submission of weekly evaluations and final cumulative evaluations from two groups. (Evaluation materials are provided with program materials.)
- Self-evaluation of each group and group summaries.
- Two letters of recommendation from professionals familiar with your work.

Certified Peer Coach: A certified peer coach is a certified group leader who has been certified/accredited after demonstrating competency as a peer coach using the IY coaching methods and processes.

- Application
- Completion of minimum of 6 IY groups
- Participated in Peer Coaching Workshop (at least 2 days)
- Nominated by certified Mentor or Trainer
- Peer Coach Video Review by Trainer
- Complete Peer Coaching with 3 Dyads
- Evaluations from group leaders receiving peer coaching (minimum 6 evaluations)
- Self-Evaluations of peer coaching given (minimum of 3)
- Letter explaining interest and goals for peer coaching

Certified Mentor: Once a person has become certified as a group leader, he or she is then eligible to be invited to become a mentor of group leaders. Certification as a mentor requires:

- Application.
- Complete multiple parent groups (more than eight).
- Video feedback from certified trainer.
- Additional training to be a mentor.
- Completion of introductory leader training groups with a certified trainer.
- Ongoing trainer supervision and observations of parent groups.
- Mentor six group leaders and submit group leader evaluations.
- Attend mentor meetings.

Introductory training includes teaching regarding engaging families (for review see Webster-Stratton, 1998a) and methods and assessment tools to evaluate program effectiveness. Once training has been completed, certified mentors and trainers provide ongoing technical assistance. A detailed description of our dissemination strategies can be found in the following reference:

"Adopting and Implementing Empirically Supported Interventions: A Recipe for Success," In A. Buchanan (Ed.) Parents and Children — What Works? (pp. 127-160) Aldershot: Ashgate.

Recommended Evaluation Tools

Demographic Information

Parent Perceptions:
- Parenting Practices Interview (PPI)
- Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1991)
- Parenting Stress Index (PSI) (Abidin, 1983)
- Eyberg Child Behavior Inventory (ECBI) (Eyberg & Ross, 1978)
- Parenting Scale (Arnold & O'Leary)

Child Perceptions:
- Wally Problem-Solving Test

Observations:
- Laboratory and Home Visits of Parent-Child Interactions (DPICSR) (Robinson & Eyberg, 1981) (Webster-Stratton, 1987)
- Observations of Peer Play

Parent Observations:
- Parent Daily Reports (PDR) (Chamberlain & Reid, 1987)

Teacher Perceptions:
- Behar Preschool Behavior Questionnaire (PBQ) (Behar, 1977)
- Teacher Behavior Checklist (Achenbach & Edelbrock, 1991)

Social Validity Measures:
- Ongoing Session Evaluations (See Appendix)
- Parent Final Program Satisfaction Questionnaire (See Appendix)

Summary of Evaluation Results

First the BASIC program was evaluated as a treatment program in a series of eight randomized studies with more than 1000 children ages three to seven referred for conduct problems. The BASIC program significantly improved parental attitudes and parent-child interactions, reduced parents' use of violent forms of discipline, and reduced child conduct problems (Webster-Stratton, 1982a; Webster-Stratton, 1982b; Webster-Stratton, 1984; Webster-Stratton, 1989; Webster-Stratton, 1990b; Webster-Stratton, 1994; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). The ADVANCE program has been shown to be a highly effective treatment for promoting parents' use of effective problem-solving and communication skills, reducing maternal depression, and increasing children's social and problem-solving skills (Webster-Stratton, 1994). Users have been highly satisfied with both programs, and the dropout rates have been low regardless of the family's socioeconomic status. Effects have been sustained up to four years after intervention (Webster-Stratton, 1990b).

Next, the BASIC program was evaluated as a universal prevention program in two randomized trials with over 600 Head Start families (Webster-Stratton, 1998; Webster-Stratton, Reid & Hammond, 2001). This population was considered to be at higher risk for conduct disorder because of the increased number of risk factors associated with poverty. Results indicated that the parenting skills of Head Start parents who received training and the social competence of their children significantly improved compared with the control group. These data supported the hypothesis that strengthening parenting competence and increasing parental involvement of high-risk low-income mothers in children's school-related activities will help prevent children's conduct problems and promote social competence (Webster-Stratton, 1998b). These findings were independently replicated in a study in Chicago with day care providers and low-income, African-American mothers with toddlers (Gross, Fogg, & Tucker, 1995; Gross et al., 1999).

Studies of the BASIC Program

Universal Prevention: In the first study, 35 non-clinic families were randomly assigned to the BASIC parent training program or to a waiting-list control group. Results indicated that the BASIC treatment caused highly significant attitudinal and behavioral changes in treated middle-class, non-clinic mothers and children (ages 3 to 6) compared with control groups. Nearly all the changes were maintained at the one-year follow-up (Webster-Stratton, 1981; Webster-Stratton, 1982a; Webster-Stratton, 1982b).

Indicated Prevention: A second study randomly assigned 35 clinic families (with children having conduct problems) to one of three groups:

- One-on-one personalized parent therapy.
- Video-based group therapy (BASIC).
- Waiting-list control group.

These clinic families were high risk because of the large number of single parents, low socioeconomic status, low mean education level, high prevalence of child abuse, and the deviant nature of the children. The BASIC treatment was as effective as high-cost, one-on-one therapy and both treatments were superior to the control group in regard to attitudinal and behavioral changes. Moreover, at the one-year follow-up, no differences were noted between the two treatment groups, and most of the children continued to improve. The BASIC program was five times more cost-effective than one-on-one therapy, using 48 hours of therapist time versus 251 hours of therapist time. Approximately 70 percent of both treatment groups maintained significant positive behavioral changes at the one-year follow-up. Families who had little or no social support were most likely to relapse following treatment (Webster-Stratton, 1984; Webster-Stratton, 1985).

Indicated Prevention: A third study was conducted to ascertain the most efficient and effective component of the BASIC program. Parents of 114 conduct-problem children, ages 3 to 8, were randomly assigned to one of four groups:

- Individually or self-administered video modeling therapy (IVM).
- Video-based group therapy (BASIC).
- Group therapy alone (GD).
- Waiting-list control group.

Compared with the control group, mothers in all three treatment groups reported significantly fewer child behavior problems, more prosocial behaviors, and less use of spanking following treatment. Fathers in the IVM and BASIC groups, and teachers of children whose parents were in the BASIC and GD groups, also reported significant reductions in behavior problems compared with control subjects. Data collected from home visits indicated that, for all treatment groups, mothers, fathers, and children exhibited significant behavioral changes. Relatively few differences were noted between treatment groups on most outcome measures, but the differences found consistently favored BASIC treatment. Cost-effectiveness, however, was the major advantage of the IVM treatment (Webster-Stratton, 1990b; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988).

At the one-year follow-up, 93.1 percent of families were assessed. All significant behavioral changes reported immediately after treatment were maintained one year later. Moreover, parent report data indicated that both mothers and fathers perceived a further reduction in child behavior problems. Few differences were found among the three treatment groups except for the differences in consumer satisfaction, which indicated that the BASIC treatment was superior. With each of the treatment programs, 70 percent of the sample showed clinically significant improvements to within normal ranges (Webster-Stratton et al., 1988).

Indicated Prevention: A fourth study was conducted to determine how to enhance the effectiveness of the self-administered video therapy while maintaining its cost-effectiveness. Parents of 43 conduct-problem children were assigned to one of three groups:

- Individually administered video modeling program (IVM).
- IVM plus therapist consultation (IVMC).
- Waiting-list control group.

In comparison with the control group, both groups of mothers receiving treatment reported significantly fewer child behavior problems, reduced stress levels, and less use of spanking after intervention. Data from home visits indicated that both treatment groups exhibited significant behavioral changes. Relatively few differences on the outcome measures existed between the two treatment conditions, but IVMC children in the video plus therapist consultation group were significantly less deviant than the children in the individually administered video program suggesting that combined treatment was superior (Webster-Stratton, 1990a).

Selective Prevention: A fifth study examined the effectiveness of the BASIC program as a universal prevention program with a sample of 362 Head Start mothers and their four-year-old children. Eight Head Start centers were randomly assigned to two groups:

- An experimental group in which parents, teachers, and family service workers participated in the intervention.
- A control group in which parents, teachers, and family service workers participated in the regular center-based Head Start program.

The results from observations at the post-intervention assessment indicated that mothers in the intervention group made significantly fewer critical remarks and commands, used less harsh discipline, and were more nurturing, reinforcing, and competent in their parenting when compared with mothers in the control group. Intervention mothers reported that their discipline was more consistent and that they used fewer physically and verbally negative discipline techniques. They also used more appropriate limit-setting techniques. In turn, the children of mothers in the intervention group exhibited significantly fewer negative behaviors and conduct problems, less noncompliance, less negative affect and more positive affect, and more prosocial behaviors than children in the control group. One year later, most of the improvements noted in the intervention mothers' parenting skills and in their children's affect and behavior were maintained, including increased contacts with new teachers, as compared with mothers in the control group (Webster-Stratton, 1998b).

Selective Prevention: A sixth study examined the effectiveness of the BASIC program and the teacher training program (described below) with a sample of 272 Head Start mothers and 61 teachers. Fourteen Head Start centers were randomly assigned to two groups:

- An experimental condition in which parents, teachers, and family service workers participated in the prevention program.
- A control condition in which parents, teachers, and family service workers participated in the regular center-based Head Start program (CONTROL).

Assessments pre- and post-intervention included teacher and parent reports of child behavior and independent observations at home and at school. Home observations indicated that mothers in the intervention group were significantly less harsh and critical in their discipline approaches, significantly more positive and nurturing, and used more problem-solving approaches in their interactions with their children than mothers in the control group. Intervention mothers reported that their discipline was more positive and less harsh or punitive, that they used more monitoring,

and that they were more involved in activities with their children than control mothers. Teachers reported that mothers in the intervention group were more involved in their children's education. Children of mothers who attended six or more intervention sessions received lower ratings on independent observations of inappropriate behavior than children in the control group and were observed to exhibit significantly fewer negative behaviors and conduct problems, less noncompliance, and less negative affect than children in the control group.

Results of classroom observations indicated that teachers in the intervention group were significantly less critical in their discipline approaches and more positive in their interactions with their students than teachers in the control group. Teachers from the intervention condition reported making significantly more effort to involve parents in their classrooms than control teachers. Students in the intervention classrooms were observed to exhibit significantly fewer negative behaviors and noncompliance with teachers and less physical aggression with peers than students in control classrooms. Intervention children were more engaged or on-task in the classroom and had higher school readiness scores (e.g., friendly, self-reliant, on task, low disruptive) than control children. Overall classroom atmosphere was significantly more positive for intervention classrooms than control classrooms. Teachers also reported the intervention students to be more socially competent than the control students.

One year later most of the improvements noted in intervention mothers' parenting skills and in their children's affect and behavior were maintained. Results indicate that this prevention program is a promising strategy for reducing risk factors leading to delinquency by promoting social competence, school readiness, and reducing conduct problems (Webster-Stratton & Reid, 1999).

Summary Regarding Evaluation of BASIC Program

As noted above, the BASIC program appears highly effective in reducing child conduct problems by promoting social competence, reducing parents' violent methods of discipline, and improving their child management skills. For clinic children with conduct problems, the cycle of aggression appears to have been halted for approximately two-thirds of the treated families. For the high-risk Head Start children, protective factors such as positive parenting and children's social competence were enhanced.

Study of the ADVANCE Program

Indicated Prevention: A seventh study, examined the effects of adding the ADVANCE intervention component to the BASIC intervention. Parents of 78 families with children with ODD/CD (conduct disorder) received the BASIC parent training and then were randomly assigned to either ADVANCE training for 12 weeks or no further contact. Families were assessed at one month, one year, and two years after treatment through parent and teacher reports of child adjustment and parent distress (i.e., depression, anger, and stress) and direct observations of parent-child interactions and marital interactions such as discussing a problem. For both treatment groups, child adjustment and parent-child interactions significantly improved and parent distress and child behavior problems decreased. These changes were maintained at follow-up. ADVANCE children showed significant increases in the total number of solutions generated during problem solving, most notably in prosocial solutions, as compared to aggressive solutions, in comparison with their counterparts. Observations of parents' marital interactions indicated significant improvements in ADVANCE parents' communication, problem solving, and collaboration when compared with parents who did not receive ADVANCE training. Only one family dropped out of the ADVANCE program, which attests to its perceived usefulness by families. All the families attended more than two-thirds of the sessions, with the majority attending more than 90 percent of the sessions.

Study of Child Training–Dina Dinosaur Curriculum

Indicated Prevention: The Dina Dinosaur curriculum for children was evaluated in two randomized trials with conduct-disordered children ages 4 to 7. In the first study, families of 97 children with early-onset conduct problems were randomly assigned to one of four groups:

- Child training only. (CT)
- Parent training only. (BASIC and ADVANCE)
- Combined parent and child training intervention.
- Waiting-list control group.

Results showed that the combined parent and child training was more effective than parent training alone and that both were superior to the control group. The child training program resulted in significant improvements in observations of peer interactions. Children who had received the Dinosaur curriculum were significantly more positive in their social skills and conflict management strategies than children whose parents got parent training only or than controls. One year later the combined parent and child intervention showed the most sustained effects (Webster-Stratton & Hammond, 1997).

Indicated Prevention: A second study randomly assigned 158 clinic families to one of six groups:

- Child training only. (CT)
- Child training and teacher training. (TT)
- Parent training. (PT)
- Parent training and teacher training.
- PT+CT+TT
- Waiting List Control.

Results replicated the findings of parent and child training and showed that teacher training significantly enhanced parent training in terms of classroom and peer behavior changes (Webster-Stratton, Reid & Hammond, 2001).

c. Risk Factors Reduced:

As noted above, the program appears to be highly effective in reducing child conduct problems by reducing parents' violent discipline and improving their child management skills. The cycle of abuse and aggression appears to have been halted for approximately two-thirds of the treated families.

See book on website, "*The Incredible Years: Parents, Teachers, and Children's Training Series: Program Content, Methods, Research and Dissemination*" (by Carolyn Webster-Stratton, 2011) for detailed reviews of studies and description of programs.

http://incredibleyears.com/about/incredible-years-series/blueprints-book/

Part 2

Planning a Parenting Program

1. Overview

2. Encouraging Every Parent's Participation

3. Preparing for Your First Group

a. Arrange the Location
b. Arrange Optimal Times
c. Arrange for Child Care
d. Preparation for Each Session
e. Materials Needed
f. Arrive Early
g. Prepare for Subsequent Sessions

General Guidelines for Leading a Parent Program

1. Overview

The Incredible Years Parents and Children Series (developed by Dr. Webster-Stratton) is a comprehensive program aimed at preventing the development of child problem behaviors and promoting children's social and academic successes. The parent enrichment component of the program emphasizes parenting skills designed to promote self-confidence and cooperation in young children. In particular, the preschool and early school-age period is a critical age where children can be helped so that they are able to make a successful transition into kindergartens in different school systems. This program was designed to promote collaboration among all those who impact children's lives in different environments—such as parents at home and school personnel.

2. Encouraging Every Parent's Participation

The first step is to advertise the parenting program to all of the parents in your setting. Do this well in advance of the program starting. There are several phases to this recruitment process:

(a) Send out flyers frequently.

(b) Talk to parents about the program when they come to enroll at your school or health center. Be enthusiastic! Encourage all the staff at your center (bus drivers, secretaries, health workers, teachers, counselors) to help advertise the program.

(c) Involve the Teachers: Ask classroom teachers to advertise the program and put up flyers on the bulletin board. The more people talking about the program, the better! Moreover, because one of the goals of the program is to increase communication between home and school, it is vital to keep teachers informed and to invite their input into what they think would be important for parents to know about day-to-day functioning in their classroom.

3. Preparing for Your First Group

(a) Arrange the location. One of the first logistical tasks is to find a central place where you can hold your parenting classes. Here are some criteria to think about when choosing a location:

Meeting Location Checklist

_____ Is the room large enough to seat 14—16 people in chairs in an open circle?

_____ Does the room have a warm feeling?

_____ Are there enough adult-size, comfortable chairs?

_____ Is there DVD equipment available?

_____ Is there a room for child care nearby? (If possible, not too close to parent meeting room due to distraction of children whining and crying!)

_____ Are there bathrooms near the parent and child care rooms?

_____ Is there a place for plugging in coffee, tea etc. ?

_____ Is there easy parking nearby?

_____ Is there a blackboard?

(b) Arrange optimal times. Review your list of participants to see what times seem most feasible for offering the program. If it has been a while since you collected this information you may need to call parents again and ask them what times are best. This is an important consideration, since day meetings are often attended by mothers only. Evening meetings, on the other hand, can be attended by both mothers and fathers. Sometimes it helps to organize meeting times around the times the children are at the centers—just after bus pick up and before drop-off.

Questions to Ask When Planning Your Group

- Do you need transportation to meetings?
  - ____ Yes
  - ____ No
  - ____ Are you willing to bring someone else who doesn't have transportation?
- What time of day would you prefer classes are held?
  - ____ Morning
  - ____ Afternoon
  - ____ Evening
- Do you need child care at the meeting place?
  - ____ Yes
  - ____ No
- What are the ages of your children who will need child care? _____
- Do you have a partner who might be interested in coming to these classes with you?
  - ____ Yes
  - ____ No

(c) Arrange for child care. When registering parents for the groups, ask what their child care needs would be for them to be able to attend the parent meetings. For evening groups, some families may find it preferable to find a sitter to take care of the children at home and other families may prefer on-site child care. If families are able to arrange their own child care, that is helpful — however, child care at the parent meeting site should also be offered. NO ONE SHOULD MISS PARENTING SESSIONS BECAUSE THEY CANNOT FIND SITTERS OR GET TRANSPORTATION!

Arranging the Child Care Site for Children

- ____ Is there a large enough room for the number of children?
- ____ Do you have adequate materials? i.e., toys, paper for drawing, crayons, tape recorder for music, play dough, books, blocks, etc.
- ____ What snacks are planned for the children? (Nutritious, safe.)
- ____ Is the bathroom nearby and easy to access without disrupting parent group?
- ____ Are the child care providers adequately prepared and trained? (review play & praise videos)
- ____ Is there an adequate ratio of adults for children? (Check your local guidelines.)

It is important to plan the child care arrangement with the child care providers. Depending on the skills of the providers, it may be necessary to provide a list of possible activities to do with the children (e.g., make cards, play dough, dance to music, play games, etc.). Teachers could be a valuable resource for helping with this planning. **It is very important that the child care providers review the Incredible Years special time, play, and coaching programs before the group starts.** They are important role models for the parents, and it is very helpful to have their approaches be consistent with what the parents are learning.

(d) Prepare for each session ahead of time. The leader should be thoroughly familiar with the program before starting a group. Before each session, the group leader should spend time reviewing the DVD vignettes and reading along with the program manual. Try asking the questions and thinking about what the DVD vignettes demonstrate without looking at the manual—then check the manual to see if you have covered all the important concepts.

For each session, review the DVD vignettes and read program manual. In addition, read the chapter for that particular session. There is also a list of commonly asked parent questions for each session and you can read this as well. If you do this preparation you will find yourself confident and at ease with the content of the program and more able to focus on the group process dynamics. It is well worth the extra effort!

Preparation for Session Checklist

____ Have I reviewed the video vignettes for the upcoming session?
____ Have I read the leader program manual (blue) for the session ?
____ Have I read the book chapter which corresponds with the session?
____ Have I sent out a letter to remind parents of date of group?
____ Have I called to remind parents of the upcoming meeting?
____ Have I provided toys or props for role plays?
____ Have I prepared a folder for every parent?

(e) Materials Needed

Materials Checklist

___ Paper, pens
___ Blackboard with chalk, a flip chart and markers
___ Name tags
___ DVD player, monitor and remote control (with batteries working!)
___ DVD for session
___ Parent handouts for home practice assignments
___ Parent folders for weekly records
___ Attendance folder
___ Snacks or meal
___ Stickers or other incentives

(f) Arrive early. We feel it is important to arrive at the meeting room about one hour in advance of the group starting—there is plenty to do! The first task is to set up the chairs, arrange the food, put out parent folders, check that DVD equipment is working, and put the agenda on the blackboard. You will also find that if parents know you are there early they will come earlier as well and you will start on time. Some parents may even come a little early to have a chance to talk privately with you ahead of time. In addition to setting up the room, you can also check in with the child care provider and brainstorm ideas for any problems that have arisen.

Am I Ready? Checklist

___ Room is set up.

___ Agenda is on blackboard.

___ Food is prepared.

___ DVD equipment has been checked.

___ DVD cued up at correct starting point.

___ Parent folders have been checked and marked.

___ Names tags are ready.

(g) Prepare for subsequent sessions. We have found that it is extremely helpful to do your planning for the next session right away after the session ends. DO NOT WAIT UNTIL THE DAY YOUR NEXT SESSION IS TO START. Here are some of the things you need to do:

Weekly Checklist

___ **Weekly Records Completed Immediately.** On the leader checklist keep records on how many vignettes you covered, and your evaluation of each parent's level of participation and attitude toward that week's material. Write any special notes to remind you of the discussion or content you want to review again the next week (see leader checklist and parent attendance forms).

___ **Review weekly Evaluations in Folders.** These will help you know if there is a parent who is distressed or not understanding the material and will trigger you to make a phone call to discuss the issue with the parent or to make an extra effort to involve that parent in the next session.

___ **Mid-Weekly Calls to Parents.** Check in with parents to see how they are doing with the material and let them know you are interested in their progress. It may not be necessary to do this every week with every parent but it is especially important for those parents who seem to be having difficulty with the material or with their child.

___ **Make-up Sessions for Missed Sessions.** If a parent misses a session, call them right away and to determine why they were absent. This call should be made within 24 hours of the class because it lets the parent know you are concerned and interested in his/her participation and are not lax about absences. It also gives you opportunity to help the parent make up the session and do the assignment before the next class.

___ **Get Parent Folders Ready.** Review parents' homework assignments and write supportive or positive notes and/or put stickers on their work and place in parents' folders.

___ **Plan next session's agenda.** Write the agenda you will follow for the next session.

Part 3

General Guidelines for Leading Parenting Groups

1. Enforce a Time Schedule
2. Welcome and Engage Families
3. Introductions and Parent Goals
4. Present Program Goals and Format
5. Ensure Group Safety: "Ground Rules"
6. Agendas
7. Parents Sharing "Home Activities"
8. How to Use the Videotape Vignettes
9. Encourage Everyone's Participation
10. Prevent Sidetracking
11. Build Rapport with Each Member of the Group
12. Normalize Problems
13. Model Questions and Wait for Group Discussion
14. Summarize and Restate Important Points
15. Leadership Style for Empowering Families
16. Reinforce Participants for Sharing Ideas
17. Use Humor and Foster Optimism
18. Take a Formal Break
19. Review Home Practice Assignments and Reading
20. Parents Complete Self-Monitoring Checklist
21. Parent Evaluation of Each Session
22. Sessions end on Time
23. Self and Peer Evaluations

General Guidelines for Leading Parenting Groups (Group Process)

1. **Enforce a time schedule.** Meetings have a tendency to start later and later unless a definite starting time is established. Meetings should begin on time even if there are only two people present.
2. **Welcome and engage families.** It is critical to create an atmosphere of acceptance, warmth and caring for every parent. Start your first session by introducing yourself and sharing your excitement about The Incredible Years group. Talk about your own experiences either raising your own children or working with children. At subsequent sessions it is important to begin by welcoming parents and expressing your care for them.
3. **Introductions and parent goals.** Then ask each parent to introduce themselves, talk about the ages of their children and what they hope to learn from the classes. PUT THE PARENTS' GOALS ON ONE HALF OF THE BLACKBOARD OR ON POSTER PAPER WHICH CAN BE SAVED. Be sure to provide name tags for everyone each week.
4. **Present program goals and format:**

Example Script for Group Leader:

"Each of you brings to the group your own strengths, as well as parenting questions. Each of you has children with different needs and different temperaments. These meetings offer all of us an opportunity to learn more about children and parenting from each other.

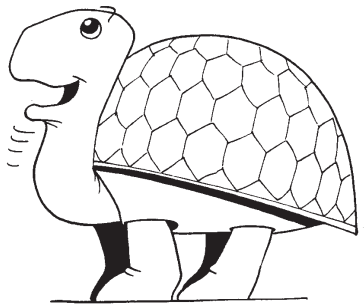
The broad goals of the program are to strengthen the connections between home and school, increase parents' effectiveness, and promote competent, well-adjusted children at home and school. The topics we will be presenting are based on research conducted at the Parenting Clinic at the University of Washington over a period of 30 years with over 1000 families with children with difficult behavior. This work has lead to an understanding of the critical parenting and teacher skills and ways to promote children's positive behaviors. We have organized the topics of these meetings so that each session builds on the previous session—so we hope you won't have to miss any sessions."

Give Handout of Topics for the Sessions and Show Pyramid

Example Script for Leader:

"Generally you will find that the first half of the program builds your children's social competence and cooperative behaviors and then in the second half we will focus on reducing those inappropriate behaviors you would like to see less of. Your discussions will be a valuable part of the program to be sure we are talking about things you are interested in. Each week we will be showing you some DVD vignettes and discussing them and asking for your ideas. We will also be giving you some ideas for things to try at home, and we will talk about how those work."*

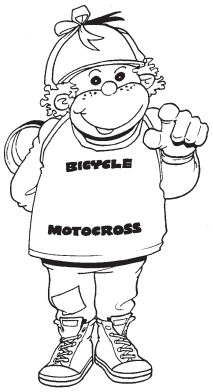
Questions. Ask the group if they have any questions about the program. Go over with the group any potential problems with child care. Tell the group about the child care arrangements and how you have prepared the child care workers for the job. Ask about any possible difficulties with transportation.



*****(Leader uses the Parenting Pyramid to illustrate the sequence of topics.)

Explain the format of the group meetings. After introductions and questions, go over the structure of the meetings — that is, video vignettes will be shown and stopped for group discussion and reactions. Encourage participants to ask questions and offer ideas in response to the vignettes.

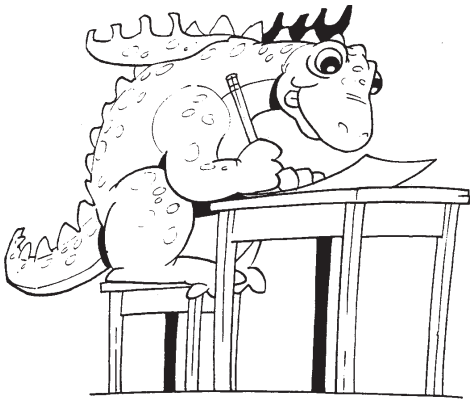
5. **Ensure group safety: Ground Rules.** One of the most difficult aspects of the group leader's role is to prevent the group process from becoming disrupted. We have found that it is necessary to establish some rules during the first meeting to keep things running smoothly. These rules are developed in a collaborative way. The leader says, *"In order to make this a safe place to talk about some difficult situations, we'll need some ground rules. What rules would you like us to follow?"* Discuss each idea. POST THESE RULES ON A POSTER which is placed up front at each meeting. One rule that is helpful, for example, is that only one person may talk at a time. If someone breaks this rule, simply say, *"One person at a time, please."* The group process can also be disrupted by a participant who challenges the group leader's knowledge or advocates inappropriate child rearing practices. The leader can deal with this situation by saying, *"That's an interesting idea, and the most relevant points you seem to be making are…"* Then the leader can delineate a more appropriate way to approach the issue without putting down the participant. If a group member continues to challenge the leader, it may be necessary to discuss the problem on an individual basis.



Example of Ground Rules

1. Everyone's ideas are respected.
2. Anyone has a right to pass.
3. One person talks at a time.
4. No "put downs" allowed.
5. Confidentiality

6. **Agendas.** Write the agendas on the blackboard or poster. Explain the agenda and objectives for each session. The session title that appears at the beginning of each session in your leader's manual provides a statement of the objectives. For example, *"The purpose of this program is to teach parents and other adults how to use praise and other social rewards effectively. . . "* It also helps to tell the group how many vignettes are going to be covered during the session.



Agenda

1. Report on Home Activities
2. Report on Play Experiences
3. New Topic: Effective Praise Skills

   Vignettes 1–12
   ~ Break ~

4. Continue vignettes & practice & praise skills
5. New Home Activity for the Week (See agenda for each week in Part 5.)

7. **Parents sharing "home activities."** After the first session, you will start every session with a discussion of the home practice assignment and reading material. This is the time you see how the parents are integrating what they are learning into their daily life at home. Here are some ideas for questions:

   What did you learn about your play or special time with your child?
   Did you learn anything new or interesting about . . .?
   Did you feel that you tried new ways of . . . ?
   Was it hard to make yourself do the assignment? What made it difficult?
   What did you think about the reading chapter for this week?
   What did you learn from observing the way you give praises (commands etc.)?
   How did it feel to try to praise more often? (Or reduce criticisms and commands?)

8. **How to use the DVD vignettes.** Keep focus of the group on the key points in the vignettes. At the first sessions when you introduce vignettes, make the point that these are examples for discussion – none are "right" or "wrong." The idea is to use the vignettes to stimulate discussion and problem-solving. After a particular vignette is presented, the group leader should pause or stop the video and give participants a chance to discuss what they have observed. The vignettes have been selected to illustrate specific concepts, and it is up to the group leader to make sure the ensuing discussion is productive and stays on topic. If participants are unclear about specific aspects of the parent/child interaction, or if they miss a critical feature in the vignette, the group leader can rewind the DVD and have the group watch the scene again. The goal is to help participants become actively involved in problem solving and sharing ideas about the vignettes. The group leader can also facilitate learning by asking the group members how the concepts illustrated in the vignettes might apply to their own situations.

Do's and Don'ts

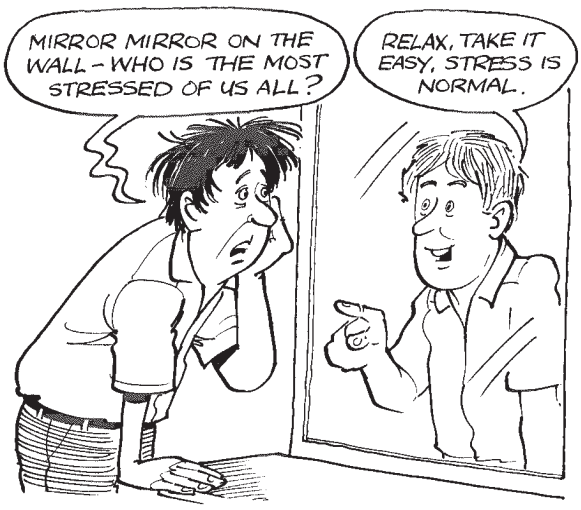
1. Pace your vignettes throughout the entire session. Avoid waiting until the last half of the program to show the majority of vignettes.
2. Allow for discussion following every vignette. If you are short of time, you may verbally highlight key points in the vignette if these points have already come up in earlier discussion. Do not run vignettes together without dialogue. Pause longer vignettes frequently to allow for reflection of the skills modeled.
3. Allow for parents' first impressions (insights) to be expressed before leader gives interpretation. Pull out parent "principles" from their ideas.
4. If parents' reactions are critical, balance their perspective by noting some positive features of the parents' behaviors. (If you allow a group to go too negative, parents may feel you could be just as critical of their mistakes.)
5. Remember to model a realistic perspective of parenting.

9. **Encourage everyone's participation.** Some people tend to be quiet and withdrawn in group situations, but it is important to involve them in the discussions. Hesitate after the first hand goes up, since many of the shy members of the group will volunteer only after someone else's hand is raised.

10. **Prevent sidetracking.** For groups that are very verbal and tend to get sidetracked or digress, it can be helpful at the beginning of each session to select a parent to act as a timekeeper. The job of this parent is to make sure all vignettes are covered, and to keep the group focused on the main topics for the session. Our evaluations indicate that participants become frustrated if the discussion wanders, and they appreciate having enough structure imposed to keep the discussion moving along. By inviting a different participant to act as timekeeper for each session, the task of monitoring the group discussion becomes everyone's responsibility.

11. **Build rapport with each member of the group.** It is important to build a relationship based on trust with each parent. This means being empathic and trying to understand each person's feelings, concerns, and views of a topic. Try to summarize and validate each participant's thoughts and emotions, maintain good eye contact when talking to members of the group, and occasionally disclose a problem or a feeling that you have had that is similar to a situation being described by someone in the group.

12. **Normalize problems.** Parents often feel they are at fault for their children's behavior problems. They may express feelings of guilt, incompetence, or hopelessness about their parenting skills. Some parents, on the other hand, place the blame entirely on the child. During the first meeting with a new group, it is important to reassure parents that all children misbehave at times, and to acknowledge that some children are more difficult to manage than others. Confirm that it is natural for parents to respond emotionally to children's inappropriate behavior even though the problems are relatively normal. For example, "It would be difficult not to respond in that way to a four-year-old child who whines all the time." Point out that persistent whining and other inappropriate behaviors can be changed by using the techniques presented in this course.



13. **Model questions and wait for group discussion.** When a leader asks for questions or comments after watching a vignette, members of the group are often uncertain about the kinds of responses that are appropriate. For this reason, questions and topics for discussion for each vignette are included in the leader's manual. Ask each question and then wait for a response. Many of these are open-ended questions which tend to generate a lively discussion, whereas questions that can be answered "Yes" or "No" tend to produce very little discussion. In addition to asking questions designated to elucidate factual information, try to elicit feelings about particular situations.

14. **Summarize and restate important points made by participants.** Paraphrasing and summarizing the viewpoints expressed prevents misunderstandings, and it shows that you are listening and validating their points of view. The leader should keep the discussion going until a consensus or conclusion is reached. PUT KEY LEARNING CONCEPTS WHICH PARENTS HAVE

SHARED ON THE BLACKBOARD. For example, Sally's rule: "Praise everyone in the family." However, if a participant's statement is irrelevant to the discussion, suggest that it is relevant to another issue and temporarily set the topic aside while the discussion continues.

15. **Leadership style for empowering families.** Do not present yourself as an "expert" on the subject matter. Even if the leader is an expert, the purpose of the group is to encourage parents to problem-solve, share and discuss the vignettes among themselves with some unobtrusive guidance from the leader. The idea is to "empower" the parents so they feel confident about their parenting skills and their ability to respond effectively to new situations that may arise when the leader is not there to help them. As the group leader you might share a time when you have fumbled as a parent with your children—this tends to move you from the mystical expert to more of collaborative leader.
16. **Reinforce participants for sharing ideas.** A good discussion is the product of a relaxed, secure environment. Each member of the group must feel comfortable participating in the discussion regardless of his or her level of sophistication or ability to communicate in groups. The leader should try to "make sense" of the statements made by participants so that no one feels ridiculed, ignored, or criticized because of something he or she has said.
17. **Use humor and foster optimism.** Some of the vignettes were included because they were humorous. Humor can be used by the leader to help participants relax, and to reduce anger or anxiety. It is also important to establish positive expectations for change. Sometimes parents are skeptical about their ability to change, especially if they see a family pattern. For example, a parent in one of our groups said, "My father was abusive too—it's the family curse!" Express your confidence in their ability to change, reinforce their efforts, and provide positive feedback for even small successes. Also, it can be helpful to refer to the research which indicates that many parents have been successful in teaching their children how to behave more appropriately; for example: "It is good that you are working with your child now, at this young age, because you are helping him stop his physically negative behaviors and learn more appropriate behaviors."
18. **Take a formal break.** Halfway through the session, take a 10-15 minute break and emphasize the importance of starting again at an agreed-upon time. Offer nutritious and fun snacks. The break time allows for informal socializing and gives the leader an opportunity to talk individually with quiet or distressed group members. Be sure to make an effort to talk with every parent on a one-to-one basis throughout the course of the program.
19. **Review home practice assignments and reading.** After the break or at the end of each session, ask parents to open their folders and review the handouts and the Activities for the Week, which include refrigerator notes of major points and the home practice assignment for the week. Be sure everyone understands how to do the home practice

assignment and how it relates to this week's discussion. In addition, there is a chapter to be read for each session. Express confidence in the ability of parents to carry out the assignments.

20. **Parents complete self-monitoring checklist.** At the end of each session, parents make a commitment to what personal goals they will achieve during the week and write it on the checklist. The following week they acknowledge their success and make goals for the next week (see form, in Appendix).

21. **Parent evaluation of each session.** Each group session should be evaluated by having participants complete the brief Weekly Evaluation Form (sample enclosed in Appendix). Parents can put these in their folders at the end of the session. This gives the leader immediate feedback about how each participant is responding to the leader's style, the quality of the group discussions, and the information presented in the session. The evaluations also bring problems to light, such as a parent who is dissatisfied or who is having trouble with a concept. The leader may want to call that parent to resolve the issue; or, if several participants are having difficulty understanding a particular concept, bring it up in a subsequent session.

22. **End the meetings on time.** It can be difficult to bring a meeting to a close when group members are in the middle of an enthusiastic discussion. This is actually a good time to end the meeting, however, because everyone will leave feeling stimulated and excited about being involved in the program. End by summarizing the group learning of the session and remind parents to bring their experiences with the home activities to the next session.

23. **Self and peer evaluation.** At the end of each session review with your co-leader both the process and content of your group. Complete the evaluation form for two sessions and ask your co-leader to evaluate your leadership of two sessions (see form in Part 6). It is optimal to complete these evaluations after session 4 and session 9.

Part 4

Maximize the Results

1. Get a Supportive Partner Involved
2. Support Networks Within the Group
3. Role-Playing and Rehearsal
4. Emphasize Home Assignments
5. Anticipate Potential Difficulties
6. Predict Behaviors and Feelings
7. Identify and Discuss Resistance
8. Ensuring Generalization
9. Benefits and Barriers Exercise
10. Using Tangible Reinforcers for Training
11. Preparing Parents for Program Ending
    a. Predict Relapses
    b. Remember the Long-Term Goals
    c. Enhancing the Long-Term Effects
    d. Share Personal Feelings
    e. Celebrate Completion and Moving On
    f. Make Follow-up Calls
    g. Schedule “Booster” Sessions

Maximize the Results

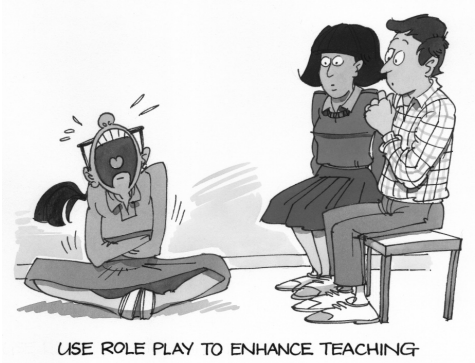
1. Get a supportive partner involved. Our one- and two-year follow-up studies indicate that the best results occurred in families in which another family member was involved in the parenting program. Having a spouse, a partner, or a close friend participate in the program makes it possible to solve problems jointly and provide mutual support. This also ensures that the child management concepts presented in this program will be applied more consistently—if one person is tired, depressed, or overwhelmed, the other person can help out. Over the past few years we have actively recruited partners, boyfriends, ex-spouses, and grandparents to participate in the program with the mother. The response to this solicitation for partners has been very positive.

2. Optimize support networks within the group—Buddy Calls. One of the purposes of the group format is to strengthen parents' abilities to give and get support from each other (i.e., build community support networks). In order to facilitate this, at session 3 the leader will introduce the "buddy concept" — that is, each group member will have a buddy from the group with whom they will talk each week about content from the session and their home practice assignment. It will be important to obtain group permission to exchange phone numbers or email addresses. If someone doesn't have a phone or internet access, the leader should try to pair up the person with someone who lives nearby. Having the buddy system is also helpful to catch up a person who misses a session.

3. Role-playing and practice exercises are an integral part of the training process both for illustrating new parenting strategies as well as for addressing issues which parents bring to the group from their home experiences. In the first sessions, in order to reduce parent's self-consciousness about role plays it can be helpful if one of the group leaders models their comfort with this process by role playing being "child." Have fun with the role-plays by exaggerating the roles and making them humorous. Sometimes it eases the tension in a role-play to ask the parents to first role-play the worst way possible and then follow it with a more effective approach.

We encourage you to do at least 3-4 role-plays or practices during every session. In the Play and Praise programs, we ask one parent to role-play being parent while another parent plays the role of child—the other parents in the room act as consultants to the parent. Role-playing the skills prepares parents for more difficult role-plays later in the program. You may even want several parents to role-play several children so you can anticipate how a parent will react with multiple children in the situation.

In the Limit Setting and Misbehavior programs, parents play the part of the "misbehaving child" and group members offer suggestions about how to deal with the child's behavior. We recommend that you avoid being the "expert" and demonstrating the "perfect parent"– rather, we find it more helpful for the parents to be the ones who demonstrate the competencies. This usually creates a lot of laughter, and engagement on the part of the parents. We do not ask parents to play the role of a critical or ineffective parent.



Here are some other suggestions for how to maximize the success of your role plays.

- **Direct the scene**. In general, after the first session, avoid participating in the role plays as either the "parent" or "child." The leader needs to be free to coach (or help the other parents to coach) the "parent," to stop the action at times and to help the group analyze what is happening in the role play. It can be confusing to the parents when the trainer is both participating in and analyzing/coaching the role play. "Pause" or "freeze the action" of the role play when you want to point out a specific strategy, give the "parent" a chance to ask a question or seek help, or you see that the situation has gotten out-of-hand or has become too complicated for the group to follow.
- **Set the scene**. In a spontaneous role play, that is, one that comes from a situation that a parent is explaining, take a moment to clarify for the group the child's age, the problem situation and who else is involved. In a planned role play, also specify the "child's" age and instruct the "child" about how cooperative or noncooperative s/he is to be. Instruct the "parent" to use the strategies that the group has discussed so far and to ask for assistance from the other parents whenever needed.

It can be very helpful to ask the parent to play the part of their child who are they are discussing. This allows them to experience the point of view of their child and to experience an alternative parent response to the situation.

- **Sequence your scenes.** It is important to direct or script your scenes so you go from simple to more complex situations. For example in session one, the first role plays utilize one "parent" and one "child" and the "child" is instructed to respond with appropriate behavior. In sessions two and three, when the group has seen and discussed many vignettes about play, the role plays can involve more than one "child" and the "child" begins to exhibit more aggressive or noncompliant behavior. Or, in the Time Out sequence of role plays where there are 5 to 6 role plays scenarios which develop from a very simple-walk through and description of the steps of Time Out, to the various complications of the technique.
- **Give everyone practice.** In addition to doing role plays in front of the entire group, it is helpful to break up into dyads or triads for practice exercises that gives everyone a turn. Several opportune times for small group or dyad practices are **after** the large group role play and processing. For example:

  One parent and child playing
  Parent explaining a sticker chart to a child
  Parent ignoring a whining child
  Parent explaining Time Out to a child

Parents are divided into teams of two or three and take turns being the "parent," the "child" and the "observer." After each "parent" practices, ask the "child" and "observer" to give positive feedback to that "parent." Then change roles.

- **Give and elicit feedback on the scenes.** The most effective role plays are usually brief and processed both from the child's and the parent's perspective. Give labeled praise to parent's willingness to participate in roles and applaud scenes. Stickers and candy rewards are fun to give out as well.

4. Emphasize home assignments and comment on parents' notes. The home practice assignment needs to be explained in detail each week so participants understand its purpose and how to do it. The home practice should be presented as an integral part of the learning process. For example:

"You can't learn to drive a car or play the piano without practicing, and this is also the case with the parenting skills you are learning here—the more effort you put into the assignments, the more success you will have with the program."

It is important to carefully review the home assignment each week before presenting new material. Participants are more likely to take the assignments seriously if they know the group leader is going to begin each session by reviewing the assignment from the previous week. If a participant fails to complete his or her homework, this should receive immediate attention and the problem should be explored in the group; for example:

"What made it hard for you to do the homework?"
"How have you overcome this problem in the past?"
"Do you think it is just as hard for your child to learn to change as it is for you?"

It is important to deal with resistance to doing the homework, and for the other participants in the group to see how committed the leader is to following up on the assignments.

In addition to discussing home assignments from week to week, it is also important to comment on parents' written notes about their assignments. We write notes to the parents about their work and include stickers and encouraging comments for their efforts. These notes of praise are put in the parents' individual folders each week. It is also important to highlight and summarize in the group examples of homework done by parents that exemplify key points. Some groups have found it helpful to have a lottery or sticker charts or small prizes for completion of homework.


PROPHESIZING SETBACKS

5. Anticipate potential difficulties. At the end of each session, the leader should ask participants to think about the difficulties they may encounter when they try to carry out the techniques they have just learned at home (visitors, working late, a bad day, and so on). For example:

"Are there any circumstances you can think of that will keep you keep from playing with your child every day for 10 minutes?"

6. Predict behaviors and feelings. Anticipate the fact that parents and children will resist change at first and will feel awkward learning new behaviors. This issue should be addressed by saying something like:

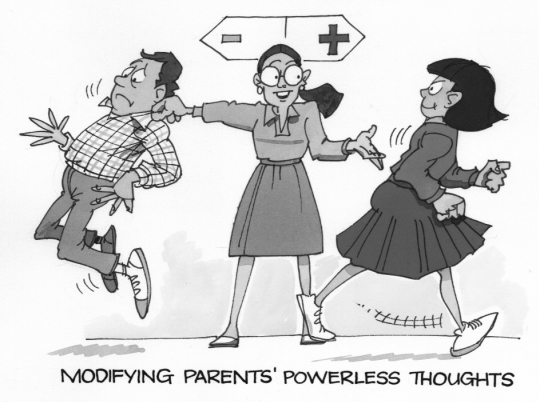
"Whenever someone learns a new behavior, there is a natural tendency to resist this new behavior and to revert back to the status quo for the family. In fact, some family members might actually pressure you to go back to the old way of doing things."

OR

"You will probably feel awkward doing this at first, especially if you haven't done much praising in the past. But the more you practice, the more natural it will become."

It also helps to build expectations for positive changes in behavior; for example:

"*We found that after parents do the daily play sessions for several weeks and increase their praise statements, their children's behavior improves substantially. We have also found that when parents give their children attention for positive behaviors, they actually have more time for themselves in the long run because their children stop behaving inappropriately to get attention.*"



7. Identify and discuss resistance. Resistance can occur in a variety of ways, such as failure to do homework, arriving late for group sessions, blaming the leader, or challenging the material presented. It is important to explore the reasons for the resistance; for example, some parents might feel that their child must change before they are willing to change, other parents may have tried a particular approach in the past and found that it did not work, still other parents may feel that the approach reminds them of something awful their parents did to them, or they may feel that the leader is presenting "pat answers" and does not really understand their situation. Sometimes resistance is simply due to the parent not adequately understanding the concepts presented, and more time may be needed to illustrate the points. Try to pinpoint the reasons for the resistance by asking about it in a nondefensive and nonconfrontive manner, for example:

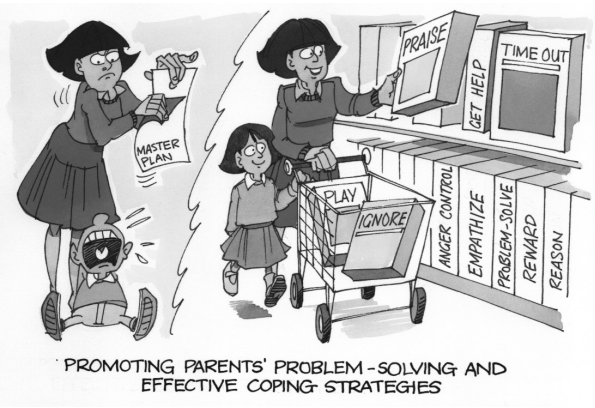
"You seem to be having difficulty with the idea of Time Out. Can you tell me what you are thinking?"

Once the reason for the resistance has been identified, the leader can encourage the parent to cooperate by agreeing with the parent's position and asking for a short experimental period; for example:

"*You may be right about Time Out, but you also said you're not happy about spanking. Time Out does not hurt children, and they often don't cry. I'd like to suggest that you do an experiment and try using Time Out consistently for three weeks. Then you can report back to the group about your experience with Time Out compared to spanking.*"

Another possibility is that the parents are resisting because they can't realistically complete the assignments. In this case it may be necessary to tailor the assignments to what the parents feel they can accomplish during the coming week.

8. Ensuring generalization. Generalization means teaching participants how to apply specific skills to deal with their current concerns, and also teaching them how to use those skills in other settings or with new types of children's misbehavior that may occur in the future. Participating in group sessions is a powerful way to enhance generalization because it exposes group members to a variety of family life situations and approaches to solving problems. Another way to ensure generalization is to present a list of children's behaviors they want to encourage or discourage and ask the group to problem-solve some strategies to deal with them. Encourage participants to come up with as many ideas as possible. A third way to enhance generalization is for the leader to engage in **"principles training."** That is, pointing out or having a group member state the basic principle which can then be applied to multiple situations that are occurring now or may occur in the future. These principles can be listed on a poster and brought to each session to facilitate continued use of the principle. Each principle could be identified by the group member's name who first stated that principle (i.e., Sally's principle: Praise everyone in the family; Jim's principle:



Behaviors which receive attention occur more often).

For a child who is having conduct problems at home and at school, it will be necessary to involve the child's teacher in a coordinated program for the child. If the parents and appropriate school personnel work together, it greatly improves the likelihood that the child's behavior will improve in both the home and school settings.

9. Benefits and Barriers exercises. At the beginning of the play, praise and limit setting programs, start the sessions by asking parents to brainstorm the benefits of the strategy (e.g., limit setting), followed by a discussion of the barriers or disadvantages of the strategy. Write these ideas on the flip chart. Follow this exercise by asking parents for their insights on what the list reveals. Usually, parents will gain insight into the notion that many of the benefits of the strategy are to the child's social and emotional growth in the long run, while in the short run there may be disadvantages to the parent. This exercise serves to help the group leader and parents understand areas of resistance for them as well as to gain a perspective on what they need to do in order to achieve their long-term goals for their children.

This benefits/barriers exercise is also done for the Time Out strategy versus Spanking strategy but it is done at the end of the explanation of Time Out and viewing all the videotapes on this topic. When doing this values exercise first do the advantages of spanking and then disadvantages, followed by the advantages and disadvantages of Time Out.

10. Using tangible reinforcers in the training. It's fun to give sweets, stickers, coupons for a door prize, positive notes or other inexpensive reinforcers to parents who: arrive on time, return from breaks on time, do the home activities, do a role play, etc. These reinforcers are given along with labeled praise starting from the beginning of the first day of the training. Thus the parents experience receiving praise and reinforcers long before these topics are discussed. When the topic of praise and reinforcers are then introduced, the parents can talk about how it feels to be given recognition in this way. Thus they can more clearly appreciate how a child would feel when recognized for positive behavior.

11. Do frequent "Buzzes." Break up parents into pairs with their buddies several times during a session. Turing these buzzes, you can ask parents to share the following: Their favorite play activity, positive behaviors they want to see more of, rewrite negative commands, their favorite pleasurable activity for themselves and ways they get support. These paired "buzzes" allow for a more private sharing between buddies and get the whole group actively working at the same time.

12. Prepare parents for program ending. Two weeks before the end of the program the leader should begin to talk about times after the parent group has ended and prepare parents for some of their feelings and reactions. There are several important points to make:

(a) **Predict relapses.** Parents should be aware of the fact that there will be some relapses in their parenting skills and children's inappropriate behaviors after the program has ended. It is therefore a good idea to brainstorm what to do if this happens. The following are some ideas that members of the group might suggest.

(1) Call another parent in the group for advice and support.
(2) Contact the group leader.
(3) Practice the program exercises in the workbook again, beginning with praises and play periods.
(4) Identify the problem behaviors and review the techniques presented in the course for dealing with them (review chapter in book).
(5) Arrange for some time away from the children to refuel and energize.
(6) Focus on positive alternatives rather than becoming immersed in feelings of failure or frustration.

Reassure parents that mistakes and relapses are "normal" and should be expected. The important point is to develop strategies to counteract relapses so that family life doesn't become too disrupted.

(b) **Remember the long-term goals and the "work" of parenting.** Acknowledge that it is not easy to be a parent, or to work with children. It is a difficult challenge that very few of us are adequately prepared for. One of the most common mistakes that adults make in relating to children is to go for the short-term payoffs (for example, to give in to a child's tantrum to stop the unpleasant behavior) at the expenses of the long-term consequences (the child learns to have tantrums to get what he or she wants). The parenting skills presented in this program may take much longer to implement, need to be repeated hundreds of times, and take a lot of work. But there are many long-term benefits in helping a child to become a self-confident, creative, nonviolent, and happy individual. As one of our parents so aptly put it, "You mean there is no magic moon dust?" No, we have no magic moon dust to sprinkle here; rather, our objective is to encourage parents to be patient with themselves and their growth as parents as well as their children's growth and development.

(c) **Enhancing long-term effects.** Maintenance refers to ensuring that the techniques continue to be used after the program ends. During some of the final sessions, participants should be asked how they will remember to use the techniques they have learned. They should be encouraged to come up with some strategies to reinforce their efforts. The following are some ideas which have been suggested as maintenance plans:

How to Continue to Feel Supported as a Parent

(1) Continue to meet as a group to support each other once a month. Study some of the other videotape learning modules together.
(2) Identify two parents from your group who are willing to act as "touch points" — who will provide a place to meet to discuss parenting issues which arrive.
(3) Put notes on the refrigerator, telephone, or steering wheel to remind yourself to use specific concepts such as praising good behavior, ignoring inappropriate behavior, and so on.
(4) Review the notes and handouts with a partner or a friend once every two weeks. Reread portions of the book.
(5) Reward yourself once a week for working on parenting skills by going out to dinner or a movie with a partner or a friend.
(6) Plan discussions of parenting issues with a partner or friend once every two weeks.
(7) Tell yourself you are doing a good job!
(8) Set aside some time to relax and refuel your energy on a daily basis.
(9) Recognize that it is okay for parents and children to make mistakes.

The Final Parent Group Session:

(d) Share personal feelings. Express your own personal feelings about the group and its ending.

"I have really enjoyed getting to know all of you and having a chance to talk about our parenting. I will miss these sessions with you. Even though we are ending, I would still like to hear from you. It is clear to me that you are committed parents and will make a difference in your children's lives."

(e) Celebrate completion and moving on. Make the last half-hour of your last session a celebration! You can give out the certificates to each parent and rejoice in their accomplishments. One option is to offer parents an opportunity to talk about what the group has meant to them. Another option is to have them verbally evaluate the program. It is fun to have some special food at the end, such as ice cream sundaes, a cake or potluck of parents' favorite foods.

After the Group Ends:

(f) Make follow-up calls. After a group completes the program, it is a good idea to make periodic telephone calls to find out how the parents are doing. We also occasionally send out newsletters, humorous cartoons about parenting techniques, and fliers that present tips and new ideas. Parents report that these are helpful reminders.

(g) Schedule "booster" sessions. Booster sessions should be scheduled automatically for families. You might plan to have two follow-up sessions in the subsequent year to discuss issues related to how the children are doing. These sessions can be used to review the principles presented in the course, to discuss any new problems that arise, and to support and reinforce the parents for their ongoing efforts. In addition, the School Readiness Series and Advance Program vignettes may be used to offer additional curriculum content at the booster sessions.

Part 5

Program Outlines, Agendas and Checklists

1. Summary of Content of Incredible Years Programs
2. Toddler Program Session Outline
3. Preschool Basic Program Session Outline
4. School Age Basic Program Session Outline
5. Sample Checklist for Preschool Basic Session One

Toddler Parenting Program Series Outline
(Children ages 1-3)

The following outline is a suggested guideline for completing the entire program in 13, 2-hour weekly sessions. If you do not complete all the vignettes in a session, you can continue showing them in the next session. Be sure to pace the learning according to parents' background knowledge and experiences.

Session One: ***Child-Directed Play Promotes Positive Relationships***
Vignettes: Part 1, 1–12

Session Two: ***Promoting Toddlers' Language with Child-Directed Coaching***
Vignettes: Part 2, 1–9

Session Three: ***Promoting Toddlers' Language with Child-Directed Coaching, cont'd.***
Vignettes: Part 2, 10–16

Session Four: ***Social and Emotional Coaching***
Vignettes: Part 3, 1–8

Session Five: ***Social and Emotional Coaching, cont'd.***
Vignettes: Part 3, 9–16

Session Six: ***The Art of Praise and Encouragement***
Vignettes: Part 4, 1–15

Session Seven: ***Spontaneous Incentives for Toddlers***
Vignettes: Part 5, 1–6

Session Eight: ***Handling Separations and Reunions with Toddlers***
Vignettes: Part 6, 1-5

Session Nine: ***Positive Discipline-Effective Limit Setting***
Vignettes: Part 7, 1–3

Session Ten: ***Positive Discipline-Effective Limit Setting, cont'd.***
Vignettes: Part 7, 4–25

Session Eleven: ***Positive Discipline-Handling Misbehavior***
Vignettes: Part 8, 1–7

Session Twelve: ***Positive Discipline-Handling Misbehavior, cont'd.***
Vignettes: Part 8, 8–15

Session Thirteen: ***Review and Celebration***

Tailoring the Incredible Years® BASIC Parenting Programs for Parents of Children (3-6 years)

Prevention Protocol

If the group leader is offering the program as a prevention program to parents of children without behavior problems, the program may be completed in 14-16 sessions. However, if the program is being offered as a treatment program to parents of diagnosed children with Attention Hyperactivity Deficit Disorder (ADHD) or Oppositional Defiant Disorder, it will be important to include the added sessions on persistence, emotion and social coaching. In addition, for parents from socioeconomically disadvantaged backgrounds leaders will want to use the 20-week session protocol with the emphasis on academic, social and emotional coaching. Leaders may also want to consider adding some sessions from the ***School Readiness or Attentive Parenting series***. For parents of such children, the BASIC program will take 18-20 sessions to complete.

For parents of children with conduct problems who are school age (6-12 years) or with ADHD it is recommended that the SCHOOL Age version of the BASIC program be shown instead of this preschool version. The SCHOOL Age version protocols are outlined in a different manual and includes a different set of DVDs. See the website for descriptions of programs: www.incredibleyears.com.

Preschool Basic Parenting Program Session Outline (Children ages 3-6)

The content covered in each session needs to be paced according to each parent groups' particular needs for discussion and content, level of participation, and prior familiarity with the parenting concepts. In general, we suggest that you try to cover 8-12 vignettes per two-hour session. You do not want to try to complete one entire tape of a topic (e.g., play part 1) in one session. Rather, try to cover at least half of a particular topic in a session and give out the home practice activities. The subsequent session is used to troubleshoot any questions or problems and to show the remaining vignettes on that topic as a review.

For children with diagnosis (e.g., ADHD, Oppositional Defiant Disorder) and for high-risk populations (child welfare populations or populations unfamiliar with content) we highly recommend the following protocols for completing the program in 20, 2 to 2 1/2-hour weekly sessions. We have listed the key vignettes to show in each session. We have omitted some vignettes. However, if parents are having difficulty with a particular topic, leaders are encouraged to show more vignettes from a particular program. Do not omit any of the vignettes listed below. If you do not complete all the required vignettes in a session, you can continue showing them in the next session.

For preventive populations it may be possible to deliver this program in 14 sessions. This will mean only one session on academic and persistence coaching and one session on social and emotion coaching. Sessions 17–20 will be omitted or offered as booster follow-up sessions.

Program One: Strengthening Children's Social Skills, Emotion Regulation, and School Readiness Skills

Session One: Introductions, Goals, Child-Directed Play

Part 1: Vignettes 1-6

Session Two: Child-Directed Play Promotes Positive Relationships

Part 1: Vignettes 7-29 (19-28 optional)

Session Three: Play–Academic and Persistence Coaching Promotes School Readiness

Part 2: Vignettes 1-16, Summary

Session Four: Play–Academic and Persistence Coaching Promotes School Readiness Cont'd

Part 2: Vignettes 17-28

Session Five: Play–Social and Emotion Coaching

Part 3: Vignettes 1-7

Session Six: Play–Social and Emotion Coaching Cont'd

Part 3: Vignettes 8-20, Summary

Program Two: Using Praise and Incentives to Encourage Cooperative Behaviors

Session Seven: ***The Art of Effective Praise and Encouragement***

Praise Part I: Vignettes 1-17

Session Eight: ***Effective Ways to Praise & Using Tangible Rewards***

Praise Part I: Vignettes 18-33. Summary

Tangible Rewards Part 2: Vignettes 1-5

Session Nine: ***Reward Programs Cont'd***

Tangible Rewards Part 2: Vignettes 6-19

Program Three: Household Rules, Routines, and Effective Limit Setting

Session Ten: ***Establishing Routines and Household Rules***

Part 1: 1-9

Session Eleven: ***Effective Limit Setting***

Part 2: 1-15

Session Twelve ***Effective Limit Setting and Follow Through***

Limit Setting Part 2: 16-36

Program 4 Handling Misbehavior Part 1: 1-13

Program Four: Positive Discipline, Handling Misbehavior

Session Thirteen: ***Ignoring Children's Inappropriate Behavior***

Part 2: 1-19

Session Fourteen: ***Time-Out to Calm Down***

Part 3: Explaining Time-Out, Vignettes 1-8

Part 3: Time-Out for Hitting, Vignettes 9-19

Session Fifteen: ***Time-Out for Aggression and Noncompliance***

Part 3: Vignettes 20-29

Session Sixteen: ***Natural and Logical Consequences***

Part 4: Vignettes 1-6

Session Seventeen: ***Teaching Children to Problem Solve***

Part 5: Vignettes 1-18

Session Eighteen: ***Teaching Children to Problem Solve Cont'd***

Part 5: Vignettes 19-27

Session Nineteen: ***Adult Problem Solving Meetings (optional)***

Part 1: Parents Problem Solving, Vignettes 1-3F

Part 3: Problem Solving With Teachers, Vignettes 12A-!2F

Session Twenty: ***Review and Celebration***

School Age Basic Parenting Program Session Outline (Children ages 6-12)

The following outline is a suggested guideline for completing the entire program in 12–20, 2-hour weekly sessions. You may select vignettes according to whether your group consists of primarily 6–8 year olds or 9–12 year olds. Session protocols with an asterix indicate vignettes that pertain to children ages 9–12 and are not relevant for 6–8 year olds. However, many of the scenes of 6–8 year olds will also be appropriate for 9–12 year olds because of the principles being covered. If you do not complete all the required vignettes in a session, you can continue showing them in the next session.

Promoting Positive Behavior (Program 9) and Reducing Inappropriate Behavior (Program 10)

Session One: **Welcome & Introduction to Program Parents' Goals**
Importance of Parental Attention and Special Time
Program 9: Part 1: Vignettes 1-9

Session Two: **Importance of Parental Attention and Special Time** (continued)
Program 9, Part 1: Vignettes 10-19

Session Three: **Social, Emotion and Perisistence Coaching**
Program 9, Part 2: Vignettes 20-27

Session Four: **Social, Emotion and Persistence Coaching**
Program 9, Part 2: Vignettes 28-41

Session Five: **Effective Praise and Encouragement**
Program 9, Part 3: Vignettes 42-58

Session Six: **Using Tangible Reward Programs to Motivate Your Child**
Program 9, Part 4: Vignettes 59-67

Session Seven: **Rules, Responsibilities and Routines**
Program 10, Part 1: Vignette 1-12

Session Eight: **Predictable Learning Routines and Clear Limit Setting**
Program 10, Part 2: Vignettes 13-33

Session Nine: **Ignoring Misbehavior**
Program 10, Part 3: Vignettes 34-43

Session Ten: **Time Out To Calm Down**
Program 10, Part 4: Vignettes 44-55E

Session Eleven: **Time Out to Calm Down**
Program 10, Part 4: Vignettes 44-55E

Session Twelve: **Other Consequences**
Program 10, Part 5: Vignettes 56-70

Session Thirteen: Review and Celebration

Note: Supporting Your Child's Education (Program 8) is optional. It should be considered for children with reading and academic difficulties and offered after session 12, prior to the final review.

Supporting Your Child's Success in School (Program 8)

Session One (13): **Promoting Reading Skills**
Program 8, Part 1: Vignettes 1-9

Session Two (14): **Dealing with Children's Discouragement**
Program 8, Part 2: Vignettes 10-15

Session Three (15): **Fostering Good Learning Habits and Routines**
Program 8, Part 3: Vignettes 16-22

Session Four (16): **Parents Showing Interest in School**
Program 8, Part 4: Vignettes 23-33

A Note about sequencing the School Age Program:

The School Age Basic Parenting program is sequenced such that if the program is started at the beginning of the school year, all units will be completed during the fall and winter. If groups are started later in the school year, group leaders will want to integrate the last program, *Supporting your Child's Education* (Program 8) earlier in the program. Otherwise the units on how to do homework with children will occur late during the school year or in the summer. To be most effective these topics should be covered at a time when parents can actually practice these strategies with their children. Here is what we suggest if starting the program later in the school year:

- **After Session 2** (Parental Attention and Special Time) add another session using the vignettes from program 8 called *Promoting Reading Skills*. (save vignette 13 & 14 from session 2 to be shown in reading session)

- **After Session 5** (Effective Praise and Encouragement) add another session using the vignettes from program 8 called *Parents Showing Interest in School and Homework.*

- **After Session 6** (Using Tangible Reward Programs to Motivate Your Child) add another session using vignettes from program 8 called *Dealing with Children's Discouragement.*

- **After Session 8** (Predicable Learning Routines and Clear Limit Setting) add another session using vignettes from program 8 called *Fostering Good Learning Habits.*

Note: Continue with the Advanced Parenting Program (purchased separately) for higher risk families with more interpersonal problems or children with conduct problems.

Outline–Session One
Introductions, Goals and Part 1: Child-Directed Play

Program One: Strengthening Children's Social Skills, Emotional Regulation, & School Readiness Skills

I. Welcome

Greet each parent.

Leaders introduce themselves.

Review agenda for session.

II. Ground Rules

Ask for parent ideas on group rules and why they think they are important. (confidentiality, respect for others, being positive, right to pass, equal time to talk)

Adopt rules for group.

Post rules each week. (A sample poster of rules is in appendix.)

III. Introductions

Find out group members' names, ages of children, and personal goals.

Have each parent describe what their child is like.

Buzz—parents' goals. Write on flip chart so you and group can refer back to them. (parents write their goals in the "Parents Thinking Like Scientists" handout)

Leader draws out themes related to parents who have children with particular problems such as ADHD or developmental issues.

IV. Program Goals and Topics

Give an overview of the program, its general goals, topics and format. (Show intro vignette.)

Talk about the developmental milestones of children ages 3-6 years.

Refer to the pyramid poster and explain how topics address their goals.

Give one book (*The Incredible Years*) and a magnet to each <u>family</u>. Offer CD as option.

V. Topic of Day: Child-Directed Play—Value of Attention

A. Brainstorm benefits to parent/child play

B. Vignettes: Play Part 1: 1-6

C. Buzz—share encouraging words to use when child says, "I can't do it."

Key Concepts:

- Value of showing attention and appreciation as a way of increasing children's self-esteem—"Attention Principle"
- Adjusting to children's temperament and activity level
- Understanding the value of child-directed play and how it promotes children's self-confidence
- Appreciating difficulties of playing with inattentive and active children

D. Role Plays/Practice

Role play (leader [as child] and parent) that demonstrates parent following child's lead. First give lots of direction, then replay being an "appreciative audience."

If time, divide group into sets of 3. Within each small group, give each parent a 2- to 3-minute time to be the child, parent and the observer.

E. Summarize Key Points (Refrigerator Notes).

VI. Review Home Activities

Pass out home practice forms.

Read aloud and make sure parents understand the home activities. Encourage each parent to practice and do the reading or listen to the CD.

Ask them to make a commitment to their goals for the week on their Self-Monitoring Checklist.

VII. Parent Evaluation

Remind parents of the importance of parent feedback for the group leader and the entire program.

Collect evaluation forms before parents leave.

VIII. Closing

Take this time to formally close the group. You may need to recap the learning.

Thank parents for coming; praise their willingness to explore and try new ways of parenting.

Remind them of any details they need to know for the next session.

LEADER CHECKLIST
Session One

Topic: ***Parent Goals, Child-Directed Play***

Vignettes: ***Play Part 1: 1- 6***

SITE: _____ **DATE:** _____

LEADER NAMES: _____ **TIME:** _____

VIGNETTES COVERED: Play Part 1:

Intro * 1* 2* 3* 4* 5* 6* (7 8 9 10 11)

* Recommended minimum vignettes. (Circle vignettes shown.)

DID I	**YES**	**NO**
1. Write the agenda on the board	_____	_____
2. Welcome and make introductions	_____	_____
3. Brainstorm group ground rules	_____	_____
4. Buzz—parents' goals (write in Scientist Handout)	_____	_____
5. Present program goals (pyramid)	_____	_____
6. Explain format for meetings	_____	_____
7. Talking about impact of children's temperament on parenting	_____	_____
8. Brainstorm benefits of parent/child play	_____	_____
9. Buzz—encouragement words	_____	_____
10. Role play/practice being "appreciative audience" in large group	_____	_____
11. Break out for "practice" in dyads or triads	_____	_____
12. Explain importance of home activities and reading assignments	_____	_____
13. Review this week's home assignment (play record sheet)	_____	_____
14. Explain Self-Monitoring Checklist	_____	_____

Handouts:

Home Activities for the Week – Child-Directed Play (Handout 1A)

Refrigerator Notes about Child-Directed Play
Parenting Pyramid
Checklist for Evaluating Your Child's Play
Parents and Children Having Fun
Record Sheet: Play Times
Parents Thinking Like Scientists
Brainstorm Benefits of Play
Properties of Play Toys

Self-Evaluation

"Gems" of Session—Reminder of things to pursue next session

Program One: Strengthening Children's Social Skills, Emotional Regulation and School Readiness Skills

Part 1: Child-Directed Play

Introductory Narration

In the Incredible Years Toddlers Program we saw how toddlers make an incredible journey of discovery and exploration as they learn about themselves as autonomous individuals–their accomplishments include their growing physical abilities as well as dramatic growth in their language expression and ability to understand others. During the preschool stage parents will be

- **School readiness** skills including language fluency, pre-writing and pre-reading skills, ability to attend to and follow adults' directions and rules and increasing independence.
- **Development of emotional regulation** skills including, self-control over aggressive behaviors, expression of emotions, ability to wait and accept limits and beginning problem solving skills.
- **Development of social and friendship** skills that including beginning to share, help others, initiate social interactions, listen and cooperate with peers.

helping their children successfully accomplish three developmental milestones:

This parenting pyramid will help explain some of the topics we will cover in the Incredible Years preschool curriculum in order to successfully help preschoolers achieve these milestones. It is similar to the food pyramid that you have seen before. Remember in the food pyramid, those items at the bottom of the pyramid such as grains, fruits, and vegetables, are considered essential foods. To stay healthy, you should eat lots of these foods each day. On the other hand those foods at the top of the pyramid are used sparingly. Just as you eat combining foods in differing amounts so must you do the same when parenting.

The first part of the Incredible Years curriculum involves parents building a strong foundation of positive interactions with their child. This foundation involves big and consistent doses of love, caring, child-directed play, positive talking, and coaching interactions. This nurturing on the part of parents is essential at all ages and stages of children's development from infancy, throughout preschool years and into the school age years and is the foundation needed to help children reach their emotional, social and academic milestones. Parents playing and talking with their children is also key to helping them learn how to form lasting attachments and relationships. Like the child without essential foods each day, children without essential nurturing will fail to grow and develop.

NOTE: Group leader could write these three developmental milestones for preschoolers on the board or flip chart. Then refer back to them throughout the sessions to show how the parenting strategies they are learning are helping their children achieve these milestones.

Narration

In the Incredible Years Toddler program we talked about how important it is that parents play with children and we noticed the importance of toddlers seeing that their parents are enjoying them. These play interactions contribute to strong emotional bonding and connections between children and parents and teaches children about joy and trust in relationships. Let's watch the mother in the next vignette playing with her 3-year-old daughter and think about what her daughter is learning from this play experience.

Importance of Parental Play with Children Vignette 1

The Scene Mother is sitting at the table with her 3-year-old daughter, Soleil. They are starting to color a picture.

Mother: What color did you want to use Soleil?

Soleil: Green.

Mother: Do you want to use markers or crayons?

Soleil: Markers and crayons.

Mother: Markers and crayons?

Soleil: (chooses orange marker)

Mother: Orange is a really good color especially for Halloween. I think I'm going to use …

Soleil: I don't know how to make these.

Mother: Oh I'll help you look… so can I use orange too? How about I use the orange crayon and you use the orange marker? Where did you want to put orange?

Soleil: Right here.

Mother: Right here… to make flowers—the flower leaves orange. And then you can color orange too wherever you want. Do you want me to color on yours and do it together?

Soleil: Yeah.

Mother: Okay.

Soleil: (colors)

Mother: So how about you do that one and I'll do this one?

Soleil: (puts cap on orange marker) I want to color on something else.

Mother: You want to color on something else?

Soleil: (chooses purple from box) I want purple.

Mother: (colors picture orange) You can do purple too, purple is good.

Pause vignette

Questions to Facilitate Discussion

1. **What is effective about this mother's responses?**
2. **What is the value of this mother's attention for her daughter?**

3. What do we see about this girl's developmental needs?

Vignette continues

Mother: What other color are you going to add?

Soleil: (chooses pink marker from box)

Mother: Pink—pink is a good color too. Let me know if you need help. What about blue? Should we put blue?

Soleil: Where?

Soleil: (whines) I wanted to do the eyes.

Mother: Okay go ahead.

Soleil: But I wanted to make the circle.

Mother: Oh you don't want to do the eyes with yellow— oh well you know what? That's okay. (brings over another copy of the same picture) Do you want to do the eyes with this one?

Soleil: Yes.

Mother: So you can work on that one and I'll finish up here.

Soleil: You're working on mine.

Mother: They can be both of ours we'll do them together.

Soleil: Okay.

Mother: You do know, look you did it, it's making a circle.

Questions to Facilitate Discussion

1. **How is this mother encouraging in her daughter's independence and confidence?**
2. **How is this mother being child-directed in her responses?**
3. **What is Soleil learning or experiencing from this play time with her mother?**
4. **How often do you have time to play with your child?**

Considerations

This little girl is showing the classic independence-dependence struggle. One minute she wants her mother's help and the next she doesn't want her help. The mother is effective because she stays calm, follows her child's lead and praises her daughter's independent choices. The mother is encouraging her child's independent decision making while at the same time letting her know she is available for support if needed. She is establishing a supportive relationship with her daughter.

NOTE: Group leader might try to pull out the "attention principle" from this discussion. This mother's attention is supporting her daughter's confidence, independent decision making, and creativity. In addition, this focused attention is contributing to building a positive relationship between the mother and her child.

Part 6
Certification

1. Certification Road Map
2. Certification as a Parent Group Leader
3. Tips for Preparing a Video for Certification Review
4. Application for Certification as a Parent Group Leader
5. Self and Peer Evaluation Form
6. Leader Collaborative Process Checklist
7. Skype Consultation

Map to Becoming Certified

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Basic steps to become a certified IY Group Leader

START

1. Attend an IY training.

2. Acquire the appropriate program for your population.

(You may do this step prior to attending training.)

3. Self Study using Leader's Manual & DVDs (with coleader).

(You may begin self study prior to training if you have the program materials.)

4. Start recruitment and planning for your groups.

5. Implement first group & submit DVD of one session for feedback from IY mentor/trainer.

(If your agency has an IY Peer Coach, schedule video review meetings with them first.)

6. Obtain in-person, group, or phone consultation with Mentor/Trainer and engage in weekly peer review.

7. Implement second group & submit DVD for feedback from IY mentor/trainer. Continue participating in consultation.

8. Once DVD review passes, send all paperwork to IY headquarters.

9. Application is reviewed. Congratulations on becoming a certified group leader!

See next page for what comes next, once you are certified as a group leader.

CERTIFICATION MAP – THE CONTINUED JOURNEY

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Next steps once you have been certified as a group leader
(Continued from "Map to Becoming Certified")

10. Continue group leader peer review every 2 weeks.

11. Group DVD consultations yearly with IY mentor/trainer.

12. Support new group leaders by delivering groups with them.

13. In-person or telephone consultations with IY mentor/trainer as needed.

14. Consider attending an adjunct IY training for a different population or age range.
(see www.incredibleyears.com for all training options)

15. Consider learning more about peer coach certification.

Contact the Incredible Years® office and consult our website (www.incredibleyears.com) for more details on further training you can receive, how to access consultation, and applying for peer coach certification.

INCREDIBLE YEARS®: PARENTS AND CHILDREN TRAINING SERIES

Carolyn Webster-Stratton, Ph.D.

Benefits of Certification As a Parent Group Leader

We consider this certification process to be of value for the following reasons: First, the certification process maximizes the quality of the performance of the group leader. We believe certified leaders implementing the full program will achieve results similar to those in the published literature. The process of certification is considered part of the training process in that the leader will get feedback from parents and peers on his/her leadership ability. Second, certification allows the individual to be listed as a certified group leader with our center. This certification permits us to give out your name for possible employment as a leader of parent groups. Third, certified leaders will be invited to workshops updating our programs and sharing ideas with other group leaders throughout the country. Finally, certification permits the individual to be eligible to take the advanced course in parent group leadership and to take the course to be a certified mentor of other group leaders.

Note: Certification is required for this program to be used as part of a research project.

Background Requirements to be Eligible for Certification

1. Extensive experience with young children (this may include being a parent, working with children as a health care provider, mental health provider, teacher, or parent educator). Two years experience minimum requirement.
2. Excellent interpersonal skills. Letters of reference attesting to your clinical experience working with individuals and groups (minimum two).
3. Experience with parenting skills and family interactions (this may include being a parent, working with families as a health care provider, psychiatrist, psychologist, social worker, nurse, teacher, or parent educator).
4. Involvement with group activities and awareness of group dynamics (ranging from having participated in PTA committee work to having led a group).
5. Educational course in child development required (credited course) (educational background in counseling helpful).

Requirements

Training

• Attend Approved Training Workshop

Only those candidates who have successfully completed the approved training qualify to submit a certification application. Approved training consists of a three-day workshop offered by a certified mentor or trainer of group leaders.

Experience Requirements

• Conduct Two Parent Groups

Conduct two parent groups utilizing the complete parent and child series (each group lasting the minimum # of weeks per program). It is optimal to have 12–14 participants, and a minimum of 50% of parents per series completing the group is required. A list of dates, locations, and number of attendees will need to be submitted.

• Submit to the Certification Committee: weekly evaluations by each parent who attends each of the 14-18+ sessions for both groups. (14 weeks for Prevention, 18+ weeks for Treatment.)

• Submit to the Certification Committee: final program evaluations by each parent who attended the two groups.

Feedback and Evaluation

• Peer and self-evaluation

Satisfactory completion of group leader self-evaluations for each group. (See attached Collaborative Process Checklist)

• Satisfactory completion of two co-leader peer evaluations, one for each group. (See attached Peer and Self-evaluation Form)

• Feedback from certified mentor or trainer

Receive a satisfactory supervisory report for a complete group session. This supervision may be done on-site by a certified mentor or by submitting a video to the Certification Committee. Most people usually submit two videos before they obtain approval. There is a separate fee for multiple certifications or for a 3rd review because it involves 3-4 hours to review one video and prepare a report.

Certified group leaders are expected to attend a one-day renewal or consultation workshop every 18 months.

Application Process

Checklist of Items Submitted for Certification

_____ Letter discussing your interest in becoming certified; your goals, plans, and philosophy of effective parenting and your clinical experience (one page)

——— Application form (See form in this section)

_____ Background Questionnaire (see website)

——— Two professional letters of reference

——— Parent weekly and final evaluations for two groups (Minimum 6 parents finishing) (see Appendix)

_____ Attendance lists for two groups

——— Session checklists for all sessions from two groups (see Intro Part 5)

——— Two co-leader peer evaluations (use peer/self-evaluation form in this section)

——— Two self-evaluations (use peer/self-evaluation form in this section)

——— Passing DVD review report from Certified Mentor or Trainer (see checklist, next page, for DVD review requirements)

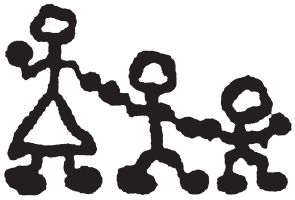
*All these forms can be found in your leader's manual AND/OR for download on our website

There is a certification fee which includes up to two video reviews and supervisory reports, registration process, and certificate of certification. Contact us for the current fee. If the supervisory report has been approved by a certified mentor (rather than an Incredible Years Trainer) then the cost of certification is less.

Send to:

Incredible Years, Inc.
Certification Committee
1411 8th Avenue West
Seattle, WA 98119
Email:incredibleyears@incredibleyears.com

You can find helpful resources on our website,
www.incredibleyears.com/certification-gl/



Checklist for Group Leader Video Review
What to send with your DVD

FIRST you will have your DVD reviewed - once you have passed your DVD review, THEN send us the rest of your paperwork. We will be in communication with you throughout this process to let you know what items we still need, and when you should send them!

_____ Application form filled out

_____ Leader collaborative process checklist filled out for this video & checklist has 85% or more "Yes" responses

_____ Video of one session

_____ The camera is focused on you, the leader

_____ You (the group leader) are the main leader for the full session

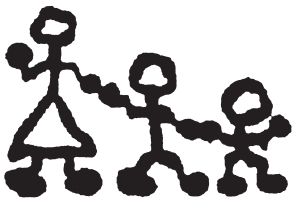
_____ There are at least six (or more) parents in the group who are attending this session

To help save time and money, and to ensure a smooth process – please do not send your video for review unless you can check off ALL of the above items.

You can find helpful resources on our website,
www.incredibleyears.com/certification-gl/

Please contact us for more information at 206-285-7565
or e-mal: incredibleyears@incredibleyears.com

Thank you!



Tips for Preparing Your Video for Review Parent Programs

Accreditation/Certification

These two words are used interchangeably in this document. Our European sites commonly refer to the process as accreditation and our US sites prefer the word certification. Both indicate the same review process!

When to send in your video for review

If your agency has an accredited IY coach or mentor we recommend that you regularly review videos of your group sessions with him/her, right from the beginning of your first group. If you don't have a coach or mentor in your agency, we recommend you and your co-leader regularly review videos of your group sessions using the Group Leader Process Checklist and the Peer and Self-Evaluation forms. By reviewing your video recordings together, you can self-reflect on your group leadership process and methods and determine goals for your learning and future sessions.

Once you have done this a few times, we recommend some outside IY telephone consultation from an Incredible Years trainer or mentor to answer your questions and discuss the group process. Next send in a video recording of one of your sessions for a detailed review by an accredited mentor or trainer.

Ideally this should occur at some point during your first group. By doing this early, you can get feedback and support for your approaches and learn of new strategies you can use to make your groups more successful. This will move you faster towards accreditation!

How many session recordings will I need to send for review?

Send one parent group session (2 hours) at a time. Then use the recommendations from their view of this session to make changes in your group leadership methods or processes. You will submit a 2nd session video recording that addresses the suggestions from your prior review. After your 2nd submission, you will receive feedback about whether or not a 3rd review will be required. It is common to submit 3 (or occasionally more) sessions prior to accreditation.

Camera Set Up

The camera should be focused on you. When you do role-plays or move about, please move the camera so the reviewer can see your work. Be sure that you have adequate sound quality so we can hear both you and the participants in the group.

Working with a co-leader and essential components for accreditation

You may send a video showing how you and your co-leader work together. We do assess the collaborative quality of how the leader and co-leader work together and support each other. However, the person whose video is being reviewed should be the primary leader throughout the session and should show their group leadership skills specifically in regard to the following:

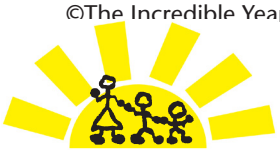
- mediating program vignettes and leading discussions of them
- setting up role plays and small group practices with leader coaching
- review home activities
- sufficient knowledge of topic content
- collaborative interpersonal style of interactions with participants
- instigating buzzes or small group breakouts
- pulling out key concepts and/or principles learned from participants
- amount of praise, encouragement and incentives given to participants
- coordination with co-leader
- schedule posted for session
- group rules adhered to
- reference made to parents' goals
- engagement of participants/level of enjoyment
- integration of cognitive, affective and behavioral components

Can my co-leader and I use the same session for accreditation?

Usually we ask for one complete session from each leader applying for accreditation. In this video, the leader applying for accreditation should be the content leader for the entire session, with the co-leader in the process role. This provides us with the best continuity for the review process. We realize that in clinical practice, group leaders usually switch content and process roles half-way through, so this is an exception to that practice. Occasionally it is possible to see both leaders doing all of the above group leader strategies in one session, and then it may be possible to use one video to review both candidates. However, this is rare. If you intend to use one session for two leaders or have other special review requests, please call or email us in advance. We will work with you, if possible, but you will save yourself time by checking with us ahead of time!

Number of Sessions

The minimum number of core, weekly, 2 hour sessions must be completed.
8 weeks for baby program
12 weeks toddler program
14-18 weeks for preschool program (depending on risk status)
12-16 weeks for school age program.
For high risk populations such as child protective service referred families or for children diagnosed with ADHD or Oppositional Defiant Disorder a minimum of 18 sessions must be completed. The parent manual differentiates between protocols for prevention



populations vs. treatment or high-risk populations, and these session protocols are also available from our website.

Number of Parents in Group

To qualify towards certification parent groups must finish with at least 6 participants. Drop out rate should not be more than 50% of group.

Number of Vignettes Shown in a Session

The updated parent programs have some longer vignettes than the older version of the program. Usually these vignettes are paused 2-3 times for discussion so they take much longer to review. The number of vignettes shown in a session is determined by the length of the vignettes shown and whether they are the older or newer ones. In general leaders are expected to show 6-10 vignettes per session. These vignettes are chosen carefully to reflect the needs and ethnicity of the population being addressed. The person reviewing your session takes into consideration the specific vignettes shown, the number of role-plays conducted and quality of discussion when reviewing a video. It is important to have a good balance of all these components but 2/3 of the session should emphasize modeling (either video or live) and practice of skills compared with cognitive discussion approaches. In general, 30 minutes is scheduled for homework discussion, 60 minutes for vignette reviews, 20 minutes for practices, and 10 minutes for wrap up summary, self-monitoring and evaluations.

How can I use a certified Incredible Years coach or mentor to assist me in achieving certification as a group leader?

If your agency has a certified IY group leader, coach or mentor, it will be ideal to start leading a group with this person because their prior experience with the program will be helpful to you. They can assist you by reviewing recorded sessions with you and giving you feedback. You will want to meet in advance of sessions to prepare for the session and decide who is responsible for which aspects of the leadership. For example, what vignettes you will lead and who will identify principles or give out rewards and how you will coordinate your role play practices.

What do I need to send in along with my video recording for review?

When you send in a video for review, please send in the application form, a brief letter summarizing the session or lesson topic covered, the nature of the population addressed (prevention vs. treatment) and your own self-evaluation of the session using the Group Leader Process Checklist and the Peer and Self-Evaluation forms. Please also indicate which leader on the video is you – hair color, what you're wearing. Please write your name and the session number on your video and/or notes accompanying the video.

Enhancing your video submission

Although not required, it is very helpful to the reviewer for the group leader to submit notes about the session. For example, the leader might provide some background information on the participants in the group and explain how this informed his/her choices of which vignettes to show or how to structure/choose activities. In addition, it is helpful for leaders to provide some narrative of his/her thoughts about the session. If leaders share ideas for what could be improved or changed, this shows an understanding of the group process that will be taken into account when the reviewer watches the video. Also you may indicate sections of the video you have questions about or particulars you would like feedback on.

Once your video has been passed off, you may then submit your application paperwork with the remaining required items:

- background questionnaire
- letter of intent
- letters of recommendation (2, professional)
- weekly and final evaluations by participants for parent program (2 sets)
- session protocols for every session (2 sets)
- 2 self-evaluations
- 2 peer-evaluations

Please Ask!

This process can be complicated and there are many steps. When in doubt, please call or e-mail us prior to sending in your DVD or materials. A well-prepared video will get you to your certification goal much faster!

Application for Certification as an Incredible Years® Parent Group Leader (Basic)

Name: _____

Home Address: _____

_____

_____ Zip/Postal Code: _____

Home Phone: _____ Work Phone: _____

E-mail: _____

Occupation: _____

Month/Year of Basic Training: _____

Trainer: _____

APPLICATION BILLING INFORMATION (NAME & ADDRESS:

Organization/Name:_____

Address:_____

City/State/Provence: _____Postal Code:_____

Country:_____

E-mail for receipt:_____

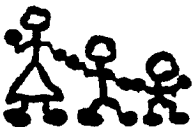
This form must accompany your submission of video for review.

Please include the following with your video submission:

- A brief letter outlining the session/topic covered and population served
- A Self-evaluation that corresponds to the session(s) you are sending for review
- The session checklist (indicating the vignettes shown) from the session(s) you are sending for review
- A Collaborative Process Checklist that corresponds to the session(s) you are sending for review

Please see website and leader's manual for certification application requirements. Contact Incredible Years office with any questions (incredibleyears@incredibleyears.com)

Send certification materials to:
Incredible Years Certification Committee
1411 8th Avenue West
Seattle, WA 98119 USA
incredibleyears@incredibleyears.com



Parent Group Leader Collaborative Process Checklist (rev. 2019)

This checklist is designed for group leaders to complete together following a session, or for a group leader to complete for him/herself when reviewing a video of a session. By watching the video of a session and looking for the following points, a leader can identify specific goals for progress. This checklist is designed to complement the checklist for the specific session, which lists the key content that should be covered.

Leader Self-Evaluation (name):_____

Co-leader Evaluation:_____

Certified Trainer/Mentor Evaluation:_____

SET UP *Did the Leaders:*	**YES**	**NO**	**N/A**
1. Set up chairs in a semicircle that allowed everyone to see the TV? (Avoid tables.)	____	____	____
2. Sit at separate places in the circle, rather than both at the front?	____	____	____
3. Write the agenda on the board?	____	____	____
4. Have last week's home activities ready for the parents to pick up, complete with praise and encouragement written on them?	____	____	____
5. Plan and prepare for daycare in advance?	____	____	____
6. Prepare and lay out the food, in an attractive manner?	____	____	____

REVIEW PARENT'S HOME ACTIVITIES *Did the Leader:*			
7. Begin the discussion by asking how home activities went during this past week - how they addressed their short term goals?	____	____	____
8. Give every parent the chance to talk about his/her experiences and select parents strategically for spontaneous practice to demonstrate successes or refine approach?	____	____	____
9. Praise and encourage parents for what they did well and recognize their beginning steps at change, rather than correct their process?	____	____	____
10. Highlight key "principles" that their experiences illustrate? (e.g., write them on flip chart or paraphrase idea in terms of how it addresses their goals.)	____	____	____

	YES	NO	N/A
11. Explore with individuals who didn't complete the home activities what made it difficult (barriers) and discuss how they might adapt home activities to fit their needs and goals?	____	____	____
12. Ask about and encourage "buddy calls"?	____	____	____
13. If a parent's description of how they applied the skills makes it clear that s/he misunderstood, did the leaders accept responsibility for the misunderstanding rather than leaving the parent feeling responsible for the failure? (e.g., "I'm really glad you shared that, because I see I completely forgot to tell you a really important point last week. You couldn't possibly have known, but when you do that, it's importnat to..." vs "You misunderstood the assignment. Remember, when you do that, it's important to...")	____	____	____
14. Make sure that the discussion is brought back to the specific topic at hand after a reasonable time without letting free flowing discussion of other issues dominate?	____	____	____
15. Limit the home activity discussion (aprroximately 20-30 minutes) to give adequate time for new learning?	____	____	____

WHEN BEGINNING THE TOPIC FOR THE DAY
Did the Leader:

16. Begin the discussion of the topic with open-ended questions to get parents to think about the importance of the topic?	____	____	____
17. Do the benefits and/or barriers exercise regarding the new topic?	____	____	____
18. Paraphrase and highlight the points made by parents - write key points on the board with their name?	____	____	____

WHEN SHOWING THE VIGNETTES
Did the Leader:

19. Focus parents on what they are about to see on the vignettes and what to look for?	____	____	____
20. Pause vignette to ask an open-ended question about what parents thought was effective/ineffective in the vignette (focus on parent thoughts, feelings & behaviors, and child's perspective)?	____	____	____
21. Acknowledge responses one or more parents have to a vignette?	____	____	____
22. Paraphrase and highlight the points made by parents - writing key points on the flip chart?	____	____	____
23. Move on to the next vignettes after key points have been discussed, rather than let the discussion go on at length?	____	____	____
24. Use vignettes to trigger appropriate discussions and/or practices, tailored to children's developmental level?	____	____	____

	YES	NO	N/A
25. Redirect group to the relevance of the interaction on the vignette for their own lives (if parents become distracted by some aspect of the vignette, such as clothing or responses that seem phony)?	____	____	____
26. Refer to parents' goals for themselves and their children when discussing vignettes, learning principles and setting up practices?	____	____	____

PRACTICE AND ROLE PLAYS
Did the Leader:

27. Get parents to switch from talking about strategies in general to using the words they could actually use? (e.g., from "She should be more specific" to "She could say, John, you need to put the puzzle pieces in the box.")	____	____	____
28. Ensure that the skill to be practiced has been covered in the vignettes or discussion prior to asking someone to role play practice it. (This ensures the likelihood of success.)	____	____	____
29. Do several large group role plays/practices over the course of the session? Break down practices according to child developmental readiness. Number of role plays: _____	____	____	____
30. Do role plays/practices in pairs or small groups (following large group practices) that allow multiple people to practice simultaneously? Dyads should be matched by child language and play ability.	____	____	____
31. Use all of the following skills when directing role plays:			
a. Select parents and give them appropriate roles?	____	____	____
b. Skillfully get parents engaged in role plays/practices?	____	____	____
c. Provide each person with a description of his/her role (age of child, level of misbehavior, developmental level)?	____	____	____
d. Provide enough "scaffolding" so that parents are successful in their role as "parent" (e.g., get other parents to generate ideas for how to handle the situation before practice begins)?	____	____	____
e. Invite other workshop members to be "coaches" (call out idea if the actor is stuck)?	____	____	____
f. Pause/freeze role play/practice periodically to redirect, give clarification, problem-solve different approach, or reinforce participants?	____	____	____
g. Take responsibility for having given poor instructions if role play/practice is not successful and allow actor to rewind and replay?	____	____	____
32. Process role play/practice afterwards by asking how "parent" felt and asking group to give feedback?	____	____	____
33. Process role play by asking how "child" felt in role?	____	____	____
34. Solicit feedback from group about strengths of parent in role?	____	____	____

	YES	NO	N/A
35. Offer detailed descriptive praise of the role play/practice and what was learned?	____	____	____
36. Re-run role play, changing roles, involving different parents, or with child of different play or language developmental level or temperament (being in role as child is helpful for partents to experience their child's perspective is a different way of responding)?	____	____	____

LEADER GROUP PROCESS SKILLS
Did the Leader:

37. Build rapport with each member of group?	____	____	____
38. Encourage everyone to participate?	____	____	____
39. Use open-ended questions to facilitate discussion and reflection?	____	____	____
40. Reinforce parents' ideas, foster parents' self-learning and confidence?	____	____	____
41. Encourage parents to problem-solve when possible?	____	____	____
42. Foster idea that parents will learn from each others' experiences?	____	____	____
43. Help parents learn how to support and reinforce each other?	____	____	____
44. Foster parents' understanding of the value of developing their own support network?	____	____	____
45. Identify each family's strengths?	____	____	____
46. Create a feeling of safety among group members?	____	____	____
47. Create an atmosphere where parents feel they are decision-makers and discussion and debate are paramount?	____	____	____
48. When needed, provide parents with information about important child developmental milestones?	____	____	____
49. Explore parents' cognition, affect modulation, and self-regulation as well as behaviors?	____	____	____
50. Help parents understand the relationship between thoughts, feelings and actions for themselves and their children?	____	____	____
50. Encourage parents to model, prompt, teach, and discuss with their children calm down methods for coping with traumatic events?	____	____	____

ENDING GROUP - REVIEW & HOME ACTIVITIES
Did the Leader:

50. Begin the ending process with about 15 minutes remaining?	____	____	____
51. Summarize this session's learning? (One way to do this is to review or have the parents review each point on refrigerator notes out loud.)	____	____	____

	YES	NO	N/A
52. Review or have parents review the home activity sheet, including why it is important, and how they will try to do it?	____	____	____
53. Talk about any adaptations to the home activity for particular families?	____	____	____
54. Show support and acceptance if parents can't commit to all the home activities? (Support realistic plans.)	____	____	____
55. Have parents complete the Self-Monitoring Checklist and commit to goals for the week?	____	____	____
56. Ask about buddy check ins (by phone, email or text)?	____	____	____
57. Have parents complete the evaluation form?	____	____	____
58. End the session on time?	____	____	____

REMEMBER: The goal in the group sessions should be to draw from the parents the information and ideas to teach and learn from each other. Parents should be the ones who generate the principles, describe the significance, highlight what was effective and ineffective on the video, and demonstrate how to implement the skills in different situations. Remember, people are far more likely to put into practice what they have discovered, talked about and experienced rather than what they have been told to do. Modeling, experiential learning and support are key Incredible Years principles.

Summary Comments:

Incredible Years® Parent Group Peer and Self Evaluation Form

Please ask your co-leader to comment on your group leader skills for one of your group sessions, using this form. Also use this form to self-evaluate your session. Afterwards talk about these evaluations together and make goals for your next session. Reviewing video of your own group leader skills is a valuable learning experience and part of continuing to learn to deliver the program with high fidelity.

Leader's Name _____

Please comment on the parent group leader's session(s) based on the following criteria:

I. Leader Group Process Skills	*Comments*
Builds rapport with each member of group	
Encourages everyone to participate	
Models open-ended questions to facilitate discussion	
Reinforces parents' ideas and fosters parents' self-learning	
Encourages parents to problem-solve when possible	
Fosters idea that parent will learn from each others' experiences	
Helps parents learn how to support and reinforce each other	
Views every member of group as equally important and valued	
Identifies each family's strengths	
Creates a feeling of safety among group members	
Creates an atmosphere where parents feel they are decision-makers and discussion and debate are paramount	

II. Leader Leadership Skills	*Comments*
Ground rules posted for group and reviewed	
Started and ended meeting on time	
Explained agenda for session and invited input	
Emphasizes the importance of homework	
Reviews homework from previous session	
Summarizes and restates important points	
Focuses group on key points presented	
Imposes sufficient structure to facilitate group process	
Prevents sidetracking by participants	
Knows when to be flexible and allow a digression for an important issue and knows how to tie it into session's content	
Anticipates potential difficulties	
Predicts behaviors and feelings	
Encourages generalization of concepts to different settings and situations	
Encourages parents to work for long-term goals as opposed to "quick fix"	
Helps group focus on positive	
Balances group discussion on affective and cognitive domain	
Predicts relapses	
Reviews handouts and homework for next week	
Evaluates session	

III. Leader Relationship Building Skills	*Comments*
Uses humor and fosters optimism	
Normalizes problems when appropriate	
Validates and supports parents' feelings (reflective statements)	
Shares personal experiences when appropriate	
Fosters a partnership or collaborative model (as opposed to an "expert" model)	
Fosters a coping model as opposed to a mastery model of learning	
Reframes experiences from the child's viewpoint and modifies parents' negative attributions	
Strategically confronts, challenges and teaches parents when necessary	
Identifies and discusses resistance	
Maintains leadership of group	
Advocates for parents	

IV. Leader Knowledge	*Comments*
Demonstrates knowledge of content covered at session	
Explains rationale for principles covered in clear, convincing manner	
Prepares materials in advance of session and is "prepared" for group	
Integrates parents' ideas and problems with important content and child development principles	
Uses appropriate analogies and metaphors to explain theories or concepts	

V. Leader Methods	*Comments*
Uses video examples efficiently and strategically to trigger group discussion	
Uses role play and rehearsal to reinforce learning	
Review homework and gives feedback	
Uses modeling by self or other group members when appropriate	

VI. Parents' Responses	*Comments*
Parents appear comfortable and involved in session	
Parents complete homework, ask questions and are active participants	
Parents complete positive evaluations of sessions	

Summary Comments:

Name of Evaluator _____

Date: _____

Check:

_____ Leader (Self-Evaluation)
_____ Co-Leader
_____ Peer Coach
_____ Mentor/Trainer

Getting the Most out of your Online Consultation with IY Mentors/Trainers

Written by: Carolyn Webster-Stratton

While face-to-face IY group consultation is the best group leader learning because of the opportunities for modeling practices and supportive input from other group leaders, it is not always possible. Barriers to this approach may include the cost of a trainer/mentor to travel to the location as well as the group leaders' time and travel. Moreover, there can be difficulty in finding a date that suits all group leaders for a face-to-face meeting without interfering with other agency obligations. Online consultations offer opportunities for more consultation scheduled at group leader convenience and in small groups, even with dyads. However, it should not replace face-to-face consultation but supplement it.

This document provides some tips for getting the most out of your online consultation calls with accredited IY Mentors and Trainers.

1 STEP ONE: DEFINE THE SCOPE AND STRUCTURE

- Online consultation calls are typically 1-hour in length and can include multiple group leaders and agency managers.
- Consultation calls can include a discussion of video segments sent to the IY mentor/trainer for review. Or, consultations may be a discussion of questions and issues related to program delivery.
- For discussion of videos, plan on reviewing no more than 2 video pair group leaders in a 1-hour Zoom/Skype call. Keep video clips to 10-20 minutes for mentor review.

2 STEP TWO: GROUP LEADER PREPARATION FOR THE ONLINE CALL

- If no video is to be sent, review your goals and questions in advance of call and email agenda to IY mentor or trainer 1-2 days prior to Zoom/Skype call.
- For discussion of video segments, first review with co-leader (using the group collaborative checklist) and pick 10-20 minute segments from the group video for mentor/trainer review. Record time code on area to be reviewed.
- Complete Online Call Prep Form that is attached. This outlines brief background of video clip (session topic and context for what has been covered previously in session) as well as your goals for the video clip and any other issues you want to discuss.
- Send video clip to mentor/trainer 7-10 days in advance of the Zoom/Skype call. Work with your agency to set up a release of the video clip that is encrypted or password protected so that only the mentor or trainer can open it.

- Include with video clip, session checklist, participant evaluations, and Online Call Prep Sheet.
- Confirm time for Zoom/Skype call.

3 STEP THREE: FOLLOW-UP CONSULTATION

- We recommend after the initial training group leaders have a face-to-face consultation early on when first delivering the program - ideally after the first or 2nd group session. This will help group leader to know the mentor and start developing a personal relationship before the online call occurs. If this is not feasible, then scheduling an online call in advance of the group starting is very useful.
- Set up Zoom/Skype calls: ideally 3 of these spread throughout the group sessions. For example, every 2-3 weeks. An 18-session group would get one call at session 4, 8 and 12.
- If feasible, a 2nd face-to-face consultation would happen about 2/3 way through the program.
- After the group has been completed it is helpful to have a follow-up online call to summarize key learning and evaluations and plan for future goals. Additionally, a Zoom/Skype call can be set up to help group leaders prepare their first set of materials for accreditation.

NOTE: Plan your goals ahead of time for each call and summarize your goals for the next call.

Preparing for your Online Consultation Call

Name of Group Leaders: _____

_____

Session Topic: _____

Date: _____

Video clip time codes: _____

Brief description of background of video clip:

Goals for video clip sent:

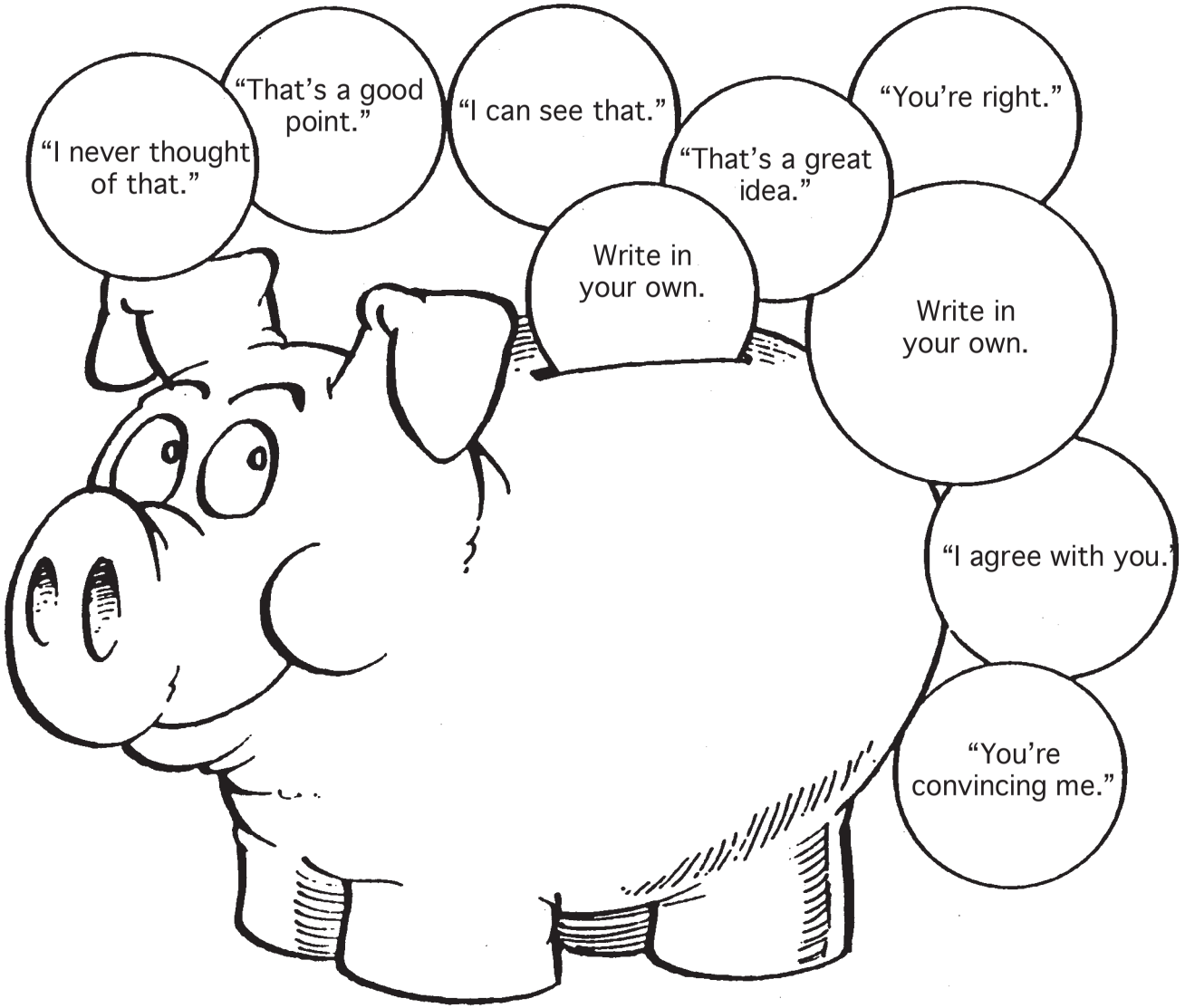
Any other specific issues I would like to discuss:

Appendix

1. Self-Empowerment Table
2. Piggy Bank Posters (to be reproduced)
3. Home Activities
4. Refrigerator Notes
5. Parents Thinking Like Scientists (2)
6. Parent Buzz Form
7. Support Network Handout
8. Refrigerator Notes
9. Brainstorm Positive Self Praise
10. Brainstorm Rewriting Commands
11. Behavior Record: Praise "Positive Opposites"
12. Brainstorm Staying Calm & Managing Anger (2)
13. Brainstorm Coping & Calming Self Talk
14. Time Out for Aggression
15. Young Child Resists Going to Time Out
16. Child Refuses to stay in Time Out
17. School Age Child Resists Going to Time Out
18. School Age Child Continues to Resist Going to Time Out
19. School Age child Refuses Time Out
20. Using Time Out for Compliance Training

Table: Sources of Increased Self-Empowerment

	CONTENT	PROCESS
KNOWLEDGE Child development Behavior management Individual and temperamental differences	Developmental norms and tasks Behavioral (learning) principles Child management (disciplinary strategies) Relationships (feelings) Self-awareness (self-talk, schema, attributions) Interactions (awareness of contingencies, communications) Resources (support, sources of assistance) Appropriate expectations Parent involvement with children	Discussion Books/pamphlets to read Modeling (videotape, live role play, role reversal, rehearsal) Metaphors/analogies Homework tasks Networking Developmental counseling Videotape viewing and discussion Self-observation/recording at home Discussing records of parents' own data Teaching, persuading
SKILLS Communication Problem -solving (including problem analysis) Tactical thinking (use of techniques/methods) Building social relationships Enhancing children's academic skills	Self-restraint/anger management Self-talk (depressive thoughts) Attend-ignore Play-praise-encourage Contracts Consistent consequences Sanction effectively (time out, loss of privileges, natural consequences) Monitoring Social/relationship skills Problem-solving skills Fostering good learning habits Self-assertion/confidence Empathy for child's perspective Ways to give and get support	Self-reinforcement Group and leader reinforcement Self-observations of interactions at home Rehearsal Participant modeling Homework tasks and practice Video modeling & feedback Self-disclosure Leader use of humor/optimism Relaxation training Stress management Self-instruction Visual cues at home
VALUES Strategic thinking (working out goals, philosophy of child rearing, beliefs)	Treatment/life goals Objectives (targeted child behaviors) Ideologies Rules Roles Relationships Emotional barriers Attributions Prejudices Past history	Discussion/debate Sharing Listening Respecting/accepting Negotiating Demystifying Explaining/interpreting Reframing Resolving conflict Clarifying Supporting Adapting



Remember to Build Up Your Bank Account With Accepting and Respecting Statements

Strengthening Children's Social Skills, Emotional Regulation, and School Readiness Skills Through Child-Directed Play

HOME ACTIVITIES FOR THE WEEK

To Do:

- **PLAY** with your child being child-directed and an "appreciative audience" for 10 to 15 minutes every day.
- **KEEP TRACK** of these play periods on the Record Sheet: Play Times handout.

To Read:

- Handouts and Chapter One *"Child Directed Play"* from *The Incredible Years* book.

OPTIONAL ACTIVITY:

- **FILL IN** the two checklists for evaluating play, and bring them to the next meeting.

Handout 1A

General Guidelines For Play Sessions with Your Child

1. Don't play a competitive game, especially with a younger child.
2. It is better to play with unstructured toys such as blocks, trucks, dolls, etc.
3. Some adults find it helpful to play at the same time every day. Another useful strategy is to take the phone off the hook so children know that the time you are spending together is important.
4. If there is more than one child in the family, try to play with each child separately if possible. It takes time to develop the skills necessary to go back and forth between two or more children effectively, so it is better not to attempt this until you have had some practice playing with each child individually.

CHILD-DIRECTED PLAY

- Follow your child's lead and interests
- Pace at your child's level.
- Don't expect too much—give your child time.
- Don't compete with your child.
- Praise and encourage your child's ideas and creativity; don't criticize.
- Engage in role play and make-believe with your child.
- Be an attentive and "appreciative audience."
- Use descriptive comments instead of asking questions.
- Curb your desire to give too much help; encourage your child's problem-solving.
- Reward quiet play with your attention.
- Laugh and have fun.

How I am Incredible!

Child's Name and Age: _____

Adults that Support My Growing and Learning:	My Temperament *(e.g., activity level, adaptability, physical sensitivity, intensity, distractibility, persistence, predictability, quiet, anxious, angry):*
My Play and Language Level *(e.g., play alone, anxious or withdrawn, want to initiate play with others but don't know how, initiate but my social interactions are inappropriate, very few words, lots of language, inappropriate language):*	My Favorite Activities *(e.g., reading, soccer, games, music, cooking, building activities, drawing, pretend play):*
Social, Emotional, Persistence, Language and Academic Skills I am Learning *(e.g., helping others, calm down methods, speaking politely, taking turns, listening):*	My Parent's Goals for Me: *(e.g., helping my child follow directions, to better at school, improve his/her academic success, reduce my own anger and stress):*

REFRIGERATOR NOTES
Promoting Your Child's Healthy Media Diet (2 to 6 years)

Excessive screen time can interfere with children's development of friendships, impact their physical fitness, contribute to obesity and lack of sleep, and decrease their interest in reading and their motivation for school success. Violent screen time content has been shown to increase children's aggressive behavior and hostility. Here are some tips for helping your child develop healthy screen time habits, while minimizing their negative effects.

Set household rules regarding how much screen time your child is allowed. The American Academy of Pediatrics (AAP) recommends the following:

- For children under 2 years, discourage all screen time.
- For children 2-5 years, limit to one hour/day of high quality programming
- For children 6-12 limit to 90 minutes/day

Supervise and monitor the content children are consuming. Decide which program, games, or sites are healthy as well as those that cannot be viewed or played. Websites such as Common Sense Media https://www.commonsensemedia.org/ can provide a guidance on media content that is appropriate for children of different ages.

Take an active role in your children's media education by watching TV programs with them and participating in their computer games so you can mitigate their negative effects and enhance their use as a way to promote interaction, connection and creativity. For example you can promote your child's social skills and empathy by talking about movie characters who are sensitive and caring, or in other cases, you can discuss a bad decision or disrespectful behavior of a character. When watching commercials, have discussions about the purpose of commercials and the messages that they send about unhealthy food or consumerism.

Keep all screens in common rooms of your house so that you can monitor or track your child's screen time use. Help your child turn off the screen when he or she has reached the daily limit. Praise and reward your child for healthy viewing habits and following the screen time rules.

Set a bedtime that is not altered by screen time activities and avoid screen time 1 hour prior to bedtime. Don't put computers, smartphones or TVs in your child's bedroom.

Strive for balance between screen time activities and other activities involving social interactions, making friends, physical activity, reading or some other special play time. Have some designated time periods or days that are "screen time-out" times for all family members. Promote a healthy media diet that encourages social, emotional and physical health.

Set a good example by modeling healthy screen time habits.

See https://www.healthychildren.org/English/media/Pages/default.aspx for a tool developed by American Academy of Pediatrics to develop your own family media plan

REFRIGERATOR NOTES
Promoting a Healthy Media Diet (6-12 years)

- Screen time including computer time, video games, I-pads, I-phones, Facebook, Twitter, YouTube and watching TV can become addictive. Research indicates that the average 8-10 year-old child spends nearly 8 hours a day outside of school with some form of screen time. Tweens and teens spend more than 11 hours a day using screens. Excessive screen time can interfere with children's friendships, impact their physical fitness, contribute to obesity and lack of sleep, and decrease interest in reading and motivation for school success. The American Academy of Pediatrics (AAP) recommends 1-2 hours of screen time per day. How can parents help children dial back screen use to meet these recommendations?
- Here are some tips for reducing screen time, making that time a positive experience, and minimizing the negative effectives of screen time.
- Discuss with your children your household rules regarding the amount of screen time allowed each day. For children 6-12 years old, approximately 90 minutes per day, or less, is generally recommended.
- Plan when screen time will occur. Avoid screen time 1 hour before bed or during dinner.
- Don't put computers or TVs in your child's bedroom. Keep them in a public place where you can monitor their use. Have a rule that smartphones and handheld devices must also be used in public places, not in children's bedrooms.
- Help children understand that homework must be completed before screen time is allowed, unless screen time is related to research and homework assignments.
- Supervise and monitor the media content children are consuming. Know what type of computer games, videos, TV programs, and web sites they are using or watching. Decide which programs, games, or sites are healthy and which are off-limits. Websites such as Common Sense Media can be helpful to provide information about age appropriate media content: https://www.commonsensemedia.org/

REFRIGERATOR NOTES (CONTINUED)
Promoting a Healthy Media Diet (6-12 years)

- Set up passwords so that children cannot download games without a parent password, and consider whether you want to set restrictions on website browsing on computers that children are using.
- Limit the amount of data you allow your child to have on devices. Explain to your child what programs use data (YouTube, streaming movies, sending video files) and discuss consequences for using more than allowed.
- Make a decision about when and how you want your child to have access to wifi. In this age group, it is recommended that children do not have access to the internet except on family computers.
- Take an active role in your children's media education by watching TV programs, YouTube videos, and movies with them and participating in their computer games so you can mitigate their effects and enhance their use as a way to promote communication and connection. For example, for promoting your child's social skills and empathy you can talk about movie characters who are sensitive, caring, and who are making good friendship choices. Some TV and social media programs can be a catalyst for a discussion about the effects of drinking, drugs, sexual activity, violence, prejudice, managing conflict and death. Discussions about the use of advertisements can help children understand messages about consumerism, food choices, gender roles, and other social issues.
- Teach your children the importance of being polite and having good media etiquette in all forms of social media. Discuss what kinds of things are okay to post on social media platforms; set guideline around posting pictures, videos, and status updates.
- Have rules that children do not share personal information on social media with anyone that they don't know. Explain that once information or an image or video is posted on the internet, it is not possible to retrieve that image.
- Understand that children in this age range do not have good long term judgement and planning and will often not be able to think through the long-term consequences of impulsive social media decisions. Monitoring and limiting their screen use is the best prevention strategy for this age.
- Talk to your children about the consequences for breaking the family rules around screen use. Monitor or track your child's screen time use. Praise and reward your child's healthy viewing habits and following the screen time rules.
- If your child is a victim of cyberbullying, take action and attend to your child's mental health needs. Stop the use of media platforms where the bullying is occurring, and report the incident to teachers or school counselors.

REFRIGERATOR NOTES (CONTINUED)
Promoting a Healthy Media Diet (6-12 years)

- Model good screen use habits. Set some non-screen times for all family members, including parents. Dinner time, the hour prior to bedtime, and other times when family members are together are good times for this.
- Strive for balance between screen time activities and other activities involving social interactions, making friends, physical activity, reading, or other activities around the house. When children are "bored" and need to find other things do to, they often find creative ways to use their time. While screen devices have great benefits if used appropriately and as part of a healthy media diet, non-screen time is crucial for your child's social, emotional, physical and learning development as well as relationships with family and friends.

See https://www.healthychildren.org/English/media/Pages/default.aspx for a tool developed by American Academy of Pediatrics to develop your own family media plan

REFRIGERATOR NOTES

Promoting Children's Healthy Life Style and Well Being

- Help your children understand the health benefits of being physically active every day. During child directed play, offer options of playing tag or Frisbee, jumping rope, swimming, dancing, playing soccer or taking a walk to the park with you.
- Avoid making comments about weight (your own or your child's). Instead, use language that focuses on healthy choices and strong bodies that allow you to be active (walk, play, climb, dance, etc.).
- Limit your child's total screen time to no more than 1 hour a day. Avoid screen time for children under 2 years of age.
- Provide healthy snacks: for example fruit or vegetables to dip in yogurt or hummus. Avoid continuous snacking, and instead, offer food at predictable meal and snack times. Limit high-fat, high-sugar, or salty snacks.
- In the context of otherwise healthy eating, offer moderate amounts of "treat" foods to help children learn to regulate their intake of sweets.
- At mealtimes provide a variety of health foods; fruits and vegetables, whole grains, lean meats; avoid foods high in trans fats and/or saturated fats.
- Allow your child to serve him/herself. Do not require children to clean their plates and do allow them to have more of anything healthy that is being served. This will help them learn to pay attention to their own hunger signals.
- Do not put your child on a weight reduction diet unless your physician supervises. For most young children, the focus is maintaining current weight, while growing in height.
- Offer children water or low/non-fat milk. Limit soda and juice intake.
- Have predictable family meals together where you have time to talk and enjoy the meal together. Establish dinner as a "no screen" time.
- Involve children in food planning, shopping, and meals preparation.
- Check that your child care providers are encouraging healthy eating and limiting junk food.
- One of the most powerful ways your children learn to be healthy is by observing you. Therefore, model being physically active, buy and eat healthy foods, express your enjoyment of food and family meals, and model positive talk about your family's healthy bodies.

Parents Thinking Like Scientists

Child Problems

Child Strengths

Goals

Strategies

Benefits

Obstacles
(thoughts, feelings, behavior in self & others)

Ongoing Plans

Parents Thinking Like Scientists

Child Problems

Child Strengths

Goals

Incredible Years Buzz!

Leader's Name: **E-mail:** **Date:**

Check what we've accomplished!

- ☐ Child Directed Play
- ☐ Academic Coaching
- ☐ Persistence Coaching
- ☐ Social Coaching
- ☐ Emotion Coaching
- ☐ Encouragement & Praise
- ☐ Self-Praise
- ☐ Incentives
- ☐ Self-Care
- ☐ Household Rules
- ☐ Predictable Routines
- ☐ Limit Setting
- ☐ Ignore, Redirect & Distract
- ☐ Logical Consequences
- ☐ Time Out to Calm Down
- ☐ Teach Children to Calm Down
- ☐ Problem Solving

The Incredible Years

www.incredibleyears.com

Reminders

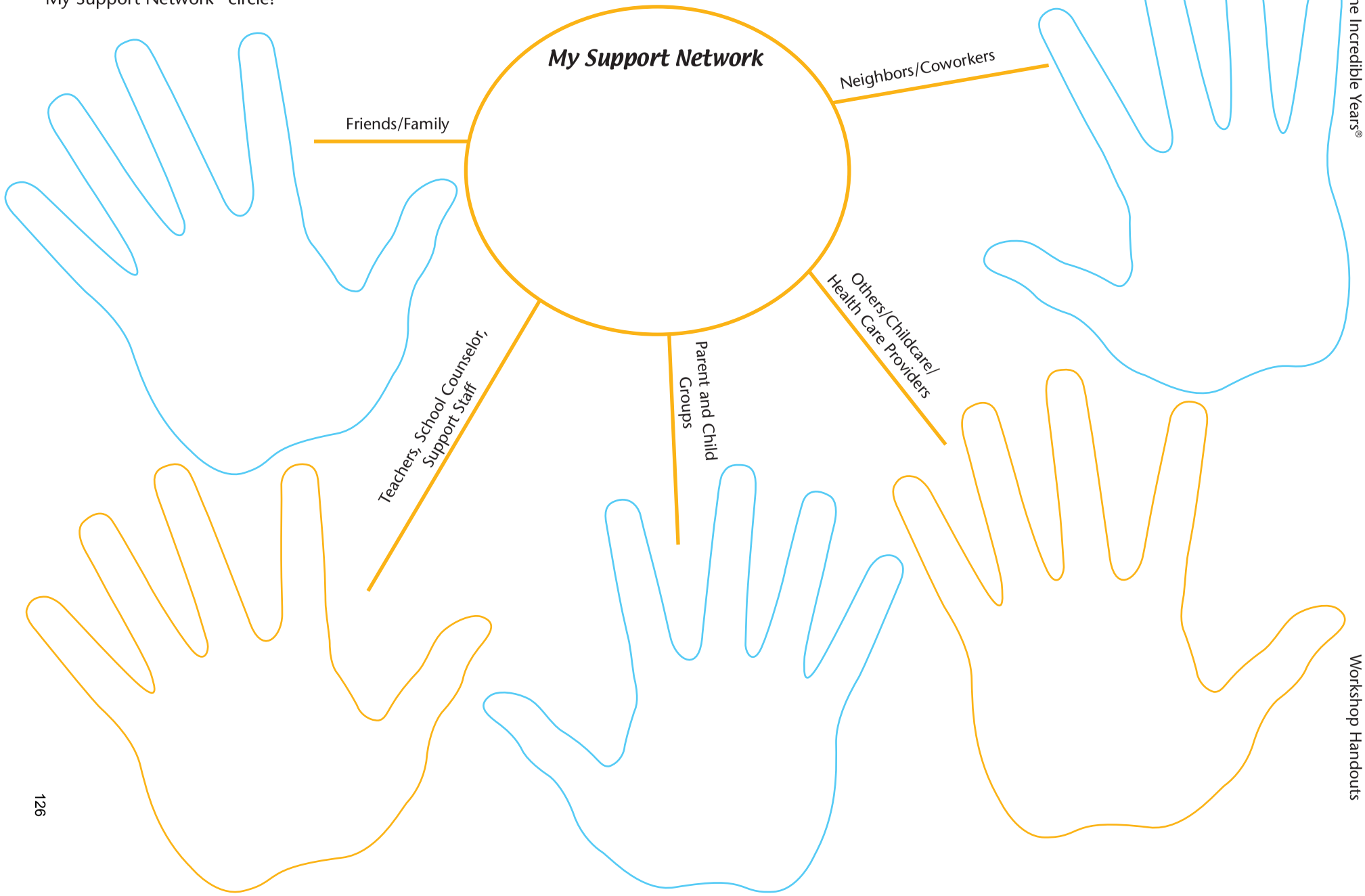
Principles

Personal Goals and Planned Practices

Parent Support Network

Who can lend a helping hand?

Think about people in your support network. Each hand represents a different group of people. Write in each hand specific people from that network who can help provide support to you and your child! You can draw or paste of picture of your family in the "My Support Network" circle!



Facilitating Children's Language & Pre-School Readiness Skills: Parents as "Academic and Persistence Coaches"

Using academic and persistence coaching to narrate children's behavior and activities is a powerful way to strengthen children's language and school readiness skills. The following is a list of actions, behaviors and objects that can be commented upon when playing with your child. Use this checklist to practice these coaching methods.

Objects, Actions	**Examples**
_____ colors _____ number counting _____ shapes _____ names of objects _____ sizes (long, short, tall, smaller than, bigger than, etc.,) _____ positions (up, down, beside, next to, on top, behind, etc.,)	"You have the red car and the yellow truck." "There are one, two, three dinosaurs in a row." "Now the square Lego is stuck to the round Lego." "That train is longer than the track." "You are putting the tiny bolt in the right circle." "The blue block is next to the yellow square, and the purple triangle is on top of the long red rectangle."
Persistence	
_____ working hard _____ concentrating, focusing _____ stay calm, patience _____ trying again _____ problem solving _____ thinking skills _____ reading	"You are working so hard on that puzzle with your friend and thinking about where that piece will go." "You are so patient and just keep trying all different ways to make that piece fit together." "You are staying calm and trying again." "You are thinking hard about how to solve the problem and coming up with a great solution to make a ship."
Behaviors	
_____ following parent's directions _____ listening _____ independence _____ exploring _____ waiting	"You followed directions exactly like I asked you. You really listened." "You have put your shoes on all by yourself." "You asked for a turn and now you are waiting for a turn on the computer. You show you are ready for school."

Emotion Learning: Parents as "Emotion Coaches"

Describing children's feelings is a powerful way to strengthen their emotional literacy. Once children have emotion language, they will be able to better regulate their own emotions because they can tell you how they feel. The following is a list of emotions that can be commented upon when playing with a child. Use this checklist to practice describing your child's emotions. You can also use the feeling cards to ask children to show you the picture of their feelings.

Feelings/Emotional Literacy	Examples
_____ happy _____ frustrated _____ calm _____ proud _____ excited _____ pleased _____ sad _____ helpful _____ worried _____ confident _____ patient _____ having fun _____ jealous _____ forgiving _____ caring _____ curious _____ angry _____ mad _____ interested _____ embarrassed	"That is frustrating, and you are staying calm and trying to do that again." "You look proud of putting that together." "You seem excited about playing in the bath." "You are so patient. You keep trying to figure out where the puzzle piece goes. You got it! You look happy." "You look like you are having fun playing with your friend, and he looks like he enjoys doing this with you." "You are so curious. You are trying out every way you think that can go together." "You are embarrassed you spilled paint on your shirt, but you look pleased with your painting." "Your friend is happy you shared with her."

Remember to Model Feeling Talk and Sharing Feelings

- "I am proud of you for sharing with your friend."
- "I am really happy playing with you."
- "I was nervous it would fall down, but you were careful and patient, and your plan worked."

Facilitating Children's Social Learning: Parents as "Social Skills Coaches"

Describing and prompting children's friendly behaviors is a powerful way to strengthen children's social skills. Social skills are the first steps to making close friendships. The following is a list of social skills that you can comment on when playing with your child or when your child is playing with a friend. Use this checklist to practice your social skills coaching.

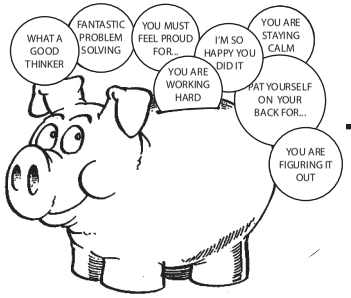
Social/Friendship Skills	Examples
_____ helping _____ sharing _____ teamwork _____ using a friendly voice (quiet, polite) _____ eye contact	"That's so friendly. You are sharing your blocks with your friend and waiting your turn." "You are both working together and helping each other like a team." "That is friendly to look at your friend."
_____ listening to what a friend says _____ taking turns _____ asking _____ trading _____ waiting	"You listened to your friend's request and followed his suggestion. That is very friendly." "You waited and asked first if you could use that. Your friend listened to you and shared." "You are taking turns. That's what good friends do for each other."
_____ responding to a friend's suggestion _____ gesturing (e.g., pointing) _____ smiling at peer _____ using soft, gentle touch _____ asking or gesturing to use something a friend has _____ cooperating _____ including another in play	"You made a friendly suggestion and your friend is doing what you wanted. That is so friendly." "You pointed to where the red block is to help your friend." "You are helping your friend build his tower. "You are being cooperative by sharing." "You worked together to figure out how to put those blocks together. You are good friends."

Prompting

- "Your friend is looking for yellow blocks. Do you think you can find her a yellow block?" (praise child if s/he tries to help and/or point to yellow block)
- "You did that by accident. You can say 'I am sorry' to your friend."

Modeling Friendly Behavior

- Parents can model waiting, taking turns, helping, and complimenting, which also teach children these social skills. For example, "I'm going to be your friend and share my block with you."



REMEMBER TO BUILD UP YOUR BANK ACCOUNT

RECORD SHEET

Academic, Persistence, Social & Emotional Coaching

Date	Time	Examples of Coaching Statements	Types of Child Behaviors Coached	Child's Response
		"You seem frustrated but are staying calm and I think you are figuring it out." *"You look proud and I'm so happy you did it."* *"The blue block is on top of the red rectangle"*		

Brainstorm/Buzz

Brainstorm possible self-praise you can use to encourage yourself as a parent. Write these statements on your note pad.

Positive Self-Praise

I can stay calm…he's just testing

I am working hard as a parent…

Goal:

I will commit to stopping my self-criticism and looking at something I did well each day as a parent.

Brainstorm–Rewriting Commands

Rewrite the following ineffective commands into positive, clear, respectful commands.

Ineffective Commands	Rewrite
• Shut up • Quit shouting • Stop running • Watch it • Why don't we go to bed? • Let's clean up the living room • Cut it out • What is your coat doing there? • Why are your shoes in the living room? • Don't shove salad in your mouth like a pig • Why is your bike still in the driveway? • You look like a mess • Stop bugging your sister • You are never ready • Your clothes are filthy • This room is a mess • Don't whine • You are impossible • Stop dawdling • Hurry up • Be quiet • Why are you riding on the road when you've been told not to? • I'll hit you if you do that again	

Handout

BEHAVIOR RECORD

Praise "Positive Opposites"

Behaviors I want to see less of: *(e.g., yelling)*	**Positive opposite behavior I want to see more of:** *(e.g., polite voice)*
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

Brainstorm/Buzz Staying Calm & Managing Anger

Rewrite the following negative self-talk with positive coping thoughts.

Negative Self-Talk	Positive Coping Thoughts
• I can't stand this—it's too hard!	
• I don't know what to do.	
• Ignoring will never work.	
• I am losing control and will explode soon.	
• I am going to hit her just like my mom did to me.	
• It's awful to let him disrespect me. It's not good to look weak in front of my child.	
• I hate being disrespected.	
• She will never change.	
• I can't let him challenge my authority.	
• He hurt me so I should hurt him.	
• I don't like him when he's like this.	

Brainstorm/Buzz Staying Calm & Managing Anger

Continued, from previous page.

Negative Self-Talk	Positive Coping Thoughts
• The neighbors will complain if I don't get this stopped. • She will never stop whining. • A little more force on my part will stop her. • That brat knows how much this bugs me—he's doing it on purpose. • I'm an inept parent—should never have had children. • I can't let her get away with that. • It's all his dad's (or mom's) fault.	

Goal: I will commit to stopping and challenging my negative self-talk and working on practicing using coping and positive self-talk as well as giving myself time to calm down.

Brainstorm/Buzz Coping and Calming Self-Talk

Think about ways to stay calm, assertive and patient when using Time Out.

Practice challenging negative self-talk and substituting positive self-talk and coping statements. On your notepad, write down some self-talk that you can use when you feel anger mounting.

Positive Self-Talk

I can handle this…

I can control my anger…

I will take a brief Time Out myself…

Challenge irrational thoughts

Tips for Using Puppets to Promote Preschool Children's Social and Emotional Development

Carolyn Webster-Stratton Ph.D.

Visit www.incredibleyears.com to learn more!

Preschool children are working to accomplish the important developmental milestones of learning social and friendship skills including beginning to share, help others, initiate social interactions, listen, and cooperate with peers. They are also working on emotional regulation skills including emotional literacy, self-control over aggressive behaviors, ability to wait and accept limits, and beginning problem solving skills.

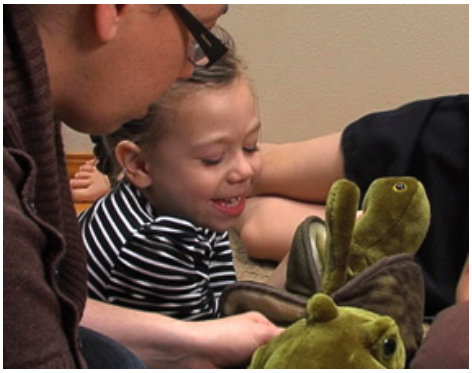
One of the ways to promote social and emotional skills in preschool children is through the use of puppet play. Puppet play is effective because it helps the parent/teacher enter into the child's imaginary world and allows children to experience the feelings of other characters (early empathy development) and learn important social behaviors and conversation skills.

With puppets, dolls, or action figures you can act out stories you are reading with children, make up fantasies, and explore solutions to pretend problems. You may be nervous at first using puppets, but try it out and before long you will experience the joy of entering into your child's thoughts, feelings and imagination, one of the most intimate places you can be at this age.

Here are a few things to have your puppet do when playing with child:

Puppet Scenarios:

• **Puppet models greeting child.** For example, "Hi I am Tiny Turtle. What is your name?" When the child tells your puppet his/her name, puppet thanks him/her for being so friendly. (Modeling friendly social greetings.)



• **Puppet models interest in child.** For example, "What do you like to do?" When the child tells your puppet his/her interests, puppet also shares his/her interests. (Learning how to get to know someone.) You can also prompt the child to ask the puppet what s/he likes to do? (Learning how to show interest in someone else.)

• **Puppet asks for help.** For example, "I can't get this block to go together, can you help me?" When the child helps your puppet, your puppet compliments his/her helping behavior. (Learning to ask for help as well as how to help a friend.)

• **Puppet shares his/her emotion.** For example, "I am embarrassed because I can't ride my bike. Do you know how to ride a bike?" Ask the child what your puppet is feeling. Encourage or prompt the child to say something to make the puppet feel better. (Learning to express emotions and think about another person's emotions.)

• **Puppet shares something with child.** For example, "I see you looking for green blocks, would you like my green block." (Modeling sharing.) If child takes your puppet's block, say "I'm happy to help you". (Connecting sharing action with emotion.)

• **Puppet waits for his turn.** For example, "I am going to wait until you finish that game, then can I have a turn?" If child gives your puppet a turn, puppet thanks him and tells him it makes him feel happy to have such a friend.

Note: If the child does not have the language skills to respond verbally to the puppet, it is still good for the puppet to model the words involved in the social interaction. You can also structure interactions that involve nonverbal responses from the child. "Would you share that with me?" "Would you like to shake the puppet's hand?" "Can you help me build this tower?" This way, the focus is on the child's friendly behavioral response to the puppet. You and the puppet can provide the verbal structure. This will support the child's eventual language development in these social situations.

Parent/Teacher Praise: Parents/teachers can use a silly/different voice for the puppet character and then go out of role as parent/teacher to praise the child for his or her social skills. Parents/teachers can look for opportunities to comment and praise the child when she/he waits, takes turns, helps, offers a friendly suggestion, asks for help, shows interest or empathy, is gentle and listens well with your puppet.

Parent/Teacher Prompts: In these puppet plays parents/teachers can prompt a child's appropriate social responses by whispering in his/her ear some ideas for what to say to the puppet. For example, "you can tell the puppet you like to play with trucks." Or, "you can say please can I have that book?" Don't worry if the child doesn't use your suggestion, just move on to something else as compliance is not required. Often times the child will copy your suggestion and then you can praise him/her for such nice asking or sharing.

Remember: Keep it simple, have fun, and do not have your puppet model negative behaviors. Try using puppets when reading stories to act out the character's feelings and communication.

For more information, please visit: www.incredibleyears.com, and see "Wally's Detective Books for Solving Problems" (set of 4). To order materials, visit www.incredibleyears.com/order/

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Responding to Child Dysregulation and Teaching Self-Regulation

Carolyn Webster-Stratton, Ph.D.

My child is upset, angry, defiant & beginning to dysregulate

Parent Self-Talk

"My child is upset because… and needs help to self-regulate and problem solve."

"I can stay calm. This will help my child to stay calm."

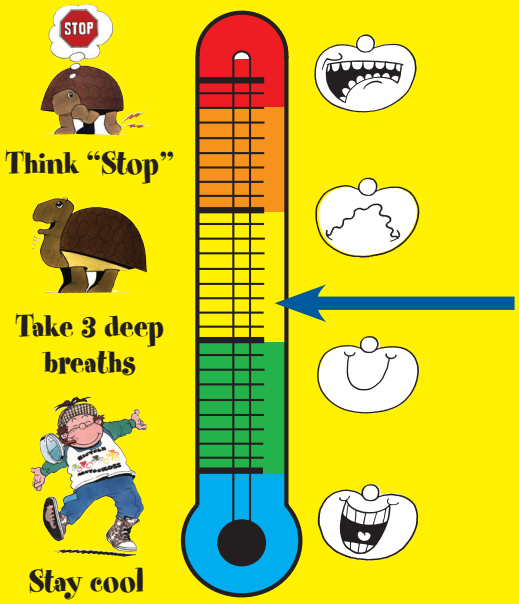
"I can ignore this behavior as long as he is not hurting someone or breaking something."

"I can be supportive without giving too much attention to disruptive behavior."

"If my child is responsive and cooperative to my coaching, then it's a good time to coach. If my coaching makes her angrier, then she needs space and privacy to calm down."

Parent Response

- Model deep breathing, patience and being sympathetic to child
- Help child use calm down thermometer and take deep breaths
- Redirect child to another activity
- Ignore child's dysregulated behavior as long as behavior is not unsafe
- Label child's emotion and coping strategy: "You look angry, but you are trying hard to stay calm with breathing and remembering your happy place."
- Stay nearby and be supportive.
- Give attention and coaching to behaviors that encourage your child's coping and emotion regulation.



Slow Down

When children are angry and dysregulated, parents may also feel angry and out-of-control and may respond by yelling, criticizing, or spanking. At these times, Time Out can provide time and space for the parent, as well as the child, to self-regulate. Here are some tips for parent self-regulation:

- STOP and challenge negative thoughts and use positive self-talk such as: "*All children misbehave at times. My child is testing the limits of his independence to learn that our household rules are predictable and safe.* This is normal for children this age and not the end of the world."
- Do some deep breathing and repeat a calming word: "relax," "be patient," "take it easy."
- Think of relaxing imagery or of fun times you have had with your child.
- Take a brief break by washing your face, having a cup of tea, putting on some music, or patting the dog. Make sure your child is safe and monitored.
- Focus on coping thoughts such as: " *I can help my child best by staying in control.*"
- Forgive yourself and be sure you are building in some "personal time" for relaxation.
- Ask for support from someone else.
- Reconnect with your child as soon as you are both calm.

Like your child you can get yourself into a "green" calm state and try again.

My child continues to dysregulate and becomes aggressive

Parent Self-Talk

"My child is out of control and too dysregulated to benefit from prompts to calm down or to discuss solutions to problems."

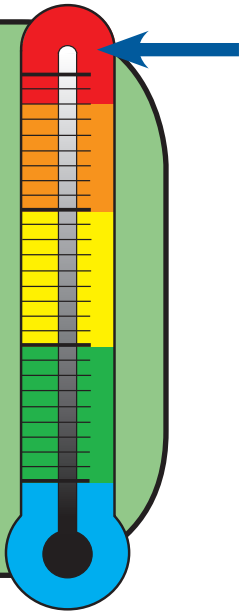
"I need to give my child time away from attention to calm down so he doesn't hurt someone."

"I have taught my child how to use the Time Out or Tiny Turtle chair to calm down so I can do that now. "

"Time Out is a safe and respectful way for my child to learn to reflect and self-regulate."

Parent Response

- I say, "Hitting is not allowed, you need to go to Time Out to calm down. " (This place has a calm down thermometer to remind my child of what to do in Time Out to calm down.)
- I wait patiently nearby to let him re-regulate and make sure others don't give this disruptive behavior attention.
- I give him privacy and don't talk to him during this calm down time.
- When he is calm (3-5 minutes), I praise him for calming down.
- I support my child to re-enter an activity or routine.



My Child Is Calm Now

Parent Self-Talk

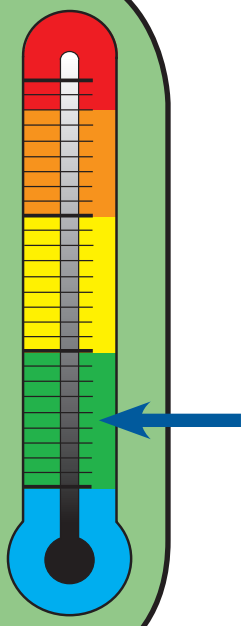
"Now I can reconnect with my child and help her learn an alternative way to solve her problem."

"She is learning she gets more attention for positive behavior than inappropriate behavior."

"I can help her learn to express her frustration and anger in more appropriate ways."

Parent Response

- I praise my child for calming down
- I distract my child to a new learning opportunity.
- I do not force my child to apologize because insincere apologies do not teach empathy
- I engage her in something else so that we have positive Time In together and she feels loved.
- I start using social coaching as my child plays
- I also look for times when she is calm, patient, happy, or friendly.
- I use emotion coaching to help her understand these self-regulated feelings get my attention.
- If she starts to dysregulate again, I name her uncomfortable feelings, help her express these verbally, and prompt her to remember her coping strategies.
- During times when my child is calm, I use puppets, games, and stories to help her learn alternative solutions to common childhood problem situations.



Bottom Line

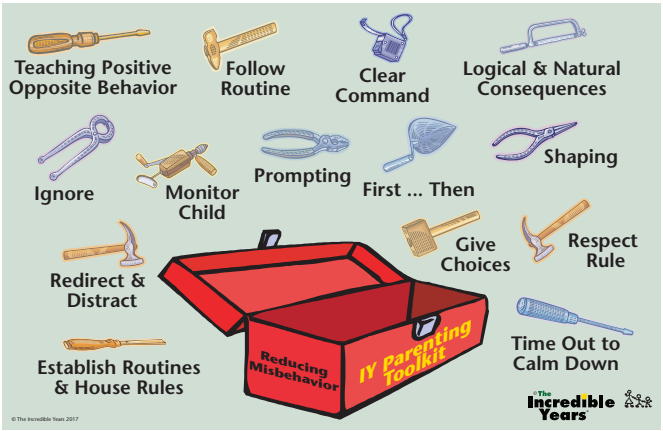
My child learns that taking a Time Out feels like a safe and secure place to calm down; it is not punitive or harsh and isolating; my child understands that when he has calmed down, he can join in family or peer activities without blame and has a new opportunity to try again with another solution to his problem. He feels loved when this strategy has been used and has sometimes seen his parents or teachers use this same strategy when they are angry. My child gets far more Time In attention from me for positive behaviors than negative behaviors. He feels loved and secure when using Time Out because it gives him time to re-regulate and try again in a loving environment. Time Out provides me with a chance to take a deep breath and calm down so I can respond to my child in a calm, firm, consistent, nurturing or caring manner.

Time Out is One of Many Tools in the Incredible Years® Tool Kit

Is Time Out used in the Incredible Years® Programs? Yes, *Time Out to Calm Down* is a non-punitive discipline strategy used strategically and sparingly in IY programs for parents, teachers, and children to promote and build children's emotional self-regulation skills. This building tool is reserved for times when a child is too physically angry or emotionally dysregulated to be able to respond rationally to other evidence-based behavior management approaches.

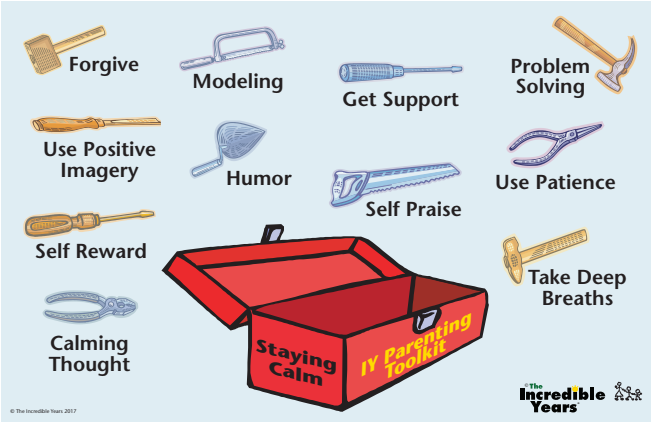
Are there alternatives to Time Out? In the Incredible Years® programs parent and teachers are taught a wide variety of relationship and behavior management tools. The training begins with a focus on relationship-building, child-directed play, social-emotional and persistence coaching, praise and encouragement, and incentives. These approaches build positive attachment and teach children replacement behaviors or "positive opposites" to inappropriate behaviors that adults want to reduce.

Next parents and teachers learn appropriate proactive behavior management tools such as clear rules, predictable routines, planned distraction, redirection, ignoring, logical and natural consequences, Time Out to Calm Down, and problem solving skills. Parents and teachers learn to choose strategies from this toolkit to set up environments that support children's social-emotional development and result in positive peer and adult relationships and optimal academic and language learning.



When is Time Out recommended? When children misbehave, parents may redirect, ignore, problem solve, set a limit, use a when/then, or give a brief consequence. For most misbehaviors, these tools work well. Time Out is reserved and used sparingly for targeted negative behaviors such as times when children are highly emotionally dysregulated and aggressive or destructive and are not able to cognitively process or respond rationally to other supportive management strategies or problem solving.

Won't children feel abandoned if parents and teachers use Time Out when children are upset? Time Out is not used in a vacuum! Children are taught about Time Out in a neutral context, when they are calm. They practice with puppets such as Tiny Turtle who teaches them how to go to Time Out, take rocket ship breaths to calm down, to go in their turtle shells, and think about their happy place. They learn about using a Calm Down thermometer to regulate their emotions from upset to calm. They are taught self-talk ("I can do it." "I can calm down."). They discuss with parents, teachers, and the puppets why Time Out is helpful. They learn what behaviors will result in their parents or teachers asking them to take a Time Out to Calm Down. They learn that parents and teachers also take Time Outs to calm down.



What does Time Out look like? Parents and teachers are taught that they need to be calm, patient, and caring when giving a Time Out. Time Outs are brief, 3-5 minutes, or until the child is calm. Time Outs are given in the same room as the parent or teacher so that the child can be monitored and will know that an adult is near. Support materials are available for children to use to calm down during Time Out (Calm Down Thermometer, Tiny Turtle puppet, or other calming objects). During Time Out, parents or teachers do not give attention, but at the end of Time Out, they reconnect with the child and the child is given a new opportunity to be successful. The focus is on the fact that the child calmed down and on ways for the child to positively re-engage in the environment. Children are not scolded or reminded about the reasons for the Time Out. When appropriate, parents and teachers may engage in positive problem solving with the child later when the child is calm and receptive.

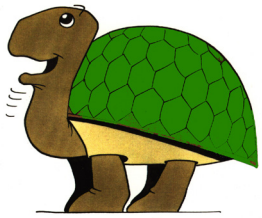
Why do some people think Time Out is harmful? In some contexts, Time Out has been used in a punitive or isolating way. When the Time Out tool is misused, it can be harmful to children and to their relationships with adults. In some cases, misuse of this tool has led to school or agency policies against Time Out. It is always important that Time Out is used thoughtfully, caringly, with patience and as one small part of a positive, consistent, loving approach and a full toolkit with a strong relationship foundation.

Is there any evidence that Time Out works? Four decades of research has shown that, when done effectively, Time Out produces positive child outcomes in terms of reducing misbehavior and increasing children's sense of security in their relationships as well as preventing child maltreatment. Many parents have told us that it helps them to stay calm themselves because they have a predictable blueprint to follow that helps them maintain their positive, respectful, and trusting relationship. When adults use this tool appropriately, they are modeling a nonviolent response to conflict that stops the conflict and frustration, and provides a cooling off period for both children and parents. It gives children a chance to reflect on what they have done, to consider better solutions, and fosters a sense of responsibility.

What do children say about Time Out? The children who have experienced Time Out to Calm down in the Incredible Years® programs often recognize that it is helpful. Some learn to take a Time Out on their own, without an adult prompting the Time Out. Below are quotes from discussions with children about Time Out:

Child to Wally Puppet after practicing Time Out: *"Wally, it's okay if you have to go to Time Out. People will still like you. You can just say 'teacher, I've calmed down now.'"*

Child about Time Out and breathing: *"It calms you down. You breathe and you let it all out."*



Child about Time Out as time for self-reflection: *"You think about 'oh what have I done. I've made a bad mistake, and I can't do it again the next day.' Then you're feeling a little bit happy."*

Child about what he learned from Tiny Turtle: *"You go in your shell when you are angry and you take 3 deep breaths…..you have to calm down when you are angry or sad."*

Handout on Using Time Out to Help Children, Parents, and Teachers Self Regulate:

This handout (see link below) describes how parents and teachers can support children to learn self-regulation skills. This teaching occurs outside of Time Out at times when children are calm and able to learn and practice. Gradually children will learn that they have the skills to do this self-regulation when they are upset: **http://www.incredibleyears.com/download/resources/parent-pgrm/Responding-to-dysregulation-and-teaching-children-to-self-regulate_parent_v4.pdf**

More detailed information about how to teach children to take Time Outs to calm down can be found in Chapter 9 of The Incredible Years parent and teacher books. **http://www.incredibleyears.com/books/the-incredible-years-a-trouble-shooting-guide-for-parents-of-children-aged-3-8-years-3rd-edition/**

http://www.incredibleyears.com/books/incredible-teachers-nurturing-childrens-social-emotional-and-academic-competence/

Calm Down Procedure for Aggression

©The Incredible Years®

Children Ages 3–6 Years

Scenario #1: Child goes to Calm Down Area.
Handling Misbehavior Part 3: Vignettes 9–12

Child hits

↓

Check in with child who was hit.
"I'm sorry she hit you. She made a mistake."

→ Command
"You hit. You need to go to the calm down area"

→ Child goes to Calm Down Area
(No attention given for 4-5 minutes)

→ Child calm for last 2 minutes

↓

Parent ends time & re-engages child
"Your body is calm. You can play with your blocks"

← Parent praises child's first positive behavior.
"That's so friendly the way you're sharing."

Young Child Resists Going to Calm Down Area

Children Ages 3–6 Years

©The Incredible Years®

Scenario #2: Child resists going to Calm Down Area.

Child hits

↓

Check in with child who was hit.
"I'm sorry she hit you. She made a mistake."

→ Command
"You hit. You need to go to calm down area"

→ Child refuses to go to Calm Down Area

→ Parent gives 1 warning.
"You can go by yourself, or I can help you." "

↓

Child complies
No attention given for 4-5 minutes, last 2 minutes child is calm

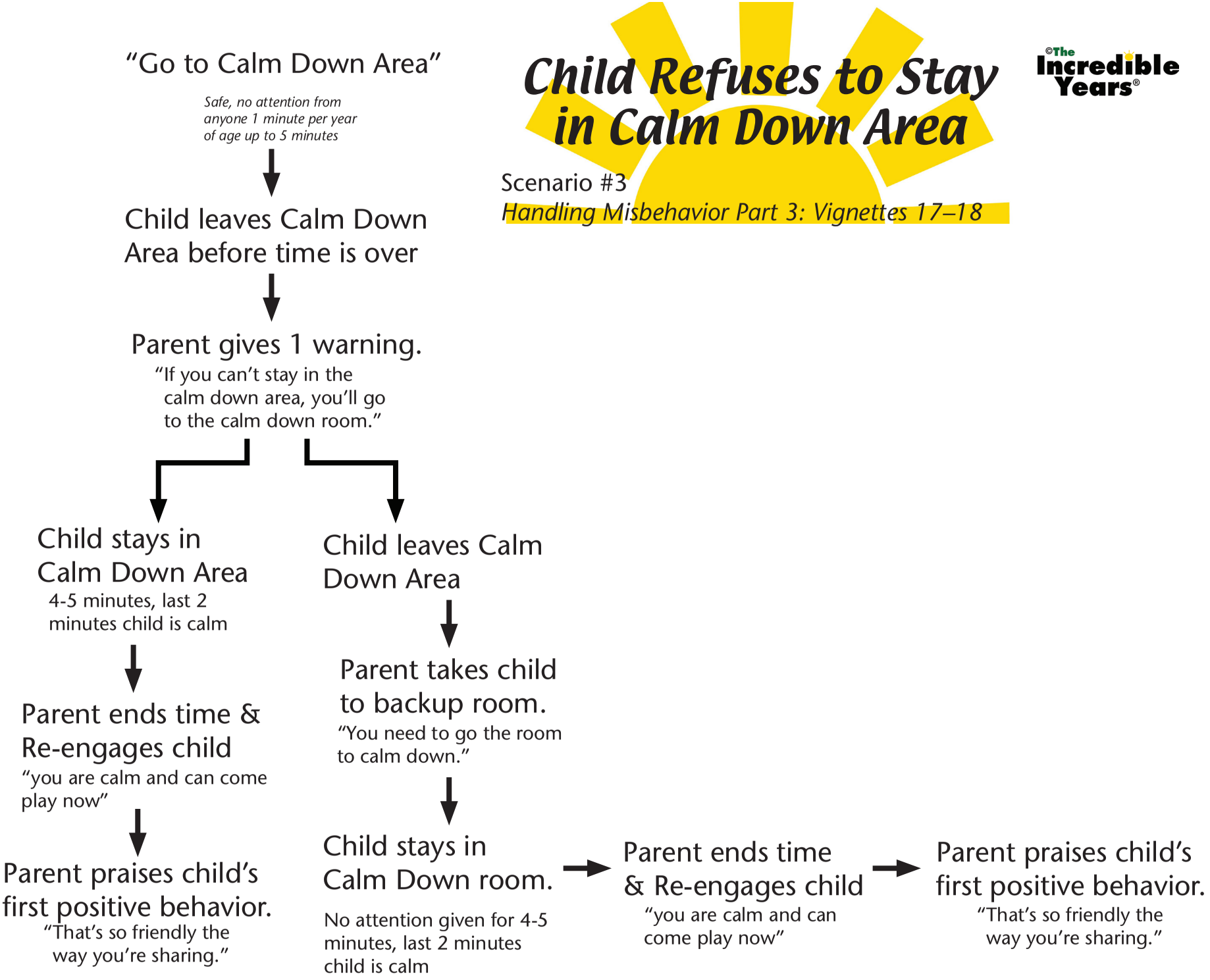
← Parent ends time & re-engages child
"Your body is calm. You can play with your blocks."

← Parent praises child's first positive behavior.
"That's so friendly the way you're sharing."

Child Refuses to Stay in Calm Down Area

Scenario #3

Handling Misbehavior Part 3: Vignettes 17–18



School Age Child Resists Going to Calm Down Area

Children Ages 6-10

©The Incredible Years®

Scenario #2B: Child initially resists going to Calm Down Area.
Handling Misbehavior Part 3: Vignette 20

Child hits

↓

Check in with child who was hit.
"I'm sorry she hit you. She made a mistake."

→ Command
"You hit. You need to go to calm down area"

→ Child refuses to go to Calm Down Area

→ Parent gives warning.
"That is one extra minute now. That's 6 minutes." (Add time up to 9 min. if child continues to refuse)

↓

Child complies
No attention given for 4-5 minutes, + extra time earned for delaying, last 2 minutes child is calm

← Parent ends time & re-engages child
"Your body is calm. Would you like to make cookies?"

← Parent praises child's first positive behavior.
"That's so friendly the way you're sharing."

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School Age Child Continues to Resist Going to Calm Down Area

Children Ages 6-10

©The Incredible Years®

Scenario #2C: Child continues to refuse to go to Calm Down Area.
Handling Misbehavior Part 3: Vignette 21

Child hits

↓

Check in with child who was hit.
"I'm sorry he hit you. She made a mistake."

→ Command
"You hit. You need to go to calm down area."

→ Child refuses to go to Calm Down Area

→ Parent gives warning.
"That is one extra minute now." (Add time up to 9 min. if child continues to refuse and give warning)

↓

Parent explains consequence.
"That 's 10 minutes now, if you don't go now you will lose screen time tonight."

← Note: if child does not go when consequence is explained, parent follows through with consequence, Calm Down time is dropped.

↓

Child goes to Calm Down Area
No attention given for 4-5 minutes, + extra time up to 10 min., last 2 minutes child is calm

← Parent ends time & re-engages child
"Your body is calm. Come see what I've made for dessert.""

← Parent praises child's first positive behavior.
"That's so friendly the way you're sharing."

School Age Child Continues to Resist Going to Calm Down Area

Children Ages 6-10

©The Incredible Years®

Scenario #2D: Child continues to refuse to go to calm down area.

Child hits

↓

Check in with child who was hit.
"I'm sorry he hit you. She made a mistake."

→ Command
"You hit. You need to go to calm down area."

→ Child refuses to go to Calm Down Area.

→ Parent gives warning.
"That is one extra minute now."
(Add time up to 9 min. if child continues to refuse and give warning)

↓

Parent explains consequence.
"That 's 10 minutes now, if you don't go to the calm down area now you will lose screen time tonight."

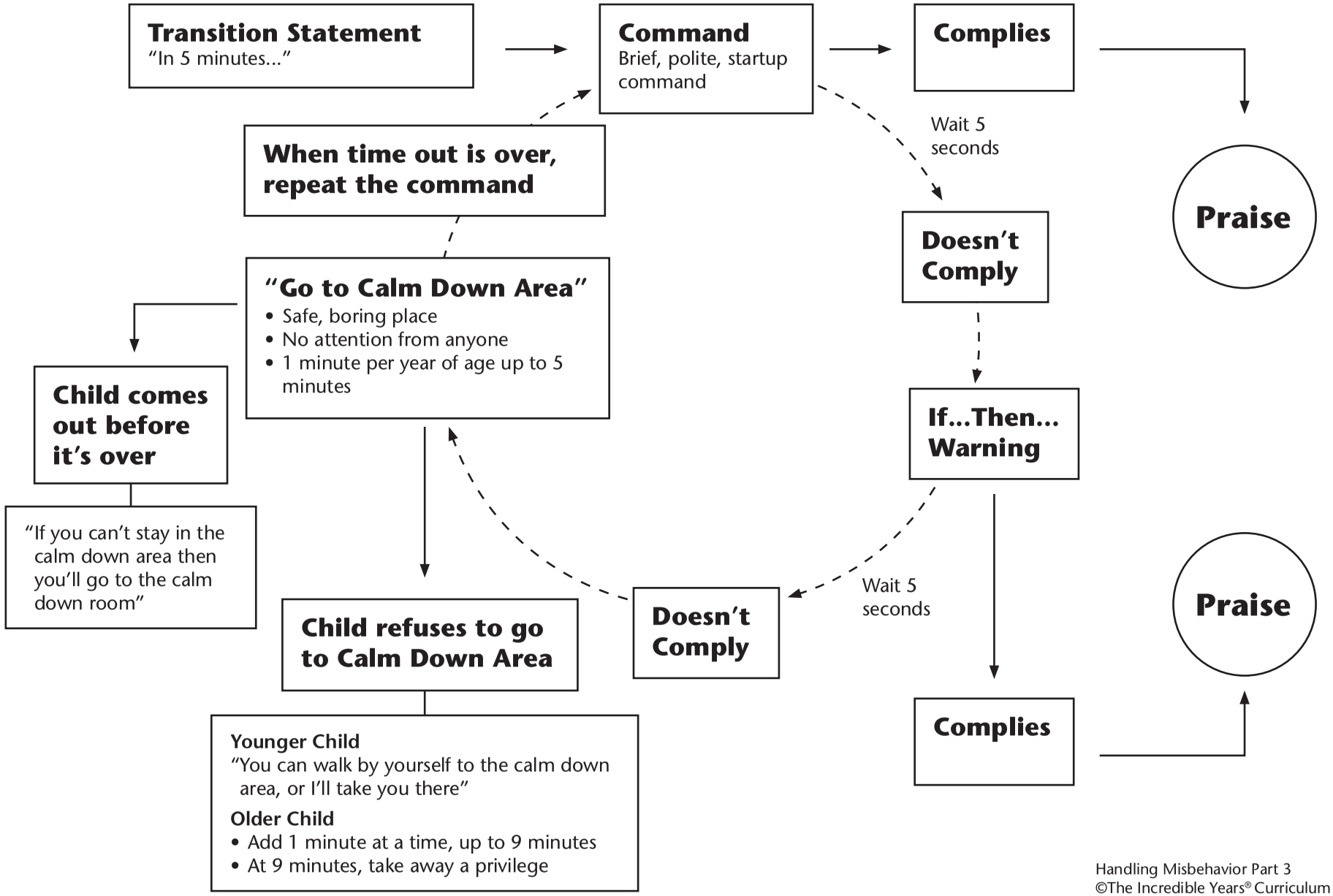
↓

Child refuses to go to Calm Down Area.

← Parent ends power struggle
"You've lost your screen time."
(Going to Calm Down Area is dropped)

← Parent follows through with consequence & ignores protests.
Note: consequence should be carried out same day.

Calm Down Procedure for Compliance Training



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7

Bringing The Incredible Years® Programs to Scale

Carolyn Webster-Stratton, Kathleen P. McCoy

Abstract

The Incredible Years® (IY) program series is a set of interlocking and comprehensive training programs for parents, teachers, and children. This article briefly reviews the theoretical foundations, goals, and research underlying these programs. The main purpose of the paper is to describe how the IY programs have been scaled up slowly and carefully with fidelity by engaging in a collaborative building project with strong links between the developer, agency or school administrator, mentors, coaches, clinicians, and families using eight foundational building blocks or fidelity tools. © *2015 Wiley Periodicals, Inc.*

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Incredible Years Program Background

The series of programs addresses multiple risk factors across home and school settings known to be related to mental health problems in adolescents. The IY parent program content was designed to reduce the malleable family risk factors, including, but not limited to, ineffective parenting, maternal depression, poor attachment, and low parent involvement with teachers. It was also designed to increase protective factors such as responsive, nurturing parenting, and support networks. The IY teacher and child programs' content focused on reducing school risk factors such as poor classroom management skills and classroom aggression. Protective factors to be increased included teacher proactive teaching strategies, positive teacher–parent relationships, and children's emotional regulation. The underlying theory is that positive parenting and teaching relationships when children are young will strengthen children's positive development and, in the long term, prevent the development of negative adjustment problems. (See http://incredibleyears.com/programs for logic models.)

Research Evidence Summary for IY Programs

The efficacy of the IY parent programs for treatment of children diagnosed with ODD/CD and ADHD has been demonstrated in multiple randomized control group trials (RCTs) (see Webster-Stratton & Reid, 2010). Results consistently show improved outcomes, such as reduced harsh discipline, conduct problems, and internalizing symptoms. Several studies have also shown that IY treatment effects are durable from one to three years posttreatment. An 8- to 12-year follow-up study of families treated because of their preschool children's conduct problems indicated that 75% of the teenagers had minimal behavioral and emotional problems (Webster-Stratton, Rinaldi, & Reid, 2010). A second 7- to 10-year follow-up randomized control group study indicated that parents with antisocial children who participated in the basic IY parent program expressed greater emotional warmth and supervised their adolescents more closely, and their children's reading ability was substantially improved in a standardized assessment, compared with families who received "usual mental health services" (Scott, Briskman, & O'Connor, 2014).

A recent meta-analytic review examined the IY parent program studies regarding disruptive and prosocial behavior in 50 studies. Findings indicated the IY program was successful in improving child behavior in a diverse range of families, especially for children with the most severe cases, and the program was considered "well-established" (Menting, Orobio de Castro, & Matthys, 2013).

The IY teacher classroom management program combined with the IY parent program was evaluated in several RCTs; results showed consistently better classroom outcomes for children in interventions that

combined parent and teacher training (Reid, Webster-Stratton, & Hammond, 2007; Webster-Stratton, Reid, & Hammond, 2004).

There have been several RCTs evaluating the effectiveness of the small-group child-training program; overall results indicated that the combined parent and child interventions showed the most positive effects over an array of behaviors for diagnosed children (Webster-Stratton & Hammond, 1997; Webster-Stratton, Reid, & Beauchaine, 2011).

Scaling Up the IY Programs With Fidelity—A Collaborative Building Project

While the IY programs have been shown in dozens of studies to be transportable and effective across different contexts, unfortunately, barriers to fidelity delivery initially impeded program delivery and outcomes. Such barriers include organizations that were not able to build adequate implementation infrastructure, as well as administrators who failed to select clinicians with the background necessary for the work. Moreover, most organization visions were short term, with limited financial resources. Seldom was there a long-term agency plan, or adequate funding, or ongoing clinician support and consultation, or internal quality control. All of these barriers are likely to result in a low clinician job satisfaction, poor quality delivery, and failure to achieve program sustainability.

Scaling up an evidence-based program (EBP) is like building a house: There must be an architect (program developer), a contractor (agency administrator), onsite project managers (mentors and coaches), and a construction team (clinicians). If there are barriers to any of these building links, the building will not be sound. Just like building a house, it is important that the foundation and basic structure be strong. The key foundational components must include the following: (a) picking the right EBP for the level of developmental status of the children, (b) adequately training and coaching clinicians so that they become accredited, and (c) providing quality control. In addition, providing adequate building scaffolding through the use of trained and accredited coaches, mentors, and administrators who can champion quality delivery greatly increases the likelihood of success.

Program fidelity is key to having a supporting infrastructure, as convincing evidence exists that high program delivery fidelity is predictive of significant positive outcomes across a number of different EBPs (Eames et al., 2009; Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002). Fidelity refers to the degree of exactness with which clinicians adhere to, or reproduce, the original training program model features, with the goal of replicating original research outcomes (Schoenwald & Hoagwood, 2001). Numerous studies have shown that dosage (Baydar, Reid, & Webster-Stratton, 2003; Lochman, Boxmeyer, Powell, Roth, & Windle, 2006) and quality of program delivery methods are related to effect size of outcomes (Eames et al., 2009; Scott, Carby, & Rendu, 2008). Research has also shown

that adding consultation, coaching, and supervision for clinicians increases the fidelity of program delivery (Henggeler et al., 2002; Lochman et al., 2009; Raver et al., 2008), which in turn leads to better outcomes.

Fidelity for IY builds upon Dane and Schneider's (1998) implementation framework and is broadly conceptualized in five dimensions: (1) program adherence, or delivery of core program components; (2) intervention exposure/dosage, recommended sequence, and length of time recommended; (3) clinician competence, or the IY group facilitator's skill level when using the training methods; (4) program differentiation, or tailored for the population served (prevention vs. treatment), which also determines program dosage; and (5) participant responsiveness and satisfaction with clinician (therapeutic alliance).

The remainder of this article describes how IY programs have been scaled up with fidelity by engaging in a collaborative building project with strong connecting links between the developer, agency administrator, mentors, coaches, clinicians, and families using eight key foundational building blocks that promote adherence to key program principles and protocols.

Building Block #1: Assure Organizational Readiness and Adequate Planning. Prior to scaling up any program, agencies should assess community risk factors, prioritize their community needs, and identify their goals and target population in order to be sure that they are choosing the EBP that is the best fit for them. The IY website provides an agency readiness questionnaire called "Launching IY Programs in Your Organization" to help organizations determine their goals and decide whether they have adequate clinical staff, managerial support, human and financial resources, and facilities and capacity to deliver the program. This questionnaire also helps them think about their organizational capacity for providing ongoing support, monitoring, fidelity checks, and program evaluation. Agencies that go through this process are able to evaluate whether the program is a good match for their needs, goals, and philosophies and to determine whether they have adequate funding sources. This process helps them to see the financial and staffing commitment needed to implement the program with fidelity.

Building Block #2: Assure Standardized Quality Training for Selected Group Facilitators. Prior to beginning any program, organizations must assess whether or not they have adequate staff to administer their program well. If an organization does not meet the minimum qualifications, the program should reassess whether or not the intervention is appropriate for the target community. For example, for the IY program it is recommended that each organization prepare a minimum of two to three clinicians for training.

Staff Qualifications. Those chosen to deliver these programs should ideally have master's or higher level degrees or professional diplomas in an appropriate field, such as psychology, social work, school counseling, or teaching; have prior experience working with parents and children; and,

preferably, have had prior training in child development, behavior management, and cognitive social learning theory. Group leader skill level must include a person who is respected as capable of providing skilled leadership while at the same time being collaborative, nurturing, and empathetic. Therapeutic alliance and the relationship between the clinician and group participants is an important factor in determining regular attendance and motivation to change (Webster-Stratton, Reid, & Marsenich, 2014). If it seems unrealistic that the staff will either meet these qualifications or get additional consultation, the organizations should carefully reexamine whether or not the IY is a good fit for their community.

Training Philosophy. Understanding the training philosophy associated with a particular intervention is also critical for successful implementation. For example, is the program a fixed-dosage, inflexible program, or is there flexibility built in? The IY series is a set of principle-driven, dynamic interventions that were developed in applied settings and that are flexibly adapted to each cultural context. The programs integrate cognitive, emotion, and behavior concepts equally and are based on ongoing discussions and collaboration between participants and training group facilitators (see therapist/group facilitator text, Webster-Stratton, 2012). The big ideas or principles, video-based vignettes, and participant books give structure to the programs, but flexible, responsive implementation gives voice to the participants and helps ensure that the content fits the context of their lives.

Initial Workshop Training. Whether a program needs a formal training session is a critical step to understanding how programs can be scaled up to a larger degree. In the case of the IY program, a three-day training workshop with no more than 25 clinicians is required prior to program administration. This workshop is delivered by accredited IY trainers and mentors who have had extensive experience delivering the IY programs themselves. The collaborative process of training clinicians models the therapeutic methods and processes that they will use when delivering their own parent, teacher, or child groups. During this workshop, standardized videos of actual group sessions led by accredited clinicians are used so that clinicians in training can observe and model how to work with groups of parents, teachers, or children.

Building Block #3: Provide Ongoing Feedback and Consultation for Clinicians. Active, collaborative, self-reflective, and principles-based training workshops are necessary but not sufficient to result in fidelity of implementation delivery or program outcomes. After the initial three-day training workshop, clinicians need time to study the manuals and materials, to practice and prepare their sessions, and to arrange logistics. Furthermore, research has shown (Webster-Stratton, Reid, & Marsenich, 2014) that combining the initial training workshop with ongoing mentoring, coaching, and consultation maximizes the learning for IY clinicians as they begin to implement the program and contributes greatly to fidelity of program delivery. Other studies with different EBPs have also shown that high program

delivery fidelity predicts significant improvements in parents', teachers', and children's behaviors (Eames et al., 2009; Henggeler et al., 2002; Lochman et al., 2009).

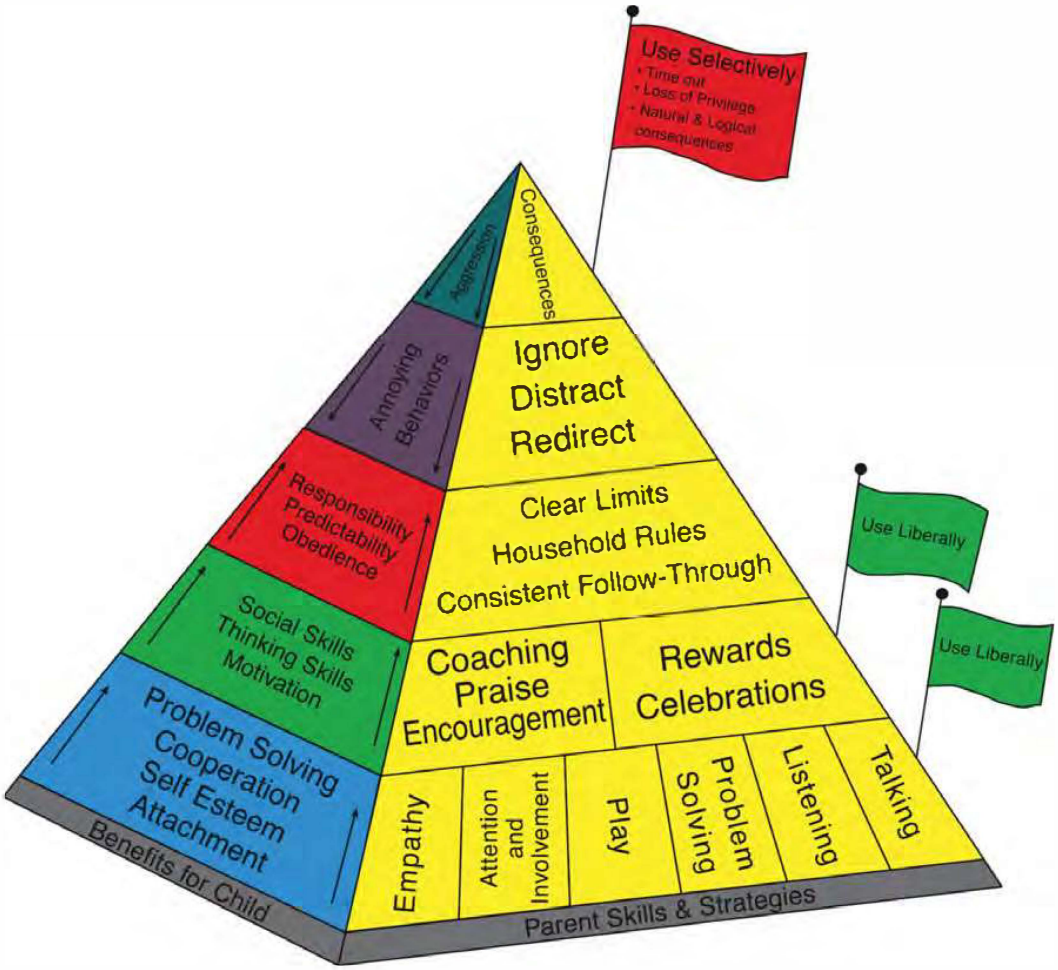
Before deciding to implement the program, administrators must look at the structure of the service delivery within their agencies and build in time for new group leaders to deliver the groups. We typically recommend that new clinicians be allowed six to eight hours per week to deliver a group (this includes studying and preparing for sessions). Very often, clinicians are expected to deliver the program in addition to all their regular workload and existing responsibilities, or are allocated two hours a week to deliver the two-hour group. This will result in program failure and clinician burn out.

It is also recommended the new clinicians obtain outside support, encouragement, and consultation from IY accredited mentors and trainers regularly during their first two to three sets of groups. Clinicians new to EBPs need help distinguishing between implementing the core or the foundational elements of the program and stifling clinical flexibility. In consultation, mentors help clinicians tailor the program to specific needs. Clinicians come to understand that the principles that guide the program include being flexible, rather than following a precise script to be recited or lectured at passive group participants. When clinicians understand this, they realize the program actually encourages the use of their clinical skills and judgment, but also provides them with a blueprint (known as the parent or teacher pyramid; see Figure 7.1) of where they are going.

Clinician support and consultation from accredited IY mentors and trainers can take several forms and may evolve within an organization depending on its size. For those sites that are implementing the program for the first time, clinician consultation and coaching are arranged through outside IY accredited trainers. Clinicians are also encouraged to submit a DVD of one of their group sessions for detailed feedback. After clinicians have had experience delivering the program, about six to nine months after training, it is recommended that they participate in an in-person group consultation training with IY trainers or mentors. These group consultation workshops involve small numbers of clinicians who come together to share selected portions of their DVDs regarding their delivery of the program. Peer sharing and feedback, along with IY mentor or trainer coaching, can be a huge asset in developing a support system that helps clinicians gain new ways to handle problems that are particularly difficult for them.

Building Block #4: Develop Peer Support Networks. Weekly peer support and time for planning sessions are key to continued learning and successful intervention, regardless of a clinician's level of expertise or education. Often, clinicians feel a lack of confidence when learning a new program and may become discouraged when a particular family or child fails to progress. Site-based peer group support, in addition to outside IY mentor or trainer consultation, helps the clinician to maintain optimism and to troubleshoot issues. When clinicians share their work and offer

Figure 7.1. The Incredible Years® Parenting Pyramid®



Parenting Pyramid®

The Incredible Years®

constructive support, they not only aid each other in conducting IY groups but also empower themselves as self-reflective thinkers, learners, self-managers, and evaluators.

Building Block #5: Adhere to Program Dosage, Order, and Protocols. Monitoring clinician's adherence to session protocols, key content, and therapeutic process principles is another aspect of consultation and supervision. Many agency administrators and clinicians believe that they can eliminate parts of a mental health intervention or shorten the number of sessions offered in order to be more cost effective. Training, mentoring, and

accreditation help clinicians and administrators understand that this approach will dilute or may eliminate the positive outcomes for the program.

Program Order and Protocols. IY program protocols for every group session are carefully designed according to age group targeted and population addressed and crafted in a sequence so that one session builds on the prior session learning. For example the IY Parenting Pyramid (see Figure 7.1) serves as the architectural plan for delivering the content and helps parents conceptualize effective tools and how they will help them achieve their goals. The base of the pyramid includes tools such as positive attention, child-directed play, coaching methods, and behavior-specific praise. Sometimes untrained clinicians skip these early tools because parents request immediate help with discipline problems. To achieve the desired outcomes, clinicians must learn to trust that the earlier positive parenting strategies are crucial to the success of the later discipline units.

Program Dosage. Over the past 30 years, IY programs have been systematically refined and updated based on ongoing experiences delivering these programs, observational evaluations of behavior outcomes that were changed or not changed, and participant feedback. While the first RCT in 1979 with a low-risk, prevention population was four two-hour sessions, the program was gradually lengthened to cover the required content for populations at different levels of risk, to allow time for group relationships to develop, and for the collaborative group discussion and practice components. Currently, the length of the parent program protocols varies from 12 to 26 two-hour sessions. With high-risk prevention populations, we have found that effect sizes increase with the more sessions that parents attend (Baydar et al., 2003).

The recommended number of sessions for these protocols is considered the *minimum number of sessions needed.* Some groups may require more sessions, depending on the degree of severity of children's problems or attachment problems, pace of parents' learning, and the size of the group. Offering fewer than the minimum number of recommended sessions for prevention or treatment populations will result in reduced effectiveness of the outcomes of the IY program.

Building Block #6: Promoting Group Facilitator Accreditation and Development of Accredited Peer Coaches and Mentors. A certification or accreditation process allows clinicians to continue to be supported in their learning of the IY program after the initial training workshop. Group leaders who achieve accreditation are acknowledged for delivering the program with fidelity and therefore are believed to achieve results similar to the developer's published results.

Some of the requirements for accreditation include: strong positive weekly and final client evaluations for two complete groups; two self- and peer-evaluations, using the peer content and the methods checklists; completion of a three-day authorized training workshop; and satisfactory

review of a complete video by an IY trainer (see www.incredibleyears.com/certification/process_GL.asp).

Accredited clinicians with exceptional group leadership skills, peer respect, and a desire to provide support to other leaders are eligible to be nominated to become accredited *IY peer coaches* and may eventually proceed to become *accredited mentors*. Peer coaches receive further training in peer coaching and video review processes. They meet individually with group leader dyads to goal set, review videos of their session, provide support, and set up practices to reenact session scenarios with new approaches. Coaches participate in a similar accreditation process to group leaders by submitting videos of their coaching sessions and evaluations from those they coached. Fidelity of quality of coaching provided posttraining to group leaders is as important as their initial workshop training. This ongoing coaching is critical to being able to scale up with fidelity.

IY mentors are accredited clinicians and peer coaches who have been selected by IY trainers to receive more extensive training in a particular IY program workshop delivery and are permitted to offer authorized training workshops within their agency or a defined district. Site-based mentors receive ongoing outside support and consultation from IY trainers, participate in yearly workshops with other mentors, obtain video feedback on their coaching and workshop delivery process, and participate in further training and updates regarding new program developments and research. The certification/accreditation progression is outlined on the IY website (http://incredibleyears.com/certification-gl).

Building Block #7: Supportive Agency or School Infrastructure and Support. No EBP can be faithfully implemented without adequate resources and internal managerial support for the clinicians delivering the program. It may be necessary for administrators to readjust clinician job descriptions to recognize their time commitments to ongoing training, peer support, supervision, and recruiting for and carrying out new interventions. Even though group approaches are more cost effective than individual approaches, administrators may not understand the additional time or costs needed to assure transportation and food for each session, to arrange day care, to prepare materials for each session, or to make weekly calls, to name just a few.

In addition, sometimes administrators are surprised to find that the initial three-day training does not prepare their clinicians to start groups the following week. It is imperative that administrators understand that preparation time is needed to start a new EBP that involves not only clinicians studying the DVDs and training manuals and meeting in peer support groups to practice, but also time to recruit families, to assure appropriate referrals, and to organize appropriate day care.

The administrative staff and internal advocates commonly referred to as "champions" need to ensure that there are plans for ongoing consultation and supervision from the outside IY trainer. An IY trainer is an

accredited clinician, coach, and mentor who either has a doctorate or has worked with the developer of the program for many years. The IY trainer collaborates with the organization's internal advocate, provides consultation to clinicians and administrators regarding program implementation, and anticipates possible barriers and difficulties with high fidelity dissemination. It is best if there is an administrative champion within the agency who understands the workings of his or her own organization, as well as the fidelity requirements of the new EBP. Research has shown that clinicians who are left to champion a program without an active administrative champion quickly burn out from the extra work, resent the lack of support and time, and often leave the agency (Corrigan, MacKain, & Liberman, 1994).

Administrators may select promising clinicians and persuade them to learn this new intervention. The program will attain a strong reputation if it begins with a few enthusiastic clinicians rather than if it begins with a mandate that everyone adopts the program. Those who are not risk-takers, the *late adopters*, will venture into new programs only after respected colleagues are successful (Rogers, 1995). Encouraging and supporting selected clinicians who become accredited to continue training to become accredited as peer coaches or mentors build the infrastructure of a sustainable program. At first, the IY trainers provide direct support to the clinician (see Building Block #3). However, the goal is to make agencies or schools self-sufficient in their ongoing training and in their support of the program. Moreover, when administrators promote accreditation as a way of supporting EBP, clinicians appreciate that they are working toward goals and a philosophy that are highly valued by the organization.

Building Block #8: Monitor Quality Assurance and Evaluation. Quality assurance procedures and ongoing program evaluation ensure the continued quality of training programs.

IY Mentor and Trainer Training Quality Assurance. Quality assurance procedures are used consistently throughout all aspects of IY training. First, only IY accredited trainers or mentors provide the training. Individuals who enter the mentor training process are supervised by accredited trainers and mentors and receive in-person feedback from them. When they have completed this training and are ready to do a solo workshop, they offer a workshop and submit videos of this workshop for review by an IY trainer. They also submit the workshop protocol checklist along with workshop evaluations from participants. All accredited mentors or trainers who do workshops must submit daily evaluations of their workshops along with their workshop checklist and daily attendance list to IY headquarters for every workshop.

Group Facilitator Evaluations and Adherence to Program Model. Embedded in the training of clinicians are efforts to enhance the quality of program delivery. Part of the delivery of this program includes weekly evaluations by group participants, final summative evaluations, submission of attendance

registers, and completion of each session's protocols. Completion of these detailed session protocols allows administrators to determine whether clinicians are adhering to program fidelity.

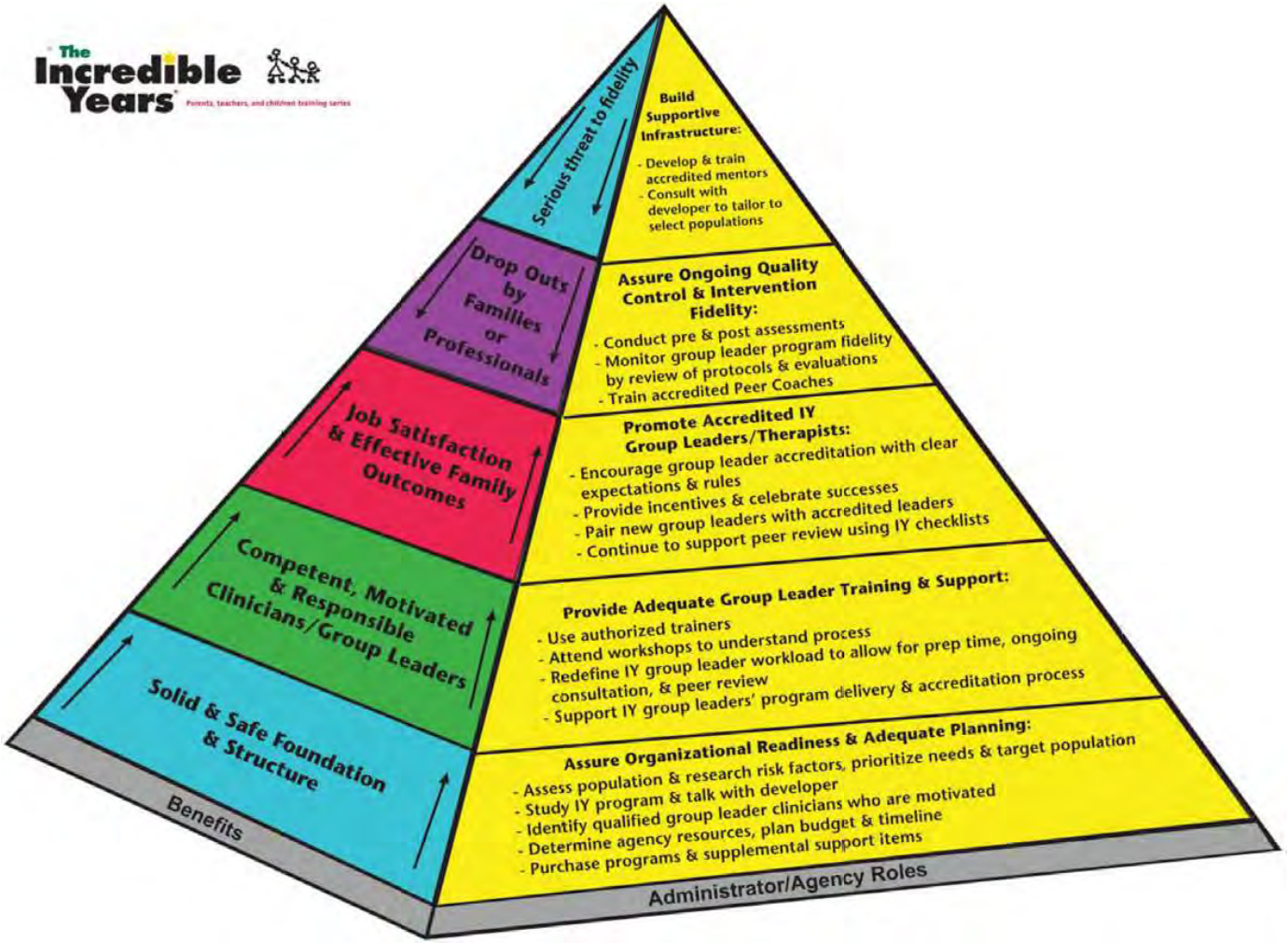
In addition, we recommend that administrators conduct ongoing program evaluation by collecting assessments of desired program outcomes. Specific outcome measures used may vary. Ideally, agencies should collect baseline and follow-up data about changes in child externalizing and internalizing symptoms, as well as changes in parenting or teacher classroom management skills. When possible, we encourage agencies to use some of the same measures used in the trials that established the program efficacy, such a high-quality parent- and teacher-rating scale. If possible, it is beneficial for agencies to track other tangible outcomes associated with the program, including group attendance and parent and teacher feedback, child academic achievement and school attendance, and feedback from other care providers who work with the child and family.

This IY pyramid (see Figure 7.2) details for administrators or IY project leaders how they can promote fidelity delivery of the program. As can be seen on this pyramid, the building blocks #1, #2, #3, and #4 are the bottom two levels, comprising the foundation of this pyramid. These lead to careful planning and organization readiness, adequate funding, quality training, and a safe and supportive agency foundation with competent, motivated clinicians. In the middle level 3 when clinicians become accredited (blocks #5 and #6), this leads to increased fidelity program delivery and clinician job satisfaction, as well as effective outcomes. The top two levels (blocks #7 and #8) ensure that the administration is monitoring quality control and building agency support with in-house accredited peer coaches and in some cases an IY mentor. This achievement leads to reduced staff dropout, promotes ongoing training as needed, and prevents any serious threats to program fidelity.

Summary

My experience scaling up IY has taught me that EBP program development must be thought of as an ongoing building process, rather than an endpoint. New data will continually emerge to inform real-world clinical practice, and each unique setting or environment can inform improvements or adaptations to the construction process and further research. For example, our work with the child welfare–referred families led us to expand parent training to include a focus on interpersonal problems, and to develop protocols for home coaching sessions to supplement the group experience. In addition, the IY series implementation manuals have been recently updated with new research and feedback, and even the suggested number of sessions has been refined based on more than 30 years of experiences and participant feedback. An important implication for prevention and dissemination science is understanding that effective programs continue to evolve and

Figure 7.2. The Incredible Years® Administrator/Project Leader Pyramid



improve based on internal audits and feedback. By way of analogy, consider how the safety features of cars continuously improve. Few people, when given the option, would opt to drive the old model without safety additions. Gathering data on what works, eliciting ongoing feedback, and actively participating in the implementation of the intervention across a variety of contexts provide the needed information to improve interventions and meet the needs of broader culturally diverse populations.

Agencies such as schools, mental health centers, and hospitals charged with improving the well-being of children and families now have good options for selecting EBPs that are grounded in an extensive research base. At the same time, it has become clear over the past decade that successful implementation of EBPs, including the IY series, requires a serious sustained commitment of personnel and resources. Some of the critical factors include selecting optimal clinicians to deliver the program; providing them with quality training workshops coupled with ongoing supportive mentoring and consultation, as well as on-site peer and administrative support; providing facilitative supports; and ensuring ongoing program evaluation and monitoring of program dissemination fidelity. Certainly it requires a collaborative team to bring about innovative change. Given that considerable time and costs are involved in delivering even ineffective programs, a much wiser choice would be to invest resources in programs known to sustain high-quality EBPs. Only then can we be sure our building construction is solid and our time and efforts have not been wasted.

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CHAPTER 21

THE INCREDIBLE YEARS® SERIES: AN INTERNATIONALLY EVIDENCED MULTIMODAL APPROACH TO ENHANCING CHILD OUTCOMES

Carolyn Webster-Stratton and Tracey Bywater

This chapter provides an overview of theory and practice of The Incredible Years® series, reviewing research support for its efficacy, highlighting emerging developments in both the United States and internationally, using examples of research and application, and including cultural adaptations or accommodations to increase inclusivity. The Incredible Years series was developed in the late 1970s and 1980s in Seattle, Washington by the first author of this chapter, to address child behavioral and emotional difficulties and enhance positive life outcomes, and it comprises programs for parents, teachers and children (Webster-Stratton, 2016).

CHILD BEHAVIORAL AND EMOTIONAL DIFFICULTIES

Rates of clinically significant behavioral and emotional difficulties are as high as 6% to 15% in 3- to 12-year-old children (Egger & Angold, 2006). These numbers are even higher for children from economically disadvantaged families (Webster-Stratton & Hammond, 1998) and higher still (50%) for children in foster care in the United States (Burns et al., 2004). Foster children in the United Kingdom have a ratio of 3.7:1 higher rates of disorder than children living in disadvantaged private households (defined as households in which the parents have either never worked or work in unskilled occupations; Ford, Vostanis, Meltzer, & Goodman, 2007). Children with early-onset behavioral and emotional difficulties are at increased risk of developing severe adjustment difficulties, conduct disorders (CD), school dropout, violent behaviors, and substance abuse in adolescence and adulthood (Egger & Angold, 2006). However, interventions, when delivered early, can prevent and reduce the development of conduct problems and strengthen child protective factors such as social and emotional competence, well-being, and school success (Kazdin & Weisz, 2010).

A variety of risk factors may contribute to early onset of behavioral and emotional difficulties, including ineffective parenting (e.g., harsh discipline, low parent involvement in school, neglect, low monitoring; Jaffee, Caspi, Moffitt, & Taylor, 2004); family risk factors (e.g., marital conflict, parental drug abuse, mental illness, criminal behavior; Knutson, DeGarmo, Koeppl, & Reid, 2005); child biological and developmental risk factors (e.g., attention deficit hyperactivity disorder [ADHD], learning disabilities, language delays); school risk factors (e.g., poor teacher classroom management, high levels of classroom aggression, large class sizes, poor school–home communication); and peer and community risk factors (e.g., poverty, gangs; Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000). Three decades of research by prominent

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researchers such as Dishion and Piehler (2007) and Patterson and Fisher (2002) have consistently demonstrated the links among child, family, and school risk factors and the development of antisocial behaviors, and this research has informed intervention development and delivery. Effective interventions for preventing and reducing behavior problems should ideally be offered and delivered early, before delinquent and aggressive behaviors become entrenched and secondary risk factors such as family isolation, lack of support, academic failure, and the formation of deviant peer groups have developed. Moreover, interventions should be multimodal, in order to target multiple risk factors at the school/community, family, and individual levels, and they should be effectively targeted to ensure that those who need support actually receive it. Furthermore, group-based interventions are recommended, because they have been shown to improve child behavior problems, strengthen social support and parenting skills, and improve parental mental health (e.g., depression, marital conflict; Furlong et al., 2012).

The Incredible Years series was designed as a set of interlocking and comprehensive training programs to prevent and treat behavior difficulties from infancy and toddlerhood through middle childhood. Incredible Years is a multimodal program that can be utilized to intervene in multiple areas and settings through parent, teacher, and child training. The model's theory of change holds that improving protective factors such as responsive and positive parent–teacher–child interactions will lead to improved school readiness and success, emotion regulation, social competence, and socially acceptable behavior in young children, subsequently leading to longer term positive outcomes such as increased academic achievement and reduced school dropout, CD, and substance abuse problems in later life (see http://incredibleyears.com/programs/ for the logic model).

The following sections will outline the underlying theoretical background for the Incredible Years Basic (baby, toddler, preschool, and school-age) parent programs, which are considered core and necessary components of the prevention model for young children. The Incredible Years adjunct parent, teacher, and child programs, and how they are used to address family and school risk factors and children's developmental issues, will also be presented. Information regarding Incredible Years program content and delivery methods will be briefly described, as will ways to promote successful delivery of the programs. The international and U.S. evidence base for the Incredible Years programs will be highlighted, with a section on transportability of programs as well as adaptations and accommodations in different countries (see Figure 21.1).

THEORETICAL BACKGROUND FOR INCREDIBLE YEARS PROGRAM CONTENT AND METHODS

The underlying theoretical background for Incredible Years parent, teacher, and child programs includes cognitive social learning theory, particularly Patterson, Reid, and Dishion's (1992) coercion hypothesis of negative reinforcement developing and maintaining deviant behavior; Bandura's (1986) modeling and self-efficacy theories; Piaget and Inhelder's (1962) developmental cognitive learning stages and interactive learning method; cognitive strategies for challenging angry, negative, and depressive self-talk and increasing parent self-esteem and self-confidence (e.g., Beck, 1979); and attachment and relationship theories (e.g., Ainsworth, 1974).

These theories inform the delivery method for all the Incredible Years programs. For example, the Incredible Years video vignettes portray parents or teachers from different cultural backgrounds using social and emotional coaching or positive discipline strategies, or children managing conflict with appropriate solutions. Video-based modeling, grounded in social learning and modeling theory (Bandura, 1977), supports the learning of new skills. Group leaders use the vignettes as tools to engage participants in group discussion, collaborative learning, and emotional support. Furthermore, participants identify key principles from the vignettes and apply them to their personal goals by practicing what they have learned in the group, home, or classroom. Participants have been shown to implement interventions with greater integrity when they receive coaching and feedback on their application

FIGURE 21.1. The international spread of The Incredible Years® in 26 countries across six continents. Adapted from "Implementation Examples," by The Incredible Years®, 2018 (http://www.incredibleyears.com/programs/implementation/implementation-examples/). Copyright 2018 by The Incredible Years®. Adapted with permission.

of intervention strategies (Reinke, Stormont, Webster-Stratton, Newcomer, & Herman, 2012).

The group format is advantageous because it is more cost effective than individual intervention; addresses risk factors such as family isolation and stigmatization, teachers' senses of frustration and blame, and children's feelings of loneliness or peer rejection; and helps reduce resistance to intervention through sharing the collective group wisdom. When participants express beliefs counter to effective practices, the group leader draws on other group members to express alternative viewpoints. The group leader is thereby able to elicit discussion of change from the participants themselves, which makes it more likely that they will follow through on intended changes. Group leaders always operate within a collaborative context, sensitive to individual cultural differences and personal values. The collaborative therapy process is also provided in a text for group leaders, titled *Collaborating with Parents to Reduce Children's Behavior Problems: A Book for Therapists Using the Incredible Years Programs* (Webster-Stratton, 2012b).

INCREDIBLE YEARS CORE PARENT PROGRAMS

The Incredible Years Basic (core) parent training programs consist of 4 different curricula to fit child developmental stages: the baby program (4 weeks to 9 months), the toddler program (1–3 years), the preschool program (3–5 years) and the school Age program (6–12 years). Each of these recently updated programs emphasizes developmentally appropriate parenting skills and includes age-appropriate video examples of culturally diverse families and children with varying temperaments and developmental issues. The programs run for 9 to 22 weeks, depending on the age of the child and the presenting issues of the parents and children in the group.

For all parent training programs, trained and—ideally—accredited Incredible Years group leaders/clinicians use video vignettes of modeled parenting skills (over 300 vignettes, each lasting approximately 1–3 minutes) which are shown to groups of eight to 12 parents. The vignettes demonstrate child development as well as parenting principles and serve

as the stimulus for focused discussions, self-reflection, problem-solving, practices, and collaborative learning. The programs support parents' understanding of typical child developmental milestones and varying temperaments, child safety and monitoring, and age-appropriate parenting responses. Participation in the group-based Incredible Years training program is preferable for the benefits of support and learning provided by other parents; however, a home-based coaching model for each parenting program exists. Home-based sessions can be offered to parents who cannot attend groups, or who do not feel ready to participate in a group, or to compensate when parents miss a group session, or to supplement the group program for very high-risk families.

Program goals are tailored to be developmentally appropriate and represented in The Incredible Years Parenting Pyramid® (Figure 21.2). The pyramid helps parents conceptualize effective parenting tools they can use to achieve their goals. The pyramid base depicts liberally used parenting tools, which are presented in the first half of the program and form the foundation for children's emotional, social, and academic learning. These include positive parent attention, communication, and child-directed play interactions designed to build secure and trusting relationships. Parents also learn how to use specific academic, persistence, social, and emotional coaching tools to help children learn to self-regulate and manage their feelings, persevere with learning despite obstacles, and develop friendships.

One step up the pyramid depicts behavior-specific praise, incentive programs, and celebrations for when goals are achieved, followed by use of predictable routines and household rules to scaffold children's exploratory behaviors and their drive for autonomy. The top half of the pyramid presents tools used more sparingly to reduce specific targeted behaviors, such as ignoring of inappropriate behaviors, distraction and redirection, and discipline tools such as time out to calm down and logical consequences for aggressive behaviors. In addition, parents learn how to develop supportive partnerships with teachers by collaborating on behavior plans and supporting their children's school-related activities.

There are two basic premises of the model: (a) a positive relationship foundation must precede clear and predictable discipline strategies, and this sequence of delivery of content is critical to the program's success; and (b) attention to positive behavior, feelings, and cognitions should occur far more frequently than attention to negative behaviors, feelings, and cognitions. Tools from higher up on the pyramid only work when the positive foundation has been solidly constructed with secure scaffolding.

INCREDIBLE YEARS ADJUNCTS TO PARENT PROGRAMS

Optional adjunct parenting programs can be used in combination with the Incredible Years Basic parenting programs outlined above, as follows:

1. The Incredible Years Advance parenting program, offered after the Basic preschool or school-age programs, was designed for selective high-risk and indicated populations and focuses on ways to reduce parents' interpersonal risk factors such as anger and depression, poor communication, lack of support, problem-solving difficulties between parents and with teachers, and children's poor self-regulation skills.
2. An adjunct to the preschool program is the school readiness program for parents of children ages 3 to 4 years, which is designed to help parents support their children's preliteracy and interactive reading readiness skills.
3. An adjunct for the toddler, preschool, and early school age programs is the attentive parenting program. This universal prevention program is designed to teach parents of children 2 to 6 years old (who do not have significant behavioral issues) social, emotional, persistence, and preacademic coaching methods as well as how to promote their children's reading, self-regulation, and problem-solving skills. It is also recommended in the form of booster sessions for indicated populations following Basic parenting program completion.
4. The autism program is for parents of children on the autism spectrum or whose children have language delays. It can be used independently or in conjunction with the Basic preschool program.

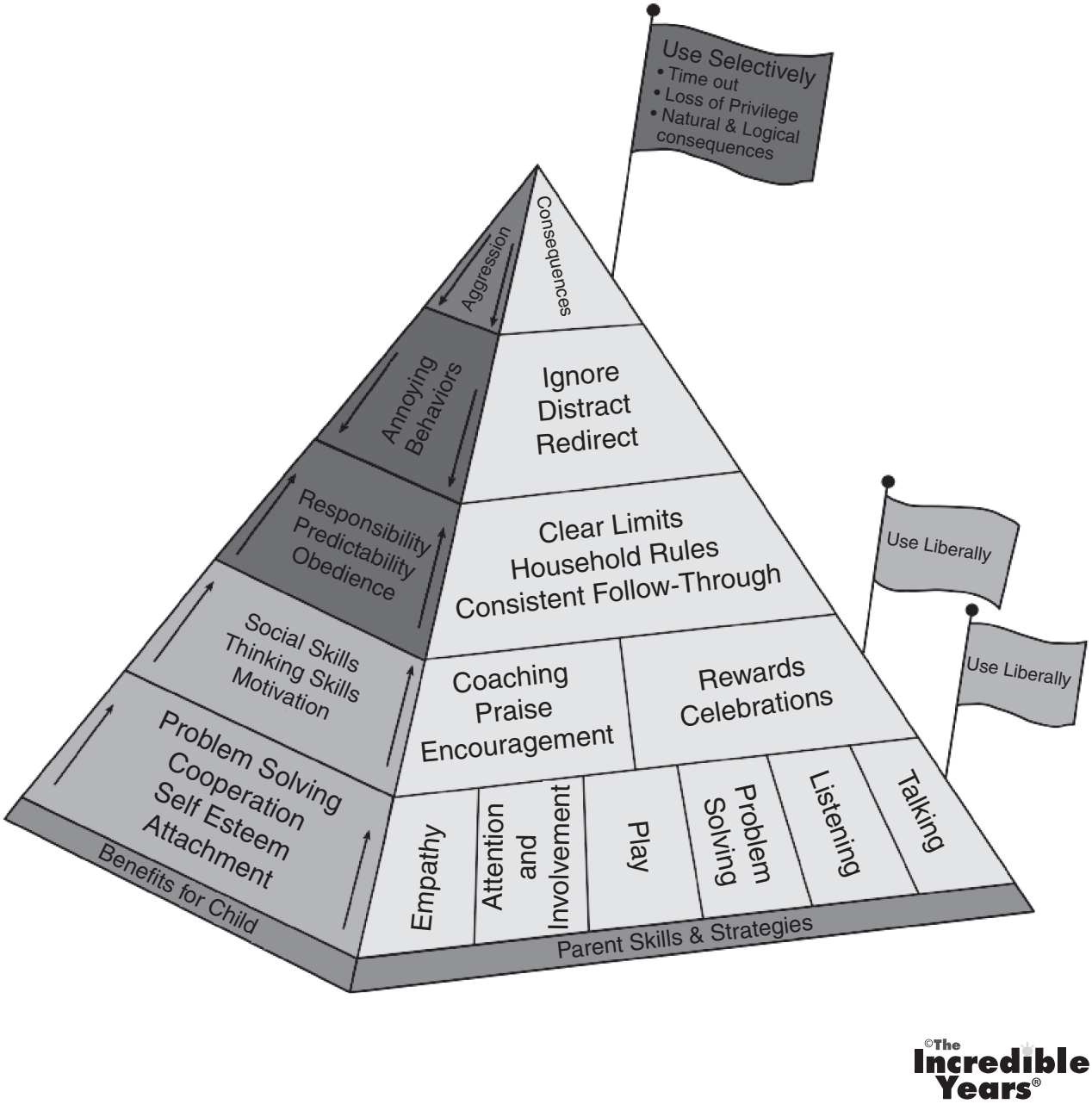

FIGURE 21.2. The Incredible Years Parenting Pyramid®. Adapted from "Supplemental Materials," by The Incredible Years®, 1984 (http://www.incredibleyears.com/programs/parent/supplementals/). Copyright 1984 by The Incredible Years®. Adapted with permission.

INCREDIBLE YEARS TEACHER CLASSROOM MANAGEMENT PROGRAM

The Incredible Years teacher classroom management (IY-TCM) program is a 6-day, group-based program delivered monthly by accredited group leaders in small workshops (including 14–16 teachers) throughout the school year. It is recommended that trained Incredible Years coaches support teachers between workshops by visiting their classrooms, helping refine behavior plans, and addressing teachers' goals. The goals of IY-TCM include (a) improving teachers' classroom management skills, including proactive teaching approaches and effective discipline; (b) increasing teachers' use of academic, persistence, social, and emotional coaching with students; (c) strengthening teacher–student bonding; (d) increasing teachers' ability to teach social skills, anger management, and problem-solving skills in the classroom; (e) improving home–school collaboration, behavior planning, and parent–teacher bonding; and (f) building teachers' support networks. The curriculum is described in the teachers' course book *Incredible Teachers: Nurturing Children's Social, Emotional and Academic Competence* (Webster-Stratton, 2012c; for more information on IY-TCM training and delivery, see Reinke et al., 2012 or Webster-Stratton & Herman, 2010).

Incredible Beginnings: Teacher and Child Care Provider Program

This 6-day, group-based program is for day care providers and preschool teachers of children of ages 1 to 5 years. Topics include coping with toddlers' separation anxiety and promoting attachment with caregivers; collaborating with parents and promoting their involvement; promoting language development with gestures, imitation, modeling, songs, and narrated play; using puppets, visual prompts, books, and child-directed coaching methods to promote social and emotional development; and proactive behavior management approaches.

Helping Preschool Children With Autism: Teachers and Parents as Partners Program

This program is designed as an add-on to the Incredible Years parent program for children on the autism spectrum and to the IY-TCM Program. The program focuses on how to promote language development and communication with peers and helps providers to provide social and emotional coaching and teach children self-regulation skills.

INCREDIBLE YEARS CHILD PROGRAMS (DINOSAUR CURRICULA)

Two versions of the Incredible Years child program have been developed: (a) in the universal prevention classroom version, teachers deliver 60+ social–emotional lessons and small group activities twice a week, with separate lesson plan sets for three grade levels (preschool through second grade); and (b) in the small group therapeutic treatment group, accredited Incredible Years group leaders work with groups of 4 to 6 children (ages 4–8 years) in 2-hour weekly therapy sessions. This program can be offered in a mental health setting (concurrent with the Basic parent program) or as a "pull-out" program in schools. Content is delivered using a selection of video programs (with over 180 vignettes) that teach children literacy, social skills, emotional self-regulation skills, and the importance of following school rules and problem-solving. Large puppets bring the material to life, and children are actively engaged in the material through role play, games, play, and activities. The content and structure of the child program reflects that of the parent training program and comprises seven components: (a) introduction and rules; (b) empathy and emotion; (c) problem-solving; (d) anger control; (e) friendship skills; (f) communication skills; and (g) school skills (for more information about the child programs, see Webster-Stratton & Reid, 2003, 2004).

CHOOSING PROGRAMS ACCORDING TO RISK LEVELS OF POPULATIONS

The Basic parent programs (baby, toddler, preschool, or school-age versions) are considered mandatory or core components of the prevention intervention training series. The Advance program is offered in addition to the Basic program for selective populations such as parents characterized as depressed or those with considerable marital discord, child welfare-referred families, or families living in shelters. For indicated children with behavior problems

that are pervasive (i.e., apparent across settings both at home and at school) it is recommended that the child training program and/or one of the two teacher training programs be offered in conjunction with the parent training program to assure child behavior changes at school or day care. For indicated children whose parents cannot participate in the Basic program due to their own psychological problems, delivery of both the child and teacher program is optimal (Incredible Years Program Implementation, 2013).

As seen in Figure 21.3, Levels 1 and 2 are the foundation of the pyramid and involve a recommended series of programs that could be offered universally to all parents, day care providers, and teachers of young children (age 0–6 years). Level 3 is targeted at selective or high-risk populations. Level 4 is targeted at indicated populations, in which children or parents are already showing symptoms of mental health problems (e.g., parents referred to child protective services because of abuse or neglect, foster parents caring for children who have been neglected and removed from their homes, children who are highly aggressive but not yet diagnosed as having oppositional defiant disorder [ODD] or CD). This level of intervention is offered to fewer people and offers longer and more intensive programming by a higher level of trained professionals. Level 5 is offered as treatment and addresses multiple risk factors, with programs being delivered by therapists with graduate level education in psychology, social work, or counseling. Additional individual parent–child coaching can be provided in the clinic or home using home coaching protocols. Child and parent therapists work with parents to develop behavior problem plans and consult with teachers in partnerships to coordinate plans, goals and helpful strategies. One of the goals of each of the prior levels is to maximize resources and minimize the number of children who will need these more time- and cost-intensive interventions at Level 5.

RESEARCH EVIDENCE FOR THE INCREDIBLE YEARS PARENT PROGRAMS

Treatment and Indicated Populations

The efficacy of the Incredible Years Basic parent treatment program for children (ages 2–8 years) diagnosed with ODD and/or CD has been demonstrated in eight published randomized control group trials (RCTs) by the program developer (Webster-Stratton, 2013). In addition, numerous replications by independent investigators have been conducted (for reviews, see Gardner, 2012; Menting, Orobio de Castro, & Matthys, 2013).

In the early U.S. studies conducted by the program developer, the Basic program improved parental confidence, increased positive parenting strategies, and reduced harsh and coercive discipline and child conduct problems compared with waitlist control groups. The results were consistent for toddler, preschool, and school age versions of the program. The first series of RCTs in the 1980s evaluated the most effective training methods of bringing about parent behavior change and established that group parent training was more effective than individual parent training, and that the most effective group model combined a trained facilitator with the use of video vignettes and group discussion. Research on the most effective program content demonstrated that the combination of the Basic parenting program with the Advance program showed greater improvements in terms of parents' marital interactions and children's prosocial solution generation. Therefore, the core treatment model for clinical populations over the last 2 decades has consisted of a facilitator-led group treatment model that combines the Basic plus Advance programs.

Independent studies have replicated the Basic program's results with treatment populations in mental health clinics and primary care settings with families of children diagnosed with conduct problems or high levels of behavior problems (e.g., Drugli & Larsson, 2006; Gardner, Burton, & Klimes, 2006; Perrin, Sheldrick, McMenamy, Henson, & Carter, 2014; Scott, Spender, Doolan, Jacobs, & Aspland, 2001). A recent Incredible Years parent program meta-analysis including 50 studies with 4745 participants from 2472 intervention families showed the program to be effective for disruptive and prosocial child behavior as measured by teacher and parent report and independent observations across a diverse range of families (Menting et al., 2013).

Two long-term studies from the United States and United Kingdom followed up with children diagnosed with conduct problems whose parents

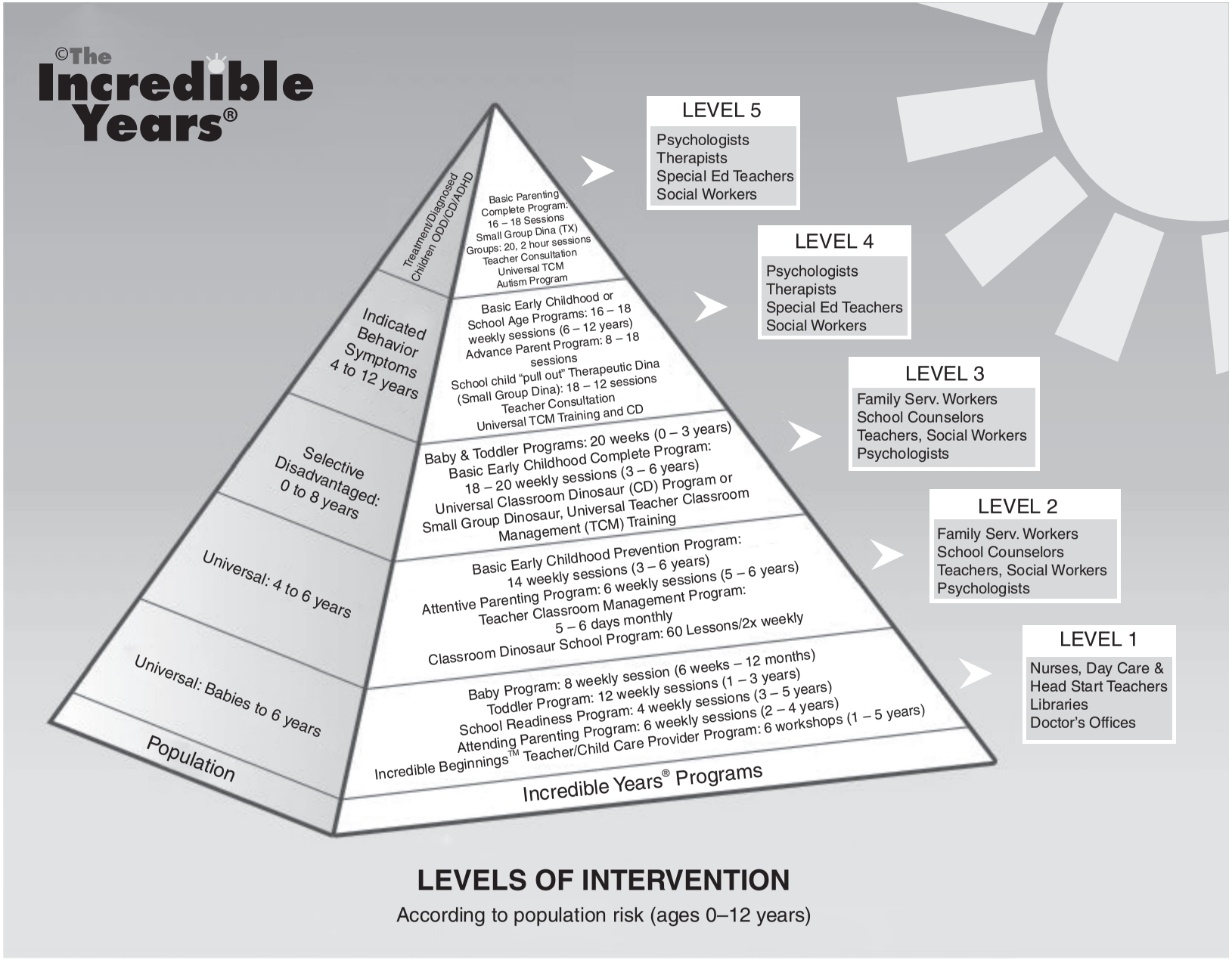

FIGURE 21.3. Levels of intervention pyramid. Adapted from "Implementing the Programs," by The Incredible Years®, 2010 (http://www.incredibleyears.com/programs/implementation/). Copyright 2010 by The Incredible Years®. Adapted with permission.

had received the Incredible Years parent program 8 to 12 years earlier. The U.S. study indicated that 75% of the teenagers were typically adjusted, with minimal behavioral and emotional problems (Webster-Stratton, Rinaldi, & Reid, 2011). The data were not significantly different from U.S. national rates of adjustment for children of the same age. The independent U.K. 10-year follow-up study reported that parents who had participated in the Incredible Years Basic parent program expressed more emotional warmth and supervised their adolescents more closely than parents in the control condition who had received individualized typical psychotherapy (parent-focused or child play therapy) offered at that time. Moreover, their children's reading ability was substantially improved in a standardized assessment in comparison with the children in the control condition (Scott, Briskman, & O'Connor, 2014).

Prevention Populations

The prevention version of the Basic program has been tested by the developer in four RCTs with multiethnic, socioeconomically disadvantaged families in schools. These studies showed that children whose mothers received the Basic program showed fewer externalizing problems, better emotion regulation, and stronger parent–child bonding than control children. Mothers in the parent intervention group also showed more supportive and less coercive parenting than control mothers (for a review, see Webster-Stratton & Reid, 2010). At least six RCTs by independent researchers with high risk prevention populations found that the Basic parenting program increases parents' use of positive and responsive attention with their children (e.g., praise, coaching, descriptive commenting) and positive discipline strategies, and reduces harsh, critical, and coercive discipline strategies (see Menting et al., 2013). The trials took place in applied mental health settings, schools, and primary care practices with Incredible Years group leaders drawn from existing staff (nurses, social workers, and psychologists). The program has been shown to be effective with diverse populations, for example, individuals with Latino, Asian, African American, and European backgrounds in the United States (Reid, Webster-Stratton, & Beauchaine, 2001), and other countries such as England, Wales, Ireland, Norway, Denmark, Sweden, the Netherlands, New Zealand, Portugal, and Russia (Azevedo, Seabra-Santos, Gaspar, & Homem, 2014; Gardner et al., 2006; Hutchings, Bywater, & Daley, 2007; Hutchings, Gardner, et al., 2007; Larsson et al.,2009; Raaijmakers et al., 2008; Scott et al., 2001; Scott et al., 2010). A complementary body of qualitative evidence exploring parents', foster carers', and facilitators' perceptions of Incredible Years parent programs indicates parent program acceptability is high across different populations and in different contexts (Bywater et al., 2011; Furlong & McGilloway, 2015; Hutchings, Griffith, Bywater, Williams, & Baker-Henningham, 2013; Linares, Montalto, Li, & Oza, 2006; McGilloway, Ni Mhaille, Bywater, Furlong, et al., 2012).

INTERNATIONAL SPOTLIGHT ON THE UNITED KINGDOM AND IRELAND

The Basic program for parents of 3- to 6-year-olds has demonstrated effectiveness in targeted RCTs in Ireland, Wales, and England (Bywater et al., 2009; Little et al., 2012). In Wales, the sample included families from rural and urban communities who spoke Welsh or English. In England, the research was conducted in the culturally diverse city of Birmingham (the second largest city in England). In Ireland, services were delivered to a predominantly Catholic population in both semirural and urban areas. In all three trials, families were eligible if their child scored over the cut-off level for clinical concern on a behavioral screener and were therefore at risk of developing CD. Results were similar, with child behavior effect sizes ranging from .5 to .89 across the three trials. The Welsh and Irish trials (Hutchings, Bywater, & Daley, 2007; McGilloway, Ni Mhaille, Bywater, Leckey, et al., 2014) included independently observed parenting (by observers blind to condition), and significant differences were found between parents who were allocated to the intervention versus waiting list groups; for example, critical parenting and aversive parenting strategies were significantly reduced in parents who attended the Incredible Years program compared with control parents. The findings of these trials replicated

those by the program developer. In addition, parent mental health improved for intervention parents. Effects were maintained at 12 months postbaseline (McGilloway et al., 2014) and 18 months postbaseline (Bywater et al., 2009). A recent review of the independent Incredible Years series research base (Pidano & Allen, 2015) demonstrates that the Basic parent program is the most researched from the series, with greater than 20 independent replication studies with a control group, and has the most established evidence base across many cultures and countries, thus illustrating the transportability of this program. A meta-analytic review of 50 control group studies evaluating only the Incredible Years parent programs (Menting et al., 2013) found similar effect sizes for child behavior for studies in the United States and Europe ($d = .39$ and .31 respectively), further illustrating the effectiveness of the programs when transported to Europe.

RESEARCH EVIDENCE FOR THE INCREDIBLE YEARS CHILD PROGRAMS AS ADJUNCTS TO PARENT PROGRAMS

Treatment

Three RCTs have evaluated the effectiveness of adding the small group child training (CT) program to parent training (PT) for reducing conduct problems and promoting social and emotional competence in children diagnosed with ODD (Webster-Stratton & Hammond, 1997; Webster-Stratton, Reid, & Hammond, 2004). Results indicated that children who received the CT-only condition showed enhanced improvements in problem-solving and conflict management skills with peers, compared with those in the PT-only condition. On measures of parent and child behavior at home, the PT-only condition resulted in more positive parent–child behavioral interactions in comparison with interactions in the CT-only condition. All changes were maintained a year later, and child conduct problems at home decreased over time. Results showed the combined CT plus PT condition produced the most sustained improvements in child behavior at 1-year follow-up. Therefore, the CT program was recently combined with the PT program for children diagnosed with ADHD, with similar results to earlier studies with children with ODD (Webster-Stratton, Reid, & Beauchaine, 2011). There are two published RCTs by independent investigators of the CT small group program with PT (Drugli & Larsson, 2006; Pidano & Allen, 2015), with two RCTs of CT as a stand-alone program delivered in schools being conducted in Wales and at the University of North Carolina (LaForett et al., 2018).

Prevention

One RCT conducted in the United States evaluated the use of the classroom prevention (universal) version of the Incredible Years child program with Head Start families and in primary grade classrooms in schools with economically disadvantaged populations. Teachers in intervention schools delivered the curriculum biweekly throughout the year. Results from the sample of 153 teachers and 1,768 students indicated that teachers used more positive management strategies, and students showed significant improvements in school readiness skills, emotional self-regulation, and social skills, as well as reductions in behavior problems, compared with control school classrooms. Intervention teachers also showed more positive involvement with parents than control teachers (Webster-Stratton, Reid, & Stoolmiller, 2008). A subsample of parents of indicated children (i.e., those with high levels of behavioral problems reported by teacher or parent) were selected and randomly allocated to (a) the parent program plus classroom intervention, (b) classroom-only intervention, or (c) control group. Mothers in the combined condition had stronger mother–child bonds and were more supportive and less critical than classroom-only intervention mothers, and they also reported fewer child behavior problems and more emotional regulation than parents in the other two conditions. Teachers reported these mothers as more involved in school and their children as having fewer behavior problems. This suggests added value when combining a social and emotional pupil curriculum with the Incredible Years parent program in schools (Reid, Webster-Stratton, & Hammond, 2007).

RESEARCH EVIDENCE FOR THE INCREDIBLE YEARS TEACHER CLASSROOM MANAGEMENT PROGRAM AS AN ADJUNCT TO PARENT PROGRAMS

The IY-TCM program has been evaluated in one treatment (Webster-Stratton et al., 2004) and two prevention RCTs (Webster-Stratton, Reid, & Hammond, 2001; Webster-Stratton et al., 2008); see also Webster-Stratton, 2012a and five RCTs by independent investigators, including trials conducted in Wales (Hutchings, Martin-Forbes, Daley, & Williams, 2013), Ireland (Hickey et al., 2017), Norway (Fossum, Handegård, & Drugli, 2017), England (Ford et al., 2018), and the United States (Reinke, Herman, Dong, in press). Research findings have shown that teachers who participated in the training used more proactive classroom management strategies, praised their students more, used fewer coercive or critical discipline strategies, and placed more focus on helping students to problem solve. Intervention classrooms were rated as having a more positive classroom atmosphere, increases in child social competence and school readiness skills, and lower levels of aggressive behavior. A recent study has replicated the benefits of the IY-TCM program for enhancing parents' involvement in their children's education (Reinke et al., 2014). A study comparing combinations of Incredible Years parent, teacher, and child programs found that combining either teacher or child intervention with Basic program parent training resulted in enhanced improvements in classroom behaviors as well as more positive parent involvement in children's education (Webster-Stratton et al., 2004). Pidano and Allen (2015) identified two additional independent studies in the United States that combined IY-TCM with PT, both of which reported positive results for child behavior.

The Pidano and Allen (2015) review of independent evidence highlights the need for more RCTs with the child programs and the newer parent and teacher programs (attentive, autism, baby, and incredible beginnings). However, given current interest in early intervention and potential cost savings later in life, there has been a pull for evaluations of the Incredible Years baby and toddler programs. The authors of this chapter are aware of at least four ongoing European studies in Denmark, England, Ireland, and Norway evaluating the baby, or baby and toddler, programs (Bywater et al., 2016; McGilloway et al., 2014; Pontoppidan, 2015).

More longitudinal studies are also needed; however, comparative longitudinal studies are rare, as intervention studies typically employ a waitlist control design in which all trial participants receive the intervention but do so at different time points. Interestingly, although there has been a focus on combining programs simultaneously, there has been little research on establishing the effectiveness of the Incredible Years parent programs as a stacked model, when delivered according to level of need. Bywater et al. (2016) are exploring the effectiveness of a universal "dose" of the Incredible Years baby book followed by attendance in the baby and then toddler programs, depending on levels of parent well-being (a strong factor in the development of child well-being and social behavior). This study applies a proportionate universalism approach as advocated by Marmott et al. (2010), which ensures that services are delivered to those that need it most and that those that need less intervention receive less.

TRANSPORTABILITY FACTORS

Assuring Fidelity With Translations, Accommodations, and Flexible Dosage

An important aspect of a program's efficacy is fidelity in implementation. Indeed, if the program is not rigorously followed—for example, if session components are dispensed with, program dosage reduced, necessary resources not available, or group leaders not trained or supported with accredited mentors—then any absence of effects may be attributed to a lack of implementation fidelity. Incredible Years Basic parenting program research shows that high fidelity implementation not only preserves the anticipated behavior change mechanisms but is predictive of behavioral and relationship changes in parents, which in turn are predictive of social and emotional changes in the child as a result of the program (Eames et al., 2010). Other U.K. research (Little et al., 2012) demonstrates that independently observed high fidelity in Incredible Years Basic delivery translates to improved family outcomes.

Both of these studies implemented the programs in more than one language, using either translators or bilingual or multilingual facilitators, in very different contexts (semirural Wales, with a total population of approximately 3 million across Wales vs. culturally diverse Birmingham City, whose metropolitan area's population exceeds that of Wales as a country). It appears from these and other studies such as those conducted in Portugal, Norway, and the Netherlands that delivery in different contexts or in different languages does not affect the effectiveness of the program if delivered with high fidelity. Accommodations such as translation of materials is also not sufficient a change to render the program ineffective (Menting, Orobio de Castro, & Matthys, 2013). Durlak and DuPre (2008) reviewed 50 Incredible Years studies on prevention and health promotion programs for children, linking implementation fidelity to outcomes, and stated that perfect implementation is unrealistic (few studies achieve more than 80%) but positive results have often been achieved, with levels around 60%. The standardization of program content, structure, processes, methods, and materials facilitates delivery with fidelity. However, programs can be tailored to specific populations, which involves great leader skill in assuring that the content and pace of programs accurately reflect the developmental abilities of children, unique family culture or teacher classroom context, and baseline level of knowledge of the participants in the group. For example, program delivery may proceed at a slower pace over a greater number of sessions for parents with highly complex needs, or when several translators are present. This is classed as an accommodation rather than an adaptation, as the program content and processes have not changed but have been tailored to accommodate the participants' specific learning needs. Examples in which the Incredible Years Basic parent program has been tailored or accommodated to population needs, without changes being made to the core components of the program, include a randomized study with foster carers in the United Kingdom (Bywater et al., 2011) and a study with parents of children with ADHD in Portugal (Azevedo et al., 2014). Both studies demonstrated the transportability of the program across different types of populations as well as contexts.

Accredited Training and Consultation

The training, supervision, and accreditation of group leaders is crucial for delivering with high fidelity (Webster-Stratton & McCoy, 2015). First, carefully selected (according to education, experience, and interest) and motivated group leaders receive 3 days of training by accredited mentors before leading their first group of parents, teachers, or children. Then, it is highly recommended that they continue with ongoing consultation with Incredible Years coaches and/or mentors as they proceed through their first groups. They are encouraged to start videotaping their sessions right away and to review these videos with their coleader using the group leader checklist and peer review forms. It is also recommended that they send these videos for outside coaching and consultation by an accredited Incredible Years coach or mentor.

In line with this advice, Incredible Years parent group leaders in United Kingdom, Norway, Spain, Ireland, and Portugal research trials received the initial training as well as ongoing support during delivery of their groups. Group leaders in these studies were also required to pursue accreditation in the program. The process of group leader accreditation involves the leadership of at least two complete groups with greater than 80% attendance, video consultation, and a positive final video group assessment by an accredited mentor or trainer, as well as satisfactory completion of group leader group session protocols and weekly participant evaluations. This process ensures delivery with fidelity, which includes both content delivery (e.g., required number of sessions, vignettes, role plays, brainstorms) and therapeutic skills. The whole process of coaching, consultation, and accreditation of new group leaders is carried out by a network of national and international accredited Incredible Years trainers, mentors, and coaches (of which there are currently 8, 63, and 52, respectively) who meet annually to learn about new research and share videos of their groups, workshops, and coaching methods. An RCT found that providing group leaders with ongoing consultation and coaching following the 3-day workshop led to increased group facilitator proficiency, program adherence, and delivery fidelity (Webster-Stratton, Reid, &

Marsenich, 2014; for a detailed discussion of the building process for scaling up Incredible Years programs with fidelity see Webster-Stratton & McCoy, 2015).

CONCLUSIONS AND FUTURE DIRECTIONS FOR RESEARCH

The Incredible Years series is transportable, with robust evidence demonstrating positive outcomes for children, families, and teachers in the short, medium, and long term. The programs can be delivered as stand-alone programs or in combination, and they are suitable for early intervention, prevention, or treatment models to suit a variety of needs, populations, and service delivery organizations. Research has been conducted by independent researchers as well as the series developer. The accreditation and training model supports high fidelity and the likelihood of achieving outcomes similar to those found in efficacy trials.

Future directions for research should include evaluating ways to promote the sustainability of results when offering additional program adjuncts such as the Incredible Years Advance program, child program, teacher program, or ongoing booster sessions. For example, children could be assigned to treatment program conditions according to their particular comorbidity combinations, as research has shown that those with ADHD will fare better when teacher or child components are added to the PT program. Further research is needed to identify children for whom the current interventions are inadequate. The newest Incredible Years parent programs (baby, attentive parenting, and autism) and the new teacher programs (Incredible Beginnings and Helping Preschool Children with Autism) are also in need of RCTs to determine their effectiveness. In addition to exploring stand-alone programs or combinations of programs across modalities (teacher, parent, child), there is a need to explore the longitudinal benefits of receiving stacked parenting interventions so that parents, especially families referred by child welfare, receive support through every developmental stage that their child encounters. Alternative designs could include trials within cohort studies (TWiCS), a model that will be used to test a variety of interventions (including parent interventions) in Bradford, England as part of a £49 million project supported by the Big Lottery Fund to enhance outcomes for children aged 0 to 3 years (Dickerson et al., 2016).

At a time when the efficient management of human and economic resources is crucial, the availability of evidence-based programs for parents and teachers should form part of the public health mission. While the Incredible Years programs have been shown, in dozens of studies, to be transportable and effective across different contexts worldwide, barriers to fidelity may impede successful outcomes for parents, teachers, and children. Lack of services and organizational funding has sometimes led to the programs being delivered by group leaders without adequate training, support, coaching and consultation, agency monitoring, or assessment of outcomes. Frequently, the programs have been sliced and diced and components dropped in order to offer the program at a level that can be funded. Few agencies support their group leaders becoming accredited, and the program is often not well established enough to withstand staffing changes in an agency. Thus, the initial investment that an agency may make to purchase the program and train staff is often lost over time. Disseminating evidence-based programs can be thought of like constructing a house—the building will not be structurally sound if the contractors, electricians, and plumbers working on it were not certified; disregarded the architectural plan; and used poor quality, cheaper materials. To build a stable house, or to deliver an evidence-based program, it is important that the foundation, basic structure, and scaffolding is strong, and that those building the house or delivering the program are fully qualified or accredited. This equates to picking the right evidence-based program for the level of risk of the population and developmental status of the children; adequately training, supporting, and coaching group leaders so they become accredited; and providing quality control. In addition, providing adequate scaffolding through the use of trained and accredited coaches, mentors, and administrators who can champion quality delivery will make all the difference. With a supportive infrastructure surrounding the program, initial investments will

pay off in terms of strong family outcomes and a sustainable intervention program that can withstand staffing and administrative changes.

With the increasing blurring of organizational boundaries among services supporting families and children, there is a growing shared responsibility for the psychological management of conduct disorders, suggesting that evidence-based behavior management training should be included in initial training for professionals who are in regular contact with families and children, including foster carers and nursery workers.

In summary, the collective evidence suggests that the effective prevention of child conduct disorder and the promotion of responsive parenting and children's optimal social and emotional well-being and school readiness rely on a combination of key ingredients, including

1. an integrated, multiagency, multimodal approach;
2. the scaling up of evidence-based universal and targeted early interventions;
3. careful attention paid to identification of at risk populations; and
4. ongoing training and fidelity to preserve the mechanisms of change.

Attention to these combined ingredients would help to reduce the considerable individual, family, societal, and service costs that are incurred by untreated ODD, conduct problems, and attention deficit disorder.

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Adapting The Incredible Years, an evidence-based parenting programme, for families involved in the child welfare system

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Abstract
Families referred to child welfare for maltreatment and neglect are frequently mandated to attend parenting programmes. Evidence-based parenting programmes (EBPs) are under-utilised or not delivered with fidelity for this population. The Incredible Years (IY) parenting programme is an EPB that has been proven to reduce harsh parenting, increase positive discipline and nurturing parenting, reduce conduct problems and improve children's social competence. There is also promising preliminary evidence that IY is an effective intervention for families involved in child welfare and for foster parents. This article describes how the updated IY parenting basic programme is delivered with fidelity to this population.

Key words
Incredible Years parenting programme; child maltreatment; evidence-based programmes; positive parenting skills

Introduction
Each year over three million calls of concern about child maltreatment and neglect are made to child welfare service (CWS) agencies in the US (US DHSS, 2006). Almost 90% of these children remain in their home, some with and many without an active child welfare case opened. About one in four of these allegations of child maltreatment are made about families who have had prior maltreatment reports filed. About one million allegations will eventually be substantiated and service cases opened. In about 75% of those cases, services will be provided to the families at home (Barth *et al*, in press). Data suggest that 27-44% of families with an open case will have parent training recommended or mandated (Stahmer *et al*, 2005) as a sole treatment to remedy inadequate parenting or as part of a multi-component service plan. Unfortunately, very few of the parenting programmes recommended have empirical support or are evidence-based programmes (EBP; Schoenwald & Hoagwood, 2001). In addition to the problematic parenting skills displayed by parents in these families, children in the child welfare system are at high risk for behavioural

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problems. Garland and colleagues (2001), as well as a national survey (NSCAW Research Group, 2002) found that 42-47% of children in the child welfare system have Oppositional Defiant Disorder (ODD), Conduct Disorder (CD) or Attention-Deficit/Hyperactivity Disorder (ADHD). Thus, parenting interventions must be designed to improve parenting skills in the context of parenting children with significant challenging behaviours and attachment difficulties.

Policy-makers and senior managers are often resistant to using EBPs with this population for several reasons. First is the cost of delivering such programmes because they are lengthier and require additional training and supervision for therapists. Second is the belief that manualised EBPs are too narrowly focused and do not deal with the complex and culturally diverse parents and children that usually comprise this population. Third is a lack of understanding about how to deliver and adapt EBPs with fidelity to meet the unique needs of these families. Although there are relatively few studies of evidence-based parent training programmes among families involved in child welfare, estimates indicate that 50-80% of parents involved with child welfare who begin parent training programmes do not complete them (Lutzker, 1990; Lutzker & Bigelow, 2002; Chaffin *et al*, 2004). This high drop-out rate may be because of stressful life circumstances or by virtue of the court mandate that often requires parents' attendance but closes their case before their programme has been completed.

Whatever the rate of attendance, parents involved in child welfare who receive parent training present additional challenges to parent trainers for a number of different reasons. For example, parents may lack motivation or be resistant to attending a mandated parenting programme, especially if they do not feel they need parenting help. Parents may have had their children removed and therefore not be able to practise new skills with their children at home. Parents may also have other mental health issues (depression or substance abuse) or stressful life circumstances (violent relationships, low income, lack of childcare or transportation) that interfere with their ability to absorb new material or attend groups. They may see their problems in parenting to be a result of the external factors and not believe that parent training is necessary or a valuable use of their time.

Relevance of EBPs for the child welfare population

The relevance of evidence-based parent training programmes for the child welfare population has been increasingly recognised (Barth *et al*, 2005). Recent field trials of EBPs for families of maltreated children – including Multisystemic Therapy, Family Connections, SafeCare, and Parent Child Interaction Therapy (PCIT) – have had promising results (Corcoran, 2000). For example, a control group study found significant reductions in physical abuse reports among parents who participated in PCIT, an individually-coached programme designed for parents of young children, in comparison with an existing community-based parent training programme (Chaffin *et al*, 2004).

The Incredible Years (IY) basic parenting series is another EBP relevant for use with maltreating families with young children. Several aspects of the IY programme make it particularly effective for families involved in child welfare. First, because it is a group-based programme, it not only costs less than individual treatment but also focuses on building support networks and decreasing the isolation and sense of alienation commonly found among these parents. Because families meet other parents in similar situations, they feel less stigmatised by their situation and more hopeful about their future. Second, the programme makes extensive use of video modelling methods, showing parents vignettes of families from different cultural backgrounds parenting in a variety of parenting styles. The diversity of the vignettes allows most participating parents to identify with the parents in at least some of the vignettes. Parents discuss these parenting interactions and start to form a list of effective parenting principles. Third, the IY programme is delivered in a collaborative discussion format and families are helped to focus on their personal goals and strengths rather than on their deficits. This leads to greater parent participation, motivation and attendance. Fourth, the programme methods focus on cognitive restructuring, emotional regulation strategies and behavioural practice methods of learning rather than on didactic lectures, since these are more likely to bring about cognitive and behavioural change.

Recently the IY parent programmes were updated and revised to include new material and separate programmes for parents of infants (up to one year), toddlers (one to three years), pre-schoolers (three to five years) and school age children (six to eight and nine to 12 years). These revisions are particularly relevant for the child welfare population because of the following additional topics and strengthened focus:

1. Parents learn about normal child development so that they have appropriate developmental expectations.

2. Parents are trained in academic, persistence, social and emotion coaching to help them foster their children's self-regulation and social skills, build their parent-child relationships and decrease their attachment difficulties.
3. Parents are helped to set up predictable routines, schedules and on-going monitoring.
4. Parents learn how to teach their children problem-solving skills.
5. Home safety-proofing and monitoring strategies are ongoing themes in sessions.

The IY Basic parenting programme has been successfully tested in numerous randomised control group studies in the US, UK and Norway as treatment for clinical populations of parents of young children (ages two to 10 years) with diagnosed ODD, CD and ADHD. Results consistently indicate significant reductions in coercive parent-child interactions and conduct problems post-treatment and increases in positive parenting, which have shown sustained effects two to three years later (Schweinhart & Weikart, 1988; Scott *et al*, 2001; Webster-Stratton & Reid, in press). These findings are likely to have great significance to maltreating families who, as noted earlier, report exceptionally high rates of disruptive behaviour, school problems and developmental delays among their children (Lutzker, 1992; Burns *et al*, 2004).

The programme has also been evaluated as a prevention programme in community samples, including socio-economically disadvantaged and multi-cultural groups of parents enrolled in Head Start (as well as in the UK with Sure Start families). Results have indicated that Head Start and Sure Start parents, regardless of ethnic group, became significantly more positive, nurturing and engaged with their children and less harsh and critical in their discipline approaches (Webster-Stratton & Reid, 2003; 2006; Webster-Stratton *et al*, 2004; Gardner *et al*, 2006; Hutchings *et al*, 2007) compared with control group parents. In addition, the children of parents who received parent training became less aggressive and more co-operative and had higher school readiness skills. Moreover, results also showed significant reductions in maternal depression and increases in maternal self-confidence, self-efficacy and problem-solving ability (Gross *et al*, 2003). This is important because of the implications for reducing neglect in families when depression is reduced and parenting confidence increased.

Studies of IY with the child welfare population

In the above Head Start study, 20% of parents reported prior involvement with child protective services (Webster-Stratton, 1998; Webster-Stratton *et al*, 2001). Hurlburt and colleagues (under review) re-analysed these data to determine whether this subset of parents responded differently to the IY programme than those Head Start parents who had no prior child welfare system involvement. The results showed that, irrespective of whether or not they were involved in the child welfare system, parents who received the IY parenting group made significant positive changes in observed parenting practices compared with a control group of Head Start parents who received no parenting intervention. Overall, intervention outcomes did not differ in any significant way for parents with and without a history of involvement with child welfare. However, parents with such a history showed higher initial levels of negative and lower levels of positive parenting practices, consistent with other studies comparing matched samples of parents with and without a history of child maltreatment (Lutzker & Bigelow, 2002). The results of this analysis are promising regarding the possible use of the IY parent training model for helping to improve key parenting competencies in the child welfare population. However, because these parents participated in the programme voluntarily and were not mandated by child welfare, it is unclear whether the results would be replicated with families who were court ordered or mandated by child protective services.

A second randomised study (Linares *et al*, 2006) evaluated the use of the IY programme jointly with foster parents paired with mandated biological parents (whose children were removed due to child neglect or abuse) in comparison with a usual care condition. Findings indicated significant gains in positive parenting and collaborative co-parenting in comparison with the usual care condition, and these results were maintained at one-year follow-up. IY attendance and completion rates for biological parents whose children were in foster care were similar to the Head Start IY study population, who had their children at home (Hurlburt *et al*, under review). Biological or foster parents who attended more than six sessions showed more improvement in positive parenting than those attending fewer sessions, indicating the importance of programme dosage. This study provides promise for the use of the IY parent

programme to train both foster parents and birth parents to use similar parenting strategies, to work together to develop behaviour plans and to provide mutual support.

A third pilot study (2007–2009) was conducted in Seattle, Washington, where child welfare referred, court-mandated families or open cases in which parents mostly had their children at home (but were at risk of having them removed) were offered the updated basic parenting programme. Fifteen parent groups with an average of eight to 18 parents per group were delivered. Of the 136 families who were signed up for the programme, 70% completed it. (In order to be classified as a programme completer, families could miss no more than four of 16-18 sessions.) Day care and dinners were provided for parents, as was transportation when needed. There were 12 group leaders who were trained and who co-facilitated delivery of the parent groups.

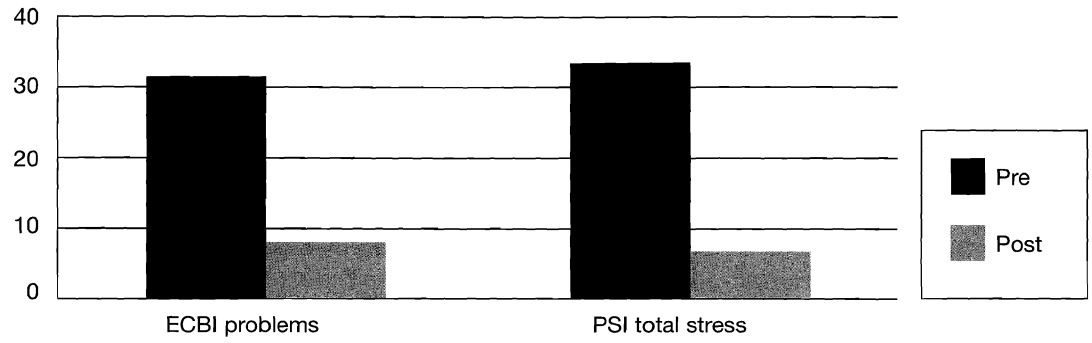
Parents were asked (but not required) to complete pre- and post-treatment data on the Parenting Stress Index/Short Form (PSI-SF; Abidin, 1990), which is a 36-item parent-report instrument of child behaviour problems and parental adjustment. The PSI/SF includes four variables: (a) a Total Stress score that provides an overall level of stress related to parenting and is derived from interactions with the child or as a result of children's behavioural characteristics; (b) a Parent Distress subscale (PD) that determines distress in the parent's personal adjustment directly related to parenting, such as impaired sense of competence, conflict with child's other parent, lack of social support, restrictions in life and presence of depression; (c) a Parent-Child Dysfunctional Interaction subscale (P-CDI) focused on parents' view that the child does not meet their expectations and that parent-child interactions are not reinforcing to them – high scores indicate that the parent feels the child is a negative element in his/her life and suggests poor parent-child bonding and risk for neglect, rejection or abuse; and (d) the Difficult Child subscale (DC), which focuses on behavioural characteristics of the children that make them easy or difficult to manage. These are often a result of the temperament of the child and may include defiant, non-compliant and demanding behaviours. Parents also completed the Eyberg Child Behaviour Inventory (ECBI; Robinson *et al*, 1980), which is a 36-item informant report measure of conduct problems for children aged from two to16 years. Two scores are derived: the Total Behaviour Problems score, which indicates the number of behaviours that a parent perceives as problematic, and the Total Intensity score, which indicates the degree to which those behaviours are a problem. Parents also completed a comprehensive consumer satisfaction questionnaire regarding the treatment they received.

Results showed that mothers who attended the IY parenting class reported significantly lower scores on the Total PSI Stress ($t [57] = 6.53$, $p < .001$), Parent Distress ($t [57] = 5.14$, $p < .001$), Dysfunctional Parent-Child Relationship ($t [57] = 4.50$, $p < .001$) and Difficult Child subscales ($t [57] = 5.03$, $p < .001$) from pre-test to post-test. Results showed that fathers reported significantly lower Parent Distress ($t [22] = 2.44$, $p < .02$) from pre-test to post-test. No other father changes were significant, although all scores were in the predicted direction and sample size was smaller. Results of the mother reports on the ECBI showed significant reductions in behaviour problems on both the Intensity Score ($t [54] = 4.08$, $p < .001$) and Problem Score ($t [51] = 3.22$, $p < .002$). Results of the father reports on the ECBI showed a significant reduction in behaviour problems on the Intensity Score ($t [19] = 3.09$, $p < .006$).

In this study we were also interested in the extent to which parents and children made clinically significant changes on both measures. Chi-square analyses were therefore used to compare the percentage of children and mothers in the clinical range on each measure at pre-test and post-test. Clinical significance analyses were not performed on the father data because of the small numbers of father reports available. Chi-square analyses showed that for the ECBI problem score, the percentage of children in the clinical range decreased significantly from pre-test to post-test ($\chi^2 = 3.98$ (1), $p < .05$). At pre-test, 31% of mothers reported that their children were in the clinical range, compared with 8% at post-test (***Figure 1***). Mothers showed clinically significant change on all subscales of the PSI. For ease of reporting, numbers are presented only for the Total Stress score ($\chi^2 = 8.82$ (1), $p < .003$). At pre-test, 33% of mothers reported stress levels in the clinical range, compared with 7% after treatment.

Parent satisfaction with the programme was also high. Following treatment, parents' average satisfaction scores were 5.7 (1 – very low rating, 7 – very high rating) on reports of improvements in mother- or father-child bonding, improvements in original problems, expectations for programme

Figure 1 Percentage of children in the clinical range on the ECBI at pre- and post-treatment and percentage of mothers in the clinical range on the Total Stress scale of the PSI pre- and post-treatment



success, confidence in handling current and future problems, and overall feelings. The highest scores (above 6.2) were for confidence in handling current and future child problems, and overall feelings were 6.35 for mothers and 6.04 for fathers. While there was no comparison group or control group in this programme evaluation, the positive evaluations and high attendance rates are very encouraging about the use of the updated IY programme for this population.

Adapting and delivering the IY parent programme with fidelity for the child welfare population

A growing body of research demonstrates a significant relationship between the fidelity of EBP programme implementation and improved outcomes (Elliott & Mihalik, 2004; Fixsen *et al*, 2005). In order to deliver the IY programmes with quality and fidelity, it is important that group leaders understand four necessary principles of delivery. First, core programme components such as essential topics or content must be covered in every group. This includes providing the minimum number of sessions (ie. programme dosage), using the appropriate, age-specific IY parenting programme and mediating and discussing the required number of vignettes. Second, programme fidelity includes key leader skills and group learning methods used to deliver the programme, such as behavioural practice or role plays, the brainstorm and values self-reflection exercises, buddy sharing, cognitive reframing, principle building and the successful implementation of home activities. Third, group and leader alliance building techniques, such as collaboration and parent involvement, leader praise, enthusiasm and reinforcement, group support and weekly leader and buddy phone calls, are fundamental fidelity alliance concepts. Fourth, the leader must be skilled at making informed clinical adaptations of the IY programme to match the needs of a particular population or family, and the barriers to participation they may encounter, without affecting core components of programme fidelity.

Often fidelity and adaptation are thought of as mutually exclusive endeavors but in the IY model they are considered not only complementary but *necessary* to achieve accreditation in the programme. For example, lengthening the IY parent programme dosage and number of sessions offered, or supplementing with adjunct IY programmes for populations whose baseline parenting knowledge is low or whose children have developmental delays due to neglect, is deemed best proactive practice. Similarly, choosing vignettes that represent the culture of the families represented in the group or the temperament and developmental issues of their children is also considered best use of modelling principles. On the other hand, reducing the minimum number of sessions or core vignettes, or leaving out key programme topics in order to deliver a cheaper or quicker programme, affects the IY theory of change and reduces fidelity and effectiveness. Research has shown that delivering the IY programme with fidelity predicts change in both parent-reported and observed parenting skills, which in turn, predicts change in child behaviour outcomes (Scott *et al*, 2008; Eames *et al*, 2009).

Core content components and topic objectives of the IY parent programme

This section reviews the objectives and core components of the updated IY programme (2006), particularly highlighting those that are relevant for the child welfare population. In the section that follows afterwards, we provide an overview of how the programme can be adapted or expanded on with fidelity to manage the barriers associated with working with families referred by child welfare for problems of abuse and neglect. We have used this enhanced focus when delivering the programme to families involved in the child welfare system – including in the pilot study discussed previously.

Strengthen parent-child relationships and bonding

- Increase parents' empathy towards their children and knowledge of normal child development and needs of infants and children.
- Help parents have age-appropriate expectations and be sensitive to individual differences in children's temperament and social and emotional development.
- Promote parents' consistent monitoring and predictable supervision of children to keep them safe at all times.
- Increase parents' positive thoughts and decrease their negative attributions about their children.
- Encourage parents to give more effective praise and encouragement for targeted pro-social behaviours.
- Help parents understand how to promote positive parent-child relationships and strengthen their attachment.
- Help parents learn to enjoy their children, play with their children and follow their children's lead during play interactions.
- Help parents learn to become social, emotion, persistence and academic 'coaches' for their children.

Strengthen parents' interpersonal skills and supportive networks

- Teach coping and self-control skills, such as depression and anger management, effective communication skills and problem-solving strategies.
- Help parents develop supportive networks with other parents and family members.
- Help parents develop confidence, be less self-critical and learn to care for themselves.

Promote routines, effective limit-setting, non-punitive discipline and problem-solving

- Help parents understand the importance of predictable schedules, routines and consistent responses, particularly in regard to separations and reunions with children.
- Help parents learn anger management strategies and affect regulation so that they can stay calm, controlled and patient when disciplining their children.
- Help parents set up and communicate realistic goals for their children's social, emotional and academic behavior.
- Help parents set up behaviour plans and develop salient rewards for targeted pro-social behaviours.
- Help parents use non-punitive discipline and reduce harsh and physical discipline for misbehavior.
- Teach parents how to teach their children self-regulation skills by using a brief 'Time Out' to calm down.
- Teach parents to help their children manage anger and aggression through problem-solving and self-regulation strategies.
- Help parents to provide children with joyful and happy experiences and memories and reduce exposure to adult arguments, violent TV and computer games and an atmosphere of fear or depression.

Informed clinical adaptations of IY content and its relevance for the child welfare population

Enhanced focus: child-directed play and coaching skills programmes – strengthening parent-child bonding and building children's social and emotional competence

The emphasis on child-directed play and academic, persistence, social and emotion coaching are core components of the IY programme but will likely involve more sessions for the child welfare population than other prevention groups. It is important not to move on to the discipline units until parents begin to understand the concept of child-directed play, coaching, praise and incentives and have begun to form more positive relationships

with their children. For this population it is recommended that all the vignettes from the child-directed and coaching programmes be shown (in groups with less challenging populations a subset of the total vignettes is suggested). In addition, these parents are provided with many more intensive behavioural practice play experiences than a typical group. Parents take turns role-playing or practising playing 'parent' or 'child'. Leaders need to simplify skills and do repeated practices before moving on to more complex parenting. This not only provides practice with new parenting techniques but also gives parents an opportunity to see the world from the perspectives of their children, which promotes feelings of empathy for their needs. Parents also have daily home assignments to practise what they are learning. If children are in childcare at the same location as the parenting group, it is ideal to allot some time at the end of each session for parents to practise the new skills with their children under the supervision and coaching from the group leader. Alternatively, parents can receive this coaching and supervision of their parenting skills during a home visit. A home visitor coach manual is available for use by group leaders or case managers who will help parents practise the skills they are learning with their children.

This child-directed play content teaches parents how to provide emotion and social coaching during playtimes in order to strengthen their attachment and positive relationships with their children. Parents learn to provide consistent, positive attention for pro-social behaviours. They learn the value of play and having fun together for promoting their relationship, teaching social skills and improving school readiness skills. When viewing and discussing the video vignettes, parents also learn about children's normal developmental needs for contingent attention, predictable responses and positive emotional experiences. They discover that this undivided parental attention results in their children feeling valued and respected and leads to their increased self-esteem. They also learn about normal development differences in children's temperament, needs for attention and social and emotional development. This helps them to be sensitive and responsive to the cues their children give that they are ready to learn or need extra support, teaching and reassurance. Parents learn to watch, listen to, observe and enjoy their child's thinking process and to follow their child's lead in the play. They learn that children benefit from being in control of certain situations and may actually be more co-operative with their parents if they have the chance to explore their own ideas and wishes in play. In addition to learning how to be an 'appreciative audience' when interacting with their children, they learn how to communicate with them effectively by refraining from asking too many questions, giving commands, correcting or criticising or trying to teach the 'right' way to play. Instead as academic, persistence and social coaches they learn to describe their children's activities, pro-social behaviours and ability to stay focused on a difficult project. For many parents in the child welfare system this is a foreign and difficult language to learn, which necessitates group leaders not only setting up many practice exercises during group sessions but also helping them write out their scripts and encouraging their practice of this at home during daily play sessions.

Parents are also asked to participate in pretend play during their play sessions in order to build their children's imaginary worlds. In addition to encouraging fantasy play, parents are taught to be 'emotion coaches' for their children. Emotion coaching involves naming the children's feelings and providing support for expression of positive emotions such as joy, love, happiness, curiosity and calmness (eg. 'Wow! You look so proud that you built that dump truck' or 'I'm so pleased that you're staying calm while you build that difficult model. You've got great self-control'). Parents are also taught calmly to label their children's negative emotions, while providing coping statements about these feelings (eg. 'I see that you're frustrated, but I think you're going to stay calm and try again' or 'That was really hard to share but that was so friendly and see how happy that made your friend feel'). This emotion coaching helps children recognise their own emotions and gives them words to express them and also helps them begin to recognise and understand others' emotions. Frequently parents referred to child welfare may have limited emotion vocabulary themselves, so this training and practice serves the double purpose of helping the parents themselves learn about appropriate expression of feelings. The net result of this added emphasis on child-directed play and coaching is the strengthening of a more secure attachment between parents and children as well as more sensitive and responsive parenting and more parental understanding when reacting to their children's behaviours. It also facilitates the strengthening of children's self-esteem, language skills and academic, social and emotional competence, all of which may have been delayed due to prior lack of adequate cognitive stimulation and language.

For parents with no children at home

Since some parents have had their children removed to foster care, they do not have children at home to practise the play skills. These parents will need extra coaching and practice during the group sessions, and extra sessions may need to be scheduled for this additional practice. This can be accomplished by more frequent small group breakouts where one parent plays child and one plays parent and they rehearse the various forms of coaching. In addition, the sound track of the vignettes can be turned off and parents can practise using descriptive commenting and coaching statements while watching the children who are shown playing on the video vignettes.

For homework, parents are encouraged to practise their play and coaching skills with the children of friends or relatives. Visitation times with their own children are an ideal time to practise the new child-directed play and coaching language. Prior to a visitation time, group time can be used to help parents plan what activity would be appropriate to do with their child and also to anticipate their child's response to seeing and playing with them after a separation. During sessions, they will rehearse how they will greet their children and collaborate with the child welfare visitation worker to provide a fun and stimulating playtime with them, and what they will say and do when it is time for their children to leave them. It is preferable if the visitation workers have been trained in the IY programme and have collaborated with the group leader so they are able to provide coaching for the parent and support the specific parenting skills the parents are trying to learn.

The focus for these parents will also be geared towards helping them address some of their personal needs for confidence-building and enhanced support networks. This is done by broadening their understanding of the purpose of play and showing how play refuels all relationships, not just those with children. The homework assignment for these parents in the first week is to find a time to play or do something enjoyable (give them a prescription to have fun) with another adult, such as meeting a friend for coffee, or taking a walk with a person they find supportive, or doing something nice for themselves. The idea of nurturing oneself and building supportive friendships begins with this first topic on play. This illustrates how the parenting principles are broadened to include relationship principles and to start the journey of improving parents' depressed and despondent affect by building in some joyful times for themselves.

Enhanced focus: praise and rewards programme – increasing positive parenting skills, thoughts and communication with others

When parents are stressed and depressed, they are less likely to praise and encourage their children or even to notice positive behaviours when they occur. Moreover, they are more likely to be irritated, critical or angry about minor annoying misbehaviours. At these times, parents need extra help to identify positive behaviours they want to encourage and to remember to praise these behaviours frequently. The video vignettes in this programme can be used to help them identify child behaviours that could be praised and then to practise thinking of praise statements that clearly describe the desired behaviours. Parents write these statements down on a special piggy bank coin to help them understand that these approaches are an investment in their children's future.

Sticker charts and incentive programmes are used to encourage parents to clearly identify positive behaviours and then to watch for them to occur. They are given colourful stickers and charts to take home so they can see the effect of this positive approach on their children's behaviour right away.

As with the play principle, parents are helped to understand the impact of praise on all relationships; for example, for promoting friendships, encouraging a partner's decision or letting a colleague know she is appreciated. In the group, they practise sending positive notes to their children's teacher about something they enjoy about their children's classroom experience. Finally, in this programme they begin to learn about the importance of positive self-talk or self-praise. They rehearse and record positive motivational statements they can use when they find themselves getting negative, such as: 'I am a good parent; I'm doing my best as a parent; I can handle this; I will cope; I can stay calm; I can help her learn to control herself; I did a pretty good job talking to my welfare worker; No one is perfect – I can do this; I try hard'. Learning to substitute these positive coping statements and self-praise for their negative self-defeating thoughts will be a recurring exercise throughout all the parenting group sessions for parents from the child welfare population.

For parents with no children at home

These parents also learn about the importance of praise for children and, as with play, are given

extra guided practice in the group setting through role plays and rehearsal with the videos of children (parents narrate appropriate praise statements with the sound turned down). For homework they are encouraged to find other children to praise. If they have telephone contact with their children, they can rehearse and practise ways to praise them on the phone and to respond positively to what they are doing in the foster home or at school. To extend their practice with praise, they are asked to praise friends, colleagues, store clerks or other adults they are in contact with. In addition to the self-encouragement statements discussed above, they learn about the importance of praise for building positive support systems. They are encouraged to work on practising positive self-talk and giving themselves rewards (known as caring times) for something they have been successful at finishing or doing. These parents are given homework to set up reward systems for themselves for things that are difficult for them to do, such as exercising, calling a friend, completing some paperwork, paying their bills, organising a teacher conference or cleaning the bathroom. Group leaders can negotiate an added bonus by providing a fun prize for parents who meet a particular goal they have set for themselves.

Enhanced focus: positive discipline programmes – increasing children's sense of safety and security

Frequently, abusive parents have unrealistic expectations of their children's behaviour. They do not understand that all children disobey about one-third of the time and all children whine, cry, have tantrums, talk back and are defiant and oppositional at times. In this programme, parents are helped to understand that these behaviours are normal and in fact quite healthy expressions of self-confidence and independence. They are also helped to identify the important and necessary rules for their family and to keep these to a minimum so that they can follow through with them. They learn to reduce excessive and unnecessary commands and criticisms and to give necessary commands clearly, politely and calmly, without fear of their children's response. The key message emphasised here is the ability to state a command assertively and respectfully but without negative affect. This requires parents to use self-control strategies and regulate their negative responses.

Parents identify and record child negative behaviours they want to see less of and the group leader reviews these to be sure they are developmentally appropriate. Next they set up positive incentive plans for the alternative 'positive opposite' behaviours. For example, if a parent is trying to help an angry child throw fewer tantrums, she would start by labelling and praising her child's calm behaviour during play times or times when her child manages conflict by using her words rather than throwing a tantrum. She learns not to yell at her child for throwing a tantrum, thereby giving it attention.

In addition to learning to establish household rules and to make positive and clear requests, parents also learn about the importance of predictable routines for their children when they go to bed, get ready for school or say goodbye to their children. Frequently, these families do not have routine schedules for daily life. The homework assignment for this programme includes establishing rules and predictable schedules for mornings or evenings, reducing the number of commands and corrections and giving five praises for every correction or criticism. During group sessions parents write down the positive proactive commands they will try to use with their children at home. They are given laminated schedules with picture cue cards and use group time with their peer buddies to establish some predictable routines they will try to set up at home. Parents learn that having predictable household rules and routines leads to them giving fewer commands in a respectful way and results in children feeling safe and secure at home.

For parents with no children at home

If parents have visitation with their children, they are encouraged to think about what rules and limits apply to their visits. As described above, they decide what commands and limits are important to them and which are unnecessary. They then practise how to communicate their expectations clearly, calmly and positively when they see their children. In the group, parents may also discuss the added stresses of setting limits in the brief time that they have with their children, and additional challenges that may come if children are upset and resentful about the separation.

In addition to learning the limit-setting skills with children, an emphasis for these parents is their ability to apply these same principles to other relationships. So, parents are encouraged to think about what is most important to them. For example, in a conflictual partner relationship where there is much fighting and arguing, a parent might

be encouraged to think of one behaviour that she would appreciate having her partner do more of (eg. cleaning up clothes and newspapers from the bedroom floor). She would be encouraged to praise him/her for any efforts in this area, while at the same time reducing the amount of nagging she does for other behaviours. Parents also practise 'speaking up' about their needs and to ask other adults for what they need in a positive, non-critical way. This is a key skill for asking successfully for support from others. Lastly, parents are encouraged to think about life circumstances that are risky or dangerous to themselves or their children (eg. an abusive or substance-using partner). They discuss safe ways to set limits on these behaviours to protect themselves and their children.

Setting up predictable routines in their personal lives can also be challenging for many parents involved with child welfare. Many do not have daily schedules for eating, doing laundry or self-care, and often do not know how to plan their weekly calendars. We recommend giving these parents calendars and helping them work out their goals for the day and the week and learn how to organise their daily lives. Their homework is tailored around helping them to focus on an upsetting aspect of their life, identify for themselves what they would like to change and their goal, and then set up a plan to try to accomplish this.

Enhanced focus: handling misbehaviour programmes – strengthening parents' and children's self-regulation skills

Parents learn successfully to ignore many of the annoying behaviours that children exhibit, such as crying, having trantrums, whining, arguing and sarcastic backtalk. With neglectful parents, the difference in briefly ignoring an inappropriate behaviour and neglecting a child is emphasised in the programme. Developmental guidelines are given to define what ignoring looks like and how to keep children safe while ignoring. The key to using ignoring successfully is that parents learn never to ignore the child but instead to ignore briefly an inappropriate behaviour. Parents are taught that proximity to the child is very important during ignoring and that the most important part of ignoring is to return their positive attention to the child the moment that the inappropriate behaviour stops. Parents also discuss the fact that planned ignoring is only effective when the parent-child bond is strong. Thus, this topic comes only in the last third of the programme after parents have spent 10-12 weeks building parent-child attachment and learning positive parenting strategies.

Parents are also trained to use a brief 'Time Out' to calm down as an immediate, non-violent and respectful consequence reserved for aggressive behaviour in children aged three to eight. They learn how to teach their children how to calm down in Time Out by deep breathing and positive self-statements such as 'I can calm down; I can try again'. However, the group leader considers carefully parents' readiness to implement Time Out at home with their children. It is important that parents are engaged in regular play times with their children and have learned successfully to coach and praise them for pro-social behaviours before starting Time Out. It is also important that parents have learned some calming strategies to use themselves when they start to use Time Out. This may mean that they practise numerous Time Out scenarios in the group before initiating this at home with their children. Lastly, parents discuss appropriate ways to monitor their child's safety during Time Out. Time Out is not an opportunity to lock a child in his or her room for the rest of the afternoon. Rather it is a brief (three to five minutes) and well-monitored period where children learn to regulate their negative emotions. It is not intended as a humiliating experience for the child, rather a time for the child (and parent) to reflect and to calm themselves. This is followed immediately by a new opportunity for the child to be successful and to receive positive parental attention.

Many of the parents in the child welfare system have used spanking or hitting in the past as their primary form of discipline and have experienced this as children themselves. They are usually unaware of how to use Time Out appropriately or why ignoring strategies work to reduce misbehaviour (withdrawal of parental attention). Therefore, it can be difficult for them to give up spanking or hitting, especially as it often seems to work to get their child to obey in the short run. Group leaders help parents understand the possible consequences of continuing to use hitting as their discipline approach. One of the exercises involves the group brainstorming the advantages and disadvantages of spanking and then contrasting this with the advantages and disadvantages of Time Out. This values exercise allows parents to look at hitting children in an objective and non-blaming way and to think about the consequences of this

approach for themselves and for their children. They discover that in the short term spanking might help them control their child but that its use leads to long-term difficulties for their child in terms of possible escalating aggression and unhappy future relationships with them. In contrast, Time Out delivered in a respectful and calm way is difficult for the parent in the short term because so much self-control is required, but in the long run results in more socially competent children who learn how to self-regulate in Time Out and ultimately enjoy happier relationships. Often this exercise helps parents to think beyond the immediate moment to their goals for themselves and their children in the future. They are willing to give up hitting because of their awareness that it will benefit their child's future success and ability to manage their anger without physical violence (because of the parents' modelling).

Discussions about spanking in the context of a group of parents who have been referred to the child welfare system will involve the reality that many of these parents are being carefully monitored. It is likely that spanking their children may result in additional consequences from the system. This provides an additional incentive to use other methods of discipline, but also may add to parents' resentment about being monitored and their helpless feelings if they feel they do not have other discipline strategies to manage misbehaviour. A discussion of the circumstances around spanking or hitting can also be helpful. Usually parents are spanking at times when they are very frustrated and do not know what else to do to control their child's behaviour. They often feel helpless, furious, out of control and, quite possibly, that they are failing as parents. In other words, they are probably spanking at the times when they have the least control over their own anger and their own behaviour. Providing parents with a chance to explore feelings of guilt, anger, inadequacy, fear of losing their children and other emotions that occur during the use of physical discipline can help parents be more receptive to learning new coping strategies. In addition to learning non-violent discipline approaches, parents learn a variety of ways to manage their own anger that are similar to what they teach their children. These include the following:

1. Recognising anger building up early (through their physiological responses and negative cognitive self-talk).
2. Deep breathing and muscle relaxation exercises.
3. Challenging negative self-talk and re-writing positive self-talk.
4. Using positive imagery.
5. Taking brief Time Outs themselves.

In these ways parents learn to be aware of their body signals when their anger is building and to use strategies to keep it under control, such as taking some deep breaths, imagining a relaxing and pleasant place or time or briefly tensing and relaxing various muscle groups. If they feel they are losing control, they are encouraged to tell their child they are taking a brief Time Out in their bedroom and will return in three to five minutes (this is not recommended for parents of infants and toddlers because of safety issues). Parents will think of an 'emergency' plan if they feel that they cannot handle a situation on their own without losing control. This may involve calling a buddy from the group, enlisting the help of an available family member or friend, calling the group leader, or some other way of obtaining support to defuse a situation. Parents will spend considerable time in groups learning and practising how to challenge their negative thoughts and cultivating more calming, coping and positive thoughts. They will engage in exercises where they re-write their negative thoughts and take them home to practise when they feel they are getting angry with their children.

The final programme in the series is helping parents learn how to teach their children to problem-solve when they are handling conflict situations. Parents help their children learn solutions they can try when feeling angry, sad, hurt or disappointed. If the child Dinosaur Programme is offered in conjunction with the parent programme, parents will have their children's solution kits, which they can use at home to reinforce using appropriate solutions. For child welfare families, it is often difficult to teach their children problem-solving skills because they have difficulty with this themselves. For this reason, taking the advance programme (described below) on adult problem-solving is recommended before the programme on teaching children to problem solve. The advance programme on family meetings is also recommended for the older age programme (eight to 12 years).

For parents with no children at home

The anger management strategies outlined above will be reinforced for these parents by helping them identify what situations cause them to get

angry or react. They are helped to identify times or situations where they could take a personal Time Out before exploding, or could ignore a particular response from someone. Parents are helped to practise self-control strategies, such as stress management, deep breathing, positive imagery and time away to refuel. They practise disputing negative and irrational thoughts and replacing them with more calming and coping thoughts. An anger thermometer is used to help them identify the physiological and cognitive stages of anger build-up and to highlight the importance of stopping this build-up of negative self-talk as soon as they can identify it happening.

Enhanced focus: monitoring and safety

In order to play, praise, set up reward systems, set limits and follow through with consequences, parents must be monitoring or watching their children and know where they are at all times. Particularly in the case of neglecting parents, monitoring is a key theme that is discussed in most sessions. Parents receive information about why they cannot leave children unattended and brainstorm what to do in situations where they feel they have to leave their children alone. Options for appropriate and safe babysitters and childcare are discussed and problem-solving occurs around barriers. Developmental expectations for different age children are also discussed: what level of monitoring is appropriate for an infant or toddler, a child starting school, a nine-year-old or a 12-year-old?

Parents discuss the value of appropriate continual monitoring for promoting their children's social and emotional development and sense of security. They brainstorm the advantages of monitoring as well as the barriers and disadvantages. The parents' ideas are written on a flipchart and reviewed so that participants can see the potential negative outcomes of not monitoring, both for their children and themselves. As part of this discussion, the role of television as a babysitter and the amount of time children spend alone with TV or computers is discussed. Since this takes place after the play units, parents can compare the value of parent-child play with that derived from watching television.

Lastly, other safety issues are covered, with an emphasis on how these change for children of different ages and developmental levels. For the babies and toddlers programme, considerable time is spent discussing child-proofing the home. Parents' homework involves completing a detailed home safety checklist. Parents and group leaders talk about how child-proofing needs change as children progress through new developmental stages. For early school-age children, guidelines around what activities children can safely do themselves are discussed. For example, the group explores issues such as: at what age can children use the microwave or stove, go for a bike ride around the block, use the internet or answer the front door. The need for adult teaching, supervision and monitoring for all these activities is also emphasised. For the older, pre-adolescent, programme (ages eight to 12 years), the importance of monitoring where children are after school or on weekends and who they are with, or how homework has been completed, or completion of chores is stressed. Parents may mistakenly think that children can be left alone at this age, not understanding the importance of knowing where and with whom children are with at all times.

Clinical adaptations to handle barriers to treatment delivery

Above we discussed ways to tailor the IY programme content to families involved in the child welfare system. In addition to the need for content adaptation, there are other barriers that may arise when working with this population. In what follows we outline ways that the IY programme can be delivered to overcome these barriers. In some cases, core therapy processes of the existing programme are already well suited to working with this population. In other cases, we will suggest how group leaders can make informed clinical adaptations with fidelity that are specific to the child welfare population (***Table 1***).

Parent engagement

One barrier is that parents involved in the child welfare system may be difficult to engage because they are angry about being required to participate in parent education. The IY parent programme model, with its emphasis on collaboration rather than didactic prescriptions and its non-blaming and non-confronting focus on parent strengths instead of deficits, is designed to counteract parent resistance. From the very first session, parents are involved in setting their own parenting goals as well as goals for their children's behaviour. Group leaders describe the group process as a partnership between the parents and themselves

Table 1 Adapting the IY programme with fidelity for the child welfare population

Core IY components	IY adaptations (with fidelity)
Standard topics and protocols for each of four basic parenting programmes according to age group targeted (2008 versions)	Cover all standard topics and protocols but increase the focus in key areas: parent-child attachment, emotion and social coaching, parental attributions and self-talk, positive discipline, monitoring and self-care
Vignette protocols	Add additional vignettes (beyond core recommended ones) if parents in the group are not mastering material
Programme dosage (18-20 sessions)	Increased dosage may be needed to cover the material adequately since it may take these groups longer to master material
Key group teaching/learning methods (behavioural practice, principle building, values exercises, tailoring to meet cultural and developmental issues, home activities)	Need to increase parent practice and role plays in sessions, develop scripts for language skills and cognitions, provide more explicit teaching about developmentally appropriate parenting practices, and adapt home activities for families without children in the home
Alliance-building techniques (collaborative learning, buddy calls, weekly leader support calls, praise to parents, incentives for parents)	All standard alliance-building techniques apply to this population, but may need increased efforts to engage families by giving more praise, using more incentives and spending longer to build a trusting relationship between parents and leaders
Food, transportation, childcare	No adaptations needed, but essential to offer these for this population
Core model does not offer home visits	Add a minimum of four home visits to coach parent-child interactions using coach home visit manuals; use these to make up missed sessions
Core model does not address collaboration with case workers or planning for visitation with children	Co-ordinate with case workers to plan for parent-child visitations. Case workers need to understand the core IY topics and parenting strategies so that they can coach families during these visits
Core model suggests use of IY advance, child and teacher programmes for children with diagnoses or very high risk families	Consider additional IY programmes: • Advance programme to teach anger and depression management and problem-solving steps • Child social, emotional and problem-solving skills programme (Dinosaur School) offered alongside parent programme

and emphasise that everyone in the group will be sharing ideas and learning from one another. Parents are assigned a buddy (another parent in the group) and are given specific assignments to contact the buddy between groups to share their experiences with each part of the programme. Group leaders also call parents each week to provide on-going support for their home practices. This approach helps to build a support system around parenting issues and diffuse parents' anger and sense of stigmatisation, because they receive validation from leaders as well as other group members who are struggling with similar difficulties in their day-to-day parenting experiences. Making new friends and sharing mutual problems and solutions is motivating and supportive for these parents, who often feel isolated and blamed (Coohey, 1996; Roditti, 2005). Moreover, the programme's incorporation of motivational concepts such as individual goal setting, self-monitoring, reinforcing motivational self-talk, examination of personal belief systems through benefits and barriers exercises, peer buddy calls and group leader coaching helps to promote demoralised parents' active engagement with the programme. These core programme group learning methods help parents to determine and accept responsibility for what they want to achieve within a supportive context.

Balancing collaboration and teaching

Group leaders work to maintain fidelity to teaching the core behaviour management principles, while

helping families see how these principles are relevant for their own goals. The leader balances the need to present basic information that the parents might not know (eg. developmentally appropriate expectations for behaviour) with acknowledging parental perspectives and knowledge and helping parents to see that different parenting styles can be effective. In some child welfare parent groups, parents may need more basic teaching than in a group of parents with more baseline skills. However, because child welfare parents may be more resistant to the programme, the group leader will also need considerable therapeutic skill to bond with parents, to highlight the skills that these parents do have and to empower them to feel as if they can make changes that will benefit their children. In a sense, a group leader working with this population needs to be more directive, and more collaborative, and more therapeutically skilled. For this reason, when group leaders are first learning the IY programme and working with this population, they will need high levels of consultation and support from accredited IY mentors.

Practical barriers: childcare and transportation

Another barrier to group attendance is addressed by providing practical assistance for families by offering dinner, childcare and transportation for the groups. These are offered in all of our community-based groups, not just to families involved in child welfare. Over and over again, when families are asked to list reasons for not attending a group, childcare and transportation are among the top reasons listed. Families who do attend the groups always rate the social dinner-time as a strong motivator for their ongoing participation.

Addressing other mental heath issues

Families involved with child welfare services are often experiencing multiple stressors that make it difficult for them to focus solely on parenting issues. For example, parents involved with Child Welfare Services have elevated rates of depression (US DHSS, 2006), anger control difficulties (Ateah & Durrant, 2005) and conflictual relationships with partners and other family members that frequently escalate to domestic violence (Hazen *et al*, 2004). The content of the Incredible Years parent advance programme addresses many of these issues as they relate to parenting and also to parents' functioning in their adult family environment, and it is highly recommended that these parents are offered both the basic programme (described above) and the advance programme (described below). Group leaders are also responsible for referring parents to other, more specialised, treatment programmes for substance abuse, domestic violence or clinical level depression.

Out-of-home placement for children

A unique barrier to delivering the IY programme to the child welfare population is that some of the children of the parents in these groups may have been removed from the home before or during parent training. The sections discussed before provide specific modifications that are made in each content area to address this issue. However, these modifications cannot make up for the fact that when children are living with their parents, the parent-child relationship and attachment is built up during the first part of the programme and becomes the foundation for later parent and child behaviour change and proactive discipline. In the absence of this chance for parents to work directly on the parent-child relationship, IY is still potentially a useful training programme for these parents because of its use of video modelling, group support, behavioural rehearsal and discrete skills practice exercises during the group sessions. These methods provide an opportunity for parents who are not living with their children to practise, watch and discuss examples of parenting interactions. The examples from the DVDs, role-plays, and other group members help to prepare parents for their children's return. It is also recommended that parents who do not have custody of their children repeat the IY parenting group after reunification so that they can practise the skills they have learned with their own children.

Group constellation

Group constellation is an issue to consider when organising a parent group. A group could consist entirely of mandated parents or could be a mixture of mandated and non-mandated parents. Both kinds of groups have advantages. If all parents in a group have been mandated, the group formation provides them with support from a number of other families who are experiencing the same challenges. Group members may share the sense of anger, shame or despair about the circumstances that have required them to be in the group. This collective experience may be useful in group bonding and also may lead to

group goals and discussions about ways to change parenting interactions to avoid future involvement with Child Protective Services (CPS). On the other hand, a group that consists entirely of parents who are mandated to attend may initially be more difficult to motivate and engage. Also, it may foster parent negativity about being victims of the system rather than focusing attention on effective parenting. One of the advantages of doing the IY programme in mixed groups (parents who are mandated combined with those who volunteer) is that parents listen to one another talking about their goals. This gives parents who are mandated a chance to observe other parents openly acknowledging that they want to be a calmer or a more positive parent, or to hit and scream less, or to find ways to manage their children's behaviour problems. This group disclosure process helps the parents who are mandated begin to realise that other parents have similar issues and are being proactive about finding solutions, regardless of their level of involvement with CPS. It is important that parents' goals for themselves and their children be revisited throughout the programme, because this allows all parents to change their views about what they might want to accomplish and to take on more responsibility for their own learning.

Supplementing with additional IY programmes

For families who are involved in the child welfare system, it may be useful to combine the basic parent programmes (toddler, early childhood or school-age versions) with other supplemental IY programmes.

The advance IY parent programme

It is highly recommended that this population receive the advance programme in addition to the basic programme. Typically, the advance programme is offered after the basic programme is completed and takes another eight to nine sessions, making up a total of 24–26 sessions. The advance programme is recommended because it focuses on adult interpersonal issues. Parents learn effective communication skills with partners and teachers, more in-depth ways to cope with discouraging and depressive thoughts, more practice with anger-management strategies, ways to give and get support from family members and other parents, and effective problem-solving strategies. However, as we have seen, some of these advance programme themes are woven throughout the basic programme. For instance, in every unit in the basic programme, there is an emphasis on how the behaviour management principles they are learning can help them cope with their own emotions and their other adult relationships as well as with their child's behaviour and emotions. If this is done skilfully and consistently, parents will have some experience with many of these concepts, even if the advance programme is not offered afterwards. In particular, the adult problem-solving programme from advance is recommended for parents of all age groups.

IY home visitor coaching and model

In addition to the IY basic group meetings, we recommend that trained home visitor coaches work individually with parents and children for a minimum of four visits to help them practise the skills they are learning in their groups. Sometimes case managers are visiting these families anyway, so if they are trained in the IY programme it is an opportunity to rehearse and reinforce skills parents are learning in the groups with their children. A coaching manual for home visitors with home session training protocols is available, as are workbooks for parents. If parents miss group sessions, these protocols can be used for home visit catch-up sessions. Moreover, for parents who cannot attend groups due to work schedule difficulties, the manual offers protocols for leaders to offer the entire programme at home with parents. This usually takes about 20 sessions to complete.

IY Child Dinosaur treatment programme

For parents in the child welfare system who have children at home, the small group child treatment programme is recommended in addition to the parent programme. This promotes children's social, emotional and problem-solving skills. It is important for this population because research shows that children who have been neglected or abused have more behaviour problems, self-regulation and emotional difficulties and other developmental, learning and social difficulties (Fantuzzo *et al*, 1991; Crick & Dodge, 1994; Jaffee *et al*, 2004; Knutson *et al*, 2005). This programme takes 18–24 weeks to complete and is offered concurrently with the parent group. It also allows for the possibility of joint parent-child activities where parents are able to practise new skills with their children in some sessions. In mixed groups where at least some parents are living

with their children, those who are not living with their children can still be involved in the joint parent-child play sessions. Parents who do not have a child to practise with may be paired up for practice with other parent-child dyads under the supervision of the group leader.

Summary

We have discussed how to deliver Incredible Years core programme principles and adapt the programme with fidelity to meet the needs of intact families referred by child welfare as well as families where the children have been removed from the home. These evidence-based programmes have demonstrated ability to improve parent-child relationships and to build parents' own sense of competence and self-control as well as strengthen their supportive family and community networks. While it is not uncommon for child welfare agencies to seek briefer interventions than IY, there is no research to provide evidence regarding the efficacy of their use. Moreover, these families are complex and in the highest risk category for re-abuse and maltreatment if not adequately trained and supported. Data in the parenting literature supports the notion that parenting curricula need to be substantial to produce sustainable effects with challenging populations (Kazdin & Mazurick, 1994). Data from the IY programmes has shown that the dosage of the intervention received and the fidelity with which it is delivered is directly linked to changes in parenting and child behaviours (Baydar *et al*, 2003; Eames *et al*, 2009). Our standard treatment recommendation for child welfare families referred because of abuse and neglect is a minimum of 18 two-hour sessions delivered by accredited IY group leaders who have high levels of support and consultation.

Parent participation in the full IY programme is expected to improve the parent-child relationship, increase parents' sense of competence and self-control, increase the use of positive discipline strategies, predictable schedules and monitoring and reduce the rates of harsh and physical discipline. In the long term, we expect that these improvements in parenting will lead to lower rates of re-abuse, fewer re-reports to child welfare services and more academically, emotionally and socially competent children. In order to break the inter-generational cycle of parent-child violence and neglect, it is also necessary to provide enough training and support to therapists to ensure programme fidelity with the goal of these children getting the best parenting possible.

Summary of implications for policy and practice

- Young children involved in the child welfare system frequently have mental health diagnoses such as oppositional defiant disorder, depression, attachment disorders and Attention Deficit Hyperactivity Disorder.
- Evidence-based programmes are under-utilised with families who are involved in the child welfare system because of child abuse and neglect. This population is in need of comprehensive, intensive, evidence-based programmes delivered by highly skilled and trained clinicians who need ongoing support and consultation to deliver programmes with fidelity.
- Evidence-based interventions need to identify core components clearly and describe how to make programme adaptations with fidelity for these complex families and diagnosed children.
- There is a need for more research evaluating the effectiveness of evidence-based programmes for parents involved in the child welfare system due to child neglect and abuse.

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Author note

Carolyn Webster-Stratton has disclosed a potential financial conflict of interest because she disseminates these treatments and stands to gain from favourable reports. Because of this, she has voluntarily agreed to distance herself from certain critical research activities, including recruitment, consenting, primary data handling and data analysis. The University of Washington has approved these arrangements.

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Weighing in on the Time-out Controversy

An Empirical Perspective

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Abstract: Appropriate implementation of time-out has been shown for decades to produce positive outcomes ranging from the reduction in child problem behaviors to reduced levels of child maltreatment. Although the literature indicating positive outcomes on time-out is abundant, time-out continues to elicit controversy. While this controversy has been long-standing, more recent, outspoken sceptics have contested time-out using widely-viewed mediums. Unfortunately, critics present arguments against time-out without consulting the abundant, empirical literature on its positive effects. Moreover, these misinformed views can have devastating consequences by swaying families away from appropriate time-out implementation who may otherwise benefit. This paper utilizes the breadth of research on time-out to addresses myths surrounding its implementation.

Keywords: time-out, children, parenting, behavior problems, evidence-based treatment

Introduction

The use of time-out with children has been debated for years (e.g., LaVigna & Donnellan, 1986; Lutzker, 1994a; Lutzker, 1994b; McNeil, Clemens-Mowrer, Gurwitch, & Funderburk, 1994; Vockell, 1977). Research indicates that the use of time-out has been recommended to reduce problem behaviors for both typically behaving and clinically referred children (see Everett, Hupp, & Olmi, 2010 for a review; O'Leary, O'Leary, & Becker, 1967). The use of time-out in the classroom has been accepted by the general public for decades (Zabel, 1986), over and above alternative forms of discipline (e.g., spanking; Blampied & Kahan, 1992; Foxx & Shapiro, 1978). This sentiment is still shared in recent community sample perspectives (Passini, Pihet, & Favez, 2014). The use of time-out has been endorsed by the American Academy of Pediatrics, Society for a Science of Clinical Psychology, and American Psychological Association, among others, as an effective discipline strategy for child misbehaviors (American Academy of Pediatrics, 1998; Novotney, 2012; Society for a Science of Clinical Psychology, 2014). However, the implementation of this widely used procedure continues to evoke controversy (e.g., Siegel & Bryson, 2014a).

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Despite abundant evidence documenting the effectiveness and utility of time-out, highly visible, non-evidence-based cautions and recommendations against its use continue to be written and publicly disseminated. Unfortunately, such unfounded arguments against time-out implementation meaningfully permeate the public discourse. For example, a recent article in Time magazine (Siegel & Bryson, 2014a) publically ridiculed time-out by claiming it negatively affected children's neuroplasticity, isolated children, deprived them of receiving their "profound need for connection" (para. 4), and worsened problem behaviors rather than reducing them. The current article details the important components present in evidence-based practices incorporating time-out. In turn, the authors directly address major concerns raised by opponents of time-out using evidence collected through a rigorous literature search and relevant news articles. Research on the subject is compiled to provide an empirical perspective on time-out myths and controversies.

Specifications of Time-out

To address questions concerning the time-out paradigm, we first define the term and operationalize the procedure. Definitional issues are important as research findings from improperly implemented discipline procedures have produced mixed results (Larzelere, Schneider, Larson, & Pike, 1996). The term "time-out" was originally coined by Arthur Staats (Staats, 1971), and is an abbreviation of what many behavior analysts or behavioral psychologists would describe as "time-out from positive reinforcement" (Kazdin, 2001). Time-out "refers to the removal of a positive reinforcer for a certain period of time" (Kazdin,

2001, p. 210). By definition, time-out includes (1) a reinforcing environment, as well as (2) removal from that environment (Foxx & Shapiro, 1978). The positive, reinforcing environment often is established through warm, supportive parenting practices (e.g., praise). Appropriate child behaviors are immediately followed by positive parental attention to increase children's use of the appropriate behavior. Time-out, therefore, is meant to follow an inappropriate response to decrease the frequency of the response (Miller, 1976). Time-out is not meant to ignore a child's essential needs such as hunger, thirst, fear, or distress due to an accident (Morawska & Sanders, 2011). There are three situations that are appropriate for time-out implementation: (1) the presence of inappropriate behavior (e.g., noncompliance to a parental command), (2) the presence of a safety issue associated with the behavior (e.g., child hitting others), (3) when the use of reinforcements by the caregiver is ineffective due to the presence of other maintaining reinforcers in the child's environment (e.g., other children laughing at the behavior in the classroom; Anderson & King, 1974).

Between the years of 1977 and 2007, Everett, Hupp, and Olmi (2010) evaluated the collection of time-out research to operationally define a best-practice time-out procedure. Of the 445 studies collected, the researchers selected the 40 highest quality articles comparing 65 time-out intervention methods. A necessary set of criteria largely accepted across the literature was summarized as a collection of "(a) verbalized reason, (b) verbalized warning, (c) physi¬cal placement, (d) location in a chair, (e) short time durations, (f) repeated returns for escape, and (g) contingent delay release" (Everett, Hupp, & Olmi, 2010, p. 252). In addition, behavioral management principles were largely recommended including "(a) remaining calm dur¬ing implementation, (b) the use of the intervention immediately and consistently following target behavioral occurrence, and (c) appropriate monitoring through which to judge intervention effectiveness" (Everett, Hupp, & Olmi, 2010, p. 252).

Overall, time-out is meant to provide a consistent form of discipline that is delivered in a calm, controlled manner. Psycho-education on the use of developmentally appropriate behaviors is often conducted, thereby helping parents to set appropriate expectations for their child's behavior. Time-out allows parents to set limits when children act defiantly. It can be utilized in conjunction with other parental methods of discipline (e.g., removal of privilege), and is often implemented when a child does not respond to other parenting approaches (Hakman, Chaffin, Funderburk, & Silovsky, 2009). Time-outs are only administered for a pre-specified period of time (e.g., typically 3-7 minutes). Therefore, the child's circle of security is maintained as the parent returns positive attention to the child after completion of the discipline procedure, such that warm, positive words and touches are used to help the child regain emotional control and rebuild the relationship (McNeil & Hembree-Kigin, 2010). A number of evidence-based programs implement a structured time-out protocol adhering to Everett and Hupp's guidelines including Defiant Children (Barkley, 2013), Fast Track Program (Slough et al., 2008), Helping the Noncompliant Child (McMahon & Forehand, 2003; Peed, Roberts, & Forehand, 1977), the Incredible Years (Webster-Stratton, 1984), the Kazdin Method for Parenting the Defiant Child (Kazdin, 2008), Oregon Model, Parent Management Training (Forgatch, Bullock, & Patterson, 2004), Parent-Child Interaction Therapy (Eyberg & Funderburk, 2011; McNeil & Hembree-Kigin, 2010), Positive Parenting Program (Triple P; Nowak & Heinrichs, 2008; Sanders, Cann, & Markie-Dadds, 2003), and the Summer Treatment Program (Chronis et al., 2004). While some argue against time-out practices, families trained in time-out, their children, and the therapists who deliver treatment rate the procedure as appropriate and acceptable to help reduce problem behaviors (Eisenstadt, Eyberg, McNeil, Newcomb, & Funderburk, 1993).

Nancy M. Wallace

The following sections will address five separate myths commonly made by time-out opponents. Within each myth, specific empirical literature will be cited to support each counter argument. The paper will conclude by summarizing key counter arguments and placing time-out in the broader context of the evidence based treatment approaches.

***Myth 1**: Time-out is Counterproductive Because Loving, Positive Parenting is the Most Therapeutic Approach to Alleviating Child Misbehavior*

Some time-out opponents support the perspective that time-out hurts children's emotional development, arguing that parents need to provide love, attention,

Amy Herschell

and reasoning to help children regulate their anger during episodes of misbehavior (Siegel & Bryson, 2014a). In contrast to this perspective, decades of research have validated the notion that optimal child development occurs in the context of both warmth, love, and clear, consistent parental control and direction. In 1967, Diana Baumrind proposed three categorizations of parenting styles: authoritative, authoritarian, and permissive (for reviews, see Baumrind, 1967; Baumrind & Black, 1967). Each style delineated a balance between various degrees of parental responsiveness (warmth) and parental demandingness (control; Baumrind, 1967 & 1978). Baumrind operationalized parental responsiveness as displays of parental warmth, communication, and the encouragement of individual expression (Baumrind, 2005; Areepattamannil, 2010). Baumrind conceptualized parental control as a high degree of demandingness in which a parent may request that a child exhibit or change his or her behavior to better conform to the rules and expectations of society (Baumrind, 2005). While authoritative parents utilize a balance of both responsiveness and consistent control, authoritarian parents employ high levels of control and low levels of responsiveness (Areepattamannil, 2010; Maccoby & Martin, 1983). Although, permissive parents utilize high levels of responsiveness, they also place few demands upon their children (Areepattamannil, 2010; Baumrind, 1996; Maccoby & Martin, 1983). Since such parental typologies were proposed, decades of empirical research have investigated the application of such categorizations with a variety of populations. Specifically, authoritative parenting has been related to positive child health outcomes (Cullen et al., 2000), positive school outcomes (Areepattamannil, 2010) and lower levels of child behavior problems (Alizadeh, Talib, Abdullah, & Mansor, 2011). Conversely, caregivers' consistent failure to set developmentally appropriate limits on children's inappropriate behavior, a primary dimension of permissive parenting, has been associated with suboptimal levels of child development. Furthermore, the permissive parenting style has been related to higher levels of child behavior problems (Driscoll, Russell, & Crockett, 2008), substance abuse (Patock-Peckham & Morgan-Lopez, 2006), and poorer emotion regulation in children (Jabeen, Anis-ul-Haque, & Riaz, 2013).

In addition, the implementation of purely positive parenting techniques alone has been found to be insufficient to obtain significant improvements in child behavior problems (Eisenstadt et al., 1985). These findings indicate that a positive relationship cannot alleviate significant problem behaviors or maintain appropriate levels of behavior without proper limit-setting (Pfiffner & O'Leary, 1987). Eisenstadt and colleagues (1993) evaluated the separate components of positive parenting practices and discipline strategies through a highly structured time-out procedure. Results indicated that children who received only the positive parenting component had slight improvements on oppositionality, but large problem behaviors were not eliminated. The children who received the discipline procedure improved to within normal limits of oppositionality. A separate review of the literature indicated that differential reinforcement alone was not as effective in reducing problem behavior as reinforcement combined with discipline procedures (Vollmer, Irvata, Zarcone, Smith, & Mazaleski, 1993). Discipline procedures are thus important components to positive parenting for all families (Cavell, 2001).

The field of applied behavior analysis has been particularly influential in the translation of behavioral principles to work with children in applied settings. Research in applied behavior analysis indicates that providing immediate attention (e.g., reasoning, hugs) for disruptive behaviors that are maintained by attention will result in increased behavior problems (Cipani & Schock, 2010). Specifically, differential reinforcement of other behavior (DRO), a commonly used behavioral schedule in applied behavior analysis, employs operant conditioning techniques to decrease the frequency and length of inappropriate behaviors otherwise maintained by attention. In contrast, a child in distress from an accident or upset about the loss of his pet should receive warm, understanding attention and emotional validation from his or her caregiver given that the behavior is not problematic, nor is its function negative attention seeking.

DRO is based off of positive reinforcement techniques in which positive behaviors are reinforced, thereby increasing their frequency, while negative and inappropriate behaviors are ignored, thereby reducing their frequency (Gongola & Daddario, 2010). Strictly speaking, other behaviors are reinforced for a

period of time while the negative, target behavior is not provided with any attention. The DRO schedule has demonstrated efficacy across a wide variety of environments and populations in decreasing inappropriate and noncompliant behavior. The DRO schedule also supports a positive environment and is an ethically appealing form of behavior modification (see Gongola & Daddario, 2010 for a review). A childhood tantrum represents a common childhood behavior that often functions as a means by which children may receive negative attention. However, if attention (e.g., reasoning, negotiating, comforting) is provided in this moment, as suggested by some authors (Siegel & Bryson, 2014a), such negative attention seeking behavior will be reinforced and the frequency and intensity of the tantrum will increase. Unfortunately, research and clinical practice indicate that verbal instruction regarding appropriate child behavior alone has not been shown to reduce a child's negative outbursts (Roberts, 1984), indicating a need for additional procedures to successfully modify aggressive and non-compliant behavior. Additionally, such attention may result in progressively escalating emotional exchanges between the parent and child in an attempt to control the situation (Dishion, French, & Patterson, 1995). By ignoring a child's tantrum and enthusiastically engaging in an appropriate activity, a parent is likely to redirect a child's attention away from his or her tantrum. Praise (e.g., for "using your words" or "calming yourself down") and positive touches may then be used to reinforce calm, emotionally regulated behavior. If the timing of such attention is provided after the tantrum has ceased and when the child is calm, the child is less likely to engage in a tantrum for attention seeking purposes in the future, tantrums are likely to decrease in duration and frequency, and instances of emotional regulation may be likely to occur. Time-out therefore, functions similarly to a DRO procedure, in that attention is removed for a specified period of time and reinstated after the allotted time is up, and the child is calm and able to complete the original request.

While typically developing children in the preschool age are likely to display regular levels of noncompliance to assert their independence (Schroeder & Gordon, 1991), most do not develop significant behavior problems because parents already provide both positive attention and appropriate limit-setting. In severe cases of persistent childhood misbehavior, however, a caregiver may be referred for evidence-based parent-training treatment to quickly modify maladaptive parent-child interactions. In such cases, research indicates that families typically enter treatment utilizing inappropriate and inconsistent strategies to handle their children's behavior (Bandura & Walters, 1959; McCord, McCord, & Zola, 1959; McNeil et al., 1994). Evidence-based practices are used to teach parents consistent discipline only after they have mastered positive approaches of interacting with their children including praising and rapport-building between the parent and child (Nowak & Heinrichs, 2008). A compilation of time-out literature concludes that approximately 77% of these research articles utilized time-out in addition to another treatment component, namely parent-child relationship building (Everett, Hupp, & Olmi, 2010). The goal of this treatment is to reduce negative parenting practices and eliminate corporal punishment techniques by the conclusion of treatment (McNeil et al., 1994). Across the time-out literature, research indicates that eighty-six percent of studies used positive reinforcement to increase positive behaviors (Everett, Hupp, & Olmi, 2010). Once an environment is built on positive, warm relationships, the time regularly spent with the child outside of time-out becomes rewarding and reinforcing. As a result, the child is increasingly motivated to avoid time away from parental attention, to work to gain positive attention, and to engage in fewer negative attention-seeking behaviors.

Cheryl B. McNeil

Myth 2: *Time-out Strategies are Manualized and Do Not Address the Individual Needs of Children*

As previously noted, a number of empirically-based parenting programs for children with severe behavior problems specify the use of a clear, step-by-step time-out procedure (e.g., Parent-Child Interaction Therapy, Eyberg & Funderburk, 2011; the Summer Treatment Program, Chronis et al., 2004). In contrast to views that manualized treatments do not address a child's individual needs, the specific components of time-out (e.g., duration, child characteristics, child age, specific behavior problems) have been investigated to maximize efficacy while minimizing the intensity of the procedure for a given child (Fabiano et al., 2004).

Evidence supporting the efficacy of individualized time-out programs within the larger framework of three manualized treatment programs (Summer Treatment Program, Chronis et al., 2004; Parent-Child Interaction Therapy, McNeil & Hembree-Kigin, 2010; Defiant Children, Barkley, 1997) will be presented.

Fabiano et al. (2004) investigated the effect of three time-out procedures of varying lengths for children attending a summer treatment program for Attention Deficit Hyperactivity Disorder (ADHD: a disorder characterized by attention difficulty, hyperactivity, and/or impulsiveness). Time-out conditions consisted of a short (5 minute), long (15 minute) and an escalating/de-escalating procedure whereby a child could increase or decrease the length of the time-out depending on the appropriateness of his or her behavior in time-out. A time-out was only assigned following the occurrence of intentional aggression, intentional destruction of property, or repeated noncompliance. In the final response-cost condition, children only lost points for exhibiting such behaviors and commands were repeated until compliance was achieved. Results supported previous literature, indicating that time-out, irrespective of duration and child's age, was effective in reducing the occurrence of problematic behaviors (McGuffin, 1991). Recognizing that responses to time-out varied by the individual, the authors recommended modifications of the procedure if the initial time-out protocol is rendered unsuccessful. For example, some children may require a more complicated time-out procedure (Fabiano et al., 2004; Pelham et al., 2000). Finally, despite the context of a manualized treatment program with clear time-out procedures, the authors reported that individualized goals and individualized behavioral treatment programs were instated for children whose behavior did not respond well to time-out. The use of such programs indicates a degree of flexibility within the model and a focus on individualized efficacy of the procedure.

Another manualized treatment approach, Parent-Child Interaction Therapy (PCIT), utilizes a variety of procedures based in behavioral theory to individualize treatment to each child and family (McNeil, Filcheck, Greco, Ware, & Bernard, 2001). For example, PCIT begins with a non-standard functional assessment in which the therapist observes parent and child behavior across three situations meant to simulate typical parent-child interactions. The function of both parent (e.g., negative talk) and child (e.g., defiance, complaining) behaviors during these interactions are specifically evaluated (McNeil et al., 2001). Such conceptualizations are used to guide treatment so that caregivers can be taught to use positive interactional skills for attending to specific prosocial behaviors displayed by their children (McNeil et al., 2001). Additionally, individualized, skill-based data from behavior observations conducted at the start of each session are immediately utilized to shape the treatment session (McNeil et al., 2001). The discipline procedures used in PCIT may also be adapted according to the child's age and developmental level (McNeil et al., 2001). Furthermore, time-out is not recommended for toddlers less than two years old in response to noncompliance (McNeil & Hembree-Kigin, 2010). Instead a procedure involving simple words and pointing to what the child should do (e.g., "give me hat") followed by a hand over hand guide and praise for compliance should be used. A short (1 minute) time-out in a safe space (e.g., high chair, playpen) is recommended for aggressive behavior (McNeil & Hembree-Kigin, 2010). In contrast, discipline procedures for older children (7-10 years) include a number of potential steps such as (1) an explanation of the command, (2) an initial "big ignore" upon noncompliance in which a parent withdraws attention from the child for 45 seconds, and (3) a time-out warning. To teach the older child to cooperate with the time-out procedure, a sticker chart may be used to reward either avoiding time-out entirely by complying with parental instructions or accepting the time-out consequence without resistance. A suspension of privilege procedure is introduced late in treatment if children refuse to attend time-out or escape from time-out. Finally, some critics believe that time-out should not be used with children on the autism spectrum as the procedure allows the child to escape from otherwise non-pleasurable demands. However, a core component of effective time-out across evidence based programs is completion of the original command, thereby inhibiting the function of time-out as escape.

Lastly, in Defiant Children, a manualized treatment for non-compliant children, Barkley (1997) also uses a time-out procedure. Similar to PCIT, parents are told to implement time-out initially for noncompliance to commands only. After noncompliance to a warning, children remain in time-out for 1-2 minutes per year of their age and are not allowed to leave time-out until they are quiet for approximately 30 seconds. A child's bedroom is used if the child escapes from the chair before the allotted time is up. The sequence concludes when the child must comply with the original command.

It is well established that manualized treatment procedures support the efficacy of time-out in reducing

child behavior problems (Fabiano et al., 2004). Although a primary time-out procedure is specified in some manualized treatment programs, many also include individualized programs dependent upon the needs and characteristics of the child. Most importantly, time-out procedures often involve more intensive back-up consequences only when a child is unable to comply with the least restrictive consequence. When applied to typically developing children, the higher steps in the procedure may not be necessary. Children are taught all procedures prior to their initiation, and the provision of various backup procedures to time-out is determined by the child's choices. As the foundation of time-out is removing the child from reinforcing events, an integral component of the procedure involves enhancing time-in by increasing the reinforcing value of the parent-child interactions. As such, time-out procedures always fall within the larger context of a warm, positive environment where prosocial child behaviors are encouraged through high rates of social reinforcement.

Myth 3: *Time-out Can Trigger Trauma Reactions Related to Harsh Discipline Practices, Thereby Retraumatizing Children with a History of Maltreatment*

There is considerable debate on the use of time-out for children with histories of trauma. However, a number of research studies spanning multiple areas of psychology shed light on the use of time-out with this specialized population (Chaffin et al., 2004). Physical abuse is likely to occur in the context of the coercive cycle whereby a parent and child use increasingly intensive verbal and behavioral strategies to attempt to control a given situation (Patterson & Capaldi, 1991; Urquiza & McNeil, 1996). Such escalation may result in child physical abuse (CPA). Chaffin et al. (2004) conducted a randomized controlled trial to investigate the effects of PCIT on physical abuse. At the two year follow-up assessment, reports of physical abuse were 19% in the PCIT group as compared to 49% in the community parenting group, suggesting that the use of a time-out procedure may have helped to reduce the occurrence of CPA.

Some may argue that the use of time-out with children who have experienced abuse may result in retraumatization. Retraumatization has been defined as, "… traumatic stress reactions, responses, and symptoms that occur consequent to multiple exposures to traumatic events that are physical, psychological, or both in nature" (Duckworth & Follette, 2012, p. 2). These responses can occur in the context of repeated multiple exposures within one category of events (e.g., child sexual assault and adult sexual assault) or multiple exposures across different categories of events (e.g., childhood physical abuse and involvement in a serious motor vehicle collision during adulthood). According to the Diagnostic and Statistical Manual of Mental Disorders-5, examples of traumatic events may include torture, disasters, being kidnapped, military combat, sexual abuse, and automobile accidents (5th ed., text rev.; DSM–5, American Psychiatric Association, 2013). An individual's response to the traumatic event may be any combination of "a fear-based re-experiencing, emotional, and behavioral symptoms… [an] anhedonic or dysphoric mood state and negative cognitions [and/or] arousal and reactive-externalizing symptoms [and/or] dissociative symptoms" (5th ed., text rev.; DSM–5; American Psychiatric Association, 2013, p. 274). Given such definitions, it seems unlikely that a three minute time-out in a chair would qualify as a traumatic event for a young child. Yet, it remains important to consider whether time-out could serve as a trauma trigger, causing a child to experience intense fear and dissociative symptoms. At the same time, we must consider how to differentiate dysregulated behavior that has been triggered by association with a past trauma (e.g., physical abuse during discipline) versus the typical yelling, crying, and tantrumming seen routinely when strong-willed children receive a limit.

In a typical time-out procedure, a child is issued a command. Following a short period (e.g., 5 seconds), a warning is given indicating that if the child does not do as instructed, then he or she will go to time-out. Following an additional period of silence, the child is led to a time-out chair (Eyberg & Funderburk, 2011). Although such procedures could be potential triggers for recalling prior abuse, time-outs involve setting clear, predictable limits which are essential to healthy growth and development. Without the ability to establish boundaries and enforce predictable limits, caregivers of children with prior abuse histories may resort to a permissive parenting style that (1) lacks the structure needed for children to develop adequate self-control and emotional regulation, and (2) has been shown to lead to poor mental health outcomes (Fite, Stoppelbein, & Greening, 2009; McNeil, Costello, Travers, & Norman, 2013).

A valid concern is that time-out procedures could very well serve as a trigger for previous abuse experiences, particularly those that involved the caregiver becoming physically aggressive during an escalated and coercive discipline exchange. Yet, instead of automatically concluding that discipline battles should

be avoided due to the possible triggering of a trauma response, it is interesting to consider that the time-out procedure could actually be highly therapeutic from an exposure perspective. A primary treatment component for individuals that have experienced trauma involves imaginal or in-vivo exposure to triggers associated with the traumatic event in the context of a safe environment. Through repeated exposure, the individual's anxiety surrounding the trauma decreases. Previous triggers become associated with feelings of safety and predictability, rather than fear and pain. From a behavioral perspective, a previously unconditioned stimulus (e.g., yelling and hitting during discipline interactions) is replaced by a conditioned stimulus (e.g., a calm, clear, and consistent sequence of caregiver behaviors). The previously unconditioned response (e.g., fear) is then alleviated by the feelings of safety associated with predictable consequences delivered by the caregiver (e.g., time-out delivered calmly and systematically). The use of a warning prior to the time-out provides control to children, allowing them to choose a behavioral response and control whether time-out is delivered. Through repeated exposure to consistent, calm limit setting, discipline scenarios are no longer associated with fear and pain, such that prior conditioning is extinguished. Through exposure to predictable and appropriate limit setting, the child develops a sense of control and feelings of safety during discipline interactions.

It is imperative to consider each child's individual abuse history in the context of each step of time-out. For children with histories of neglect or seclusion, an alternative back-up procedure (other than a back-up room) may be considered as a consequence for time-out escape, as the back-up room may have ethical concerns as the exposure may be too intense (more of a flooding experience than systematic desensitization; McNeil & Hembree-Kigin, 2010). In these types of extreme cases, alternative back-ups to the time-out, such as restriction of privilege, may be used to allow a more systematic exposure to the time-out sequence, allowing children to regulate their emotions while maintaining the efficacy of such procedures (McNeil, Costello, Travers, & Norman, 2013). If a back-up space is deemed appropriate, the caregiver is instructed to remain in close proximity (i.e., within two feet of the child) so that the child is aware of the parent's presence, thereby preventing the child from experiencing any sense of abandonment. Following time-out, the parent and child are encouraged to engage in calm, loving interactions, often in the form of play. These warm interactions help to maintain the positive parent-child relationship, while also communicating that the parent loves the child but does not condone the child's defiant and aggressive behavior (McNeil, 2013).

Myth 4: *Time-out is Harmful to Children*

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Some time-out opponents believe that time-out causes children to feel intense relational pain and feelings of rejection from their caregiver. Additionally, some argue that time-out causes children to fail to have a chance to build important social and emotional skills including emotion regulation, empathy and the ability to solve problems (Siegel & Bryson, 2014a). While there is an abundance of research indicating the positive outcomes stemming from time-out implementation, equal importance should be placed on the alternative outcomes if parent training (including both positive parenting skills and discipline techniques) is not delivered to high-risk families. Regardless of the feelings individuals have about the use of "aversive" practices (e.g., time-out), the unfortunate truth is both high- and low-risk families can inflict severe, inappropriate consequences on their children when caught in a coercive process. Passimi, Pihet, and Favez (2014) explored a community sample of highly educated, generally stable families to determine their acceptance of discipline techniques used with their children. Mothers indicated strong beliefs in a warm relationship with their children and agreed with explaining household rules regularly. The use of time-out was also highly accepted, however there was significant variation across parents indicating that strong feelings were present about the appropriateness of various discipline approaches. Discipline techniques such as yelling and spanking received the lowest acceptance by these parents, with spanking practices more accepted than yelling. In spite of their acceptance rates, both yelling and spanking were implemented by the sampled families. Moreover, although yelling was the least acceptable practice rated by mothers, yelling was implemented as frequently as time-out in this sample.

While families can be well-intentioned, parents and children may unknowingly become caught in a negative interaction cycle explained by Patterson's coercion theory (1982). Patterson's theory explains a process of mutual reinforcement between parents and their children in which parents inadvertently reinforce a child's problem behaviors. More specifically, Patterson's (2002) theory posits that a parent may give a command to a child who then resists or becomes frustrated by the request. Such child misbehavior causes the parent to become angrier, the child to become more defiant, and the interaction to escalate. If parents give in to the child at this point in the coercive exchange, it results in the strengthening of the child's problem behavior. The coercive escalation also can lead parents to react with inappropriate discipline strategies to elicit a form of control (Patterson, 1982; Patterson & Capaldi, 1991). When these styles of interaction become the norm, children learn a pattern of defiance, leading to behavior problems that can maintain during the course of development (Granic & Patterson, 2006). Fortunately, the use of time-out interrupts the coercive process between caregivers and children. Evidence-based practices provide parents with specific words and actions to prevent the escalation of problem behaviors (Morawska & Sanders, 2011).

Families referred for parent training have higher rates of physical punishment and inappropriate discipline strategies (Patterson & Capaldi, 1991). In one clinical sample, for example, parents admitted to spanking their children approximately 13 times a week (McNeil et al., 1994). Referred caregivers are more likely to respond to their children's frequent, regular misbehaviors with yelling, critical statements, threats, and physical punishment (Mammen, Kolko, & Pilkonis, 2003). When no positive discipline alternatives are provided to highly stressed parents who are confronted with severe behavior problems, they are likely to resort to spanking out of desperation and frustration. When spanking is unsuccessful, physical punishments may escalate into child physical abuse.

Although some outspoken opponents argue that time-out makes children "angrier and more dysregulated" when children have not "built certain self-regulation skills" (Siegel & Bryson, 2014a, para. 5, 7), the research has in fact indicated that the opposite is true. Time-out represents a safe, effective form of discipline in which a caregiver and child are able to remove themselves from a potentially stressful parent-child interaction and are given the space needed to regain control of their thoughts and emotions. Specifically, recent research indicates promising outcomes using time-out for children with disruptive mood dysregulation disorder. Therefore, implementing a parenting intervention with both relationship-building and discipline (i.e., time-out) components produced significant positive effects such as a reduction in defiance and an increase in a healthier mother-child relationship. Further research supports the notion that time-out is effective in helping children's externalizing and internalizing behavior to come within normal limits, demonstrate greater self-control and achieve better emotion regulation abilities (Graziano, Bagner, Sheinkopf, Vohr, & Lester, 2012; Johns & Levy, 2013; Webster-Stratton, Reid, & Stool-Miller, 2008). Additionally, the length of time-out is short (e.g., approximately 3 minutes or 1 minute per year of the child's age) across most empirically-based

parenting programs (Everett, Hupp, & Olmi, 2010).

Kazdin (2002) argues that, the failure to use appropriate discipline and parenting techniques to protect a child who is acting out may be detrimental, and itself may meet the definition of abuse. If negative discipline procedures escalated to the level of severe physical punishment, abuses such as these have been shown to be associated with a child's increased likelihood of drug dependency, personality disorders, and a number of mood disorders (Afifi, Mota, Dasiewicz, MacMillan, & Sareen, 2012). These negative skills are linked to child psychopathology such as oppositional defiant disorder and conduct disorder (Falk & Lee, 2012). Moreover, Afifi and colleagues (2012) found that harsh physical punishment accounted for 4 to 7% of disorders including intellectual disabilities and personality disorders in addition to 2 to 5% of all other diagnostic criteria for Axis I of the DSM-IV-TR (Afifi et al., 2012).

Parents who have psychopathology themselves are at high risk of using inappropriate discipline strategies when faced with challenging child behavior (Harmer, Sanderson, & Mertin, 1999). More specifically, caregivers with psychopathologies respond at increased rates with hostility, anger, and irregular, unfair discipline techniques despite the child's behavior (Harmer, Sanderson, & Mertin, 1999; Paulson, Dauber, & Leiferman, 2006). Similarly, some children are already predisposed to high risk behavior. For example, researchers have recently concluded that children on the autism spectrum and with ADHD have a weakened sense for danger and more frequently engage in behaviors that place them at risk for harm and even death (Anderson et al., 2012; Barkley, 2005).

Research on parenting styles shows that effective parenting requires a combination of a nurturing relationship and effective limit-setting strategies (authoritative parenting style; Baumrind, 1967). Children raised by authoritative parenting styles score higher in measures of competence, academic achievement, social development, self-esteem, and mental health (Dornbusch, Ritter, Leiderman, & Roberts, 1987; Lamborn, Mounts, Steinberg, & Dornbusch, 1991; Maccoby & Martin, 1983). While slight variation in needs may be present on a cultural level, overall findings indicate successful outcomes across cultural groups when children are raised using an authoritative style of love and limits (Sorkhabi, 2005).

Myth 5: Time-out Skills Should Not Be Taught to Parents Because They Could Use Them Improperly

Some researchers opposed to time-out procedures have noted potential danger in teaching parents to utilize therapeutic discipline practices (Lutzker, 1994b), particularly ones that involve holding preschoolers or carrying children to time-out, for fear that such procedures may be misused. Still others, have argued that highly stressed caregivers may not possess the emotional abilities to express care and concern toward their children (Joinson et al., 2008) and may overly focus on time-out, allowing negative caregiver-child interactions to perpetuate (Morison, 1998). Although it is possible that a given discipline procedure may be misused (Kemp, 1996; Morawska & Sanders, 2011), it is important to consider the multitude of responsibilities that parents in our society take on to ensure the health and well-being of their children. Are we to argue that we should not prescribe potentially helpful medication because the parent may give the child too much? Instead, the implementation of time-out must be considered in the larger context of positive parenting practices (e.g., warmth, sensitivity). For example, one evidence-based practice, PCIT (McNeil & Hembree- Kigin, 2010), has a strict set of guidelines which prevents families from receiving the time-out program until they have mastered the positive "PRIDE" skills (praise, reflection, imitation description, and enjoyment). Families also are not able to graduate from PCIT until they have mastered, under close supervision, the procedures required to implement an appropriate time-out. Defiant Children (Barkley, 2013), another evidence based program, states that the time-out procedure is not implemented until step 5, after parents have learned and practiced a number of positive parenting skills over the course of at least 4 weeks. Such components include (1) education regarding causes of child misbehavior, (2) practicing differential attention in order to reinforce positive behavior, (3) practicing positive play time for homework in order to build warmth and positivity in the parent child relationship, (4) learning to give effective commands, and (5) instating a token economy to increase compliant child behavior.

Time-out procedures taught in the context of parenting programs are based on empirical literature documenting their efficacy. If parents struggling to discipline their child are not taught such procedures under the close guidance of a trained mental health professional, they are at risk of resorting to dangerous physical discipline practices modeled by their own abusive parents. Whereas the risk of harm in teaching an evidence-based time-out protocol is low, there is a

high possibility of harm if dysregulated and stressed caregivers are left to their own devices to discipline children who are displaying severe behavior problems. Finally, when parents are guided through effective time-out procedures, they learn how to conduct a time-out appropriately (e.g., warning statement, unemotional responding, short duration) instead of resorting to popular but ineffective practices, such as reasoning and having a child contemplate their actions (Morawska & Sanders, 2011).

Concluding Thoughts

Opinion pieces in lay periodicals have been published for a number of years arguing against the use of time-out. For example, the recent article by Siegel and Bryson in Time magazine (2014a) was widely distributed. Without regard to the huge volume of high quality research supporting time-out (Wolf, 1978), the authors argued against the practice, resulting in negative perceptions about time-out by nonprofessionals, lay persons, and clients. In this way, a single high-profile story in a magazine can lead to a serious setback in scientific advancement and clinical practice. The negative impact on public opinion is especially concerning as treatments viewed as acceptable by the consumers are more likely to be initiated and adhered to once they are learned by those who need it most (Kazdin, 1980). If inaccurate information continues to be spread without proper filtering, the outcomes could mean large, negative effects for evidence-based practice.

Although the author of this article in Time magazine later responded to criticisms of time-out (Siegel & Bryson, 2014b) by specifying that, "the research that supports the positive use of appropriate time-outs as part of a larger parenting strategy is extensive," the original lack of specification when criticizing time-out implementation quickly did more harm than good for informing the general public (para. 7). As researchers, it is our responsibility to disseminate high-quality findings to the lay public to improve our overall positive public health impact. In this instance, regardless of the researchers' intentions, failing to operationally define time-out and recognize an entire body of research dedicated to "appropriate use" of time-outs did a disservice to a large group of experts who have been conducting this research for decades, while also greatly misleading the public. To protect the public and our profession, we must critically evaluate, interpret, and communicate current literature in such a way that it can be comprehended by lay consumers. Unfortunately, one of the cited articles used in the debate against time-out by Siegel and Bryson was a research article by Eisenberger, Lieberman, and Williams (2003). Siegel and Bryson claimed that findings from this 2003 study indicated social

isolation, which they argued is characteristic of time-out situations, yields similar brain imaging patterns to traumatization or physical pain (Siegel & Bryson, 2014a; 2014b). Eisenberger and colleagues' 2003 study is instead researching brain patterns of college-aged adults socially isolated by their "peers" during a virtual reality ball-tossing game. Interestingly, during times of participation and other periods of unintentional exclusion, individuals showed the same brain imaging patterns. In addition, the Eisenberger and colleagues' study based their argument off of a summary article showing brain patterns of pre-weaned rat pups isolated from their mothers for extended periods of time (Nelson & Panksepp, 1998). As any practiced researcher is aware, these highly disparate concepts should not be used as justification for the illegitimacy of time-out, as the argument lacks scientific validity and leads to false conclusions and misunderstanding.

Rigorous research studies examining the use of parenting programs including time-out demonstrate reduced aggressive behavior, increased child compliance (Eyberg & Robinson, 1982; Pearl et al., 2012), generalization of behaviors across school (McNeil, Eyberg, Eisenstadt, Newcomb, & Funderburk, 1991) and other environments, and maintenance of effects for several years (Boggs et al., 2004; Eyberg et al., 2001; Hood & Eyberg, 2003). The use of time-out has also been a critical factor in helping children to gain emotion regulation capabilities (Graziano et al., 2012). Furthermore, emotion regulation has been linked to the broader context of self-control, which has been shown to predict a variety of life outcomes (Moffitt et al., 2011).

The use of time-out as a tool to help caregivers set limits has been a critical component of many evidence-based treatment programs such as PCIT, shown to decrease recidivism rates of child physical abuse to 19% in a group of previously physically abusive caregivers compared to 49% in a community treatment sample (Chaffin et al., 2004). Research also demonstrates that PCIT reduces child traumatic symptoms following exposure to trauma (Pearl et al., 2012). In addition to its demonstrated efficacy, PCIT is represented on the Kauffman list of best practices for children with a history of trauma (Chadwick Center for Children and Families, 2004) and is endorsed by the National Child Traumatic Stress Network (NCTSN) as an evidence-based intervention for child trauma (nctsn.org). In conclusion, time-out represents a safe, effective form of discipline which, in the context of a larger environment dominated by positivity, consistency, and predictability, has been shown across hundreds of research studies to be beneficial to the overall emotional and developmental functioning of young children.

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Incredible Years® Time Out Works Because of

Quality of Time In

Carolyn Webster-Stratton Ph.D.

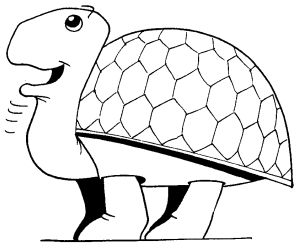
The use of Time Out as a self-regulation calm down strategy for children between the ages of 3 and 9 years old is part of a comprehensive positive behavior management plan in 77% of empirically validated parent programs for young children (Everett, Hupp, & Olmi, 2010; Fabiano et al., 2004; Graziano et al., 2014; Kazdin, 2008). Time Out has been researched for three decades and shown to be effective in producing positive outcomes in terms of reducing children's aggressive behavior as well as preventing parental child maltreatment. However, despite abundant empirical literature, the use of Time Out is still a controversial topic, with many people feeling uncomfortable about its use. Much of this controversy stems from anecdotal evidence about the negative impact of Time Out on children's attachment, or inaccurate information in non-peer reviewed magazines (e.g. Time magazine) that Time Out negatively affects children's neuroplasticity (Siegel & Bryson, 2014). In some cases, this discomfort about Time Out is so great that individuals or agencies choose not to use an evidence-based curriculum that incorporates Time Out.

Before it is possible to discuss the use of Time Out, it is important to define what is meant by an effective evidence-based Time Out procedure. There are some versions of Time Out delivery that are not evidence-based and are, indeed, reactive, punitive, harsh, non-supportive, developmentally inappropriate, unpredictable or delivered in a non-respectful way that shames

and marginalizes the child. Such inappropriate approaches can lead to further child misbehavior and a break down in the parent-child or teacher-child relationship and attachment. It is not supportive of children's development of emotional skills or closeness to the parent or teacher and is a missed learning opportunity for the child. The evidence-based and appropriate use of Time Out is brief, infrequent, thoughtful and delivered calmly in an effort to help a child self-regulate followed by a new learning opportunity and positive connection. When professionals, parents and teachers are disagreeing about whether Time Out is a recommended strategy, it may be that they are actually talking about very different procedures. Unfortunately, the use of the term "Time Out" can be used both for appropriate and inappropriate approaches.

In Incredible Years® (and in most other empirically validated parent programs), Time Out is taught as way for children to learn to calm down and re-regulate in the midst of strong emotions and to give children time to reflect on a better solution to the problem situation. It works because it is Time Out from a reinforcing environment established through positive parent teacher-child interactions. In the Incredible Years® programs parents, teachers, *and* children are taught to see the Time Out as taking a break in order to calm down. This helps children learn a strategy to calm down and also helps adults to self-regulate and model an appropriate response to a conflict situation. Research has shown that when this predictable and respectful strategy is used appropriately, reductions in children's aggressive behavior and increases in their feelings of safety and security in their relationships with caregivers are seen. Parents who use Time Out to calm down as one tool in their positive parenting repertoire show reductions in their use of critical or abusive parenting responses (Everett et al., 2010; Fabiano et al., 2004; Kennedy et al., 1990). We will first briefly outline how the evidence-based Incredible Years (IY) Time Out is taught to therapists, parents, teachers, and children in the IY programs.

The Incredible Years® Time Out Strategy (aka Tiny Turtle Technique)



3 Take a slow breath

First teach the child how to calm down: Prior to using Time Out, children are encouraged to discuss with their parents and teachers (often with the aid of a puppet) times when they are having strong and unpleasant emotions. They are helped to realize these negative feelings (anger, frustration, anxiety, loneliness) are a signal they have a problem that needs solving. Adults help them understand that any feeling is normal and okay, but that there are some behaviors and words that are not okay to use when they are angry, disappointed, or sad such as hitting or hurting someone else, or breaking something. Adults help children understand that sometimes it's hard to think about a solution when they are very upset and that this means they first need time to calm down. *This discussion is geared towards the developmental age of the child—3 year olds participate in a very simple discussion, 8-9 year olds engage at a more complex level.* Using the puppet as a model, children learn how to take a Time Out to calm down. For example, the Tiny Turtle puppet explains how he withdraws into his shell, takes some deep breaths and thinks of his happy place when he is having trouble and then comes out to try again with a different solution. Children learn that they can do this on their own as a strategy for calming down, or that an adult can tell them that they need a Time Out if they have hurt someone else, broken a rule, or if they are too upset to think clearly. At times when children are calm and not in a conflict situation, adults help them practice and rehearse how to go to Time Out, and how to calm down in Time Out by taking deep breaths, using positive self-talk and thinking of their happy place. One way to teach the children this strategy is to have a puppet such as Tiny Turtle make a mistake and then ask the children to help him follow the Time Out steps. Afterwards the adult and the children help the turtle puppet to understand that Time Out is not a punishment, but rather a way to calm down. The children learn that everyone, including adults, sometimes need time away to calm down. Parents and teachers model using this strategy themselves when they are becoming angry. They may also use *Wally Problem Solving Books* which are a series of problem situations the puppet Wally Problem Solver has at home and at school (Webster-Stratton, 1998). The children are asked to be detectives and to come up with solutions for Wally's problem. After talking about these possible solutions they act out the out the ways to solve the problem using hand puppets. Sometimes one of the solutions involves using a calm down strategy to self-regulate before coming up with other more proactive solutions.

Teaching parents, teachers, and therapists to use Time Out to calm down: In the Incredible Years programs group leaders have parallel group discussions in their trainings with parents,

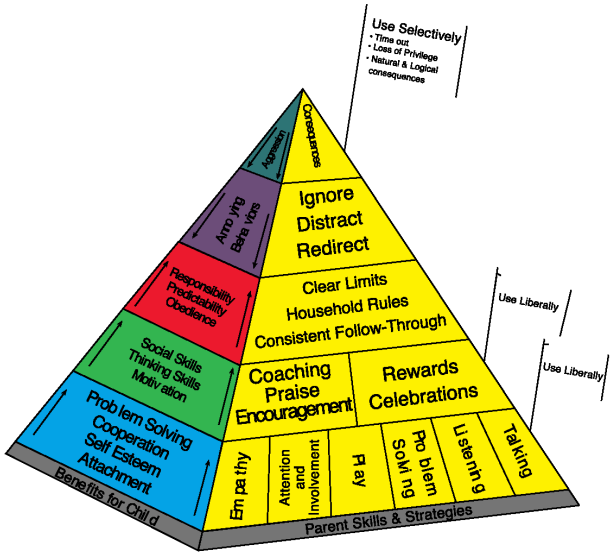
teachers and therapists. Group leaders help them understand this kind of Time Out is *not* a punishment but a self-regulation strategy for children (and for adults). They learn that these Time Outs are brief (3-5 minutes) and that their own behavior when implementing the Time Out is critical to their success with this technique. They learn to give Time Outs in a calm, respectful, predictable and controlled way, not to give negative messages to children. When Time Out is taking place, they also learn how to be nearby to monitor the Time Out. Their physical presence can reassure the child *without* giving direct attention during the Time Out.

The parents and teachers are also taught the importance of reconnecting with the child immediately after the Time Out is completed. The child's circle of security is resumed by focusing on positive messages and warm touches rather than rehearsing or discussing the negative behavior or forcing an apology. This approach helps the child maintain emotional control and feel reassured about his relationship with his parent or teacher.

A positive relationship Incredible Years Pyramid foundation is necessary for effective Time Out teaching

The first half of the Incredible Years® Parent and Teacher programs focus on strategies for building positive relationships with children by being responsive, warm, nurturing and giving more attention to positive behaviors than negative behaviors. During this time parents and teachers learn social, emotional and persistence coaching methods: to encourage children's persistence, frustration tolerance, social skills, problem solving, emotional literacy, empathy, language development and self-regulation skills. Research has shown that children with more social and emotional awareness and language skills are better able to self-regulate and solve problems. These skills, as well as the parent-child relationship, form the foundation that supports children to respond to frustrating or upsetting situations in ways that are not violent, out-of-control, or destructive. For Time Out to work this foundation must be in place, and when this foundation is firmly in place, the need for Time Out is greatly reduced.

Below are some of the common questions that come up when discussing the use of Time Out. All the answers here reflect the assumption that the Time Out used is similar to the Incredible Years Time Out procedures described above.



Parenting Pyramid™

Why is the bottom (positive parenting) of the Incredible Years pyramid not enough? Why do reasoning, holding, and hugs sometimes cause more child misbehavior and insecurity? Why does yelling, scolding, and adding consequences make misbehaviors worse? Why is it important for parents to learn some evidence-based disciplinary methods?

Positive, responsive parenting and teaching is core to parent-teacher-child relationships. Without a strong and secure parent- or teacher-child relationship, adult-child interactions are disrupted and are often not functional. This does not mean, however, that all child behaviors can be responded to all the time with reasoning, holding, and continued interactions. Positive relationships are necessary but not sufficient to obtain improvements in child's behavior problems (Cavell, 2001). At times when children have strong negative emotions and are dysregulated, it is often the case that they are so emotionally and physically out of control that they are beyond reasoning. At these times, adult attempts to comfort, reason, control, or argue with the child are likely to increase the intensity of the child's emotion and actually to reinforce it. Parents and teachers are also likely to be feeling strong emotions themselves and are vulnerable to exploding in appropriate ways or giving in to the child's demands in such a way that they are actually teaching the child that aggression, violence, or arguing are effective ways to manage conflict. This is called the "coercive process"—that is, a cycle described by Patterson (Patterson, Reid, & Dishion, 1992) in which parents, teachers and children each

escalate their unpleasant, aggressive, and dysregulated responses to each other. The process usually ends when the child's behavior becomes so aversive that the parent or teacher either gives in to the child, or becomes so punitive that the child's capitulation is controlled by fear. This coercive process has been carefully researched for decades by Patterson and others and Time Out was designed to stop this aversive cycle.

When is it developmentally appropriate to use the IY evidence-based Time Out discipline approach with children? Time Out is a respectful and calm way to disrupt or interrupt the coercive process. Instead of escalating the negative interaction, the adult calmly uses the planned strategy of helping the child take a break to calm down. Even if the child continues to escalate, the adult's commitment to staying calm and not retaliating, engaging or arguing provides the opportunity for the interaction to de-escalate because the misbehavior is not rewarded with adult attention. Without the adult's strong emotions to react to, the child can more easily regulate his/her own emotions. The adult is also providing a model for self-calming. Moreover, when parents or teachers are trained in this predictable routine and understand the underlying theory, they feel confident in their ability to stay calm and understand that, in the long term, this leads to better outcomes for the child's emotional and social development and the parent-child relationship.

What is this the best age for this method? For what misbehaviors? What is the theory underlying why Time Out works? Time Out is recommended only for higher level behaviors such as aggression, destructive behaviors, and highly conflictual noncompliance. It is not meant to be used to address a child's essential needs for support when in pain, or in fearful or distressful situations. Many other proactive strategies are recommended in the Incredible Years programs for managing milder challenging behaviors. Time Out is only used for children who are cognitively developmentally ready and old enough to learn to self-regulate and to have a sense of time and place. Typically, Time Out works for children who are between the ages of 3-9 years old. Some three year olds will be too young for Time Out, and some 9 year olds will be too old for Time Out. Rather than using the child's chronological age as the cue for when to start using Time Out, it is better to use the child's developmental age as the criteria. In the Incredible Years programs, Time Out variations are introduced for older and younger children, for children with ADHD and developmental delays, and alternative procedures for children on the Autism Spectrum are discussed. One size does not fit all when using Time Out.

Why are the Incredible Years Programs really all about "Time-In"?

Time Out only works if the majority of time with children is spent with children in "time in", that is, engaged in child-directed play, social and emotional coaching, responsive and nurturing parenting, focused attention on positive behaviors, praise, predictable routines and schedules.

IY Time Out is only one tool in an IY tool box of many different parenting tools, all of which are taught in the 8-12 sessions prior to introducing Time Out (*e.g., child-directed play, social and emotional coaching, differential attention, descriptive commenting, praising, rewarding, loving, being responsive, using predictable routines, consistent separation and reunion plans, redirections, refocusing, ignoring, logical consequences, and teaching children self-regulation skills and how to problem solve.)* Time Out can only be used when the adult-child relationship foundation has been well established with positive "time in" methods.

How is IY use of Time Out tailored or individualized for different children? What is "core" and what is flexible? As with every other parenting or teaching strategy, the use of Time Out requires clinical sensitivity, flexibility and adjustments according to the child's developmental level and family or classroom context. IY group leaders who are training parents, teachers, and therapists in the use of Time Out must take many factors into consideration. These factors include: the child's developmental level, the parent-child relationship and attachment history, and the parent's mental health and self-control skills. Time Out procedures are adapted to different situations. In some cases, a parent or child may not be ready for Time Out and need to work longer on the praise and coaching methods as well as other relationship building skills and other disciplinary strategies such as distractions, setting clear rules and ignoring first. The length and location of Time Outs may be modified to fit a family's needs. Parents are also taught ways to support a child during Time Out keeping them safe, while still following the principle that Time Out is a low-attention response to a child's high negative affect.

How does Time Out help children learn to self-regulate and support their emotional development? Prior to adults using Time Out, children are taught and practice how to use Time Out to regulate their emotions. During Time Out parents model staying calm using the self-regulation strategies that their children have been taught (breathing, self-talk). Time Out stops the parent and child from engaging in the stressful interaction and gives them space to regain control. During Time Out, out-of-control child misbehavior is not reinforced with attention.

Does Time Out teach children anything? Yes, children learn that out-of-control behavior is not an effective way to manage strong emotions because it is not reinforced. But Time Out alone is not enough. The majority of children's time is spent out of Time Out in meaningful and positive

interactions with parents and teachers consisting of child-directed play, social, persistence and emotional coaching, praise and nurturing scaffolding. During these times, children learn positive ways to regulate their emotions, navigate interpersonal relationships, and ask for what they need or want. It is important that these positive replacement behaviors have been taught and practiced prior to instigating Time Out. When this is in place and children have been sent to Time Out to calm down, they are eager to get into parents or teachers positive spot light where they have learned there are more benefits.

Why is Time Out an important strategy for parents and teachers to learn? Are there some parents who should not be taught to use Time Out?

The fear that some parents or teachers may misuse the Time Out procedure due to lack of emotional ability to express nurturing care, stress or psychopathology prevents some professionals from teaching this strategy to parents or teachers. Although it is possible that Time Out may be misused, it is important to consider what happens if such parents or teachers are not given an evidence based discipline method they can use. Without the ability to enforce predictable limits or to prevent children responding aggressively to other children, adults may become too permissive, which can also lead to children becoming more aggressive as they learn that aggressive and out-of-control responses work. The inability to establish boundaries and enforce predictable limits has been shown to lead to poor mental health outcomes for children (Fite, Stoppelbein, & Greening, 2009). Kazdin (Kazdin, 2002) argues that parent failure to use appropriate discipline to protect a child who is acting out may itself meet the definition of abuse. Conversely, the opposite can also be true—without a nonviolent and predictable way to respond to high intensity negative behaviors, parents or teachers may become overly controlling, respond with critical or physical discipline, giving children the message that aggressive responses are an acceptable way to manage negative affect and conflict.

In addition to assuring that parents and teachers have worked for 8-12 weeks intensively in the Incredible Years Program on positive social and emotional coaching methods, child-directed play, praise, rewards and relationship building before being introduced to Time Out, the Incredible Years programs also spend considerable time in teaching the correct method of using Time Out and on strategies for adults to use to stay calm and regulated. Participants learn to self-praise and self-reward, how to challenge negative thoughts and replace them with positive self-talk and coping statements, and stress management strategies. Group sessions include adults practicing simple Time Outs with guidance and gradually increasing their complexity focusing on the behavioral, cognitive and emotional components. Therapists make weekly calls to check in on their experiences and make themselves available as parents or teachers first take on this procedure with a child.

Can Time Out cause traumatic reactions or re-traumatize children? Does it lead to physical abuse or brain imaging patterns similar to those who are traumatized?

Teaching parents to use Time Out has been shown to reduce child physical abuse (Chaffin et al., 2004). While some may argue that use of Time Out with children who have experienced abuse will retraumatize them and trigger a fear response there is no evidence to support this claim when Time Out is delivered appropriately. Time Out is not a trauma event if done respectfully and predictably, as outlined above. Time Out is not a trauma event if the parent is primarily working on responsive nurturing parenting using Time In. When working with parents and children who have experienced trauma, therapists use clinical judgement as to when, how, and if it is appropriate to use Time Out. As with any other parenting strategy or decision, Time Out can be used incorrectly or abusively. This does not mean that Time Out should be abandoned as a strategy, but that parents, teachers, and therapists should be taught to use Time Out in respectful, effective and evidence-based ways.

Is Time Out beneficial to the child? When Time Out is done in a predictable, systematic, structured and calm way embedded in a normally positive nurturing relationship, it actually helps children feel safe and a have sense of control rather than being afraid of yelling and unpredictable adult responses. It leads to a relationship where children know they can safely go to their parents or teachers for help with solving their problems. Research has shown it is a critical factor in helping children gain emotion regulation capabilities and self-control and reduce adult physical abuse & traumatic child symptoms (Chaffin et al., 2004).

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Trauma-informed Incredible Years Approaches and
Trauma-Focused Cognitive Behavior Therapy (TF-CBT) Approaches
To Help Children Exposed to Adverse Childhood Experiences (ACEs)

Carolyn Webster-Stratton, Ph.D.

What is childhood trauma? What is ACEs (Adverse Childhood Experiences)?

An increasing body of research identifies the long-term impact and health harm that can occur because of chronic stress on children in childhood. Collectively such childhood stressors are called Adverse Childhood Experiences ACEs. ACEs experiences can include physical and sexual abuse or neglect, witnessing domestic abuse and violence due to drug and alcohol problems, incarceration of a parent, severe accidents, natural and human-made disasters, violent or accidental death of a parent, sibling or important relationship figure, parental separation or divorce and exposure to terrorism, or refugee conditions. Children who experience these traumas may develop PTSD responses such as overgeneralized fear, anxiety or inappropriate cognitions, or aggressive behaviors. These children may also be experiencing the concurrent loss of a primary attachment figure. For example, a child who is removed from the home because of maternal neglect and abuse by her mother's boyfriend is separated from siblings and placed in foster care. This child faces the trauma of both the physical abuse as well as the loss of her home and relationship with her mother and siblings. Research has shown that greater exposure to ACEs can alter how children's brains develop and ultimately lead to their own health harming and anti-social behaviors in adulthood. Children who experience 3+ ACEs are more likely to develop health harming behaviors such as drug or alcohol problems, to be involved in violence, and to be incarcerated. Thus, these children exposed to ACEs are at increased risk of exposing their own children to ACEs. Data suggests that nearly one in eight children (12%) have had 3 or more ACEs associated with stress that could harm their health and development.

Helping families and children prevent ACEs and cope in healthy ways with ACEs when they do occur can have a major impact on the long-term emotional and health outcomes for children.

What is TF-CBT?

TF-CBT is an empirically validated treatment approach (J. A. Cohen, Mannarino, & Deblinger, 2017) for children, adolescents and their families that combines humanistic, trauma-sensitive interventions, cognitive behavioral principles as well as relationship building and family involvement to overcome the negative effects of traumatic experiences. The TF-CBT treatment targets children who have trauma-related emotional and behavioral problems related directly to the traumatic experience. Symptoms can include dysregulated affect (fear reactions, sadness, anger, anxiety), aggressive and defiant misbehavior, inaccurate and unhelpful cognitions (self-blame, guilt, shame, negative self-image), self-injury and interpersonal difficulties (avoidance of trauma reminders, withdrawal from peers). Trauma symptoms often

occur in response to *trauma reminders or triggers,* that are internal or external cues that remind children of their original trauma experiences. These can include people, voices, objects, situations, smells, or internal sensations that the child associates with the traumatic event. However, it is important to note that not every behavioral or emotional symptom expressed by a child is related to a child's trauma experience. Careful assessment and screening for trauma is critical in planning the appropriate treatment. Children who had significant conduct or emotional problems prior to the trauma may see greater improvement with approaches that first help them overcome these difficulties.

One documented factor that significantly impacts children's response to trauma is the amount and quality of trauma-related emotional support that they receive. Parent support has been found to be a significant predictor of children's mental health outcomes in several TF-CBT outcome studies (Cohen 2000).

How the TF-CBT Model Works

TF-CBT treatment is short-term and generally lasts up to 16 sessions. It consists of a series of components provided separately to parents and children in individual sessions with some con-joint parent-child sessions at the end focusing on interactive practice. The skill-based components of PRACTICE are tailored to individual needs and include the following sequenced order:

Psychoeducational and **P**arenting skills
Relaxation
Affective modulation
Cognitive coping
Trauma narration and processing
In-vivo mastery of trauma reminders
Conjoint child-parent sessions
Enhancing future safety and development

Phase One of TF-CBT. Phase One is referred to as the *stabilization and skill-building phase* begins with a focus on general education of the parent and child about the frequency of the specific trauma, who typically experiences it, and common causes and symptoms. Also it includes information about the normal psychological and physiological responses to trauma and reinforces accurate cognitions about what occurred. This phase includes helping the child and parent to be aware of trauma reminders and how they are connected to the misbehavior so they can develop more adaptive responses. It is important that families are offered hope and reassurance that the child will get better and that there are well-validated studies attesting to positive outcomes with this approach (J. Cohen, Mannarino, & Iyengar, 2011; J. A. Cohen et al., 2017; J. A. Cohen et al., 2016). Talking about the trauma is a gradual and supportive process and is typically not initiated until the child has learned some phase one skills to help him cope with the stress. During this stabilization phase of the treatment parents learn appropriate parenting skills and the importance of normal routines and consistency of limits.

Three other aspects of TF-CBT Phase One include relaxation, affective modulation and cognitive coping. Relaxation skills such as focused deep breathing, progressive muscle relaxation and guided imagery are taught early in the treatment. Affective regulation involves helping children to identify their feelings and developing feelings literacy to be able to talk about their feelings with their therapist and parents. Parallel sessions with parents help them to understand the importance of listening and validating their children's feelings. Cognitive coping helps children to stop their negative, inaccurate and unhelpful thoughts with replacement thoughts by "changing the channel", or using the STOP sign signal as well as positive self-talk. Young preschool children with vivid imaginations are prone to inaccurate thoughts so it is important to help them learn they can control their thoughts. Helping the child come up with a clear safety plan also helps children regulate their emotions. Teaching children social skills and problem solving is also part of Phase One goals because of the benefits for self-regulation.

Phase Two of TF-CBT: This phase of therapy includes trauma narration and processing. Each phase builds on the prior phase and assists in gradually introducing trauma over the course of treatment. The trauma narration and processing is unique to TF-CBT and is designed to unlink thoughts, reminders or discussions of the traumatic event from overwhelming negative emotions. Over the course of a number of sessions the child is encouraged to gradually describe more and more details of what happened before, during and after the traumatic event. This has been described as an exposure procedure whereby repeated discussion, writing and drawing of what happened during the trauma serves to desensitize the child to trauma reminders and begin to integrate the experience into his or her total life. This trauma narrative is usually finished before it is shared with the parent.

Phase Three of TF-CBT: This phase includes *invivo* mastery of trauma reminders, conjoint-parent-child sessions and enhancement of safety and future development. The *invivo* mastery component is optional and only used for children with extreme ongoing avoidance of situations or cues and in which the avoidance is interfering with optimal development. The other sessions in this phase include sessions with the parents and children together once the parents have control over their own emotions. These can include sharing the trauma narrative but is not mandatory. Other discussions can include safety planning, sharing of emotional reactions to the experience and how they have changed during the treatment.

Can Incredible Years ® (IY) parent and child programs be used to help families whose children have experienced trauma? Is the Incredible Years Program a Trauma-Informed therapy?

As described above, the primary focus and goal of TF-CBT relates to outcomes related to stress-reactions from trauma. Although TF-CBT can successfully address and resolve certain behavioral problems related to the traumatic event, it may not be ideally suited for children whose primary difficulties reflect preexisting behavioral problems such as conduct problems, ADHD, language delays, and inappropriate parenting skills. In these instances it may be clinically appropriate to use another evidence-based program such as the Incredible Years (IY) Parent and Child Programs for emotional and behavioral problems followed by or in conjunction with TF-CBT. It is important to note that the IY interventions are not meant to take the place of

Trauma Focused Cognitive Behavior Therapy for parents or children who are experiencing Post Traumatic Stress Disorder. Rather the IY programs were originally designed for children who have or are at risk for developing behavior problems such as Oppositional Defiant Disorder, Conduct Disorders and ADHD.
We suggest that the IY Parent Program may be used in conjunction with TF-CBT to help support parents in learning ways to parent effectively as well as to build a parent support group designed to strengthen their parenting confidence and increase their empathy, understanding and patience when managing their children's misbehavior. In turn the IY *IY Dina Dinosaur's Social, Emotional, Academic and Problem Solving Curriculum for Young Children* (4-8 years) program was designed to teach children self-regulation methods, emotional literacy, social skills and problem solving skills. The small group format helps children make friends and build a peer support network. While neither the IY parent or the child program covers trauma narration and processing directly the IY child program does provide opportunities for children to talk about traumatic events if they want to by having the puppets bring up common trauma theme scenarios similar to what the children may have experienced. The Small Group Dinosaur Program is designed to be used in conjunction with the IY parent program wherein both parents and children have weekly home practice activities designed to reinforce what they are learning in their sessions in other settings.

The rest of this document will provide a summary of how the IY Parent and Child Programs (4-8 years) are "trauma-informed" and weave many of the Phase One TF-CBT trauma-focused cognitive, affective and behavioral elements throughout the program and are tailored according to the developmental and cognitive status of young children and their particular experiences. (see table at the end of this document for a summary of these approaches)

What are the IY Parent and Child Programs?
The IY evidence-based parent and child programs have been used and evaluated for decades as treatment for children diagnosed with conduct problems, oppositional defiant disorder and ADHD (A T. A. Menting, B. Orobio de Castro, & W. Matthys, 2013; Webster-Stratton & Reid, 2017; Webster-Stratton, Reid, & Beauchaine, 2013). In addition these programs have been evaluated as selective and indicated prevention interventions for high risk, economically disadvantaged families, foster parents, and families referred because of abuse and neglect (Webster-Stratton, 1998; Webster-Stratton & Reid, 2011; Webster-Stratton, Reid, & Hammond, 2001) and even for incarcerated parents (A.T.A. Menting, B. Orobio de Castro, & W. Matthys, 2013b). Within these populations are many families whose children's behavioral problems are a manifestation of their emotional and psychological difficulties because of single or multiple traumatic family life experiences. Multiple randomized control group studies have indicated the success of the IY parent programs in promoting more responsive and nurturing parent-child interactions, reducing child externalizing and internalizing problems and promoting positive child social competence and emotional regulation (A.T.A. Menting, B. Orobio de Castro, & W. Matthys, 2013a).

IY Parent Programs
The "trauma informed" IY parent basic program begins with parents learning ways to build a

sensitive, responsive, nurturing relationship with their children through child-directed play. Parents learn the importance of using emotion and social coaching with their children to build their children's emotional literacy and capacity to communicate about their feelings and problems. Throughout the program, parents are helped to understand the triangle relationship between thoughts, feelings, and behaviors for themselves as well as their children. In addition to learning developmentally appropriate parenting skills, IY parent programs, especially the treatment protocol, which includes the IY Advance parenting program, (Webster-Stratton, 1994) help parents to regulate their own emotions and affect, improve their positive communication and listening skills, and build support networks in their communities. These goals are achieved using strategies such as challenging self-negative talk, modifying inaccurate thoughts and guilt or shame about trauma, using deep breathing, relaxation methods, positive imagery and the importance of self-care. Building support networks is integral to the group-based approach to delivering the IY programs.

The group-based parent program is designed to have therapists work collaboratively with each family in the group to address the life-context, child presenting problems, family situation, and culture. Please see parent therapist book for further information about the collaborative therapeutic process (Webster-Stratton, 2012). Therapists help families set realistic short term and long term goals based on their particular situation. So for these families where children (or parents) have experienced trauma, this would constitute a huge part of their life-context and would need to be addressed in every session as part of the tailoring group leaders do for each family. Parents are helped to understand the impact of trauma on their children's emotional or behavioral problems, what situations are trauma reminders or triggers for misbehavior and how to help them feel safe and loved with consistent child-directed play that incorporates social and emotional coaching, praise and rewards, predictable routines, household rules, clear limit setting and teaching of self-regulation strategies. Many parents feel guilty about disciplining, especially after their child has experienced something traumatic. Parents are helped to understand the importance of not being either overly protective with their children or too permissive and are helped to appreciate their children's strengths as well as to be aware of possible triggers for misbehavior and how to cope with them. Please see a chapter that talks about some of the ways that the material can be presented for children with attachment or neglect problems and families who are divorced or who have experienced loss. http://www.incredibleyears.com/wp-content/uploads/tailoring-the-incredible-years-parenting-program_9-19-07.pdf

This collaborative way of using the IY parent program can also apply to other types of trauma that children or families have experienced. So, all the information that the therapist has about each family would influence the way that the program is delivered throughout each session. Therapists working with these families in the parent group start from the life-context that these families are living with and their goals and then help parents apply each of the new skills and principles to their own unique situations. More than half of the program content time is spent on the foundation of the parenting pyramid in terms of building relationships, attachment, and parent-child bonding particularly in cases where those bonds are not strong to begin with. Parents in these groups share their own experiences of being parented (which may have

been abusive) and talk about how this has impacted their parenting choices with their own children. They also identify their goals for their relationships with their children and what parenting choices they want to make to achieve these goals.

With the context of prior trauma in mind, some topics (such as ignoring and Time Out) are sometimes delayed and extra sessions offered initially to establish more secure attachment and parent-child bonding. When the ignoring, Time Out, and discipline strategies are eventually presented to address child destructive behaviors that cannot be redirected or self-regulation methods prompted, discussion around these strategies focuses on how these strategies are meant to encourage child and parent self-regulation. Parents learn to use them briefly, respectfully and non-punitively without jeopardizing the child's sense of safety. Following a planned ignore or Time Out to calm down experience, parents then reunite with their child in a positive way to provide their child with new learning opportunities to use other solutions to the problem situation (such as communication about feelings, or getting help, or walking away, or finding a friend or safe person to talk to). For families where there is a history of trauma discussion time is spent talking about the difference between the positive use of these strategies and punitive or neglectful parenting behaviors. Time Out strategies may be modified in certain circumstances to reduce trauma reactions. When used thoughtfully, patiently and calmly, these strategies are important skills for all parents to learn as part of non-violent, proactive and positive discipline.

It is also important for parents to assess and understand the reasons for and functions of children's misbehavior. They consider whether their child's misbehavior stems from needs for parental attention which the child can't get consistently and regularly with positive behaviors, or whether the child's misbehavior occurs because of prior modeling and the fact that s/he hasn't been taught other more prosocial behaviors to get what s/he wants, or whether the child is acting out because of fear and insecurity in their relationship due to triggers of prior traumatic experiences of being abandoned, neglected or abused. Parents then work with the therapists to tailor intervention strategies that are most appropriate to the situation.

The minimum number of sessions recommended for the parent treatment protocol based on our research is 2-hour weekly sessions for 18-20 weeks. However, with the added attention needed for trauma informed situations where more time is spent on parent interpersonal issues (e.g., depression, marital conflict, thoughts of guilt and shame), safety issues and relationship building as well as the added inclusion of the Advance program content, more sessions are often needed. In one study where the full advance program was combined with the basic parent program the average number of sessions was 24-26 sessions (Webster-Stratton, 1994).

Key Points about Delivering IY Parent Programs that are Trauma-informed

• Help parents and children to normalize their responses to traumatic events, by providing information about typical psychological and physiological responses to trauma and reinforcing accurate cognitions about what occurred

• Parents learn the importance of listening and supporting their children's ability to

communicate their thoughts and feelings by using child-directed play and emotion and social coaching methods
• Parents are encouraged to be aware of potential trauma triggers or reminders that can result in the child's misbehavior and understand how to manage and help children cope with these responses
• Parents learn how to help their children self-regulate by modeling and teaching deep breathing methods, positive imagery, positive self-talk and how to ask for what they need in order to feel safe and loved
• Parents understand the importance of staying calm, patient and predictable in their responses to their children's misbehaviors
• Parents learn the value of developing their own support networks through their group experience and IY weekly buddy assignments. This support helps them cope with the stress of managing their children's trauma reactions
• Understand how the IY program is similar to and different from TF-CBT and consider whether the family may need a referral to TF-CBT prior to or after participating in an IY treatment.

IY Small Group Treatment Programs
Therapists delivering the child dinosaur small group treatment program to help children to learn and practice emotion language, to manage their anger, fears and depression through self-regulation strategies such as deep breathing, positive self-talk and positive imagery (happy places), to problem solve and to develop social skills in order to build supportive friendships (Webster-Stratton & Reid, 2005, 2008). Strategies in both the IY parent and child programs include cognitive, affective, and behavioral strategies which are also key elements in trauma-focused therapy. In essence, trauma-informed elements are woven throughout the IY parent and child programs. Frequently the child dinosaur program is offered alongside the parent program so that the language and methods used in the child program can be reinforced at home by the parents using similar strategies.

In the small group Dinosaur treatment program therapists using large life-size puppets develop scenarios (such as a trauma event) for the puppets that mirror some of the children's problems. For example, one puppet might be living with his grandmother or is in foster care because his mother is unable to care for him safely. This puppet talks to the children about what s/he does to stay safe and who s/he can talk to feel loved and then asks the children for their ideas about what to do when s/he feels unsafe when she visiting her mother. Or, a puppet might talk about her worries when s/he hears her parents fighting and ask the children for help knowing what to do when this happens. Recently, in a school that experienced the death of one of the students, the therapist prepared a lesson on loss and grief. The puppet shared with the children his sad and confused feelings about the recent loss of his grandfather. This allowed the children to develop an emotional vocabulary for talking about grief and sadness when they lose someone, realize the normality of these feelings, and learn things to do to cope with these feelings and ways to keep the memory of a loved person going. While all the children learn emotion vocabulary and the basic steps of problem solving, anger management and self-regulation strategies, they are helped by therapists to practice these strategies. Frequently the puppet is used either to model strategies or to ask for help from the children. By teaching the puppet

how to use a self-regulation strategy or to solve a problem, the children gain mastery over the material.

The children also learn coping skills such as using positive self-talk, positive imagery, behavioral practices, and methods or plans to stay safe. In the group they make friends who are supportive and may have had similar experiences. Video vignettes are another method of providing positive coping models for children. Children watch videos of other children who are expressing a variety of different emotions or who are interacting with peers, parents, and teachers in common every-day settings. Group leaders also model these positive cognitive self-talk and emotion language. Please see a chapter for more details about how the IY Child Social, Emotional and Problem Solving Curriculum prepares children to cope with trauma on our web site.

Summary

The table below summarizes the differences and similarities between the IY Trauma-informed IY program approach and the Trauma-focused treatment. For children whose primary difficulties reflect preexisting emotional and behavioral problems the IY programs may be sufficient. For those children whose primary behavior difficulties are triggered by trauma reminders then using the TF-CBT may be more appropriate. Some children and families may benefit from participating in both programs. Using the IY parent and child programs together offers promise for helping those children who have experienced multiple ACEs to develop supportive, nurturing relationships within a family that models developmentally appropriate parenting skills, emotional regulation, and effective problem solving. In turn, this leads to the development of children who feel safe, socially and emotionally competent and supported to cope in healthy ways with life's challenges.

Table I: Comparison of Content of IY Trauma-informed and TF_CBT

IY Trauma-informed	Trauma-focused TF-CBT
Psychoeducation In the IY parent program parents receive education about the causes of child misbehavior. They learn about the coercive cycle of misbehavior and the ABC's of functional analyses of how the antecedent (A) stimulus results in a particular misbehavior (B) that may or may not be reinforced by the consequences (C). They are taught the cognitive triangle connection between feelings, thoughts, and behaviors as well as how to develop behavior plans for targeted misbehaviors. They are encouraged to be aware of possible trauma reminders (A) that may result in inappropriate behavior. They learn there are many	**TF-CBT Phase one: Psychoeducation** Parents receive general education about the frequency of the specific trauma, who typically experiences it, what causes it and what common trauma related symptoms children exhibit as a way to obtain relief. This education reinforces accurate parent and child cognitions about what occurred, helps normalize their responses and helps them be aware of their child's trauma reminders that may trigger their trauma symptoms.

reasons for child misbehavior such the need for attention, because of negative behaviors modeled by parents, because other more prosocial behaviors have not been taught, or because of dysregulated emotional states (anger, frustration, anxiety, fear). Throughout the IY program parents learn about the importance of having a positive, nurturing, responsive relationship in terms of enhancing their children's social, emotional and academic development. The groups provide them with a support network which normalizes and validates their experiences while providing them with alternative coping approaches.	
IY Parenting Program IY parent program provides extensive training on being child directed, how to use persistence, social and emotion coaching, predictable routines, clear and consistent limits, proactive and patient ways to manage misbehavior, and approaches for teaching children emotional self-regulation, social skills and problem solving. Parents learn about effective communication skills and the importance of listening and validating their children's feelings. The benefits of developing a parent support team is an on-going theme. The family's life-context is also considered throughout the program and parent and child-interactions are considered in the context of the family's goals, needs, and circumstances.	**TF-CBT Phase one Parenting Skills** TF-CBT recognizes the difficulty of parenting effectively when a child or family has experienced trauma**.** TF-CBT promotes positive, nurturing parent-child relationships, differential attention to appropriate behavior, predictable routines and appropriate discipline responses to misbehavior.
Relaxation Methods **IY Parent Program** Focuses on helping parents to both model and teach self-regulation strategies for children such as use of deep breathing, positive self-talk, positive imagery and muscle relaxation. Additional attention is given to self-care methods for parents to refuel their energy and ability to stay calm. **IY Child Program**	**TF-CBT Phase one: Relaxation** Relaxation skills are taught early in TF-CBT therapy to help both parents and children manage stress. This includes focused breathing, and muscle relaxation exercises.

Therapists through the use of child-size child puppets teach children self-regulation strategies such as deep breathing, muscle tension relaxation and positive imagery.	
Promoting Feelings Literacy & Emotional Regulation **IY Parenting Program** Focuses on persistence, emotion, social and narrative language coaching with children and self-regulation strategies both for parents themselves to model as well as for ways parents can teach these self-regulation and problem solving skills to children. Parents learn about the importance of stopping and challenging their own negative thoughts and replacing them with coping thoughts, positive forecasting and self-praise. **IY Child Program** Therapists through the use of child-size puppets model emotional language and how to identify feelings in self and others. Children learn to use the calm down thermometer to manage their anger and stress through deep breathing, positive self-talk and positive imagery. The puppets help the children to learn how to ask for what they need in order to feel safe and loved by modeling this skill themselves. They model positive coping thoughts when describing their problem situations and asking for help. .	**TF-CBT Phase one: Affective Modulation** TF-CBT helps children express and modulate their feelings more effectively through the use of games and activities. Parents are helped to work through their own feelings about the trauma and to understand the importance of managing their own emotional regulation and to support their children's expression of their emotions verbally.
Social Skills and Problem-Solving **IY Parent Program** Focuses on helping parents learn how to teach their children social skills and to problem solve through the use of coached parent-child play times and during peer interactions. Parents focus on positive thinking about behaviors they want to see more of when working with children and challenge their negative thoughts about misbehavior by understanding the reasons for the misbehavior. **IY Child Program** Therapists, with the help of their child-size puppets,	**TF-CBT Phase one: Cognitive Coping** TF-CBT works on helping families make sense of the traumatic event. The therapist works to correct inaccurate or unhelpful cognitions about the traumatic event and parents are helped to understand the connection between thoughts, feelings and behaviors.

teach and coach children's problem-solving and friendship skills. Children make some of their first meaningful friendships in these groups. Cognitive coping is integrated in these sessions by helping children use alternative thoughts for a particular conflict situation. For example, understanding a child's action might have been a mistake or misunderstanding versus a deliberate attempt to blame or reject or hurt the child.	
Because the Incredible Years works with young children (ages 4-8 years) with a variety of behavior problems due to a variety of causes there is no separate program component that is includes a direct trauma narration exposure. In the child program the puppets mirror trauma or life events that have been experienced by the children in the group. The purpose of this is to allow the children to talk about their feelings or experiences with similar events if they desire. Frequently the puppets ask the children for solutions to help them manage sad thoughts or feelings about particular stressful events. The children inevitably want to help these the puppets learn to cope with their problems. The puppets and children act out some of these solutions to see how they will work.	**TF-CBT Phase Two: Gradual exposure through trauma narration and processing** Over the course of several sessions children are helped to describe more and more details of what happened before, during and after the traumatic event. The goal is to desensitize the child to traumatic reminders and decrease their withdrawal or avoidance or anxiety behaviors. During this interactive process of unweaving the trauma event, there is some type of book or poem or drawing that is created from the child's trauma story.
IY Parent-Child Practice Sessions The IY parent groups typically occur at the same time as the child groups (6 per group) but in separate rooms. At the end of some sessions one child will come in to the parent group with the child therapist to share what they have learned. Each week both parent and children have home practice child directed assignments designed to practice and reinforce the particular skill they have worked on during the weekly session. So parent-child interactions are worked on at home throughout the program and are debriefed at the start of every session. Parents and children practice these skills first in the separate parent and	**TF- CBT Phase Three: Integration and Consolidation** **Conjoint Parent-Child Sessions** In TF-CBT parents and the child meet at the end of each of their separate sessions to review review information, practice skills, share the child's trauma narrative and enhance their comfort in talking to each other. These sessions are not scheduled until parents have sufficient emotional control to participate in a positive way.

child groups and then are asked to try them out at home. Parents turn in home record diaries of these experiences so that therapists can determine the progress or difficulties parents are having. .	
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Using the Incredible Years Parent Program to Help Parents Promote Children's Healthy Life Style and Well-Being

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Introduction

Promoting children's healthy life style habits and nutrition should be an integral part of parenting intervention programs designed for young children. The rate of overweight children has doubled in the past two decades with an estimated 23% of United States preschool-aged children reported as being overweight or obese, with higher rates in lower socioeconomic groups (Ogden, Carroll, Kit, & Flegal, 2014). Research indicates that childhood obesity leads to higher risk for other chronic health conditions such as dental caries, asthma, sleep apnea, hypertension, cardiac disease, diabetes, cancer and depression. Furthermore, children with obesity are often bullied, teased and discriminated against more than normal weight peers, leading to social isolation and lower self-esteem. Children with obesity are more likely to be obese as adults, resulting in lifelong physical and mental health problems.

On the other hand, 2016 reports estimated that 13 million children (18%) in the United States experienced hunger and food insecurity, that is, lacking access to sufficient quantity of affordable nutritious food (Service, 2000). However, it should be noted that the majority of people (58%) who are food insecure do not live in poverty and the majority of people who live in poverty (61%) are food secure. Chronic undernourishment regardless of socioeconomic status can have adverse outcomes on children's cognitive development, school performance, language development, and result in higher rates of illness, school absence, and academic underachievement (Hinton, Heimindinger, & Foerster, 1990). The stress of hunger, undernutrition and food insecurity can result in children being irritable, having difficulty concentrating and learning and limit their physical activity. Even skipping breakfast has been shown to adversely affect children's performance in school (Pollitt, 1995).

Refugee children are at high risk for poor health, growth, and development and often arrive in the US with either under or over nutrition. A recent study in Washington State with 1047 refugee children from Somalia, Ira, and Burma were compared with low income children in Washington. Overall, showed that nearly one-half of all refugee children had at least one form of malnutrition (44.9%). Refugee children ages 0-10 years were affected by wasting (17.3%), stunting (20.1%) overweight (7.6%) and obesity (5.9%). Refugee children less than 2 years of age in the US were reported to have higher obesity rates than their low-income non-refugee US counterparts (Dawson-Hahn et al., 2016). After refugees resettle, there is an increasing prevalence of obesity, particularly for older refugee children.

It is well established that parents have a critical influence on the development of positive health habits and childhood development (Golan, 2006). Parents influence the food and physical activities of their children through their own modeling of eating behavior and physical activities, attitudes, parenting styles, and child feeding practices (Birch & Davison, 2001; Moore et al., 1991). Adverse family experiences (AFEs) such as those stressors experienced by refugee families and those living in poverty can negatively impact parenting around feeding and development of healthy life habits (Shonkoff & Garner, 2012). However, despite the large number of evidence-based parenting programs available, very few have measured their outcomes in terms of promoting children's life style changes such as healthy eating patterns, or increased physical activity, or assessed whether these improvements in parenting stress and more positive parenting lead to a reduction in childhood obesity, malnutrition or improvements in physical health, academic potential and overall well-being.

The Incredible Years (IY) Series of prevention and treatment parenting programs (toddler, preschool and school-age) were designed for young children ages 1-12 years. The IY series have had decades of multiple randomized control group trials by the developer and independent investigators from many countries assessing the programs transportability to different cultural groups (Gardner, Montgomery, & Knerr, 2015; Menting, Orobio de Castro, & Matthys, 2013; Webster-Stratton, 2009). Results with selective and indicated interventions for high risk economically disadvantaged families and families that have been referred for abuse and neglect have indicated significant reductions in children's behavior problems and increases in social and emotional skills and school readiness skills according to both parents and teachers reports and observations. Program outcomes also show reduced parent stress, improved positive parent-child relationships, and more positive behavioral management strategies (Gardner et al., 2015; Scott, Briskman, & O'Connor, 2014; Webster-Stratton & Bywater, in press). Of importance is that the parent and child outcomes have not been shown to differ across families with different socioeconomic and ethnic backgrounds (Leijten, Raaijmakers, Orobio de Castro, Ban, & Matthys, 2017). The IY program delivery is non-didactic, trauma-informed, and utilizes a multi-cultural collaborative approach by encouraging parents' own solutions to problems that acknowledge their personal and cultural norms and promotes their connection to cultural identity (Webster-Stratton, 2009, 2012, 2017). The cultural sensitive character of the IY program methods and processes suggests it may be effective for refugee families from different backgrounds although this has not been specifically studied.

Two studies have examined the IY Preschool Program's potential for influencing health outcomes for children. The first study (Brotman et al., 2012) to consider the possible health effects of the Incredible Years (IY) Parent and Child treatment programs followed up 186 minority, at risk preadolescent youth 5-6 years after completing the IY program. The original study goals were to promote effective parenting and prevent behavior problems during early childhood for high risk children but did not focus on physical health outcomes. At follow-up, health outcome measures were collected during a physical exam. Youth who received the treatment had significantly lower rates of obesity, determined by body mass index (BMI) at follow-up compared to controls. There were also significant differences in treatment children's physical and sedentary activity, blood pressure, and diet. This study suggested that effective

parenting and preventing behavior problems early in children's life may contribute to reduction of obesity and health disparities during the preadolescent period.

In a more recent study (Lumeng et al., 2017) Head Start families were randomly assigned to 3 conditions: (1) Head Start (HS) plus Obesity Prevention Series (POPS) plus Incredible Years (IYS); (2) HS+Pops, or (3) HS. The IYS condition consisted of both training in the IY Parent Program as well as the IY Teacher Classroom Management Program. Results indicated that the combined HS+POPS+IYS had improved teacher reports of children's self-regulation compared with HS+POPS and HS, but there was no effect on the prevalence of obesity post intervention for the two combined interventions compared with HS alone. No effect on other outcomes was found except for sugar-sweetened beverage intake which showed a greater decline for the HS+POPS+IYS combined condition than in HS condition. Unfortunately, in this study parent attrition was high, attendance in the parent groups was low, and at this time, no longer term outcomes have been collected.

The findings from these two studies are contradictory in terms of their conclusions about whether the IY intervention is an effective prevention program for promoting healthy behaviors or obesity prevention. Both studies showed intervention effects on the child behavioral outcomes that are typically targets of this intervention: enhanced self-regulation and reductions in conduct problems. This indicates that the intervention was successful at promoting change in some areas. It is interesting that the Brotman study, that was not targeting obesity as an outcome, found these obesity results at follow up, while the Lunmeng study, which added an additional obesity intervention, found no effects on obesity related behaviors. Possible explanations for this may be found in the timing of the measurement point or in the dose of intervention. The Brotman study (Brotman et al., 2012), which offered 22 sessions, had high rates of parent and child participation during the intervention phase and health outcomes were measured 5 years after intervention. If these effects are attributable to the intervention, perhaps parents changed overall parenting behaviors that, overtime, contributed to their children's longer term nutritional health. Although the Lunmeng study targeted this kind of health behavior, parent participation in the intervention was low and the impact on effective parenting behaviors was not measured. The positive child outcomes related to self-regulation may have been a result of the teacher portion of the intervention, rather than the parent intervention. It could be hypothesized that in order for children's health behavior to be impacted, parents would need to make meaningful changes at home. In addition, perhaps the assessment interval, which immediately followed intervention, was too short to show any meaningful outcomes. Further research is clearly needed to assess whether the healthy life style findings in the Brotman study using the Incredible Years Parent and Child programs can be replicated with other families. If the IY parent programs do have longer term healthy life style effects, the mechanisms for these results should be explored and evaluated.

IY Focus on Promoting a Healthy Life Style and Child Well-Being

The IY programs were not developed to be exclusively focused on obesity prevention, nutrition or the importance of exercise, or healthy life style habits. Instead they were designed to be led

in a multi-cultural, collaborative way, with group leaders taking cues from parents about their goals for themselves and their children. Parents come to the groups with a variety of goals for themselves and their children, and there are many etiologies for children's behavior problems including temperament, ADHD or other developmental delays, parenting styles, and traumatic or stressful live events or environments. Discussions in the parenting groups often focus on children's challenging temperaments or traumatic life experiences and how parents can help their children communicate about their feelings and problems as well as how to manage parental emotions and affect, improve their communication and listening skills, and build their family support systems (Webster-Stratton, 2017). When parents bring up concerns about eating habits and health or physical exercise issues, then there are many possibilities for the IY group leader to facilitate discussion of parent strategies to promote children's healthy behavior habits. However, given the serious problem of malnutrition and obesity in youth today, it seems prudent for IY group leaders to be proactive about bringing up these discussions on healthy eating habits and life styles and weave them through the IY parenting sessions, whether or not families have identified nutrition or health care habits as their primary problem. Moreover, improvements in healthy eating and exercise can also contribute to positive mental health and a reduction of behavior problems.

In the program materials, there are a number of ways that the topics of healthy eating and life style can be covered. For example, the program contains video vignettes showing family meal times that can be used to stimulate discussions about healthy eating habits. There are also vignettes about tooth brushing and bedtime routines which can be used to elicit discussions of establishing predictable health habits and rules about the importance of regular dental care and adequate sleep and bedtime routines. Vignettes showing parents playing Frisbee, soccer or biking with their children can be used to promote discussion of the value of increased physical activity. Other vignettes lead to discussions of reduced screen time, predictable meal routines, and household rules regarding healthy food choices and snacks, dental care and appropriate bedtime. Aspects of the IY basic parenting programs that promote children's healthy life style, food habits and obesity prevention and can be highlighted throughout all four parts of the basic toddler, preschool and school age IY parent programs. The remainder of this document outlines some ways that group leaders can integrate healthy life style principles into their parent group discussions. See Table 1 for list of some of the vignettes that can be used to promote healthy life-styles as well as questions that group leaders can ask to stimulate discussion and generation of key principles.

IY Program One Part 1: Child-Directed Play Promotes Positive Relationships & Physical Activity.

This program teaches parents about the importance of child-directed play for building positive parent-child attachment as well as facilitating the child's self-esteem and sense of wellbeing. During this program parents learn about the "modeling" principle; that is that children will imitate what their parents do and that this is a powerful way to teach children healthy behaviors and social interactions. Parents learn about the value of physical play as well as manipulative and exploratory play, social play, and symbolic or pretend play for promoting

children's physical and mental health and ability to problem solve. Parents are encouraged to follow their child's lead in play and do activities their children are interested in in order to promote their positive relationship. While there are many vignettes of parents and children playing with Legos, blocks, playdough, games or puzzles, doing art projects together, or engaging in pretend play, there are also some vignettes showing outside physical activities. It is noteworthy that fathers are targeted as well as mothers for modeling healthy life style habits for there is research evidence showing the positive health benefits for children whose fathers model physical activity and healthy eating habits (Morgan et al., 2011). When showing vignettes in Program 1, Part 1, the group leader can emphasize the importance of child-directed play that involves some physical activities such as playing ball, soccer or Frisbee, going to the park, hiking, and biking together. Group leaders help parents understand how physical exercise can improve their children's fitness, self-esteem and strengthen their cardiovascular system as well as their relationship. The group leader can ask parents questions to prompt parents' understanding and reflection about the importance of physical exercise for their child's physical and mental health.

Some basic principles or key ideas group leaders can help parents to discover in this discussion of the vignettes include:

• *Children need daily physical activity for 20-30 minutes. Special time activities that can promote activity need to child-led and can include: playing tag or Frisbee, jumping rope, swimming, dancing, playing soccer or taking a walk together.*

• *One of the most powerful ways your children learn to be healthy is by observing you. Therefore, model being physically active yourself and encourage your child to join you. Be involved in making exercise and fitness an integral part of your family's way of life.*

IY Program One Part 3: Social and Emotional Coaching Promotes Healthy Eating Habits and Positive Family Meals.

This program helps parents teach children social skills, emotional literacy, and beginning self-regulation skills. Vignettes include peer and sibling interactions so that parents learn how to prompt and coach social skills such as sharing, trading, taking turns and waiting so that they can make good friends. Emotion coaching is taught to help children learn emotional literacy and how to express their emotions in nonviolent and appropriate ways. Identifying problem feelings and using feeling vocabulary is an important precursor to self-regulation, ability to problem solve and reduction of behavior problems. Clearly child health and wellbeing is influenced by multiple combining factors such as physical, social, behavioral, emotional and environmental ~ all of which can impact on early childhood physical development. Vignettes in this program can be used to continue the discussion about increasing children's physical activity and also include vignettes that can be used to discuss reducing screen time. For vignettes in this program the group leaders help parents understand how these physical activities promote their children's healthy lifestyle habits, social and cooperative interactions, and emotional regulation skills when playing with their peers and family members.

Two principles about screen time that parents may develop from these discussions include:

• *Limit your child's "screen time" (TV, video games, Internet) to no more than 1 hour a day. Avoid screen time for children under 2 years of age.*

• *When your children watch TV, watch with them so you can use this as an opportunity to talk about unhealthy foods being advertised or to discuss good sportsmanship when watching sports and the value of being a good team player both socially and physically.*

Vignettes in Program One Part 3 provide an opportunity for parents to discuss family meal times and the healthy eating patterns that children learn during these times. By asking open-ended questions about food preparation and choices provided by different cultures, mealtime expectations for children, and children's involvement in grocery shopping, the group leader helps parents understand how using these social and emotion coaching methods during mealtimes can promote meals that are a fun relaxed time when children are not forced to eat, or required to have clean plates, but are provided with healthy food choices. Parents will discover that children are more likely to try a new food in a quiet, calm mealtime.

Some possible principles group leaders can help parents discover from these vignettes are:

• *At mealtimes provide plenty of vegetables, fruits and whole grain products; serve reasonable child-sized portions, encourage water drinking and limit sugar-sweetened beverages. Include low fat or non-fat milk or dairy products. Avoid foods high in trans fats and/or saturated fats. Check out the latest published Dietary Guideline recommendations made by major health promotion organizations.*

• *Involve your children in meal preparation so they have some control over this process and you can teach them about healthy food choices.*

• *Providing a calm, reassuring atmosphere at meal and snack times leads to healthy eating and a sense of well-being and happiness.*

• *Provide healthy snacks: for example fruit or vegetables to dip in yogurt or hummus. Avoid continuous snacking, and instead, offer food at predictable meal and snack times. Limit high-fat, high-sugar, or salty snacks.*

• *Have predictable family meals together each day where you have time to talk and enjoy the meal together. Give your children healthy choices of foods to eat.*

•*Make dinner a no screen time for everyone in the family.*

•*Allow children to eat to their own fullness without pressure to overeat.*

IY Program Two Part 1: The Art of Effective Praise and Encouragement to Promote Children's Healthy Life Style Habits and Sense of Well-Being

In this program parents learn about effective ways to praise and encourage their children's positive social and emotional behaviors and promote their healthy lifestyle and food choices. Parents start by making a list of behaviors they want to see more of and learn the importance of both modeling positive social behaviors themselves as well as providing encouragement, labeled praise and positive attention whenever these social behaviors occur in their children. Mealtimes are frequently a source of frustration for parents and too often the child's lack of interest in eating turns into a power struggle. Sometimes parents worry that poor eating habits will lead to illness, malnutrition, weight loss and life-long problems. Or, sometimes parents have worked hard to prepare a nutritious meal and are offended and angry or feel unloved when their children seem ungrateful and won't eat or even try the food. These situations can result in parents pleading, criticizing, threatening or punishing children for not eating. Unfortunately, children may learn that this is a way of controlling, or getting even with, or getting attention from their parents and eating becomes a battle of wills leading to under or over eating or stressful feelings about mealtimes.

By showing vignettes of family mealtimes, group leaders help parents to relax, disengage from the power struggle, and to control their own emotional responses. Group leaders explore with parents why they are worried about their children's nutrition or health, whether there are financial difficulties and whether there is any real danger of malnutrition or overeating, or whether their child's behavior triggers a difficult memory of their own uncomfortable childhood mealtime experiences. The goal is to identify and address barriers to good nutrition and help parents identify and encourage developmentally appropriate mealtime behaviors for their children and provide healthy food choices in order to create a mealtime atmosphere that is calm without negative reactivity, behavior problems or pressure from parents to eat. Parents learn to be realistic about children's appetite variations as well as about how long they can sit at the table, or their ability to control how much children will eat. Through viewing and discussing the vignettes, they learn that parental nagging is actually reinforcing the eating problem. Instead parents use the attention principle to ignore their child's fussiness and misbehavior, while praising and attending to their children's positive meal behaviors. Sometimes children will drag out mealtimes by eating slowly, complaining, and playing with their food. In this case group leaders help parents determine a reasonable amount of time for a child to finish eating and to avoid pleading or nagging if they don't eat. This time-limited approach is especially useful for children who find it hard to remain seated at the table throughout a meal. For picky eaters, parents learn to offer an alternative healthy choice of food that the child likes which gives the child a face-saving way out of conflict. For economic barriers group leaders can link families to local services for Supplemental Nutrition Assistance Program (SNAP or WIC) and coordinate care with community partners.

Several vignettes in this program about tooth brushing and difficulties with teeth flossing also help parents think about how poor dietary habits, especially high sugar foods and poor dental care habits that can lead to painful dental caries. Through discussion of these dental care

vignettes parents learn about using praise and rewards to increase their child's cooperation with teeth flossing and tooth brushing and the importance of developing predictable habits around dental care.

This program also helps parents think about the critical messages that children may be receiving. Parent watch vignettes where other parents are critical of their children's efforts to wash their hands and wash the dishes or the way they are eating. The group leader helps parents think about the impact of critical messages on children's behavior and self-esteem, including behaviors around mealtime manners or eating habits or efforts to help at mealtimes. Parents learn to give positive attention to what their children are doing well at the dinner table rather than give attention to their misbehavior. All of the vignettes about food preparation, hand washing, table manners and table clean up are shown with a goal to make food and eating times a fun, cooperative time for everyone. The social and emotional coaching methods that the parents learn help to scaffold this as a happy time together.

Two principles that a group leader can help parents discover with these vignettes include:

• *Set up predictable routines to encourage healthy habits such as washing hands before meals, helping with dinner serving and cleaning up, and brushing and flossing teeth after eating. Provide praise and support as your children are learning these habits.*

• *Ignore mealtime behaviors that are irritating such as messing with food, using fingers to eat, complaining about the taste or refusing to try a new food, and focus on praising what children are doing well, or praising other family members' positive table manners.*

IY Program Two Part 2: Motivating Children through Non-food Incentives.

In this program parents learn about rewarding and motivating children for learning particularly difficult target behaviors such as going to bed at set time and staying in bed at night, flossing teeth, doing homework, getting dressed on time for school, staying by the grocery cart in the store, not interrupting parent while on the phone, taking a bath and toilet training. Parents are encouraged to reward children with nonfood related items such as special stickers, time playing a game or reading together, or going to the park, watching a special movie, or having a special friend overnight. When food is used as a reward, the parent offers choices that involve healthy foods, not junk food such as salted chips, soft drinks or candy. Some parents whose goals are to manage dinner time behavior problems are helped to set up a tangible reward system for specific behaviors such as staying in their dinner seat until the timer rings, talking quietly or finishing eating before the timer rings. It is most effective to reward dinner behaviors *other than eating*. Removing the focus from eating emphasizes that food is not a source of conflict between the parent and child, so that what goes in the child's mouth is his or her own choice, as long as healthy food options are provided.

Some vignettes in this unit show parents offering food as a reward. In some cases, candy is offered and in other cases fruit is the reward. The group leader asks the parents for their

thoughts about using candy as a reward and facilitates a discussion about potential dental problems and obesity if sweets are used frequently. Parents are helped to understand that sugar causes dental decay and that it can be almost addictive, decreasing children's interest in other more nutritious but less exciting foods such as fruits and vegetables. For this discussion the parents are encouraged to explore different healthy options for a food reward, or other types of rewards such as parent play time with parents.

One principle that a group leader can help parents discover with these vignettes includes:

• *Avoid using high sugar or salty snacks and sweetened beverages for use as rewards. When possible use non-food rewards such as positive time with parents.*

IY Program Three Part 1 and 2: Establishing Routines, Household Rules and Effective Limit Setting to Promote Healthy Life Style Habits.

In these two programs parents learn about establishing predictable routines and household rules around family meals and mealtime behavior, TV or screen time, bed time, household chores, morning routines, wearing a helmet, as well as rules for what foods are healthy to eat and what foods are not healthy. The vignettes in this program provide a chance to reinforce themes that have come up in earlier discussions around routines and help families to articulate rules that support a healthy life-style. Parents learn to be thoughtful and positive about the commands that they give their children, and they spend time rewriting their negative commands into positive commands that describe the behavior they want to see rather than the behavior they don't want to see. They practice giving clear, positive and respectful commands. Group leaders help parents know how to follow through with the command and rules.

One principle that a group leader can help parents discover with these vignettes includes:

• *Consistent and clear rules and routines help children feel safe, secure and loved by their children as well as learn a healthy life style.*

IY Program Four Part 1 and 2: Follow Through with Commands and Ignoring Children's Inappropriate Responses

In Program Three parents have established their household rules and routines and have limited their commands to those that are most important and learned to give them in clear, polite ways. Parents learn about the importance of follow through with household rules and commands in order to promote healthy behaviors and wellbeing. Naturally children will attempt to argue about the rule or test the command, or try to talk their parent out of the rule or throw a tantrum to see if they can get what they want. This is quite normal, especially if commands have been inconsistently enforced in the past. During Program Four Parts 1 and 2, parents learn how to ignore misbehavior at mealtimes and give attention for healthy lifestyle habits and ways to build their self-esteem. Parents are encouraged not to lecture or provide a rationale when children dysregulate about the limit being set but to stay calm and avoid giving

this misbehavior their attention. Vignettes in this unit show children pushing limits by arguing, tantruming, fussing, or asking for something that they can't have. The vignettes show parents responding in effective and ineffective ways as they try to set limits around household rules in order to elicit discussion of key behavior management strategies. Parents learn to ignore attention seeking behavior and follow through consistently with rules and limits. Group leaders talk with parents how to stay calm when using the ignoring strategy.

A principle that a group leader can help parents discover with these vignettes include:

• *Children learn from the attention they get for their behaviors. Therefore more positive attention should be given for healthy life style behavior than unhealthy behavior. Even negative attention is reinforcing.*

Group Mealtimes

While parents are participating in these parenting groups, many agencies provide dinners for the whole family before the group begins. It is important that families are provided with healthy food choices such as fruits and vegetables so that group leaders are modeling the very dietary habits that they want the parents to use. Also during these meals, group leaders can model and coach parenting skills that support children's healthy eating habits. Parents can be supported to coach and praise their children's healthy choices during the meal. Essentially the dinner times can be an opportunity for parents to practice the skills they are learning in the parenting groups and receive positive feedback from the group leaders.

Summary

The IY Parent Program delivery is based on an approach that is not didactic or prescriptive but rather a collaborative, training process that is active or experiential, self-reflective and built on a reciprocal relationship that utilizes equally the group leader's knowledge and the parent's knowledge, strengths and cultural perspectives. Collaboration implies that parents actively participate in goals for themselves and their children that includes making lists of target behaviors they want to increase or decrease. Some parents may have goals related to reducing mealtime behavior problems or problem food choices while others may be concerned about their children's defiance, sleep problems, TV or screen time addiction, toilet training or tooth brushing issues, fears and anxiety, hyperactivity or dawdling. This document and the table provide some examples of open-ended questions the group leader can use when mediating video vignettes to encourage parents' ideas, reflections and problem solving about life style habits. The group leader listens reflectively, and affirms positive steps parents have taken to understand and make changes. From the parents' discussions the group leader pulls out key "principles" of behavior management, relationship building and ways to promote healthy lifestyle habits and a child's sense of wellbeing. This collaborative group training approach has been shown to be more likely to increase parent's confidence and self-efficacy in regard to their belief they can change their own and their children's behaviors than a didactic teaching approach. Moreover, the group discussions allow parents to share and problem-solve with

each other which serves as a powerful source of support as they realize they are not alone with their problems and that many of their parenting problems are typical, regardless of their cultural background.

The collaborative approach allows for group leaders to "tailor" the program to the specific goals of the parents as well as to the particular family cultural backgrounds and experiences as well as the particular developmental stage and temperament of the child. Once parents learn the "principles" of behavior management in the Incredible Years Program the group leader helps them apply these principles to their specific goals be it promoting their children's healthy eating or sleep habits, or table manners, or physical activities, or reducing sibling rivalry and aggressive behavior. There have been many randomized control group studies showing the effects of the IY program in terms of promoting positive parenting and attachment relationships, strengthening children's social competence and emotional regulation and reducing behavior problems. However, there has been very little research assessing the impact of this program for promoting healthy eating and exercise lifestyle habits, and preventing obesity or malnutrition.

The purpose of this paper was to highlight some of the vignettes in the Incredible Years Preschool Program that are relevant for stimulating discussions about healthy life style habits and obesity prevention. A similar approach can be taken with the IY Toddler and School Age programs. These discussions relate to the goals of helping parents encourage children's healthy eating of fruits and vegetables, reducing sugar-sweetened beverages and high fat or high sugar snacks, reducing screen time, developing predictable dental care routines, increasing physical activity and promoting children's involvement in food planning, shopping and preparing meals and having relaxed and fun family meals. The vignettes and questions listed in Table 1 can be helpful in promoting these discussions. However, the overall program effectiveness will depend on the group leaders' ability to weave these health-related discussions into broader discussions about all the other social, emotional, and behavioral content that is outlined in the leader manual, and to overall, be responsive and respectful of the goals and cultural norms of parents in the group. These discussions about healthy eating and healthy life style habits are one small part of a more comprehensive goal to help reduce family stress, build support systems and develop stronger parent relationships with their children in order to promote children's self-esteem and sense of wellbeing, to learn how to use more positive and effective parent management strategies, and to manage misbehavior in a consistent and calm way. These parenting skills are foundational to children's emotional and behavioral outcomes.

Interestingly, it has been theorized that parents' poor emotional and behavioral regulation, negativity, and failure to set limits on children's screen time is linked to obesity risk, so it could be theorized that the IY program's effects in promoting more effective parenting and reducing behavior problems may have an ancillary effect for reducing obesity in later years and promoting lifelong health and wellbeing (Anzman-Frasca, Stifter, & Birch, 2012; Thamotharan, Lange, Zale, Huffhines, & Fields, 2013). Additionally, family stress due to poverty and adverse life experiences may negatively impact parenting around feeding and create food insecurity on the part of children. Helping parents develop positive support networks, reduce stress and

manage life stressors may be the key change agent for them to make positive parenting and life style changes. Nonetheless, there are multiple risk factors within the poverty pathway and additional economic solutions are also needed in order for low-income and refugee families to have access to inexpensive healthy food. Further research is clearly needed to assess the effects of Incredible Years parent programs on children's longer term healthy life style effects and the mechanisms involved in bringing about change. While child health and wellbeing is clearly influenced by multiple social, emotional and cultural factors, the potential to influence future child healthy lifestyles as well as social, emotional and academic outcomes via early intervention parent programs is clearly needed.

Refrigerator Notes
About Promoting a Healthy Lifestyle

• Help your children understand the health benefits of being physically active every day. During child directed play, offer options of playing tag or Frisbee, jumping rope, swimming, dancing, playing soccer, biking or taking a walk to the park with you.

• Avoid making comments about weight (your own or your child's). Instead, use language that focuses on healthy choices and strong bodies that allow you to be active (walk, play, climb, dance, etc.).

• Limit your child's total screen time to no more than 1 hour a day. Avoid screen time for children under 2 years of age.

• Provide healthy snacks: for example fruit or vegetables to dip in yogurt or hummus. Avoid continuous snacking, and instead, offer food at predictable meal and snack times. Limit high-fat, high-sugar, or salty snacks.

• In the context of otherwise healthy eating, offer moderate amounts of "treat" foods to help children learn to regulate their intake of sweets.

• At mealtimes provide a variety of health foods; fruits and vegetables, whole grains, lean meats; avoid foods high in trans fats and/or saturated fats.

• Allow your child to serve him/herself. Do not require children to clean their plates and do allow them to have more of anything healthy that is being served. This will help them learn to pay attention to their own hunger signals.

• Do not put your child on a weight reduction diet unless your physician supervises. For most young children, the focus is maintaining current weight, while growing in height.

• Offer children water or low/non-fat milk. Limit soda and juice intake.

• Have predictable family meals together where you have time to talk and enjoy the meal together. Establish dinner as a "no screen" time.

• Involve children in food planning, shopping, and meals preparation.

• Check that your child care providers are encouraging healthy eating and limiting junk food.

• One of the most powerful ways your children learn to be healthy is by observing you. Therefore, model being physically active, buy and eat healthy foods, express your enjoyment of food and family meals, and model positive talk about your family's healthy bodies.

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	Vignette Number	Description of Vignette	Sample Questions to Promote Health Behaviors
Program 1 Part 1	**Child-Directed Play Promotes Positive Relationships & Physical Activity**		What is the value of doing physical activity with your child? Does your child understand the importance of physical exercise? What are you modeling for your child when you engage in physical activities yourself? Why is this important? How often do your children do a physical activity in a day or a week? What is the ratio of your child's physical activities versus his or her sedentary activity?" How much time do your children spend watching TV?" How much time do you watch TV?" Is your child involved in any physical team sports?" How can you promote more physical activities in your child's regular routine?
	25	Father and son playing Frisbee	
	26	Mother and daughters dancing outside	
Program 1 Part 3	**Social and Emotional Coaching Promotes Healthy Eating Habits and Positive Family Meals**		
	5	Father with children outside on bicycles	
	8	Mother playing video game with daughter	
	9	Children playing ball outside with parents	
	12	Children building fort in living room with dad	
	20	Playing ball	
	14	Family breakfast preparation	What is the value of having children involved in meal preparation? What do children learn about healthy eating and food choices when they cook or shop with you? What healthy food choices do you provide at meal times? How much time do you have for breakfasts? How can you involve your children in making healthy food choices? When the boy in the video vignettes wanted a snack, what does he learn when his mother offers him blueberries for his snack? How do you manage snack time at your house? What is the value of offering a regular snack time? How can you promote healthy mealtime habits? Why are children more likely to try a new food in a quiet, calm setting? How much sugar does your child have each day? How might you set limits on when these children can have the cookies they are making in this vignette?
	15	Family breakfast preparation	
	17	Grocery shopping	
	18	Cooking with parents	
	19	Cooking with parents	

Program 1, Part 1	**Praise and Encouragement to Promote Children's Healthy Life Style Habits and Sense of Well Being**		
	1	3 year old leaving table to go to the bathroom	What routines to you have around mealtimes? Why was it necessary for this father to supervise his son's handwashing? How long to you expect a 3-year old to sit at the table for dinner? A 5-year old? What behaviors do you praise at dinner time? What do you teach your children about teeth brushing and flossing? When do your children brush their teeth each day? Do your children know what foods make their teeth decay? How do you coach, praise and supervise children when brushing their teeth?
	2	Helping with dinner prep	
	3	Dinner conversation	
	5	Washing hands before dinner	
	7	Teeth flossing	
	12	Parents critical of hand washing	
	13	Parents critical	
	14	Parents critical of child washing dishes	
	22	Child complains about dinner	
	24	Eating with fingers, then using napkin	
	31	Setting table	
Program 2, Part 2	**Motivating Children through Non food Incentives**		
	4	Offering candy as a reward	Why do parents often offer candy as a reward? What are the disadvantages of offering candy as a reward? What are children learning if candy is a frequent reward? What are some alternatives to candy as a reward? Can healthy foods be rewarding for children?
	6	Raisins and stickers as a reward	
	7	Raisins and stickers are a reward	
	9	Nonfood reward for teeth flossing	
	17a	Blueberries as a reward	
Program 3	**Establishing Routines, Household Rules and Effective Limit Setting to Promote Healthy Life Style Habits**		
Part 1	7	Setting table routine	Do you offer your children opportunities for your children to help at dinner time? What is the value of this? What dinner behaviors should be given attention and which ones can be ignored? Why is it important to offer food choices rather than give commands? What are your goals for meals?
	8	Clearing table routine	
Part 2			
	8	Dinner time	
	9	Dinner time	

			How can you set up mealtimes to encourage healthy eating and food choices? When should you set limits on mealtime behavior? Why does the mother in the vignette want to teach her daughter to sit longer at the meal? What else might she do to foster her meal involvement? Do you think children should have to sit at the table until everyone is finished eating?
	17	Mom watching TV	What rules do you have about the amount screen time your children have? How can you model healthy use of screen time? What other activities can your children engage in besides screen time? What other rules do you have about TV? Do you limit particular programs? Do you have the TV on during meals? What rules do you have about I-pad or computer use? How can you be involved with their screen time learning? Do your children have computers or TV in their bedrooms?
	20	Vague command to come to dinner	
	29	Command to turn off TV	
Program 4	**Follow Through with Commands and Ignoring Children's Inappropriate Responses**		
Part 1	1	Tantruming girl wants to eat	What is the problem with a parent giving in to the child's protests and arguments? What behavior is the mother reinforcing when she gives in to protests or continues to argue?" What is the boy in the vignette learning?" What healthy snack could the mother offer instead?" What are the long-term advantages of continuing to ignore even if it is hard to listen to whining?? How might you distract a child after ignoring the protests?
	2	Tantruming girl wants to eat	
	9	Girls want cupcakes	
Part 2	6	Boy wants cookie before dinner	
	8	Arguing for candy	
	9	Annoying dinner behavior	
	12	Cookie before dinner	

Key Clinical and Review Articles and Books for Therapists/Group Leaders Using IY Parent Programs

Incredible Years Therapist/Group Leader Book

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**Starred articles are research with prevention, indicated or selective populations; remaining are treatment-—diagnosed research trials*

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Articles may be downloaded from Incredible Yeas web site:
www.incredibleyears.com/research-library
Another reference list for the teacher and child research can also be provided by IY if needed.

Clinical and Review Articles and Books Relevant for Therapists/Group Leaders Using IY Parent Programs

Parent Books

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