THE INCREDIBLE YEARS®
Parents, Teachers and Children Series

Child Group Leader Consultation Day

Workshop Guide

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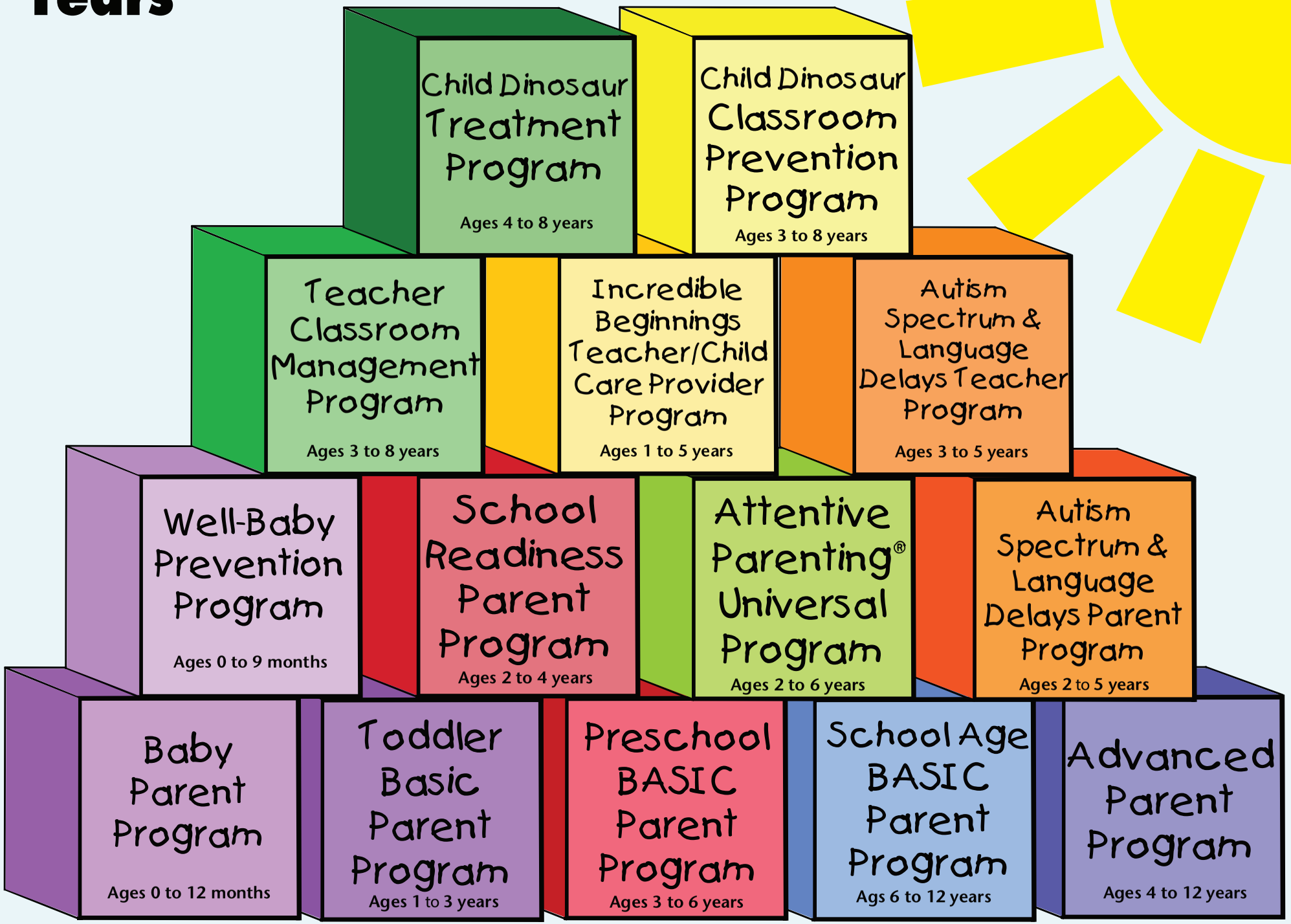
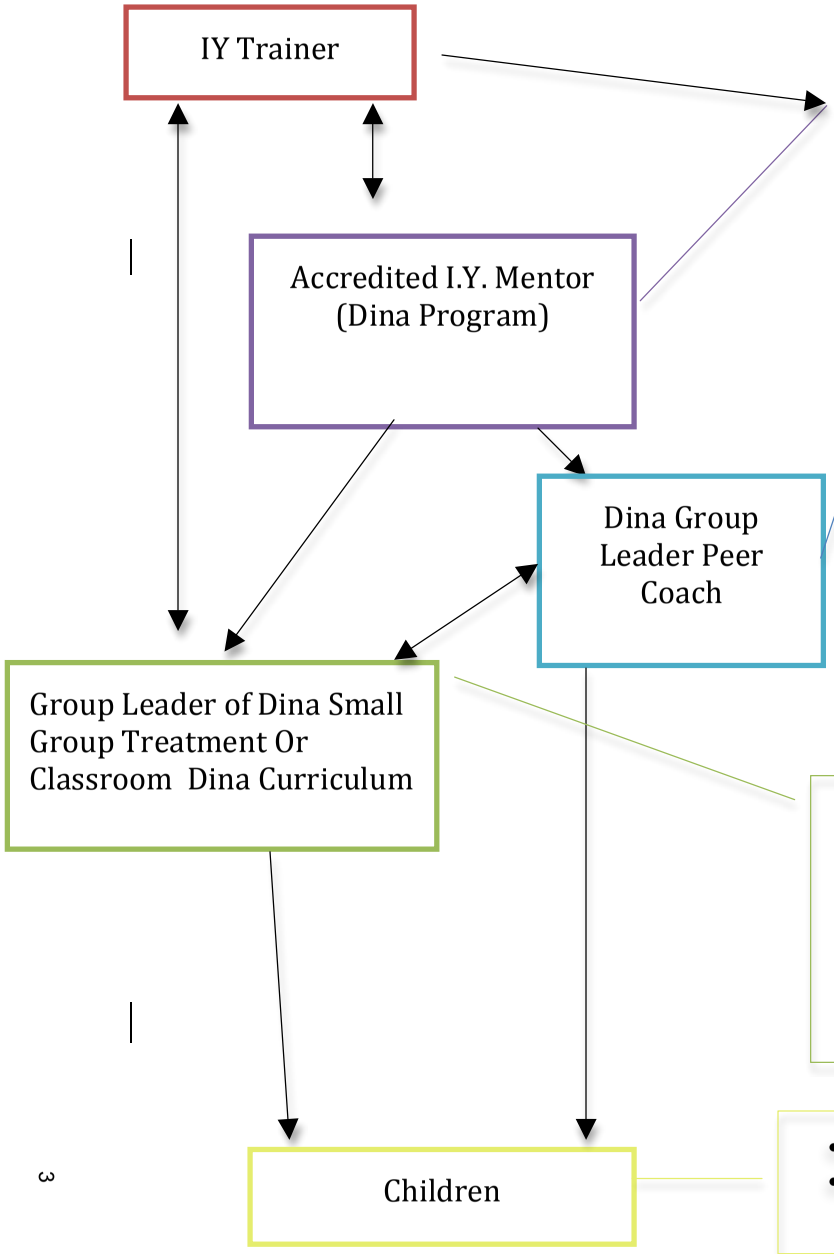


Incredible Years Dinosaur Program Training, Coaching, and Support Infrastructure



- Provides 3-day training to Dina Group Leaders (teachers or therapists)
- Provides telephone consultations to Group Leaders and Coaches
- Reviews DVDs of Dina group leader groups or classrooms for accreditation
- Provides consultation workshops with group leaders

- Assists & observes dina group leaders with delivery of dina small group treatment or classroom dina curriculum
- Provides DVD feedback of new group leader's dina program delivery
- Conducts individual meetings with dina group leaders regarding goals, behavior plans, and additional support
- Attends mentor 3-day training (when invited by mentor)

* *must be accredited first as dina group leader to be peer coach*

- Provides children with dina treatment program or classroom curriculum
- Meets with peer coach for DVD review, planning and feedback regarding behavior plans
- Collaborate with parents and with teachers to promote consistency of strategies, learning and goals across settings
- Attend consultation days with mentor or trainer
- Submits materials to IY for accreditation

- For treatment, children attend 18-20, weekly 2-hour group sessions
- For classroom delivery, children receive curriculum lessons 2-3 times weekly throughout the year

Small Group Dinosaur Therapist/Child Group Leader Collaborative Process Checklist

This checklist is designed for group leaders/therapists to complete together following a session, or for a group leader to complete for him/herself when reviewing DVD of a group session. By watching the video of a session, and looking for the following points, a leader can identify specific goals for progress.

Leader Self-Evaluation (name):_____

Co-leader Evaluation:_____

Certified Trainer/Mentor Evaluation:_____

Date:_____

Session number & Topic:_____

SET UP ***Did the therapist/group leader(s):***	**YES**	**NO**	**N/A**
1. Set up the chairs (or carpet squares) in a semicircle that allowed everyone to see the TV? (name tags for first sessions)	____	____	____
2. Sit on either side of the TV and flip chart?	____	____	____
3. Have chips in visible and accessible spot? (sticker basket, prize box, chip cups with names)	____	____	____
4. Have dinosaur schedule posted?	____	____	____
5. Have healthy snack prepared?	____	____	____
6. Have session materials ready? (home activities manual, cue cards, DVDs, prizes, puppets, stickers, rules poster, dina poster for coloring in total of chips earned each week, art supplies, markers and flip chart, TV & DVD Player, helper list, give me five card)	____	____	____

CIRCLE TIME: REVIEW CHILDREN'S HOME ACTIVITIES & STARTING CIRCLE TIME DISCUSSIONS
Did the therapist/group leader(s):

7. Have puppets arrive and greet children in a predictable and enthusiastic manner (e.g. "One, two, three, Dina!" or a greeting song?)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

8. Begin the discussion with brief review of home activities and ask what skills children remembered to use during the week.

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

9. Give every child the chance to share?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

10. Enthusiastically praise whatever effort children made this week?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

11. Applaud successes and give stamps or stickers for home activity?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

12. Explore with children who didn't complete the home activities what made it difficult and challenge them to a new goal for this week? Can do this individually during coached play time.

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

13. Have puppets talk about their issues/problems that week and things they need help with?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

14. Establish individual goals/ personal challenges for individual children?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

15. Review learning from prior session?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

WHEN PRESENTING THE NEW LEARNING IN CIRCLE TIME

Did the therapist/group leader(s):

16. Begin the discussion of the topic with open-ended questions to prompt children to think about the importance of the topic? (e.g. What are some rules for the class? Or what are some friendly behaviors?)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

17. Work to include all children in the discussion?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

18. Paraphrase and highlight the points made by children? (Reinforce their ideas by having them role-play or demonstrate, hold a cue card, or give them chips and praise for their ideas.)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

19. Use puppets in lively and enthusiastic way as active participants in entire session?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

20. Co-leader attends to group process by giving frequent verbal and nonverbal praise, nods, thumbs up for paying attention, participating with answers, helping others, etc.?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

21. Uses picture cue cards as prompts to reinforce new behaviors being taught?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

22. Use a style that is playful, engaging, fun, and paced at children's level of attention?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

23. Present clearly and model new behavior with puppets and. role plays?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

24. Actively involve children by letting them hold cue cards, pause DVD, use smaller puppets, give out snacks, be line leader, etc.?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

25. Provide legitimate opportunities for active children to move and stretch? (e.g., Group stretch break or wiggle space for a particular child.)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

26. Set up activities during circle time such as songs, games, large group bingo, feeling dice, large turtle shell, pass the hat, practicing skill with puppets?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

27. Take time to acknowledge disappointment at not being called upon? Provide children with coping strategies to manage this? (e.g. Self-pat on the back or "maybe next time.)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

28. Take a group snack break and reinforce social behavior. Encourage children to share interests and experiences. Perhaps use puppets to model listening, asking questions, sharing.

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

WHEN SHOWING THE VIGNETTES

Did the therapist/group leader(s):

Number of vignettes shown: _____

29. Focus children's attention before showing vignette?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

30. Give them a specific behavior or emotion to watch for? Pause longer vignettes at least once to ask questions about segments of the vignette and to predict what happens next?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

31. Begin by asking an open-ended question to children about what they thought was happening in the vignette?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

32. Acknowledge, praise and non-verbally acknowledge children who are focused on a vignette?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

33. Move on to the next vignettes after key points have been discussed? Pace material to maintain children's interest?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

34. Allow for discussion following each vignette? (If vignettes are played one after another, children may not catch the key points illustrated. Additionally, they won't have an oppor- tunity to process emotional reactions they may have to vignettes. IF children are distracted vignette may need to be replayed.)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

35. Use vignette scene to prompt a role play/practice of the skill viewed on the DVD? When setting up role play, select student strategically and coach them with script of prosocial behavior to practice.

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

36. Demonstrate and explain small group activity before leaving large circle discussion?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

ROLE PLAYS

Did the therapist/group leader(s):

Number of role plays done: _____

37. Have children practice new concepts in circle time through puppet plays and role plays?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

38. Role plays are set up to practice positive—not negative— behaviors and are strategically set up according to children's behavior goals to promote a high rate of engagement?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

39. Role plays are carefully set up to help children be successful? (e.g. providing the words that they will say, prompting a behavior, setting up role play with a child and a puppet so that puppet can help guide the practice.)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

SMALL GROUP PRACTICE ACTIVITIES

Did the therapist/group leader(s):

40. Plan small group activity or game to reinforce new learning? (e.g. cooperative art activity, feeling game, blocks, play dough, art activity, bingo, pass the hat, visualization)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

41. Prepare small group activity materials ahead of time to minimize children's waiting time during transition from circle time to small group activity?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

42. Participate in small group activity using acadmic, persistence, social and emotional coaching, prompting children to use new skills and praising newly taught skills when they occur?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

43. Promote reading skills by associating printed work with language?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

44. Promote writing skills by taking dictations, writing words to be copied and reinforcing children's beginning attempts to write?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

45. Provide children with time for less structured peer play with legos, trains, dress-up materials, play dough, etc., and coach social interactions and problem solving during this time?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

46. Give as much time to small group activities as to circle time discussions?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

47. Make adaptations in small group activities in order to be developmentally appropriate for every child?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

BEHAVIOR MANAGEMENT AND RELATIONSHIP BUILDING SKILLS (DURING ALL SEGMENTS)
Did the therapist/group leader(s):

48. Build relationship with individual children by asking personal questions about their experiences, listening to their stories using child's name, responding to them uniquely?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

49. Create a feeling of safety in the group?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

50. Promote optimism and show belief in children's ability to learn and be successful?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

51. Use physical touch (back rubs, hugs, lap time) appropriately?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

52. Share aspects of self when appropriate (e.g. something about their families or a mistake they made)?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

53. Use proximal praise and labeled praise for prosocial behavior?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

54. Avoid making critical or negative statements about children's behavior?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

55. Act in a fun, playful and engaging way with children?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

56. Show respect, warmth and calmness with children?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

57. Involve children actively in learning through games, activities, stories, fantasy?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

58. Use songs and movement activities strategically when children need to move or have a break?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

59. Have predictable routines for opening and closing circle time, bringing out and saying goodbye to puppets, transitioning to snack time or small group activities, saying goodbye?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

60. Ignore targeted misbehaviors or attention seeking behaviors? (blurting out, off seat)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

61. Use Time Out appropriately, for aggressive behavior or repeated noncompliance? (Number of time outs given:_____)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

62. Use redirects and distractions to re-engage children who are off-task?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

63. Use warnings for disruptive behavior? (Warnings should let children know what will happen if they do not comply. If noncompliance continues, therapists should follow through with consequence.)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

64. Praise and give rewards (chips, hand stamps, stickers) to individual children who are following rules and showing appropriate behaviors?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

65. Use team incentive approach?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

66. Use emotion coaching?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

67. Use social coaching?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

68. Use academic and persistence coaching?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

69. Respond to individual and group developmental needs? (Change pace if children are restless, modify activities and questions depending on children's skill, adjust circle time content and length to children's attentions span and level of engagement.)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

70. Prepare for transitions to new activities effectively? (visual or auditory cues)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

71. Give clear and simple directions and model expected behavior?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

72. Minimize amount of waiting time for children?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

73. Attend to and reinforce appropriate behavior much more often than attending to inappropriate behavior?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

REVIEW HOME ACTIVITIES AND WRAP UP

Did the therapist/group leader(s):

74. Begin the wrap up process with about 15 minutes remaining?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

75. Review Detective Home Activity for the week?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

76. Have children count chips and trade in for prizes?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

77. Conduct compliment circle time?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

78. Meet with the parents?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

79. End the session on time?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

CHILDREN'S RESPONSES

80. Children appeared engaged and on-task during session?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

81. Children were enjoying themselves during activities?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

82. Children were involved in asking questions, role plays and suggesting ideas?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

LEADER COLLABORATION

Did the therapist/group leader(s):

83. Did the two leaders have clear, complementary roles in each of the different activities? (take turns leading content and focusing on process)

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

84. Did leaders work well as a team reinforcing each other, while attending to different roles with children?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

85. Are leaders implementing behavior plans for children targeted with special needs?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

86. Are leaders talking to parents about dinosaur home activities and about how they can reinforce children's learning at home?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

ADHERENCE TO SESSION PROTOCOLS AND CONTENT

Did the therapist/group leader(s):

87. Followed session protocols for session?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

88. Knowledgeable about content to be presented to children?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

89. Showed the appropriate number of vignettes for age and temperament of children?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

90. Modifications or adaptations were made when necessary to help keep children actively engaged and successful with activities?

1	2	3	4	5
Never	Rarely	Sometimes	Frequently	Very Frequently

REMEMBER: Your goal in the group sessions should be to draw from the children the information and ideas to share with each other. They should be given plenty of opportunities to practice new behaviors.

Summary Comments:

Lesson reviewed by: _____

Date: _____

Group Leaders Thinking Like Scientists

Problem

Strengths

Goals

Strategies

Benefits

Obstacles
[thoughts, feelings behavior in self & others]

Ongoing Plans

Group Leaders Thinking Like Scientists

Problems

Strengths

Goals

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Group Leader and Coach/Mentor Gems

Date _____ Group Leader(s) _____ Coach/Mentor _____

Program: Parent ☐ Teacher ☐ Child ☐ Video viewed? ☐ Topic _____ Date for next meeting _____

Fidelity Issues Discussed:

- ☐ Attendance
- ☐ Participant evaluations
- ☐ Home activities engagement
- ☐ Principles
- ☐ Mediating vignettes & Number
- ☐ Role play/practices/ buzzes & Number
- ☐ Participant goals
- ☐ Tailoring to needs
- ☐ Weekly calls
- ☐ Session checklists
- ☐ Peer & self-evaluation forms
- ☐ Group process checklists
- ☐ Self-reflection inventories
- ☐ Accreditation/ Certification
- ☐ Coaching evaluation

Group leader prior goals reviewed:

Group leader goals for group DVD review:

Issue problem solved and practiced:

Summary of Key Learning:

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Group Leader and Coach/Mentor Gems

New Goals and Plans:

Coach/Mentor Actions:

Additional Notes:

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Group Leader and Coach/Mentor Gems

Date _____ Group Leader(s) _____ Coach/Mentor _____

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Group Leader and Coach/Mentor Gems

New Goals and Plans:

Coach/Mentor Actions:

Additional Notes:

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Group Leader and Coach/Mentor Gems

Date _____ Group Leader(s) _____ Coach/Mentor _____

Program: Parent ☐ Teacher ☐ Child ☐ Video viewed? ☐ Topic _____ Date for next meeting _____

Fidelity Issues Discussed:

- ☐ Attendance
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Group leader prior goals reviewed:

Group leader goals for group DVD review:

Issue problem solved and practiced:

Summary of Key Learning:

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Group Leader and Coach/Mentor Gems

New Goals and Plans:

Coach/Mentor Actions:

Additional Notes:

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Group Leader/Therapists' Hot Tips for Delivering Incredible Years® Small Group Child Dinosaur School

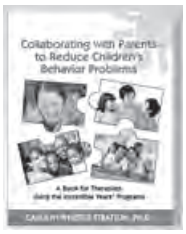
Carolyn Webster- Stratton

7/31/14

Overview

As an Incredible Years® group leader you are an essential element in bringing about children's ability to learn social and emotional skills. When delivering this program group leaders will be using research-based classroom management skills such as academic, social, emotional and persistence coaching methods and positive attention, praise and incentives for appropriate behaviors as well as proactive discipline approaches such as ignoring, redirection, clear limit setting and problem solving.

The following tips are provided to cover some of the main questions that we hear from group leaders or difficulties we see when reviewing videos of child group sessions.



Also, there is a helpful book for therapists to use to continue their learning about how to deliver this program successfully.

Webster-Stratton, C., *Incredible Teachers: Nurturing Children's Social, Emotional and Academic Competence.* 2012, Seattle: Incredible Years Inc.

We hope you find joy and fun delivering this program to children. Children are so imaginative at this age that you will find that by using puppets, games, songs and small group activities you learn a great deal about these children's ideas, thoughts and dreams. Consultation and support from IY mentors and trainers can be obtained by calling us at 888-506-3562, emailing us at incredibleyears@incredibleyears.com, or check out the website for other resources, www.incredibleyears.com.

Wishing you incredible dinosaur child groups, Carolyn

Room Set Up is Well Organized and Inviting

One section of the room is set up for the small group circle time structured learning. Six children are seated in child-size chairs, or on carpet squares on the floor that are positioned in a semi-circle—with the TV monitor, easel, chip cups, cue cards, and group leaders up front facing them. This room set-up allows children to easily get up to move, to see the chips as they earn them, view the video vignettes, puppets and group leaders. This will also simulate the typical classroom set up for circle time or rug learning. Be sure to also provide a chair or carpet square for Molly or Wally as well as a home or sleeping bag for Dina where she sleeps until it is time for her to come out. Another section of the room has two small tables for small group activities and enough space for games that involve physical activities.

Follow a Predictable Schedule for a Two Hour Group

This suggested schedule is a guideline; times can be adjusted according to the developmental needs of the children in your group, but we recommend including the full range of activities listed below—and that children are spending equal or even slightly more time in hands on activities than in structured circle time. Younger children (ages 4-5 years) and children with ADHD will need 2-3 circle times broken up by 3-4 small group activities. Older children (6-8 years) may be able to manage a longer circle time (which include some dancing, songs and play acting) and one longer small group activity time. The dinosaur group schedule and children's job for each session should be posted on the wall.

• ***Coached play and Home Activities (10-15 minutes):*** Greet children at the door, have them visit the bathroom, and then start coached playtime as soon as they arrive. For children who arrive early or before other children arrive, this allows you to have special time playing one-on-one with a child. One therapist will actively coach three children's social skills as they play together (praise sharing, taking turns, waiting). You will also model and prompt these social skills for children who don't initiate these skills on their own. While this is happening the second therapist is looking at the home activities for the other three children—sitting with each child and giving positive individual feedback and putting Dina stickers on their pages. When all the children have home activities checked and have had about 10 minutes of playtime, then start your circle.

• ***Circle (20-30 minutes):*** Set up a predictable opening circle time routine by singing songs for children to learn. Give a brief acknowledgement of children's home activities achievements, and then a short review of old content. Preferably this review should be done with a game, role-play, or with a story from Wally—not just asking the children what they learned last time. Introduce new content with a situation from Wally and then show 2-3 vignettes. Each vignette is followed by a role-play practice. Circle time may also include group games and physical movement to teach new content.

• ***Small Group Activity (10-15 minutes):*** This should be a hands-on activity that is structured to practice the skill or topic that was covered in circle time. Some of these activities include small Wally Problem Solving Detective books for use with hand puppets or with writing or drawing assignments, pass the hat game, bingo, friendship game, food projects and cooperative art projects. Academic and persistence coaching is carried out by therapists constantly during these activities along with social and emotional coaching. Typically children break out into 2 small groups of 3 children at a table each with a therapist to do these activities. This allows therapists to tailor each of these 2 groups according to developmental abilities for some activities. In addition to recommended activities in the manual protocol for the session, the manual also includes a wide range of other small group activities for each of the Dinosaur Program topics. Please check these out, as you may want to select some other activities according to your children's specific developmental abilities and individual children's goals. There are pre-reading and pre-writing activities as well as activities for those who read and write as well as activities that encourage fine motor skills and use math and science concepts.

• ***Snack (10 minutes):*** Snack and bathroom break, if needed. Therapists should sit with children during the snack time and facilitate social interactions between the children by using social and emotion coaching. Wally or Molly may also join snack time to model social skills and to model how to share experiences and feelings with other children.

• ***Second Circle (20 minutes):*** This circle is usually shorter and similar in structure to the first circle—puppet situation or problem, game, songs, 2-3 vignettes and more role-plays.

• ***Second Small Group Activity (10-15 minutes):*** Another hands on small group activity is provided to reinforce circle time content.

• ***Coached play and Chip Counting (15 minutes):*** This closing experience is similar to the coached play session that opened the group. During this time children are individually pulled aside in pairs to count their chips and to choose their prizes.

• ***Parent report (5 minutes):*** If a parent group runs concurrently, one therapist visits the parent group room to give parents a brief report on the content and tell them about the home activity for the week.

• ***Compliment Circle (5-10 minutes):*** Dina and/or Wally or Molly join the closing circle to facilitate the modeling of how to give each other compliments. Dina also reviews the dinosaur home activities to be done with their
parents.

Use Academic, Persistence, Social and Emotion Coaching Methods During Child-directed Play Times

The coached unstructured playtime is a valuable chance for children to practice using emotion language and social and problem solving skills in real play situations with their peers. The playtime is set up with several toys placed in different parts of the room. Legos, blocks, imaginary play figures, and puzzles are all good activities. Toys are rotated each week so that children can interact with different toys. Children are usually allowed to choose where they want to play and therapists move about the room to coach different groups. Occasionally the therapist will deliberately pair two children together to work on particular skills. Therapists use narrated child-directed commenting, social, emotional, and persistence coaching to support children's play interactions.

Singing and Use of Music is Key to a Group's Success

Music should be an integral part of opening and closing circle times and transitioning between the activities. The Dina's Greatest Hit's CD has songs that can be used for regular transitions as well as songs that support each of the Dina curriculum content areas. The content songs should be used regularly to support each unit of the curriculum. For some of the transition songs (*Everybody Sit Down, Shake Hands With a Friend* and *Dina Wake Up*), it's recommended that the therapist use the CD to learn the songs and then sing them "live" with the children. In addition, it's often useful to sing the song several times, until all children are regulated and engaged. In addition to the songs from the CD, therapists may bring in supplemental wiggle break songs, finger plays, and stretch breaks. Most groups will need 2-3 songs or wiggle breaks in a 20-minute circle.

Dinosaur Chip Giving Should be Frequent

Most dinosaur chips are given out during circle time—this is the most structured time of the group and is, therefore, the hardest for most children to manage. Chips can also be given for special behaviors during playtime, small group activities and snacks, but often, these activities are engaging enough that chips are not needed to maintain positive behaviors. Each time a chip is given, the child's name should be used and the behavior should be labeled. For example, *"John is getting a chip for giving a compliment to a friend." "Mary is getting a chip for sitting in her spot."* Children typically get chips very frequently, for many small, positive behaviors. On a typical night, children usually earn enough chips to get two prizes (16 chips).

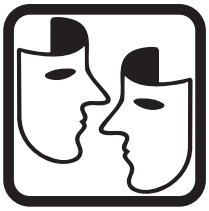
Chips should be given for genuine positive behaviors, but after several sessions therapists can begin to individualize according to a child's developmental abilities and target goals. One child may get chips for being in his seat for 30 seconds, while another child may be earning chips for friendly behaviors or putting up a quiet hand.

If a child is having a particularly difficult night, therapists should work hard to find opportunities to give chips for small positive behaviors. If possible, even on difficult night, it is good for a child to earn at least 8 chips. This ensures that therapists are working hard to notice positive behaviors, and that the child leaves with one prize—and a tangible marker of success. Therapists should ask parents for suggestions of what kind of prizes will motivate their children such as baseball cards, colored crayons, small cars, finger puppets, bubbles etc.

Vignettes Are to Be Mediated

It will not be possible to show all recommended vignettes that are listed in the protocol for each session. Therapists should show between 3-4 vignettes in each of the two circles. It is important to pick vignettes carefully to focus on the skills that are most needed for the particular children in the group. The protocol gives suggestions of vignettes that are more appropriate for older or younger children. It is better to show fewer vignettes and to mediate them in an interactive way, with discussions and role-plays, than to show many vignettes in a didactic way. Start by introducing and orienting children to the vignette before showing it—let children know what they're going to see and look for in the video. For example, you might say, *"This is a movie about Oscar and he is feeling badly—I want you to listen and tell me his problem."* Then involve the children to start the vignette by saying, *"Ready, set, action."* Pause vignettes part way through to get children to process what they've seen. At the end of a vignette, first ask the children what they saw, what the problem was, what the children felt or did, and then always follow up with a role play practice to have them show you and each other what they've learned—or have them practice the positive solution that they've suggested.

Do Many Role Play Practices



Role-play practices are a very important component of every circle time. Each child in the group should have at least one chance to practice a skill in each circle time. Ideally, every solution or idea that is discussed is also practiced. Almost every vignette should be followed by a practice. Role-plays can be brief, but should always be scaffolded. For example: *"That's a great idea to ask for a turn. Let's pretend that Wally is using a truck that you want (set the scene). You're going to come up and try your idea: "What words would you use to ask him?"* Check to make sure the child has a script. For younger children, the therapist may provide the script or model it first by whispering in their ear the words. Then start the practice and guide and prompt the action, if needed. Depending on the situation and the children in the group, role-plays may be acted out between two children or between a puppet and a child. Children are NEVER asked to act out negative behaviors. If negative behavior is going to be shown, the puppet acts out the negative behavior. Even then we limit the amount of negative behavior that is acted out. The role-play might be started after the negative behavior happened. For example: *"We'll pretend that Wally took your car, and you're going to tell him that you want it back."* Wally also makes it clear that the role-play is pretending by saying, *"Okay, I'll pretend that I took it so we can practice, but I wouldn't really take your car!"* Or, Wally may share with the children a problem he had and a mistake he has made (such as yelling or pushing or taking the car) and ask the children for their help with a better solution that is safe, fair and leads to better feelings. After the children have suggested other solutions, Wally acts out the positive replacement behavior to illustrate how he learned from their ideas.

Leader Roles are Clear, Separate and Choreographed

For each circle, assign a content therapist and a process therapist. The content therapist has a puppet and leads the vignettes, asks most of the questions, sets up the role plays, and games. This leader keeps the action going. The process leader gives praise, chips, and attends to the behaviors of the children. If a Time Out or other discipline is needed, the process therapist attends to this so that the content therapist can keep the circle content discussion going. There is some give and take in these roles and the content therapist may also give chips and praise and the process leader may also add to the content; so therapists always support each other in the whole process.

But having a clear content and process leader role makes is easier to keep a continual flow of the content and to make sure that someone is pacing the content. This role usually switches for first and second circle—e.g. Therapist A and Wally might lead the first circle and Therapist B and Molly or Dina might lead the second circle. If you have groups with high levels of ADHD or conduct problems you may also need a third person who can sit just behind the semi-circle. This person's role will be to give out hand stamps, whisper ideas they can contribute, take children to the bathroom if needed and monitor any Time Out to Calm Down episodes.

Bring Puppets Alive and Make them Real

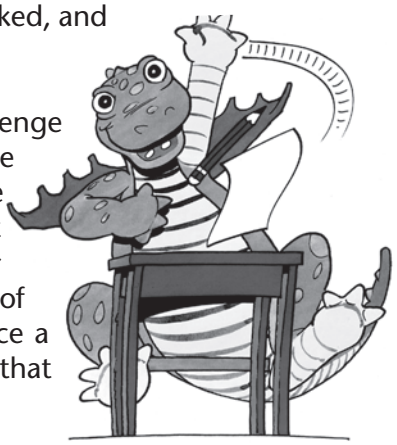
Puppets should be an integral part of the group, particularly during circle time. A puppet will be present for almost all of each circle. Typically one puppet joins the circle at a time, and is used by the content leader. Occasionally the session scripts call for two puppets to interact (Wally and Molly are together a few times), but these are brief interactions and then the process person's puppet leaves. It is extremely hard for the process therapist to be attentive to process, give out chips and to use a puppet effectively at the same time.

Puppets enter and exit in predictable ways. Usually Dina lives in a box, house or sleeping bag and children sing to her to wake her up. Molly and Wally may be present at the beginning of the group; they come to circle with the children and have a chair to sit in. They wear different clothes each week and therapists have developed bio sketches for them so they can share with other children information about their family situations and interests. Puppets should not be left lying around the room. At the end of the circle, they should be gently placed in a chair: *"Wally, will you wait here till we come back from snack?"* or should be put away, with proper goodbyes. For example, *"Wally is going to go back into his house, can you all tell him 'goodbye?'"*

As much as possible, have the puppets share as a group member in the learning and discussion of the new content. Children will be more interested if Wally shares an idea or a problem than if the therapist does. Much of the new content is presented as a problem that the puppet needs help with. The manual suggests scripts that can be used, and therapists can tailor the presentation of new problems to match issues that children in the group are experiencing. Wally and Molly model the appropriate social skills and share their emotions and experiences with the issues being discussed.

Establish Special Challenges Directed at Children's Target Behaviors

Around session 5, therapists will introduce special challenges to the children. These are specific behaviors that children are aware of and are actively working on. They are tailored to different children's needs. Two children in the group may be working on raising a quiet hand to talk, another child in the group may be working on giving on-topic answers to questions that are asked, and two children may be working on giving compliments to others.



Special challenges should be set up so that the child can earn the challenge each week. Typically, systems are set up that require the child to do the behavior 6-8 times during the group in order to earn an extra prize. These goals can be marked in a variety of ways. For example, therapists might use special gold chips that go into the child's chip cup, or a star chart for each child that is displayed on the easel in front of the group. The goal of special challenges is that each child has multiple opportunities to practice a behavior that is harder. It is often up to therapists to set up situations that allow the child to be successful.

In this sense, the child's success is often dependent on the therapists' behavior. For example, if the child's goal is to raise a quiet hand, the therapist might say: *"John, I'm going to ask a question now—if you can raise your quiet hand, you'll get a stamp for your special challenge."* Without this prompting, the child would forget, but with the prompt, the child can usually do it. If the goal is giving compliments, then the therapist might say: *"Let's stop and do a compliment check. Mary, can you think of a compliment for the way that Sean did that role play?"* If a child refuses to respond to a prompt (e.g., says "no" or is actively defiant), then the therapist should let it go, ignore, and not give a token/stamp. The therapist then looks for a new chance to prompt the behavior.

When explaining the special challenges to children, the therapist must clearly define the behaviors and have each child practice the goal and earn the first star during this practice. It is also important to have a visual picture reminder of each special challenge posted next to the child's name/chart.

Wally should be involved in explaining the special challenges. For example: Wally might come out and the therapist might say: *"Wally, today is such an exciting day, because it's the day that you and the kids in the group are all going to get a special challenge!"* Then the therapist explains Wally's challenge to him. *"Wally—you have so many ideas in circle and you want to share them all. That's great! Your special challenge is going to be to remember to raise your quiet hand when you want to talk."* Then Wally might say: *"I think I can do that."* The therapist says: *"I know you can, Wally! We're going to practice right now—so I'm going to ask you a question, and I want to see if you can show me your quiet hand."* Give Wally a reward for being successful.

Then each child will get a challenge, a chance to practice and earn a first star—you may break into 2 groups to do this—3 children with each therapist, because it is time consuming to explain and practice each challenge. The challenge is explained to the children just the way it was explained it to Wally with a very simple description of the exact behavior.

Be Sure to Connect With Parents After Every Session

If parents are picking their children up from group, each child should be individually walked over to his/her parent so that the therapist can reinforce positive behavior from the session. For example, *"I wanted to let you know that Maria was so friendly tonight. During playtime, she was building a beautiful Lego house and another child asked to play with her. I could see that the house was important to her, but she agreed to let the other child build with her. That was hard to do, but her friend was really happy and they worked so well together!"* Be specific and positive. In many cases parents and children in these groups will not have experienced this kind of positive message from teachers. The end of group should always convey this positive and hopeful message. If a child had a hard night, it is still important to be positive with parents. Find something to praise. If the child had a bad night, consider what needs to be shared. If the negative behaviors were taken care of in the group, and if the child is calm and positive at the end of the group, then focus on that. If the child had a very hard Time Out or an incident that was upsetting, then parents will need some information to help the child process:
"I wanted to let you know that I'm proud of Johnny—he had a rough time in the first circle and he had a Time Out—I know that was really hard. But he really worked hard to calm down and then in the second circle, he earned so many chips for listening!"

Parents should be given the message that all behaviors are handled in Dinosaur School, so they do not need to discipline or talk about negative behaviors with their children. Instead, they can praise the child for calming down, predict a better time next session, and focus on positive skills. Parents will want to hear about the children's progress and behavioral issues, but that is done in the context of phone calls or behavior plan meetings where the focus is on how the systems that are in place to support positive behaviors and on strategies for managing positive behaviors.

Give Out Parent Communication Letters

The manuals include letters to parents, which include information about the content of the child group session and provide suggested tips for how they can support and reinforce their child's learning and practice of the specific skill they have learned at home. These letters may be sent home with parents and explained when children are picked up at the end of group or maybe emailed to parents.

Involving Teachers is Important and Well Worth the Effort

In addition to helping parents understand the program goals and content, it is equally important to involve teachers in this partnership. Most parents will give you permission to share information about their child's program with their child's teacher and most teachers will be grateful for the support and happy to be part of the team. The manual includes sample letters that be regularly sent to teachers which include session goals and provide tips for how teachers can support the child's practice of the target behavior for that segment of the program in the classroom. The manual also includes some editable forms that can be sent via email to teachers. In addition to emails and letters, it is highly recommended that teachers be called and invited to provide information in regard to the child's behavior plan. If possible it can also be very helpful if the therapist can observe the child in the classroom. Following this observation establishing at least one meeting between one of the therapists, the parent and the teacher to review the behavior plan and target goals is extremely useful.

Finally, in our studies with children with ADHD, we offered teachers an in-service training day to help them understand what the dinosaur program was about and to review with them the behavior management strategies we felt were working with the children. In addition, we provided them with materials they could use in the classroom that were used in the small group such as the Calm Down Thermometer, Wally's solutions, stickers and copies of award certificates such as Happy Grams. See website for some of these awards: http://incredibleyears.com/resources/gl/child-program/

Prepare for Certification/ Accreditation

Be sure to go for certification or accreditation as a group leader. This process validates your skills and competency to deliver this program with high fidelity. Not only that the self-reflection and coaching you receive is empowering and gratifying. Learn more about certification in your leader's manual and on our website: http://incredibleyears.com/certification-gl/

Tips for Preparing Your DVD for Review Small Group Dinosaur School

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 DVD 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 these DVDs 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 DVD 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 DVDs will I need to send for review?

Send only one session at a time. Then use these recommendations to make changes in your group leadership methods or processes and submit a 2nd DVD 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 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 DVD 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 DVD is being reviewed should be the primary leader throughout the session and should show their group leadership skills specifically in regard to the following:

- using puppets in collaborative way to demonstrate positive social skills and elicit problem solving
- designing developmentally appropriate small group activities
- demonstrating persistence, social and emotional coaching through child-directed play with peers during session and during small group activities
- effective classroom management skills (ignoring misbehavior, giving attention and praise to on task behavior)
- tailoring vignettes and activities to children's attention span and individual needs
- using chips and incentives targeted an individual children's specific goals
- mediating DVD vignettes and leading discussions of them
- setting up role plays and small group practices with leader coaching
- reviews home activities
- sufficient knowledge of topic content
- collaborative interpersonal style of interactions with participants
- amount of praise, encouragement and incentives given to participants
- coordination with coleader
- schedule posted for session
- 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 DVD, 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 DVD 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 of 18 weekly, 2-hour sessions must be completed.

Number of Children in Group

To qualify towards certification, Small Group Dina groups must not have fewer than 4 children, and ideally there are 5 or 6. All groups need to have at least 2 group leaders.

Number of Vignettes Shown in a Session

The number of vignettes in the protocols varies greatly by session (ranging from 4-18). The number of vignettes actually shown in a session will depend on the age group addressed (preschoolers vs. school age) and children's diagnoses. Younger children and children with ADHD or developmental delays cannot sit very long to attend to the vignettes and discussion so more time will be spent in practices and small group hands-on activities. Reviewers will take into account whether group leaders are being sensitive to the developmental needs of the children in the group. For example if a group leader continues to show vignettes to children who are disengaged and off task, this will not be seen as a productive use of time. In this case, a positive review would be given for more movement activities, role-plays with puppets and small group activities. However, it would not be acceptable for a group leader to leave out all the video vignettes and to rely solely on other means of teaching. The group leader should strive for a balance between activities. In general it is typical to show between 5-10 vignettes in a 2-hour session (the lower end for young and wiggly children, the higher end for older, more attentive children). Typically in this program, vignettes that are missed in one session will be shown in the next session for a review or continuation of the prior lesson's content.

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 DVD 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 children who get chips or rewards or hand stamps, who is using the puppet or who will monitor time out needed.

What do I need to send in along with my group DVD for review?

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

Enhancing your DVD 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 DVD you have questions about or particulars you would like feedback on.

Once your DVD has been passed off, you submit your application with the remaining materials:

- background questionnaire
- letter of intent
- attendance list
- letters of recommendation (2, professional)
- final evaluations by parents
- session protocols for 18 sessions minimum (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 DVD will get you to your certification goal much faster!

3

THE INCREDIBLE YEARS® SERIES

A Developmental Approach

Carolyn Webster-Stratton

Introduction

Rates of clinically significant behavioral and emotional problems are as high as 6–15% in children aged 3–12 years (Egger & Angold, 2006; Sawyer et al., 2000). These numbers are even higher for children from economically disadvantaged families (Webster-Stratton & Hammond, 1998). Young children with early-onset behavioral and emotional difficulties are at increased risk of developing severe adjustment difficulties, conduct disorders, school drop-out, violence, and substance abuse in adolescence and adulthood (Costello, Foley, & Angold, 2006; Egger & Angold, 2006). However, the good news is that research has consistently indicated that early intervention with evidence-based parent, teacher, and child programs can prevent and reduce the development of conduct problems, strengthen social and emotional competence and school readiness, and, in turn, prevent later development of secondary risk factors such as school underachievement and deviant peer groups (Kazdin & Weisz, 2010; Snyder, 2001).

Multiple risk factors contribute to young children's behavioral and emotional problems, including: ineffective parenting (e.g., harsh discipline, low parent involvement in school, neglect and low monitoring; Jaffee, Caspi, Moffitt, & Taylor, 2004); family risk factors (e.g., marital conflict, parental drug abuse, mental illness, and criminal behavior; Knutson, DeGarmo, Koeppl, & Reid, 2005); child biological and developmental risk factors (e.g., attention deficit hyperactivity disorders (ADHD), learning disabilities, and language delays); school risk factors (e.g., poor classroom management, high levels of classroom aggression, large class sizes, and poor school–home communication); and peer and community risk factors (e.g., poverty and gangs; Collins, Maccoby, Steinberg, Hetherington, & Bornstein, 2000). Effective interventions for preventing and

Webster-Stratton, C., The Incredible Years series: a developmental approach. In Family-Based Prevention Programs for Children and Adolescents. M. Van Ryzin, K. Kumpfer, G. Fosco, & M. Greenberg, Editors. 2016, Psychology Press.

reducing behavior problems ideally target multiple risk factors and are best offered as early as possible.

Need for Early Intervention

Extensive research over the past 30 years has consistently demonstrated the links between child, family, and school risk factors and the subsequent development of antisocial behaviors. Several prominent researchers (e.g., Dishion & Piehler, 2007; Dodge, 1993; Moffitt, 1993; Patterson, Reid, & Dishion, 1992; Patterson & Fisher, 2002) have helped coalesce this literature into strongly supported theories about the development of antisocial behaviors, which in combination with developmental theory have had some obvious implications for interventions. First, early intervention timed to key child developmental periods is critical. Treatment-outcome studies suggest that interventions for conduct disorders (CD) are of limited effect when offered in adolescence, after delinquent and aggressive behaviors are entrenched and secondary risk factors have developed, such as academic failure, school absence, substance abuse, and the formation of deviant peer groups (Dishion & Piehler, 2007; Offord & Bennet, 1994). Second, effective interventions need to target multiple risk factors across various settings. The increased treatment resistance in older CD probands results in part from delinquent behaviors becoming embedded in a broader array of reinforcement systems, including those at the family, school, peer group, neighborhood, and community levels (Lynam et al., 2000). Moreover, a recent Cochrane review by Furlong and colleagues (Furlong et al., 2010) showed that group-based parenting programs improve child behavior problems (whether measured independently or by parents) not only because they strengthen parenting skills but because they also improve parental mental health due to the support provided by the group. This suggests the added value of programs that reduce participant isolation and stigmatization and increase their support networks.

For these reasons, the Incredible Years® (IY) Series, a set of interlocking and comprehensive group training programs, was designed to prevent and treat behavior problems when they first begin (infancy–toddlerhood through middle childhood) and to intervene in multiple areas and settings through parent, teacher, and child training. Early intervention across multiple contexts can counteract malleable risk factors and strengthen protective factors, thereby helping to prevent a developmental trajectory toward increasingly aggressive and violent behaviors in later life. The model's hypothesis is that improving protective factors such as responsive and positive parent–teacher–child interactions and relationships as well as group support will lead to improved school readiness, emotion regulation, and social competence in young children. These short-term gains should, in turn, lead to increased academic achievement and reduced school drop-out, conduct disorders, and substance abuse problems in later life.

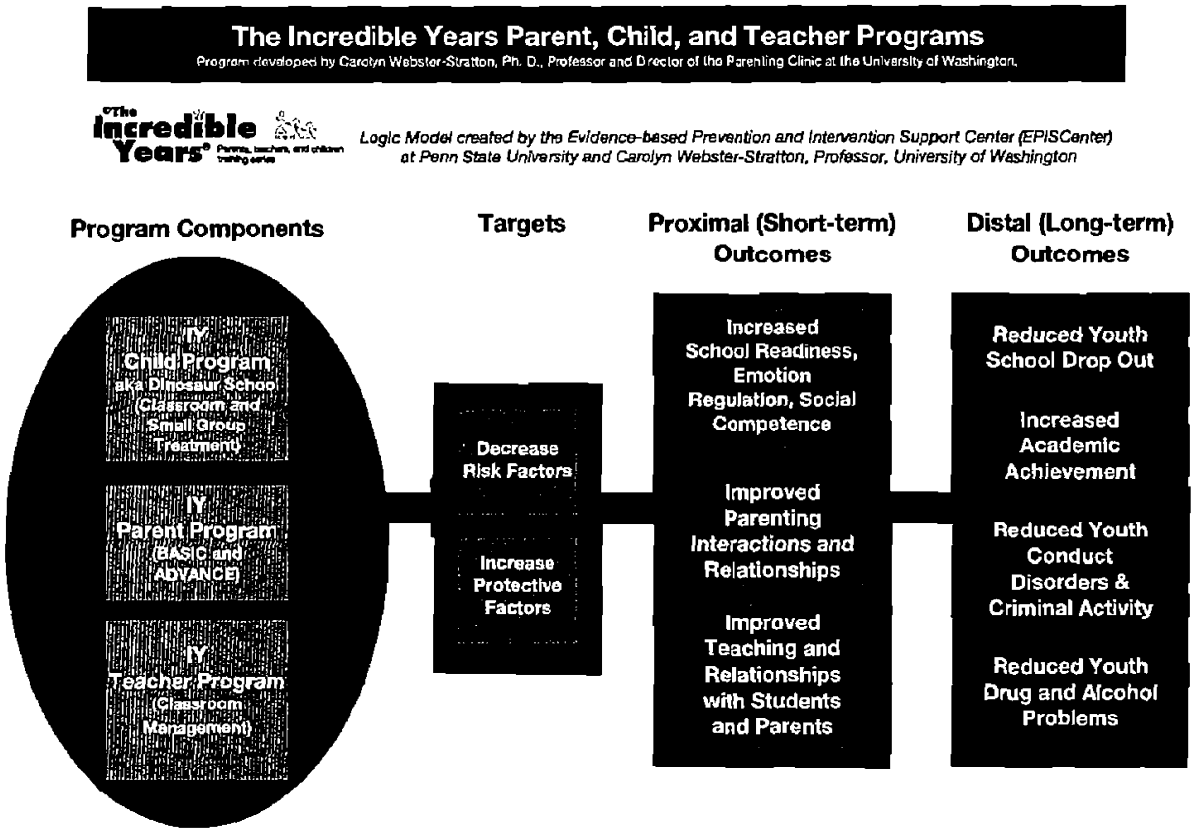


FIGURE 3.1 The Incredible Years® Parent, Child, and Teacher Programs. Source: www.incredibleyears.com

This chapter will focus on the underlying theoretical background for the IY Parent, Teacher, and Child Series. It will discuss four IY BASIC parent programs (baby, toddler, preschool, and school-age) that are considered "core" and a necessary component of the selective prevention model for young children. In addition it will discuss how the other IY adjunct parent, teacher, and child programs are added to address family risk factors and children's developmental issues as well as several IY programs designed for universal delivery. Information regarding IY program content and delivery methods will be briefly described, along with research evidence and ways to promote successful delivery of the programs. More information regarding specific program objectives can be found on the web site: http://incredibleyears.com/?s=objectives.

Theoretical Background for Incredible Years® (IY) Parent, Teacher, and Child Program Content and Methods

The main underlying theoretical background for the parent, teacher, and child programs includes:

- Cognitive social learning theory, and in particular Patterson's "coercion hypothesis" of negative reinforcement developing and maintaining deviant behavior (Patterson et al., 1992).
- Bandura's modeling and self-efficacy theories (Bandura, 1986).
- Piaget's developmental cognitive learning stages and interactive learning method (Piaget & Inhelder, 1962).
- Cognitive strategies for challenging angry, negative and depressive self-talk, and increasing parent self-esteem and self-confidence (Beck, 1979; D'Zurilla & Nezu, 1982; Jacobson & Margolin, 1979).
- Attachment and relationship theories (Ainsworth, 1974; Bowlby, 1980).

Program Content

Content goals for each individual parent, teacher, and child program will be described in more detail later in this chapter. However, it is important to note that all the IY programs include goals for promoting positive parent–teacher–child relationships and avoiding "coercion traps" by attending more to positive than negative child behavior, as first described by Patterson (Patterson, Reid, Jones, & Conger, 1975). The content taught in each program is adjusted according to children's cognitive developmental learning stage (Piaget & Inhelder, 1962). For example, program protocols for children aged 3–5 years focus more on coaching methods for enhancing social and emotional language and development, predictable routines, and school readiness skills. School-age protocols include incentives to motivate target behaviors, problem-solving training, and ways to support children's success in school. All the programs help

parents, teachers, and children learn how to challenge negative thoughts and replace them with more positive coping thoughts, positive imagery, and self-regulation strategies in order to build their self-confidence and self-efficacy (Bandura, 1989; Beck, 2005). All of the programs help build parent, teacher, or child support networks.

Program Methods

Bandura's (1977) cognitive social learning, modeling, and self-efficacy theories underlie the delivery method for all the IY programs. Advocates of video-based modeling techniques contend that observation of a model on video can support the learning of new skills. The IY programs make use of this teaching method by showing participants vignettes of parents, teachers, and children from different cultural backgrounds in a variety of home, school, and playground interactions. Some vignettes show effective interaction, while others represent less effective interactions. Trained group leaders use the vignettes to engage participants in focused group discussion, self-reflection, experiential practices, collaborative learning, and emotional support. During these discussions, group leaders help participants identify key "principles" from the vignettes, and apply them to their personal goals. Behavioral rehearsal is also a key component of the program; parents receive coaching while they practice new skills in scenarios that are tailored to their own goals and situations. Previous research indicates that participants tend to implement interventions with greater integrity when they are coached and given feedback on their use of the intervention strategies (Reinke, Stormont, Webster-Stratton, Newcomer, & Herman, 2012; Stormont, Smith, & Lewis, 2007). After learning and practicing new strategies in the group, participants make decisions about how they will apply the ideas to address their personal goals in their homes or classrooms.

All the IY programs use a group-based learning method that has several advantages. First, group intervention is more cost-effective than individual intervention. It also addresses important risk factors for children with behavior problems, including the family's isolation and stigmatization, the teacher's sense of frustration and blame, and children's feelings of loneliness or peer rejection. The group provides participants with a much needed support network. Another benefit of the group format is that it helps reduce resistance to the intervention through motivational interviewing principles (Miller & Rollnick, 2002) and use of the collective group wisdom. Rather than receiving information solely from an expert, participants are given the opportunity to interact with each other. When participants express beliefs counter to effective practices, the group leader draws on others to express other viewpoints. Through this discourse, the group leader is able to elicit change talk from the participants themselves, which makes it more likely they will follow through on intended changes. When group leaders position themselves in the "expert model" arguing for change, it

is more likely to cement the attitudes of participants who are resistant to the intervention (see Miller & Rollnick, 2002). On the other hand, video vignettes allow group leaders to elicit behavioral principles from the participants' insights and serve as the stimulus for collaborative learning, practice exercises, and building self-efficacy.

Group leaders always operate within a collaborative context that is designed to ensure that the intervention is sensitive to individual cultural differences and personal values. The program is "tailored" to the individual needs and personal goals of each parent, teacher, or child, as well as to each child's personality, developmental ability, and behavior problems. 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, 2012a).

Incredible Years® Core Parent Programs

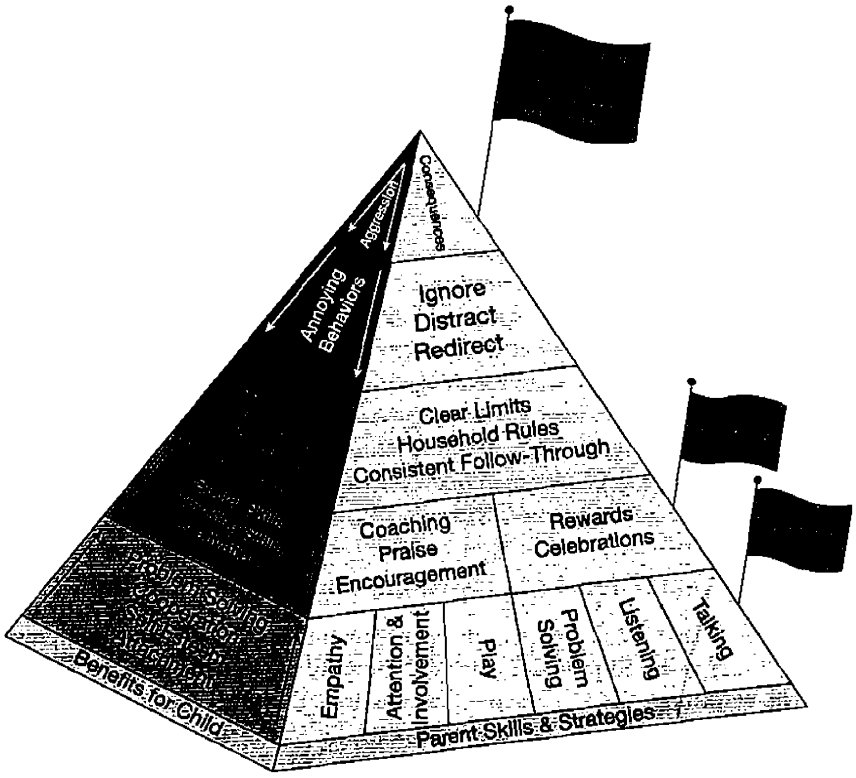
The BASIC (core) parent training consists of four different curricula designed to fit the developmental stage of the child: Baby Program (4 weeks to 9 months), Toddler Program (1–3 years), Preschool Program (3–5 years), and School-Age Program (6–12 years). Each of these recently updated programs emphasizes developmentally appropriate parenting skills and includes age-appropriate video vignettes of culturally diverse families and children with varying temperaments and developmental issues. Trained and accredited IY group leaders/clinicians meet weekly for 2 hours with groups of 10–12 parents and use selected DVD vignettes to trigger discussions, problem solving, and practices. The number of weekly sessions ranges from 10 to 24 weeks, depending on which of the four curricula is selected and whether the group leader is following the prevention or high risk and treatment session protocols (see web site for protocols). The program protocol for high-risk populations such as socioeconomically disadvantaged families or those families whose children are diagnosed with Oppositional Defiant Disorder (ODD) or ADHD is longer than protocols for the prevention population. It is recommended that the group leader show at least the minimum number of recommended sessions for the population addressed and that they pace the learning according to family goals, needs, and progress. Frequently, several additional sessions are needed in order to complete the curriculum.

While participation in the group-based IY training program is highly recommended because of the support and learning provided by other parents, there is also a *Home-based Coaching Model* for each parenting program. These home-based sessions can be offered to parents who cannot attend groups, as make-up when parents miss a group session, or to supplement the group program for very high-risk families such as those referred by child welfare. Adding the individualized home-based program alongside the group delivery

gives home coaches a chance to supplement group training with additional vignettes and to practice key skills in targeted parent–child interactions.

Goals of each the four programs are tailored specifically to the targeted age group and developmental stage of the child and include: (a) promoting parent competencies and strengthening families by increasing positive parenting, parent–child attachment, and parenting self-efficacy; (b) increasing parents' ability to use child-directed play interactions to coach children's social-emotional, academic, verbal, and persistence skills; (c) reducing critical and physically violent discipline and increasing proactive discipline strategies such as ignoring and redirecting, logical consequences, time-out to calm down, and problem solving; (d) increasing family support networks; and (e) strengthening home–school bonding and parents' involvement in school-related activities and connections with teachers.

The Incredible Years Parenting Pyramid® serves as the architectural plan for delivering content and is used to describe the program content structure. It helps parents conceptualize effective parenting tools and how these tools will help them achieve their goals. The bottom of the pyramid depicts parenting tools that are used liberally, as they form the foundation for children's emotional, social, and academic learning. The base of the pyramid includes tools such as 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, persist with learning despite obstacles, and develop friendships. One step further up the pyramid, parents are taught behavior-specific praise, incentive programs, and celebrations for use when goals are achieved. Next, parents discuss the use of predictable routines and household rules which scaffold children's exploratory behaviors and their drive for autonomy. The top half of the pyramid teaches parenting tools that are used more sparingly, to reduce specific targeted behaviors. These include proactive discipline tools such as ignoring inappropriate behaviors, distraction, and redirection. Finally, at the very top of the pyramid are more intrusive discipline tools such as time out to calm down and logical consequences. After the top of the pyramid is reached, the last part of the training focuses on how parents can come back down to the base of the pyramid. This refocuses parents on positive and proactive strategies for teaching children to problem solve, self-regulate, and manage conflict. At this point parents have all the necessary tools to navigate some of the challenging, but inevitable, aspects of their interactions with their children. A basic premise of the model is twofold: first, a positive relationship foundation must precede clear and predictable discipline strategies. This sequence of delivery of content is critical to the program's success. Second, 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.



Parenting Pyramid®

FIGURE 3.2 Parenting Pyramid®. Source: www.incredibleyears.com

Incredible Years® Adjuncts to Parent Programs

In addition to the four core BASIC parenting programs, there are also supplemental or adjunct parenting programs which can be used in combination with BASIC for particular populations. The ADVANCE parenting program is offered after completion of the BASIC preschool or school-age programs (using selective and indicated protocols). The program is designed for selective high-risk populations such as child welfare-referred families and for indicated populations such as parents with children diagnosed with ODD and ADHD. This 10–12 week program focuses on parents' interpersonal risk factors such as anger and depression management, effective communication, ways to give and get support, problem solving between adults, and ways to teach children problem-solving skills. The content of both the BASIC and ADVANCE

programs is also provided in the text that parents use for the preschool and school-age programs, titled *The Incredible Years: A Troubleshooting Guide for Parents* (Webster-Stratton, 2005; Webster-Stratton & Reid, 2006).

A second optional adjunct training is the *School Readiness Program* for children aged 3–4 years that was designed as a universal intervention to help parents support their children's preliteracy and interactive reading readiness skills. A third optional adjunct is the *Attentive Parenting Program* for children aged 2–8 years. This group program was also designed as a universal prevention program to teach all parents social, emotional, and persistence coaching, and ways to promote their children's reading skills, self-regulation skills, and problem-solving skills. The *Attentive Parenting Program* is not designed for parents of children with behavior problems, although can be used for this population after the BASIC Toddler or Preschool parenting program is completed and parents have learned the basic parenting tools. Finally, the most recent *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.

Incredible Years® Teacher Classroom Management Program

The Incredible Years® Teacher Classroom Management (IY-TCM) training program is a 6-day group-based program delivered monthly by accredited group leaders in small workshops (14–16 teachers) throughout the school year in order to provide teachers of children aged 3–8 years with ongoing support. There is also a program for teachers and day care providers of toddlers (1–3 years) called Incredible Beginnings. It is also recommended that trained IY coaches support teachers between workshops by visiting their classrooms, helping refine behavior plans, and addressing teacher goals. The goals of the teacher training program are: (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. A complete and recently updated description of the content included in this curriculum is described in the book that teachers use for the course, titled *Incredible Teachers: Nurturing Children's Social, Emotional and Academic Competence* (Webster-Stratton, 2012b). More information about the training and delivery of the IY teacher program can be found elsewhere (Reinke et al., 2012; Webster-Stratton & Herman, 2010).

Incredible Years® Child Programs (Dinosaur Curricula)

There are two versions of the IY child program. In the universal prevention classroom version, teachers deliver 60+ social-emotional lessons and small group

activities twice a week, with separate lesson plans for preschool to second grade. The second version is a therapeutic treatment group where accredited IY group leaders work with groups of 4–6 children in 2-hour weekly sessions. Children referred to this program may include those with externalizing or internalizing problems or developmental delays. The therapeutic version of the program can be offered in a mental health setting (often delivered at the same time as the BASIC parent program) or can be delivered as a pull-out program during the school day. Program content is delivered using a series of DVD programs (over 180 vignettes) that teach children feelings literacy, social skills, emotional self-regulation skills, the importance of following school rules, and problem solving. Large puppets are used to bring the material to life, and children are actively engaged in the material through role play, games, and activities. Organized to dovetail with the content of the parent training program, the program consists of seven main components: (1) Introduction and Rules; (2) Empathy and Emotion; (3) Problem Solving; (4) Anger Control; (5) Friendship Skills; (6) Communication Skills; and (7) School Skills. More information about the child programs can be found in other reviews (Webster-Stratton & Reid, 2003, 2004).

Evidence Supporting the Incredible Years® Parent Programs

Treatment and Indicated Populations

The efficacy of the IY BASIC parent treatment program for children (aged 2–8 years) diagnosed with ODD/CD has been demonstrated in eight published randomized control group trials (RCTs) by the program developer plus numerous replications by independent investigators (see review on web site http://incredibleyears.com/books/iy-training-series-book/).

In the early studies with indicated populations, the BASIC program was shown to improve parental confidence, increase positive parenting strategies, and reduce harsh and coercive discipline and child conduct problems compared to wait-list control groups (moderate to large effect sizes). The results were consistent for toddler, preschool, and school-age versions of the programs. The first series of RCTs evaluated the most effective training methods of bringing about parent behavior change. The video-based parent group discussion training approach (BASIC) was compared with the one-on-one personalized "bug in the ear" approach and a control group. Results indicated that the video-based discussion approach was as effective as the one-on-one parent–child training approach but far more cost-effective and had more sustained results at one-year follow-up (Webster-Stratton, 1984b). In the next study, treatment component analyses compared three training methods: group discussion alone without video led by a trained clinician, group discussion plus video with a trained clinician, self-administered video with no clinician, and a control group. Results

indicated that the combination of group discussion, a trained clinician, and video modeling produced the most effective and lasting results (Webster-Stratton, Hollinsworth, & Kolpacoff, 1989; Webster-Stratton, Kolpacoff, & Hollinsworth, 1988). Next, the self-administered video program was compared with and without clinician consultation. Both programs showed significant improvements and there were few outcome differences, except that parent satisfaction was higher for the consultation condition (Webster-Stratton, 1992). Subsequently, a study was conducted to determine the added benefits of combining the ADVANCE program (focused on interpersonal parent problems such as depression and anger management) with the BASIC program (Webster-Stratton, 1994). Results indicated that the combined program had greater improvements in terms of parents' marital interactions and children's prosocial solution generation in comparison to the BASIC-only treatment condition families. As a result, the combined BASIC plus ADVANCE programs became the core treatment for parents of children diagnosed with ODD and/or ADHD, and has been used for treatment studies in the last two decades.

Other investigators have replicated the BASIC program's results with indicated and treatment populations in mental health clinics or doctors' offices with families of children diagnosed with conduct problems or high levels of behavior problems (Drugli & Larsson, 2006; Gardner, Burton, & Klimes, 2006; Lavigne et al., 2008; Perrin, Sheldrick, McMenamy, Henson, & Carter, 2014; Scott, Knapp, Henderson, & Maughan, 2001; Spaccarelli, Cotler, & Penman, 1992; Taylor, Schmidt, Pepler, & Hodgins, 1998). A recent meta-analytic review examined the IY parent training programs regarding disruptive and prosocial behavior in 50 studies where the IY intervention group was compared with a control or comparison group. Results were presented for treatment populations as well as indicated and selective prevention populations. Findings reported the program to be successful in improving child behavior in a diverse range of families, especially for children with the most severe problems, and the program was considered "well-established" (Menting, Orobio de Castro, & Matthys, 2013).

Several studies have also shown that IY treatment effects are durable 1–3 years post-treatment (Webster-Stratton, 1990). Two long-term follow-up studies evaluated families whose children were diagnosed with conduct problems and had received treatment with the IY parent program 8–12 years earlier. One study indicated that 75% of the teenagers were typically adjusted with minimal behavioral and emotional problems (Webster-Stratton, Rinaldi, & Reid, 2010). A recent study by an independent investigator reported that parents in the IY BASIC parent condition expressed greater emotional warmth and supervised their adolescents more closely than parents in the control condition who had received individualized "typical" psychotherapy offered at that time. Moreover, treatment children's reading ability was substantially improved in a standardized assessment compared with the "usual services" control condition children (Scott, Briskman, & O'Connor, 2014).

Selective Prevention Populations

Additionally, four RCTs have been conducted by the developer using the selective prevention version of the BASIC program with multiethnic, socioeconomically disadvantaged families in schools (Reid, Webster-Stratton, & Beauchaine, 2001; Webster-Stratton, 1998; Webster-Stratton, Reid, & Hammond, 2001a). Results showed that children whose mothers received the BASIC program showed fewer externalizing problems, better emotion regulation, and stronger parent–child bonding than mothers of control children. Mothers in the parent intervention group also showed more supportive and less coercive parenting than control mothers (Reid, Webster-Stratton, & Hammond, 2007).

At least six RCTs by independent investigators with selective prevention populations have found that the BASIC parenting program increases parents' use of positive and responsive attention (praise, coaching, descriptive commenting) and positive discipline strategies with their children, and reduces harsh, critical, and coercive discipline strategies (for review, see Webster-Stratton & Reid, 2010). These replications were "effectiveness" trials in applied mental health settings, schools, and doctors' clinical practices, not a university research clinic, and the IY group leaders were existing staff (nurses, social workers, and psychologists) at the centers or doctors' offices (Perrin et al., 2014). The program has also been found to be effective with diverse populations including those representing Latino, Asian, African American, and Caucasian background in the United States (Reid et al., 2001), and in other countries such as the United Kingdom, Ireland, Norway, Sweden, Holland, New Zealand, Wales, and Russia (Gardner et al., 2006; Hutchings et al., 2007; Larsson et al., 2009; Raaijmakers et al., 2008; Scott, Spender, Doolan, Jacobs, & Aspland, 2001; Scott et al., 2010). These findings illustrate the transportability of the BASIC parenting program to other cultures and countries.

To date, one RCT has been conducted by an independent investigator in Norway using a briefer version of the BASIC Preschool Program with a universal, non-high-risk population that has shown promising results (Reedtz, 2010). Another Norwegian study using the *Attentive Parenting Program* as a universal delivery is currently being evaluated. Finally, a pilot study in Wales evaluated the *School Readiness Program* as a universal program for parents in schools, with promising results (Pye, Bywater, & Hutchings, in preparation).

Evidence Supporting the Incredible Years® Child Programs as an Adjunct to IY Parent Programs

Indicated Prevention and Treatment Populations

Three RCTs have evaluated the effectiveness of combining the small-group child-training (CT) program with the parent training (PT) to reduce conduct

problems and promote social and emotional competence in children diagnosed with ODD/CD (Webster-Stratton & Hammond, 1997; Webster-Stratton, Reid, & Hammond, 2004). Results indicated that children who received the CT-only condition showed greater improvements in problem-solving and conflict-management skills with peers compared to those in the PT-only condition (moderate to large effect sizes). On measures of parent and child behavior at home, the PT-only condition resulted in more positive parent–child behavioral interactions in comparison to interactions in the CT-only condition. One-year follow-up assessments indicated that all the changes noted immediately post-treatment were maintained over time. Moreover, child conduct problems at home had decreased over time. Analyses of the clinical significance of the results suggested that the combined CT + PT condition produced the most sustained improvements in child behavior at one-year follow-up. For this reason, the CT program was combined with the PT program in a recent study for children diagnosed with ADHD. Results replicated the earlier studies with children with ODD (Webster-Stratton, Reid, & Beauchaine, 2011). There has only been one RCT of the CT small-group program conducted by an independent investigator (Drugli & Larsson, 2006).

Selective Prevention Populations

One RCT has evaluated the classroom prevention version of the child program with Head Start families and primary grade classrooms in schools addressing economically disadvantaged populations. Matched schools were randomly assigned to intervention or control conditions. In the intervention classrooms, teachers offered the curriculum in biweekly sessions throughout the year. Results from multi-level models of reports and observations of 153 teachers and 1,768 students indicated that teachers used more positive management strategies and their students showed significant improvements in school readiness skills, emotional self-regulation, and social skills, and reductions in classroom behavior problems. Intervention teachers showed more positive involvement with parents than control teachers. Satisfaction with the program was high, regardless of the grade levels (Webster-Stratton, Reid, & Stoolmiller, 2008). A subsample of parents of indicated children (due to high levels of behavior problems by teacher or parent report) were selected and randomly offered either the combined parent program plus classroom intervention, classroom-only intervention, or control group. Mothers in the combined condition reported their children had fewer behavior problems and more emotional regulation than parents of children in the classroom-only or control conditions. Mothers in the combined condition had stronger mother–child bonding and were more supportive and less critical than the classroom-only or control conditions. Teachers reported that mothers in the combined condition were significantly more involved in school and their children had fewer behavior problems. This

study indicates the added value of combining a social and emotional curriculum for students in the classroom with the IY parent program in schools (Reid et al., 2007).

Evidence Supporting Incredible Years® Teacher Classroom Management (IY-TCM) Program as an Adjunct to IY Parent Programs

The IY-TCM program has been evaluated in one treatment (Webster-Stratton et al., 2004) and two prevention RCTs (Webster-Stratton et al., 2001a; Webster-Stratton et al., 2008) and five RCTs by independent investigators (for review, see Webster-Stratton, 2012c). 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, higher levels of child social competence and school readiness skills, and lower levels of aggressive behavior (moderate to large effect sizes). In a study where BASIC parent alone treatment was compared with a treatment condition that combined BASIC with the IY-TCM teacher training program and with the combination of BASIC plus IY-TCM plus CT programs, the results indicated that combining IY-TCM and/or CT programs with BASIC parent training resulted in greater improvements in classroom behaviors as well as more positive parent involvement in their child's education. A recent study has replicated the benefits of the IY-TCM program alone for enhancing parent involvement in their children's education (Reinke et al., 2014).

Factors Affecting Intervention Outcomes

In addition to studying the specific training methods (group support vs. self-administered video vs. combined video plus group support) and the benefits of adding adjunct components to the IY Basic Parenting Series programs (advance parenting, teacher, and child training), over the past 30 years a number of studies have been conducted to determine mediators, moderators, and predictors of outcomes. For example, parental and familial factors such as life stress, depression, marital adjustment, socioeconomic status, parental age, ethnicity, and history of substance abuse (Beauchaine, Webster-Stratton, & Reid, 2005; Hartman, Stage, & Webster-Stratton, 2003; Reid et al., 2001; Webster-Stratton & Hammond, 1990), father involvement in treatment (Webster-Stratton, 1984a) and intergenerational family psychiatric history of antisocial behavior (Presnall, Webster-Stratton, & Constantino, 2014) have been analyzed in regard to treatment response. Additionally, child risk factors such as age, gender, psychiatric comorbidity, degree of externalizing problems, and comorbidity with attentional

factors (Hartman et al., 2003; Webster-Stratton, 1996; Webster-Stratton, Reid, & Hammond, 2001b) and anxiety/depression (Beauchaine et al., 2005) as well as physiological measures of cardiac activity and reactivity (Beauchaine et al., 2013) were also analyzed. In general, results indicated the beneficial effectiveness of IY parent programs irrespective of family variables. Counter to expectation, one study showed better long-term child outcomes with younger mothers and those with a history of parental substance abuse (Beauchaine et al., 2005). Moreover, the IY programs were equally effective regardless of child gender, age, or comorbidity with attentional problems (Hartman et al., 2003) or anxious depression scores (Beauchaine et al., 2005). However, critical, harsh, and ineffective parenting both predicted and mediated outcomes at one-year follow-up (Beauchaine et al., 2005) and long-term follow-up (Webster-Stratton et al., 2010). These findings suggest that specific parenting goals should be achieved before the parent program is discontinued, or that parents who still have high levels of coercive parenting (despite improvements from baseline) should be selected for continued treatment with the advance parent program until therapeutic effectiveness has been achieved.

Implementation with Fidelity

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 eliminated or program dosage is reduced, necessary resources are not available, or group leaders are not trained or supported with accredited mentors), then the absence of effects may be attributed not to the inefficacy of the program but to a lack of fidelity in its implementation (Hutchings et al. 2007). Recent research with the Incredible Years® BASIC parenting program shows that implementation with a high degree of fidelity 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).

One important aspect that facilitates the application of a program with fidelity is the standardization of program content, structure, processes, methods, and materials. In Incredible Years®, all components relating to the implementation of the program content are described in detail in DVDs and manuals, which also lay out the basic theoretical and empirical elements of each part of the program. For Weisz (2004), one of the main advantages of the Incredible Years® program, from the point of view of clinical practice, is precisely the program's accessibility for clinical use, along with its appealing nature and low abandonment rates.

In the context of implementation with fidelity, the training and supervision of group leaders warrants great attention (Webster-Stratton, 2004). First,

carefully selected and motivated group leaders receive three days of training by accredited mentors before leading their first group of parents or teachers. Then, it is highly recommended they continue with ongoing consultation with IY coaches and/or mentors as they proceed through their first group. They are encouraged to start videotaping their sessions and to review these videos with their co-leader using the group leader checklist and peer review forms (Webster-Stratton, 2004). It is also recommended that they send these videos for outside coaching and consultation by an accredited IY coach or mentor as soon as possible. Group leaders find this video review immensely helpful and supportive.

The process of group leader accreditation is demanding, involving the leadership of at least two complete groups, video consultation, and a positive final video-based group assessment by an accredited mentor or trainer as well as satisfactory completion of group leader session protocols and weekly participant evaluations. This process ensures that leaders are delivering the program with fidelity, which includes both content delivery (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 IY mentors and trainers. A recent RCT has shown that providing group leaders with ongoing consultation and coaching following the three-day workshop leads to increased group facilitator proficiency, program adherence, and delivery fidelity (Webster-Stratton, Reid, & Marsenich, 2014).

Planning and Implementation of IY Programs According to Risk Level of Population

The BASIC parent program (baby, toddler, preschool, or school-age version) is considered a mandatory or a "core" component of the prevention intervention training series. The ADVANCE program is offered in addition to the BASIC program for selective populations such as families characterized as depressed or 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 also recommended that the child Dinosaur program and/or teacher training program be offered in conjunction with the parent training program to assure 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.

Again, the pyramid is used to depict the levels of intervention according to risk level of populations. As seen in Figure 3.3, Levels 1 and 2 are the foundation of the pyramid and recommend a series of programs that could be offered *universally* to all parents of young children (0–6 years). These programs could be offered in pediatricians' offices, Head Start programs, day care centers, preschools,

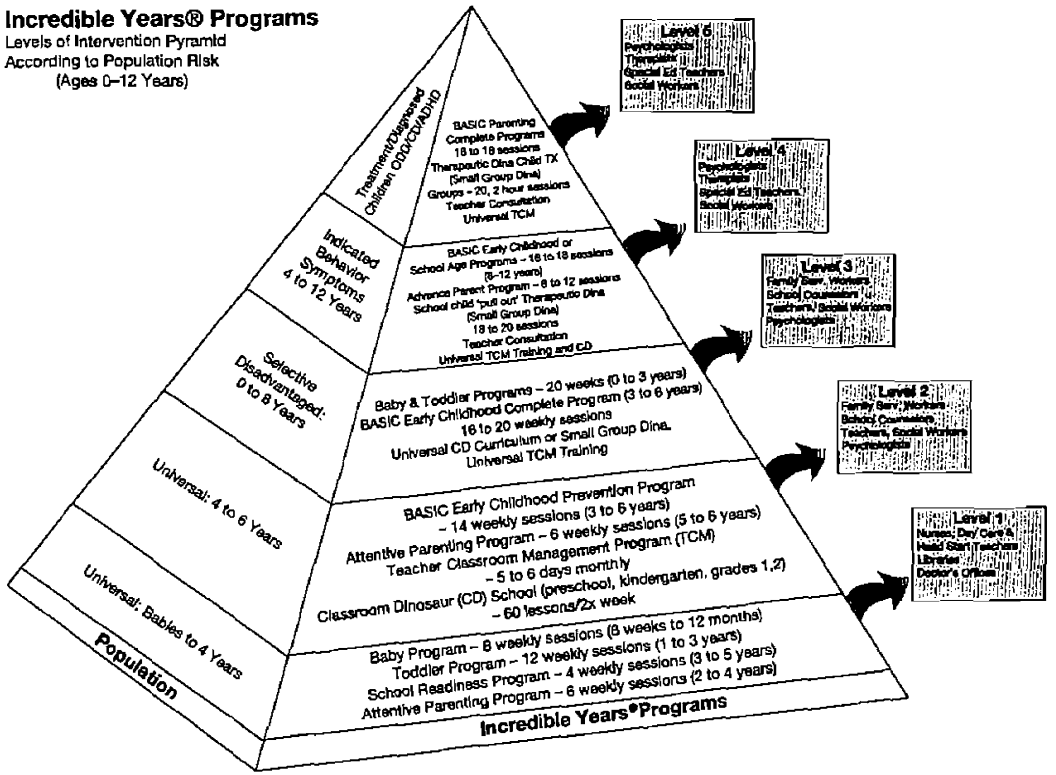


FIGURE 3.3 Incredible Years® Programs: Levels of Intervention Pyramid According to Popular Risk (Ages 0–12 Years). Source: www.incredibleyears.com

or elementary schools. The group format is a cost-efficient way of disseminating information to large numbers of people as a strategy to optimize positive parent–child interactions and to strengthen children's social and emotional competence and school readiness so that they are ready to start the next phase of their education.

Once children are in day care or preschool, providing universal supports for all children at this young age includes enhancing the capacity of day care, preschool, and Head Start teachers to provide structured, warm, and predictable environments. Thus, level 2 also involves training all early childhood teachers in effective classroom management strategies using the IY-TCM Program. After this training is completed, teachers also have the opportunity to receive training to deliver the child Dinosaur curriculum as a universal social skills intervention. This includes three different sets of lesson plans for preschool, kindergarten, and grades 1 and 2. Ideally, children receive this curriculum for three subsequent years, resulting in a strong emotional and social foundation by the time they are seven years old. This social and emotional competence is theorized to contribute to higher academic competence as children progress through school.

Level 3 is targeted at *"selective" or high-risk populations.* These are populations that are socioeconomically disadvantaged and highly stressed because of increased risk factors such as parental unemployment, low education, housing difficulties, single parenthood, poor nutrition, maternal depression, drug or alcohol addiction, child deprivation, new immigrant status, or lack of academic preparedness for school. These economically disadvantaged parents would benefit from the complete baby, toddler, and early childhood parent programs because of the ongoing support provided in the groups, the hope for change shown to them by group leaders, as well as their experiential learning that despite economic obstacles they can provide the best early years of emotional, social, and cognitive parenting possible for their children. In addition, the teachers and child care providers of these children could receive the IY-TCM program so that they are skilled at managing classroom behavior problems, which are exhibited at higher rates in this population. Lastly, children in these families aged 3–8 years would benefit from the child Dinosaur program at least twice a week year-round. This investment in building the social and emotional abilities in the first eight years of life for these vulnerable children can help to break the intergenerational transmission of disadvantage.

Level 4 on the pyramid is targeted at *"indicated populations"*, where children or parents are already showing symptoms of mental health problems. This could include, for example, 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, or children who are highly aggressive but not yet diagnosed as having ODD or CD. As can be seen on the pyramid, this level of intervention is offered to fewer people and offers a longer and more intensive

parenting program by a higher level of trained professionals. These parents or caregivers would complete the entire age appropriate BASIC parenting program followed by the ADVANCE program.

The teachers of these children should receive the IY-TCM program and offer the child Dinosaur program. In addition to this classroom curriculum, children with symptoms of externalizing or internalizing problems or ADHD are targeted to be pulled out of class twice a week for the small group therapeutic Dinosaur program delivered by school psychologists, counselors, specially trained social workers, or special education teachers. These children will meet in small groups (4–6 children) to get extra coaching and practice with social skills, emotional regulation, persistence coaching, literacy, and problem solving. This will reinforce the classroom learning of the program and will send these children back to a classroom where peers understand how to respond more positively to their special needs. In other words, the whole classroom community has learned solutions to how to respond to a peer who may be aggressive or one who is sad, withdrawn, or lonely.

Level 5 is the most comprehensive intervention, addressing multiple risk factors, and is usually offered in mental health clinics by therapists with graduate-level education in psychology, social work, or counseling. One of the goals of each of the prior levels is to maximize resources and minimize the number of children who will need these time- and cost-intensive interventions at level 5. At a minimum, the parents will receive the entire BASIC and ADVANCE curriculum for 24–28 weeks, while the children attend 2-hour weekly therapeutic Dinosaur groups at the same time. Therapists dovetail these two curricula and keep parents and teachers fully informed of the skills children are learning in their child groups so that they can reinforce these at home or in the classroom. Additionally, if parents need individual coaching in parent–child interactions, this can be provided in the clinic setting or in supplemental home visits using the home coaching protocols. Child and parent therapists work with parents to develop behavior problem plans and consult with teachers in partnerships to coordinate their plans, goals, and helpful strategies. Successful interventions at this level are marked by an integrated team approach with clear communication among all the providers and adult caregivers in the various settings where these children spend their time. Ideally mental health agencies would embody these services within schools, which allows for less stigmatization for parents, greater coordination with teachers regarding behavior plans, and more frequent pull-out groups for children.

Conclusion

Future directions for research on IY programs should include evaluating ways to promote the sustainability of results such as by targeting parents whose baseline or post-intervention parenting practices are particularly harsh or

ineffective with additional resources such as offering a greater number of sessions, additional program adjuncts such as IY Advance Program, or IY Child Program and ongoing booster sessions. Similarly research concerning matching children to appropriate treatment combinations is needed. For example, children could be assigned to treatment program conditions according to their particular comorbidity combinations. Our research suggests that children with ODD are comorbid for other diagnoses such as ADHD, depression or anxiety, language delays, and Autism Spectrum Disorder. Our initial findings suggest that children scoring high on Attention Problems or with ADHD will fare better when IY-TCM or CT components are added to the PT program. Further research is needed for identification of children for whom the current interventions are inadequate. Finally, our three newest IY Programs (Baby Program, Attentive Parenting Program, and Autism Program) are in need of RCTs to determine their effectiveness.

At a time when the efficient management of human and economic resources is crucial, the availability of evidence-based programs to parents and teachers should form part of the public health mission. While the IY programs have been shown in dozens of srudies to be transportable and effective across different contexts worldwide, barriers to fidelity of delivery impede the possibility for successful outcomes for parents, teachers, and children. The lack of sufficient funding has led to IY programs being delivered by group leaders without adequate training, sufficient support, coaching and consultation, and without agency monitoring or assessment of outcomes. Frequently, the programs have been sliced and diced and components dropped in order to offer the program in a dosage that can be funded. Few agencies support their group leaders to become accredited, and the program is often not sufficiently established 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. If we think of disseminating evidence-based programs like constructing a house, it is as if the contractors hired electricians and plumbers who were not certified, disregarded the architectural plan and used poor-quality, cheaper materials. Under these conditions, the building will not be structurally sound. Just like building a stable house, it is important that the foundation and basic structure for delivering evidence-based programs be strong. This will include picking the right evidence-based program for the level of population risk 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.

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Incredible partnerships: parents and teachers working together to enhance outcomes for children through a multi-modal evidence based programme

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Abstract

Purpose – *The purpose of this paper is to explore the utility of an evidence-based suite of programmes, The Incredible Years (IY), to enhance outcomes for children using a parent-teacher partnership model.*
Design/methodology/approach – *A review of the broad evidence base for the IY parent, teacher and child programmes, uniquely focusing on the inter-relationships between home and school contexts.*
Findings – *Evidence suggests that it is beneficial to parents, teachers and children to deliver IY programmes applying a multi-modal approach.*
Originality/value – *This paper, read in conjunction with other contributions in this volume, demonstrates the growing viability of partnership strategies that support children, their families and teachers to enhance school readiness, and promote positive child outcomes.*

Keywords *Child behaviour, Home learning environment, Incredible Years programmes, Parent-teacher partnership, School readiness, Social-emotional wellbeing*

Paper type *General review*

Received 22 February 2015
Revised 29 May 2015
27 July 2015
Accepted 27 July 2015

Conflicts of interest: Carolyn Webster-Stratton has disclosed a potential financial conflict of interest because she disseminates these programmes 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.

Professor Carolyn Webster-Stratton wishes to thank NIMH, NINR and NIDA for 30 years of funding to undertake this research. Professor Tracey Bywater's time is partially supported by NIHR CLAHRC Yorkshire and Humber (CLAHRC-YH).

Introduction

This paper introduces the initial importance of the home learning environment for promoting children's readiness to learn prior to attending school. When children enter nursery, and then primary school, supportive parent-teacher partnerships become important as they can impact on children's social and emotional development and wellbeing, academic readiness, learning and academic outcomes. These partnerships optimally begin in the pre-school years and continue in primary schools. Parents play a major role in developing children's school readiness (Lau *et al.*, 2011), and in forming children's good relationships with peers and teachers (Howes *et al.*, 2008). These relationships help children to settle into school, reduce conduct problems and lead to good academic attainment (Fantuzzo and McWayne, 2002).

The Incredible Years (IY) programmes are outlined and evidence is presented demonstrating how parents and teachers can work in partnership to enhance or improve child outcomes through delivery of the programmes in a multi-modal format. The main emphasis of the paper is on children in toddlerhood through to primary age, and the associated, age-appropriate, IY programmes.

Home learning environment

There is convincing evidence that children's early home experiences contribute to school readiness and school achievement, especially in language development (Sylva *et al.*, 2010). Children who grow up in homes with a nurturing, language-rich environment and positive parent[1]-child interactions show more school readiness with regards to social competence, emotional literacy, conflict management skills, language development, as well as later reading success and school attainment scores (Sylva *et al.*, 2008, 2010). Once children start nursery or primary school, positive parent-teacher relationships that support parental involvement in children's academic and social-emotional learning have further effects in promoting children's school engagement and academic achievement (Stormont *et al.*, 2013; Herman and Reinke, 2014).

In the UK the longitudinal Effective Provision of Pre-School Education (EPPE) project (Sylva *et al.*, 2008) demonstrated the importance of the home learning environment. A quality home learning environment, where parents are actively engaged in activities with children, promoted child intellectual and social development. Although parents' social class and levels of education were related to child outcomes, the quality of the home learning environment was found to be more important. One of the project's conclusions was that "what parents do (with their children) is more important than who they are".

Conversely, a stressful or non-nurturing home environment puts a child at risk for poor outcomes such as delayed language and academic readiness, delayed social development, conduct disorder (CD) and other unwanted behaviour such as school drop-out and drug abuse (Jaffee and Maikovich-Fong, 2011). Other family risk factors include poor parental supervision, inconsistent, neglectful or harsh discipline and a failure to set clear expectations for children's behaviour, poor parental mental health, parental conflict, social isolation, lack of support and family disruption (Farrington and Welsh, 2007).

Protective factors attenuate children's exposure to risk and include not only a strong bond of affection with a parent, but also their growing sense of feeling valued in school and the wider community (Farrington *et al.*, 2012). Reviews have concluded that association with parents, teachers and other adults who model healthy, pro-social standards of behaviour is protective (Anderson *et al.*, 2005).

Academic readiness

The quality of the home learning environment has the biggest impact on cognitive development, and has three times the impact on literacy than quality of pre-school attended (Sylva *et al.*, 2008). Although the EPPE project found that the home learning environment was more important than the social class of parents to promote positive child outcomes, there are distinct differences between high- and low-income families' language use in the home, which impact on child literacy. Ferguson (2005) found that parents with low income encourage their children less, adopt harsher parenting styles and are less engaged with their child's schoolwork. Similarly, Hart and Risley's (1992) study found parents with lower income said fewer different words in their cumulative monthly vocabularies to their children at age three years compared to the most economically advantaged families (500 vs 1,100), with higher income children hearing approximately three times the number of words per hour than their less advantaged counterparts, equating to a three vs 11 million words per year. The type of words and quality of interactions used in each income level showed startling differences with low-income children hearing a ratio of 5:11 positive to negative words and high-income children hearing 32:5.

More recently a US study by Fernald *et al*. (2013) demonstrated similar results showing by age three years low income children have heard 30 million fewer words than higher income children. If this language exposure gap continues through pre-school, by age five years children from lower income families are already two years behind their peers in vocabulary and school readiness skills. Since early vocabulary is connected to later success in reading comprehension, this language gap presents a barrier to these children's future academic learning achievement.

School influences

Outside of the home environment other factors such as geographical location and community factors, such as levels of disadvantage, can impact on child wellbeing. However, schools can

positively influence wellbeing through their ethos, organisation, teaching and disciplinary practices and pastoral care, thereby encouraging motivation to learn (Farrington and Welsh, 2007). Underachievement emerging during junior school is an important factor for negative life outcomes, with children who perform poorly more likely to truant, and be at risk of negative outcomes such as unemployment (Anderson *et al.*, 2005). Furthermore, language and reading delays contribute to the development of friendship problems, academic failure, school drop-out and conduct problems (Bennett *et al.*, 2003). Conversely conduct problems can contribute to poor academic readiness and a multitude of other negative outcomes as outlined below.

Conduct problems

The combination of the home and wider context that a child grows up in contributes to a child's mental health and behaviour. Negative experiences may result in a child displaying problematic behaviour. Conduct problems are the most common reason for referral for psychological and psychiatric treatment in childhood, and if left unchecked up to 40 per cent of children with early behavioural difficulties will develop CD (Coid, 2003). The prevalence of CD is reported to be 10 per cent in the USA and UK general population (Burke *et al.*, 2002; National Institute for Health and Clinical Excellence (NICE), Social Care Institute for Excellence, 2006).

Conduct problems include defiant, disruptive and aggressive antisocial behaviour, and if severe and persistent, a diagnosis of "early onset" (under ten years) CD may be given (based on ICD-10 or DSM-V criteria). Environmental, family, school and child risk factors contribute to the development of early onset CD, with higher rates found in disadvantaged areas (20 per cent) (Attride-Stirling *et al.*, 2000), among "looked-after" children (37 per cent) (Tapsfield and Collier, 2005), and in boys (2:1 boy to girl ratio) (Green *et al.*, 2004). Early onset conduct problems can lead to negative life outcomes including lack of academic success, criminal behaviour and psychiatric disorders, with increased costs to the education, health, social and criminal justice services (Bywater, 2012).

A recent Cochrane review (Furlong *et al.*, 2012) demonstrated that parenting programmes for three- to 12-year olds at risk of developing CD can promote positive parenting skills, reduce parental depression and stress and enhance child social and emotional wellbeing. Enhancing social and emotional wellbeing enables children to be more self-aware, to problem solve, to recognise their feelings, to be able to calm down more easily, to cooperate with peers and adult directions and therefore be more "ready" and able to learn at school (Webster-Stratton and Reid, 2004). Preventing and treating conduct problems in young children is a matter of public health importance and should begin as early as possible in the home learning environment, followed by home and education settings working in partnerships (Bywater, 2012).

Although parenting programmes are implemented nationally in the UK, it is sometimes difficult for parents to identify where to access this local support. A report by the Centre for Mental Health found parents frequently request advice from their child's teacher about managing their child's behaviour. However, the survey found that UK schools lack information around referral routes to support parents (Khan, 2014). Schools can be important pathway or "referral" routes for families to get additional parenting support delivered locally, or even to parent programmes delivered within the school. It is important that parents who need them receive evidence-based programmes as early as possible, although unfortunately there can be misunderstandings around what constitutes rigorous "evidence".

Recent moves in the UK, for instance the formation of the Early Intervention Foundation (EIF) (www.eif.org.uk/), the Education Endowment Foundation (http://educationendowmentfoundation.org.uk/) and the UK Implementation Network (www.uk-in.org.uk/) seek to promote high-quality implementation of evidence-based programmes, which generally have defined logic models, structured training models and quality materials to enable faithful delivery and replicability of outcomes across contexts. The EIF recently published a rapid review (Axford *et al*., 2015) of the evidence of several parent programmes across a variety of outcomes, rated on standards of evidence (results forthcoming), which should make it easier for commissioners to establish which programme is most effective for their local needs.

Appropriate interventions with proven logic models and robust evidence to reduce child risk factors and enhance protective factors are needed. One such intervention is the suite of IY® programmes for parents, teachers and children, as presented in the logic model (Figure 1), building blocks diagram (Figure 2) and detailed in the following sections.

The logic model indicates "school readiness" and "parent/home – teacher/school partnerships" as short-term outcomes with "academic attainment" as a distal outcome. IY has theoretical underpinnings from social learning theory, and the programmes incorporate identified effective components for behaviour change (NICE, Social Care Institute for Excellence, 2006; Hutchings *et al.*, 2004), including a collaborative model of participant engagement, behaviour modelling and practice (making full use of rewards and praise), with the emphasis on building positive relationships.

Incredible Years®

The core parent programmes

The IY BASIC (core) parent training consists of four different currciulum designed to fit the developmental stage of the child: Baby programme (one to nine months), Toddler Programme (one to three years), Pre-school programme (three to five years) and School-Age programme (six to 12 years) (see bottom row of Figure 2). Each of these programmes emphasises developmentally appropriate parenting skills and include age-appropriate video examples of culturally diverse families and children with varying temperaments and developmental issues. The programmes run from ten to 22 weeks, for two hours per week depending on the specific programme selected and the risk level of the population. For example, recommended programme delivery length is longer for higher risk and child welfare referred families as well as for parents whose children have conduct problems, Attention Deficit Disorder (ADHD) and/or developmental delays.

For each IY parent programme, trained IY group faclitators show short one to three minute selected DVD vignettes of modelled parenting skills to groups of ten to 12 parents. The vignettes

Figure 1 Incredible Years® logic model

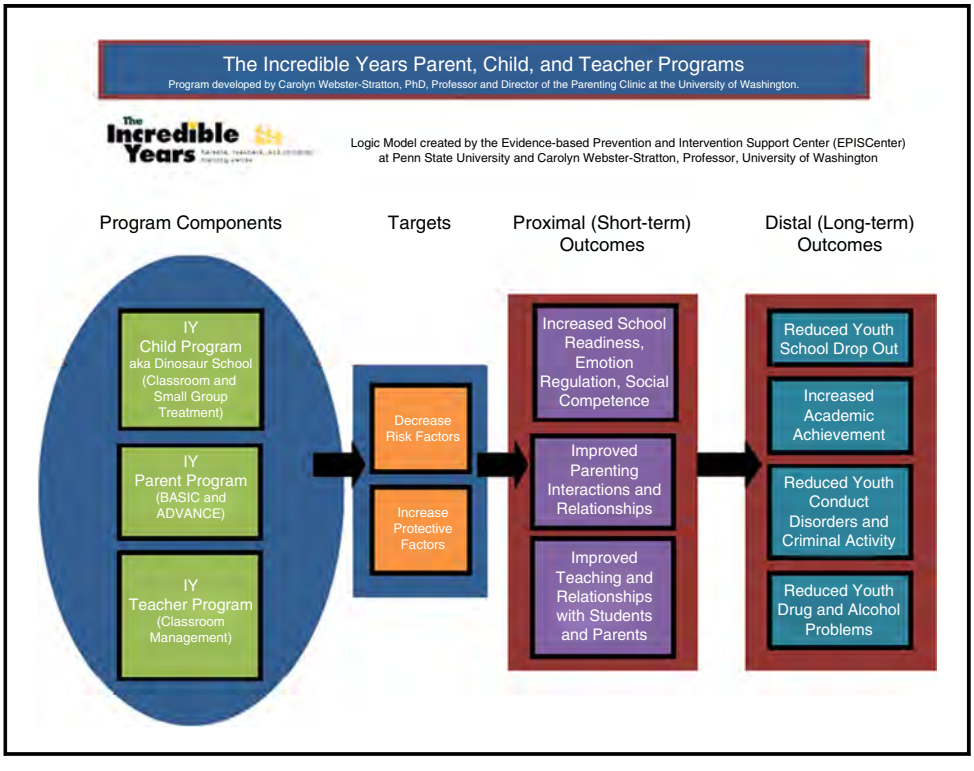
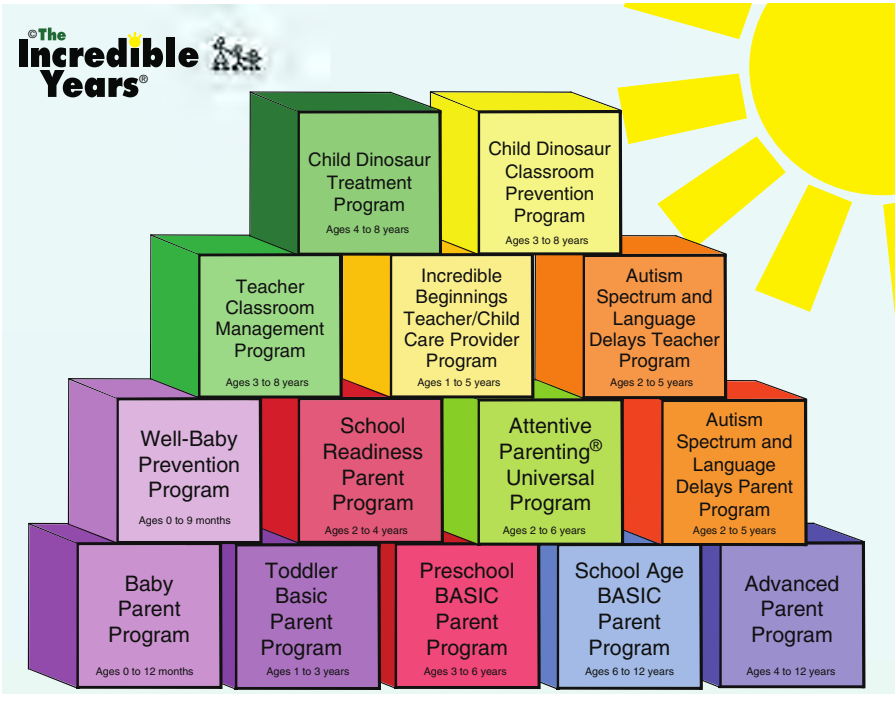


Figure 2 The suite of Incredible Years® programmes



demonstrate child development and parenting principles, and serve as the stimulus for focused discussions, self-reflection, problem solving, practice exercises and collaborative learning. The programmes are designed to help parents understand typical child developmental milestones, child safety-proofing and adequate monitoring, as well as age-appropriate child management skills.

All four parent programmes focus on ways to strengthen parent-child relationships and attachment and encourage children's language, social and emotional development and self-regulation skills. The Pre-school and School-Age programmes additionally focus on ways parents can collaborate and problem solve with child care providers and teachers regarding their children's academic goals and behaviour plans. Parent home activities include ways to promote children's reading skills, set up predictable, daily homework routines, persist with learning despite academic discouragement, motivate children with tangible reward systems, help children problem solve and show active interest in their children's learning at home and at school. See Table I for component content for the Toddler, Pre-school and School-Age parent programmes which, after the programme descriptions, will form the main focus of this paper along with the child Dinosaur training programmes (second row form the top of Figure 2), and the Teacher programme (top row of Figure 2).

Incredible Years® adjuncts to parent programmes

Supplemental or adjunct parenting programmes can be used in combination with the core IY BASIC programmes. The ADVANCE parenting programme, offered after completion of the BASIC Pre-school or School-Age programmes, was designed for selective high risk and indicated populations and focuses on parents' interpersonal risk factors such as anger and depression management, effective communication, ways to give and get support, problem solving between adults and ways to teach children problem-solving skills. A second optional adjunct training to the Pre-school programme is the School Readiness Programme for children ages three to four years designed to help parents support their children's preliteracy and interactive reading readiness skills. A third optional adjunct for the Toddler, Pre-school and early School-Age programmes is the

Table I IY summary of content

Content components for IY BASIC parent programmes (Toddler, Pre-school, School-age), the Teacher Classroom Management Programme (TCM) and the Child Dinosaur Programme (Dino)	*Toddler*	*Pre-school*	*School-age*	*TCM*	*Dino*
Promoting language development and academic readiness	X	X			
Child-directed play, positive attention, special time – positive relationships	X	X	X		
Building parent support networks	X	X	X		
Social and emotional coaching	X	X	X		
Promoting reading skills and school involvement	X	X	X		
Art of praise and encouragement	X	X	X		
Spontaneous and planned incentives	X	X	X		
Rules and predictable routines	X	X	X		
Responsibilities and monitoring		X	X		
Teaching children and parents self-regulation and calm down skills		X	X		
Teaching children and parents problem solving		X	X		
Parents partnering with teachers		X	X		
Academic and persistence coaching		X	X		
Teachers' classroom management skills, proactive teaching, effective discipline				X	
Academic, persistence, social and emotional coaching with students				X	
Strengthening teacher-student bond				X	
Teaching social skills, anger management and problem-solving skills in class				X	
Home-school collaboration, individual behaviour planning				X	
Building teachers' support networks				X	
Learning about school rules					X
Understanding and detecting feelings					X
How to problem solve					X
Anger control					X
How to be friendly – including teamwork at home and school					X
How to talk with friends – positive peer interaction					X
How to do your best in School – concentrating and good classroom skills					X

Note: X, signifies which programme includes this content

Attentive Parenting Programme for children ages two to six years. This universal group prevention programme is designed to teach all parents social, emotional and persistence coaching, reading skills and how to promote their children's self-regulation and problem-solving skills.

Incredible Years® Teacher Classroom Management (IY-TCM) programme

IY-TCM training programme is a six-day group-based programme delivered monthly by accredited group leaders in small workshops to 14-16 primary school teachers. Like the parent programme the training approach is based on teachers' collaborative, interactive learning, role play practices and shared problem-solving discussions of DVD vignettes of teaching skills. For example, teachers are encouraged to involve parents in developing a home and school incentive programme to help a child achieve a targeted goal. Or, teachers practice setting up a behaviour plan and problem solving with a difficult or resistive parent. Every workshop includes information and discussions about the importance of teachers promoting parent involvement in their child's social, emotional and academic learning. Teachers' assignments between workshops include building a positive connection with a challenging child or parent, practising coaching methods, developing a behaviour plan in partnership with parents and forming positive collaborative parent-teacher-child relationships and a consistent discipline heirarchy, and forming positive relationships with parents. Teachers are given parent home communication letters at every workshop that can be tailored and delivered to parents. The letters include home tips on how parents can support their child's learning in the classroom. Every workshop includes information and discussions about how teachers can continue to promote parent involvement in their child's social, emotional and academic learning.

See Table I for component content for this programme and the teachers' course book *Incredible Teachers: Nurturing Children's Social, Emotional and Academic Competence* (Webster-Stratton, 2012a).

Incredible Years® child programmes (Dinosaur curricula)

There are two versions of the IY child programme. In the universal prevention classroom version, teachers deliver 60+ social-emotional lessons and small group activities twice a week, with separate lesson plans and curricula for three different developmental age levels (four to five, six to seven and seven to eight years) teacher curriculum includes 20-30 minute circle time lessons, followed by small group practice activities and promotion of the skills throughout the day. The programme includes letters for teachers to send home which provide suggested activities parents can do with their children to reinforce dinosasur classroom learning and promote parent involvement.

The second version of the programme is a small group therapeutic treatment group where accredited IY group leaders work with groups of four to six children in two-hour weekly sessions. The therapeutic version can be delivered as a pull-out programme during the school day for children who require additional support around behaviour or wellbeing. Programme content is delivered using a series of DVD selected vignettes that teach children feelings literacy, social skills, emotional self-regulation skills, importance of following school rules and problem solving. Large puppets are used to bring the material to life and children are actively engaged in the material through role play, games, play and practice activities. Organised to dovetail with the content of the parent training programme, the programme consists of seven main components (see Table I; Webster-Stratton and Reid, 2003, 2004). This programme also includes letters to parents outlining goals for session topics and ways to reinforce this learning at home. Additionally, group leaders call parents weekly to support their efforts in reading and supporting their children's school learning at home as well as calling and/or meeting with teachers monthly to co-ordinate goals and behaviour plans for the child.

Table I highlights IY component content in three parent programmes from toddlerhood in to primary school age, the teacher programme and the child programme – both delivered in primary school. Several objectives, or goals, are included under each of these content areas (for detailed objectives please see www.incredibleyears.com).

Content has been summarised in this simple table to facilitate the readers' understanding of the cross-fertilisation between programme components to enable generalisation of child skills and learning across contexts and the importance of parent-teacher partnerships in this multi-modal system.

The IY programmes can be applied using a systematic approach to building parent-teacher partnerships and can be embedded holistically within schools to enhance child wellbeing, motivation to learn and reduce disruptive conduct problems. Table I highlights that the Toddler parent programme builds strong school readiness indicators such as language development, while the toddler and the pre-school and school-age all include promoting reading skills and school involvement, social-emotional coaching, rules and routines, positive interactions and use of praise. The pre-school and school-age addditionally include content around parent-teacher engagement and self-regulation and problem solving. The TCM and Dina programmes reflect the parent programme content with a continued strong emphasis on partnership working to include teacher-child, child-child, parent-child, teacher-parent and teacher-child-parent.

The logic model (Figure 1) and the content table (Table I) strongly suggest that a multi-modal approach may yield stronger effects, i.e. better behavioural, social emotional and academic (particularly language) outcomes in the short and long-term for children, by building on an early improved home learning environment and early parent relationships with teachers.

The aim of this paper is to explore whether the programmes are effective in enhancing school readiness at home, parent-teacher partnerships and school practices to enhance child learning outcomes.

We will now present the evidence for the IY parent programme as a standalone programme and when delivered in combination with either, or both, the IY teacher and child programmes. The parent and child evidence is presented for both selective populations (high risk), indicated populations (children with symptoms) and treatment populations (children with DSM diagnoses).

Evidence supporting the Incredible Years® parent programmes

Numerous studies have shown that IY parent programmes, delivered as standalone programmes, result in improvements in parents' positive relationships and coaching language with children, and parent-school involvement, as well as children's social and emotional literacy, problem-solving skills, behaviour problems and academic readiness.

Treatment populations

The efficacy of the IY BASIC parent treatment programme for children (ages two to eight years) diagnosed with Oppositional Defiance Disorder (ODD) or CD has been demonstrated in eight randomised control group trials (RCTs) by the programme developer plus numerous effectiveness trials by independent investigators. The results were consistent for Toddler, Pre-school and School-Age versions of the programmes (IY publications are available at http://incredibleyears.com/research-library/ and an IY book of 30 years research synthesis (Webster-Stratton, 2011) is accessible at http://incredibleyears.com/books/iy-training-series-book/. Combining the ADVANCE programme with the BASIC programme results in greater improvements in terms of children's pro-social solution generation in comparison to the BASIC only (Webster-Stratton, 1994).

A recent meta-analytic review (Menting *et al.*, 2013) examined 50 studies where the IY parent programme intervention was compared with control or a comparison group. This review included studies from various locations including the USA, UK and Norway. Results were presented for treatment populations as well as indicated and selective prevention populations and the programme was effective in improving child disruptive and pro-social behaviour in a diverse range of families, especially for children with the most severe problems; the programme was also considered "well-established". These findings are important as children with ODD or CD generally have poor academic outcomes; reducing these difficulties may enable children to be more ready to learn.

Two recent long-term follow-up studies from the USA and the UK evaluated families whose children were diagnosed with conduct problems and had received treatment with the IY parent pogramme eight- to 12-years earlier. The US study indicated that 75 per cent of the teenagers were typically adjusted with minimal behavioural and emotional problems (Webster-Stratton *et al.*, 2010). The UK study, conducted by an independent investigator, reported that parents in the IY BASIC parent condition expressed greater emotional warmth and supervised or monitored their adolescents more closely than parents in the control condition that had received individualised "typical" psychotherapy offered at that time. Moreover, their children's reading ability was substantially improved in a standardised assessment, suggesting that an improved home learning environment and more positive parent-child relationships had resulted in increased academic outcomes in relation to reading (Scott *et al.*, 2014a). This is one of the first studies to evaluate long-term academic outcomes as follow-up studies to date have mostly focused on social, emotional and behavioural outcomes.

This section suggests that the parent programmes, delivered as a standalone programme, improve the home learning environment by enhancing parenting skills, child behaviour and emotional regulation, which in turn leads to increased academic outcomes (reading skills) in treatment populations.

Selective and indicated prevention populations

Additionally, four RCTs conducted by the developer used the prevention version of the BASIC programme with multiethnic, socio-economically disadvantaged families delivered in schools (Reid *et al.*, 2001; Webster-Stratton, 1998; Webster-Stratton *et al.*, 2001). Results showed that children whose mothers received the BASIC programme showed fewer externalising problems, better emotion regulation and stronger parent-child bonding than control children. Intervention mothers showed more supportive and less coercive parenting than mothers in the control condition (Reid *et al.*, 2007). As part of the programme parents are encouraged to talk to the teacher to promote early relationship buidling around the child, delivering the programmes in school facilitates this process at the earliest opportunity.

At least six RCTs by independent investigators with high risk prevention populations have found that the BASIC parenting programme increases parents' use of positive and responsive attention with their children (praise, coaching, descriptive commenting) and positive discipline strategies, and reduces harsh, critical and coercive discipline strategies (see review by Webster-Stratton and Reid, 2010). The social learning, modelling and self-efficacy theories (Bandura, 1986) that underpin the IY programmes suggest that children who receive positive attention by role models such as parents and teachers, display more positive child behaviour and a motivation to learn.

In addition the BASIC programme has been found to improve child reading outcomes. Recently the BASIC parent programme with and without the SPOKES literacy supplemental programme was compared to a control condition (Scott *et al.*, 2014b). Significantly improved outcomes with BASIC alone programme compared with the combined programme and control conditions in terms of reading literacy at one-year and two-year follow-up assessments were reported. This evidence, combined with evidence of reading improvements in a treatment popluation outlined in the previous section strongly implies that the IY content components including language, academic coaching and reading skills, combined with behaviour change principles based on social learning theory are effective.

The programme is transportable and effective with diverse populations and cultures, including Latino, Asian, African-American, Native American and Caucasian background in the USA (Reid *et al.*, 2001), and in England, Ireland, Wales, Norway, Sweden, Holland, New Zealand (including the Maori population), Portugal and Russia (e.g. Azevedo *et al.*, 2013; Bywater *et al.*, 2009; Gardner *et al.*, 2006, 2015; Hutchings *et al.*, 2007; Larsson *et al.*, 2009; Little *et al.*, 2013; McGilloway *et al.*, 2012; Raaijmakers *et al.*, 2008; Scott *et al.*, 2001, 2010; see also Knerr *et al.*, 2013).

In addition to being effective, there is a growing complementary body of qualitative evidence exploring parents'/carers' perceptions of IY parent programme acceptability (McGilloway *et al.*, 2012; Furlong and McGilloway, 2014; Bywater *et al.*, 2010; Hutchings and Bywater, 2013; Oriana Linares *et al.*, 2006). The IY BASIC programme is also cost-effective, or good value for money (Edwards *et al.*, 2007; O'Neill *et al.*, 2011).

A limitation of delivering standalone parenting programmes is that child behavioural or social improvements in the home may not transfer to school settings (Durlak *et al.*, 2011). Schools are excellent settings for the delivery of parent programmes as they can enhance parent-teacher partnership working and break down perceived barriers. Schools are increasingly dealing with significant numbers of children with behavioural and self-regulatory difficulties, particularly in disadvantaged areas where levels of CD reach 20 per cent (Attride-Stirling *et al.*, 2000). These difficulties make it hard for the individual and for children around them in class to concentrate.

A multi-modal delivery model may therefore be more appropriate, for example adding the child and teacher programmes to the parent programme to improve child behaviour in school, and increase positive TCM and parent-teacher partnerships (Webster-Stratton and Hammond, 1997; Webster-Stratton *et al.*, 2004). The following two sections explore in more detail the evidence of this approach.

Evidence supporting IY-TCM programme as an adjunct to IY parent programmes

The IY-TCM programme has been evaluated by the developer in one treatment (Webster-Stratton *et al.*, 2004), and two selective prevention RCTs (Webster-Stratton *et al.*, 2001, 2008), plus five RCTs by independent investigators (Webster-Stratton, 2012b). Research findings have shown that teachers who participated in the IY-TCM 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 and made more efforts to involve parents in their child's school learning – these are all core IY content components (see Table I). 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 behaviour, thus demonstrating impact as a standalone programme.

However, one study where indicated children were randomly assigned to receive the combined IY-TCM with IY-Dina, plus the BASIC parent programme or only the IY-TCM, indicated that the combined intervention group showed more, supportive and less coercive parenting and teachers reported that parents were more involved in their child's school learning and communicated more with them than mothers in the classroom only and control conditions (Reid *et al.*, 2007). The teacher classroom involvement measure asked teachers to rate parents' comfort in the classroom environment, how much parents valued education, how much time they spent in the classroom or with homework and how comfortable the teachers feel with parents. These results suggest that parent training brings about improved partnerships between parents and teachers which did not occur in the classroom only intervention condition. Research has suggested that parent-school bonding in the early grades is an important predictor of later academic success (Hawkins *et al.*, 1998). Scott's recent studies support this hypothesis (Scott *et al.*, 2014a); again these promising results suggest improved academic outcomes with parent-teacher partnerships.

A recent US study with primary grade teachers has evaluated the benefits of the IY-TCM programme for targeting teacher awareness of the importance of enhancing parent involvement in their children's education (Reinke *et al.*, 2014b) and for improving student academic competence (Reinke *et al.*, 2014a). Preliminary results suggest that improving teacher-parent bonding and parent involvement holds promise for improving child performance at school. In this group randomised clinical trial with 105 teachers and 1,818 students, Herman and Reinke (2014) found that IY-TCM led to significant improvements in parent educational involvement according to teacher reports. Specifically, IY-TCM classroom parents were more likely to transition to adaptive teacher-rated parenting profiles after the intervention compared to control classroom parents. Moreover, patterns of parent involvement were strongly related to student academic and behaviour outcomes.

This section highlights the positive effects of IY-TCM on children's learning outcomes, parent-teacher partnership and continued attention to enhancing children's social emotional and behavioural competencies through applying praise and acknowledgement of achievements. It shows that combining the IY-TCM and BASIC/child training programmes leads to increased improved classroom behaviour and more involvement of parents in their child's education. In addition IY-TCM has qualitative evidence of acceptability from Ireland (Hyland *et al.*, 2014), and is cost-effective (O'Neill *et al.*, 2011). Furthermore Foster *et al.*'s (2007) study indicates that combined programme delivery is cost-effective.

Evidence supporting the IY child programmes as an adjunct to IY parent programmes

Treatment populations

Three RCTs have evaluated the effectiveness of combining the IY small group child-training (Dinosaur Curricula) programme to parent training for reducing conduct problems and promoting social and emotional competence in children diagnosed with ODD/CD (Webster-Stratton and Hammond, 1997; Webster-Stratton *et al.*, 2004). Results indicated that the combined child and parent training condition produced the most sustained improvements in child behaviour at the one-year follow-up. For this reason the child training programme was combined with the parent training programme in a recent study for children diagnosed with ADHD. Results replicated the earlier ODD studies (Webster-Stratton *et al.*, 2011, 2013).

Selective and indicated prevention populations

One RCT in the USA has evaluated the classroom prevention version of the child programme with families enroled in Head Start (a Pre-school programme for socio-economically disadvantaged children) and primary grade classrooms in schools addressing economically disadvantaged populations. Intervention teachers offered the curriculum in biweekly classroom sessions thoughout the school year. Results from multi-level models of reports and observations of 153 teachers and 1,768 students indicated that teachers used more positive management strategies and their students showed significant improvements in school readiness skills, emotional self-regulation and social skills and reductions in behaviour problems in the classroom. Intervention teachers showed more positive involvement with parents than control teachers, and satisfaction with the programme was high (Webster-Stratton *et al.*, 2008).

The study by Reid *et al.* (2007), outlined in the IY-TCM section above, indicates the added value of combining the IY-Dina in the classroom with the IY parent programme in schools.

The previous two sections highlight the added benefit of offering IY programmes in school settings for enhancing parent-teacher partnerships and for improving children's behaviours and academic learning across parent-teacher settings. It is important to recognise the benefits of parent-teacher partnerships not only for enhancing children's academic outcomes but also for providing a mutually supportive infrastructure.

Conclusions

IY has a clear logic model (Figure 1), effective core components to promote behaviour change, such as behaviour modelling and use of praise and rewards, and role play/practice, in addition to detailed programme content components with several specific objectives (Table I).

This paper has presented evidence demonstrating that IY programmes promote child learning at home, and in school, particularly through parent-teacher partnership working. The parent programmes support parents to interact positively with their children, which promotes better child behaviour and social and emotional wellbeing – which are pre-requisites for being a good learner. The school-based programmes promote positive peer, parent and teacher relationships and also impact on child behaviour, wellbeing and academic performance. It is vital that evidence-based parent and school-based programmes use similar strategies and techniques and shared goals or objectives to ensure that a child has a consistent approach to enhancing positive behaviour, wellbeing and learning. The evidence presented in this review suggests that IY is such a programme. The programmes help parents and teachers work together to achieve common goals and, as a multi-modal approach, can tackle multiple problems in children's lives and acknowledge the increasingly varied influences on their life trajectories (Utting, 2003).

Association with parents, teachers and other adults who model healthy, pro-social standards of behaviour is protective against school failure (Anderson *et al.*, 2005). There is a growing shared responsibility for the prevention of CD and enhancement of children's social emotional and academic competence, suggesting that evidence-based training should be considered as an inclusion in initial training for professionals who are in regular contact with families and children, including nursery workers and school staff.

Implications for policy and practice

- The home environment, particularly parenting practices, and parent partnerships with teachers, impact on children's social, emotional and language development, and academic readiness or achievement.
- The school context offers a unique opportunity to apply a multi-modal approach to increase parent-teacher partnerships, reduce behaviour problems, increase social and emotional competence and bring out academic success.
- IY parent, child and teacher programmes:
  - share common content and objectives, with partnership working as a main aim;
  - can be delivered as a multi-modal intervention;
  - are effective in enhancing child social and emotional wellbeing and school readiness;
  - reduce conduct problems and internalising problems;
  - are transportable to different countries, cultures and contexts; and
  - are acceptable to those participating in or delivering a programme.

Note

1. Defined here as anyone with the responsibility for caring for a child in a parenting role.

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Adapting the Incredible Years child dinosaur social, emotional, and problem-solving intervention to address comorbid diagnoses

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Abstract

Young children who are referred to mental health agencies because of oppositional defiant disorder (ODD) and conduct problems (CP) frequently have comorbid diagnoses or symptoms such as attention deficit disorder (ADD) with or without hyperactivity (ADHD), language/learning and developmental, or autism spectrum disorders. Research has shown that the Incredible Years Child Dinosaur programme offered to children with comorbid issues is successful at reducing behaviour problems and increasing social and emotional competence. This article examines ways in which this small group therapy programme is tailored to address the individual goals of each child so that the intervention is developmentally and therapeutically appropriate. It discusses group composition, as well as the importance of specific content and teaching methods for children with ADHD, academic and language delays and mild autism.

Key words

Incredible Years; group therapy programme; programme adaptation; ADHD; conduct problems; autism

Introduction

Young children (ages three to eight years) who are referred to mental health clinics because of oppositional defiant disorder (ODD) and conduct problems (CP) (eg. aggressive, oppositional behaviour, emotional dysregulation) frequently have comorbid diagnoses or symptoms such as attention deficit disorder (ADD) with or without hyperactivity (ADHD) or language/learning and developmental delays or autism spectrum disorders (Campbell *et al*, 2000). In a sample of more than 450 families referred to the Parenting Clinic at the University of Washington for children's ODD or conduct problems, 44% exhibited attention problems in the clinical range and 7% had language delays. In a more recent sample of 98 families referred to the clinic for the primary diagnoses of ADHD, nine children had autism spectrum disorders (pervasive developmental delay or Asperger's syndrome). Although these comorbid diagnoses often are not the presenting problem for a child with ODD, they convey additional risk in short- and long-term treatment outcomes and may be directly or indirectly contributing to the externalising behaviour problems (Webster-Stratton, 1985, 1990).

Thus, treatments that target children's oppositional and aggressive behaviours, such as the Incredible Years (IY) child dinosaur curriculum, must

be flexible enough to meet the needs of children with complicated profiles. Since young children cannot easily communicate their feelings or worries and the reasons for their misbehaviour, it is important for therapists to look beyond the aggressive symptoms to the underlying reasons for the misbehaviour. The skilled therapist will need to develop a working model and set realistic goals for every child and their parents based on the child's biological make-up, developmental ability, comorbidity and functional analyses of the behaviour problems. This article examines ways in which this small group therapy programme is tailored to address the individual goals of each child so that the intervention is developmentally and therapeutically appropriate. It feeds into the growing practice and research interest in the planned adaptation of proven programmes for different contexts and different populations (Bumbarger & Perkins, 2008).

Current research

The IY child dinosaur curriculum is an evidence-based programme that has been shown in two randomised control group treatment trials and one prevention trial by the developer (Webster-Stratton & Hammond, 1997; Webster-Stratton *et al*, 2004; Webster-Stratton *et al*, 2008) and in one independent replication (Drugli & Larsson, 2006) to significantly reduce conduct problems, strengthen positive parent-child interactions and increase social problem-solving skills with peers. (For a review of these studies see Webster-Stratton & Reid, 2003, 2005a.) As noted above, although the presenting diagnoses for these treatment studies were ODD or CP, these programme evaluations represent treatment outcomes for children with comorbid diagnoses of ADHD, learning delays and autism spectrum disorders.

One study evaluated the differential treatment effects of the child dinosaur curriculum for children with ODD alone or comorbid ADHD/ODD. The comorbid children made as significant behavioural improvements as children without this comorbidity (Webster-Stratton *et al*, 2001). Currently we are engaged in the fourth year of a randomised trial with children (ages four to six) whose primary diagnoses is ADHD. Adjustments have been made to our delivery of the child programme for these children and are discussed in this article.

We have found that in order to deliver the Incredible Years treatment model successfully, the therapist must understand how to tailor the manualised treatment protocol according to each child's developmental needs and social and emotional goals. Therapists can achieve flexible applications of the manual when there is understanding of the treatment on multiple levels, including the core treatment model, content, and methods, as well as the elements involved in adapting and tailoring the treatment to the individual needs of each child. This article summarises this treatment model with special attention to the way the model is adapted to meet the particular goals of children with ADHD, developmental and language delays and mild autism. The leader's manual (Webster-Stratton, 2007a) provides recommended protocols for offering the child dinosaur social, emotional and problem-solving curriculum (dinosaur school) to groups of six children, aged four to eight, with a primary diagnosis of ODD/CP. The treatment version of the program is offered weekly in a mental health setting for 18–22 weeks in two-hour sessions. The protocols are considered the *minimal* number of core sessions, vignettes and content required to achieve results similar to those in the published literature. However, the length of the programme, number of vignettes shown and the emphases given to certain components of the programme will vary according to the particular needs of the children in each group. There is also a separate classroom curriculum that is designed to be offered two to three times a week to whole classrooms of children as a prevention program for improving children's social, emotional, and academic competencies (Webster-Stratton & Reid, 2004). Recent research shows that this preventive classroom curriculum is effective in reducing classroom aggressive behaviour and promoting social competence, especially for the highest risk students (Webster-Stratton *et al*, 2008).

The IY Training Series also includes a number of parent training options. When working with children with diagnosed conduct problems and ADHD, it is recommended that the parent programme be offered in conjunction with the child dinosaur curriculum, as the strongest long-term follow-up results have been found when parent programmes are offered together with child interventions (Webster-Stratton & Hammond, 1997; Webster-Stratton *et al*, 2004). The parent programmes are described in detail elsewhere (Webster-Stratton, 2006) and have been shown to be as effective for children with comorbid ADHD/ODD as for pure ODD children (Hartman *et al*, 2003). In addition, the parent programmes should be tailored to address the particular goals of parents and developmental abilities of their children. These modifications are outlined elsewhere (Webster-Stratton, 2007b).

Overview of the child dinosaur social skills and problem-solving curriculum

As noted above, the dinosaur curriculum targets children with ODD and CP but is also appropriate for addressing comorbid problems such as ADHD, language or developmental delays and mild autism spectrum disorders. The programme can be delivered by counsellors, therapists or early childhood specialists and teachers who have experience treating children with conduct problems.

In order for therapists to begin tailoring the programme for children with comorbid diagnoses, it is extremely important to understand the core content of the program and the teaching methods and therapeutic process of the program delivery. This programme is described in great detail in the programme leader's manual (Webster-Stratton, 2005). Therapists with a thorough understanding of the programme quickly see that it is designed to allow for tailoring the teaching and learning process, as well as the behavioural goals, to the individual children in the group.

Content

Table 1 provides an outline of the core content (presented in the specific order) for all groups of children. Each unit builds on the prior unit and skills, so it is important not to skip units or complete them out of order. However, therapists make developmentally appropriate modifications based on the children's needs in the group. For example, in the 'doing your best in school' unit, groups of very young children (four to five years) would focus on listening, waiting and raising their hand, while older groups (six to seven years) would learn to ignore distractions and to concentrate on work. Similarly, as outlined in the subsequent sections, particular content areas can be emphasised for children who have differing sets of behavioural problems and developmental delays.

Methods

The methods of teaching are similar regardless of the make-up of the group. All groups use music, video vignettes, role play, child-size puppets, hands-on practice activities, homework assignments, letters and phone calls to parents and teachers. Within these methods, the therapists make adjustments according to the needs of the children in their groups. For example, the puppets frequently bring in problem scenarios and ask the children to help them problem solve. These problems are formulated to directly reflect the reality of children's issues in the group. For example, Wally (one of the puppets) could be constantly scolded for getting out of his seat at school (ADHD), angry because someone took his ball and he got cross and hit them (emotion regulation problems), or embarrassed and frustrated because he is the only child in his class who cannot read (reading and language delays). This article suggests key content areas to focus on and adjustments to be made in the methods and process for children with comorbid ADHD, language, learning and developmental delays. Methods for working with children with depression and internalising problems, attachment disorders and reactions to divorce can be found in a separate document (Webster-Stratton & Reid, 2005b). It is important for the therapists to use the puppets to individualise these suggestions to meet the needs of children in their groups. It is always more engaging to first have the puppet talk to the children about his or her feelings about a problem and then to have the children engage in a discussion of possible solutions or suggest ways to cope with the situation.

Selecting children for groups

When offering the small group child training programme for diagnosed children, it is ideal to carefully select the type of children who will be in each group. Typically we recommend no more than six children per group. A general guideline for group selection is to include at least one same sex and same age peer for each child (eg. do not place one girl in a group of five boys or one four-year-old in a group of six-year-olds). However, as long as each child has a peer, we often recommend mixing genders, ages and diagnoses to make more heterogeneous groups. It is recommended, for example, to include two typically developing peer models in each group. This will ensure that there will be children who can help to model appropriate social behaviour and self-regulation for other children who have more difficulties with conduct problems, hyperactivity and developmental delays. These peer models will also benefit from the programme because of the leadership skills they practise, as well as the understanding and empathy they learn for children with different developmental abilities. If peer models are not possible, it can also be helpful to have a mixed gender group. Even if the girls are diagnosed with conduct and attention problems, we have found that their behaviours present differently enough that a group of two girls and four boys (all with ODD) runs more smoothly than a group of six diagnosed boys. We recommend mixed-age groups (eg. three four-year-olds and three six-year-olds or two four-year-

Table 1 Content and objectives of Dina dinosaur social skills and problem-solving programme

Programme component	Objectives
Making friends and learning school rules	■ Understanding the importance of rules ■ Participating in the process of rule making ■ Understanding consequences if rules are broken ■ Learning how to earn rewards for good behaviour ■ Learning to build friendships
Dina teaches how to do your best in school	■ Learning to listen, wait, avoid interruptions, and quietly put up a hand to ask questions in class ■ Learning to handle other children who tease or interfere with the child's ability to work at school ■ Learning to stop, think, and check work ■ Learning the importance of co-operation with the teacher and other children ■ Practising concentrating and good classroom skills
Wally teaches about understanding and expressions	■ Learning words for different feelings ■ Learning how to tell how someone is feeling form verbal detecting feelings and Non-verbal ■ Increasing awareness of non-verbal facial communication used to portray feelings ■ Learning different ways to relax ■ Understanding feelings from different perspectives ■ Practising talking about feelings
Detective Wally teaches problem-solving steps	■ Learning to identify a problem ■ Thinking of solutions to hypothetical problems ■ Learning verbal assertive skills ■ Learning to inhibit impulsive reactions ■ Understanding what apology means ■ Thinking of alternative solutions to problem situations such as being teased and hit ■ Learning to understand that solutions have consequences ■ Learning to critically evaluate solutions
Tiny Turtle teaches anger management	■ Recognising that anger can interfere with good problem solving ■ Using the turtle technique to manage anger ■ Understanding when apologies are helpful ■ Recognising anger in oneself and others ■ Understanding that feeling anger is okay but acting on it by hitting or hurting someone else is not ■ Learning to control anger reactions ■ Practising alternative responses to being teased, bullied, or yelled at by an angry adult ■ Learning skills to cope with another person's anger
Molly Manners teaches how to be friendly	■ Learning what friendship means and how to be friendly ■ Understanding ways to help others ■ Learning the concepts of sharing and helping ■ Learning what teamwork means ■ Understanding the benefits of sharing, helping and teamwork ■ Practising friendship skills
Molly explains how to talk with friends	■ Learning to ask questions and tell something to a friend ■ Learning to listen carefully to what a friend is saying ■ Learning to speak up about something that is bothering you ■ Understanding how to give an apology or compliment ■ Learning to enter into a group of children who are already playing ■ Learning to make a suggestions rather than give a command

olds, two five-year-olds, and two six-year-olds), so that older peers can serve as models for the younger children. We also recommend that one group is not made up entirely of children with comorbid ODD and ADHD. We have found that these groups have such high levels of distractibility and disruption that they are very difficult to run productively.

One exception to our recommendation of mixed diagnosed groups is for children with Asperger's Syndrome or other mild autism spectrum disorders. For these children, we recommend treatment in a group of other children with similar diagnoses, along with typically developing peer models. It is our experience that children with autism spectrum diagnoses may be dysregulated if placed in a group made up of highly hyperactive and aggressive children because of the high level of noise, activity and physical stimulation. We also believe that the inclusion of typically developing children is crucial for these groups because of the need for prosocial peer modelling.

Process

Each treatment group is set up with clear and contingent behavioural expectations that are necessary to manage and teach children with oppositional and aggressive conduct problems. During the first group session, rules and expectations are reviewed and role-played. Children participate actively in this process and help to establish the classroom rules. A predictable and routine schedule helps children feel safe in this environment and know what is expected of them. A picture schedule for the group is displayed prominently on the wall, with each segment of the group given its own picture and written heading (eg. homework review, circle time, small group activity, snack time, play choice time). Each week, one child is given responsibility for tracking the schedule by moving an arrow to point to each activity as it happens. Predictability is also established within the routines and rituals of each group. For example, every circle time lesson starts with familiar songs. Puppets enter the group in a similar way each week and greet the children individually. Video vignettes are always introduced with the 'ready, set, action' statement to ensure that children are focused. Children are also assigned jobs each week (schedule change, line leader, snack helper) and these jobs are pictured for them to see easily. Consistency in routines and schedules makes it easier for children to attend to the learning.

A token system is used whereby children earn tokens ('dinosaur chips') for appropriate behaviour. These chips are exchanged for stickers and small prizes at the end of the group. Children receive very high levels of praise with the chip reinforcement. As little attention as possible is given to negative behaviours. Much off-task behaviour is ignored, and children are redirected or prompted with non-verbal cues. When necessary, children are given warnings of a consequence (loss of privilege or brief time out) for disruptive or non-compliant behaviour, and leaders follow through with the consequence if the misbehaviour continues. Aggressive behaviour receives an automatic brief time out away from therapist and peer attention in order to provide children a time and place to calm down.

This behaviour management process is also manipulated to meet the individual needs of the children in the group. For instance, not all children earn chips for the same behaviours. For a very young child who has ADHD, chips and praise may be given every 30 seconds if she is sitting with her bottom on the chair, or every time she remembers to quietly raise their hand. For an older child who has difficulties with peer relationships, leaders will focus on giving praise and tokens for prosocial interactions (helping, sharing, giving a suggestion, listening, problem- solving with a friend). Leaders look for ways to make sure that children who are working hard at their individual goals are earning chips at relatively equal rates. Some very young and impulsive children with ADHD will not be able to wait until the end of a group to trade in tokens for prizes. In this case, it is appropriate to offer multiple, more frequent opportunities to trade in chips. Other children may not be able to understand a token economy at all, either because they cannot count or cannot anticipate consequences or understand the connection between waiting for a certain number of chips and obtaining a prize. For these children, other more concrete and immediate reward systems will be used. For example, the children could earn marbles in a jar for targeted social behaviours, and when the jar reaches a certain level (marked clearly) the group earns a special snack or activity. These children may also benefit from earning stickers or hand stamps given immediately after the positive behaviours occur. In this way, each child in the group is working on target goals within a system that is clear, developmentally appropriate, has been negotiated ahead of time and feels fair to all children.

Therapists may have somewhat different behavioural expectations for each child in the group and, therefore, will set different limits accordingly. For example, a very impulsive and fidgety child may be given some latitude to move around in space marked off around his chair, or to take a break in

a specially designed 'wiggle space', while other children will be expected to attend and stay seated on their chairs.

Children with ADHD

Over 40% of children in our studies for ODD and CP also had ADHD (Beauchaine *et al*, 2005). These children have difficulty attending to, hearing or remembering adult requests, and, therefore, do not seem to be co-operative. They often have difficulty completing tasks such as schoolwork, homework, chores or other activities that require sustained concentration or longer term memory. Many children with ADHD have trouble making friends (Coie *et al*, 1990). Their impulsivity and distractability makes it hard for them to wait for a turn when playing or to concentrate long enough to complete a puzzle or game. They are more likely to grab things away from other children, or disrupt a carefully built tower or puzzle because of their activity level and lack of patience. In fact, research has shown that these children are significantly delayed in their play and social skills (Barkley, 1996; Webster-Stratton & Lindsay, 1999). For example, a six-year-old with ADHD plays more like a four-year-old and will have difficulty with sharing, waiting, taking turns and focusing on or persisting with a play activity for more than a few minutes. Such children are more likely to be engaged in either solitary or parallel play. If they are in the parallel play stage of play development, they will be fairly uninterested in other children and rarely initiate interactions. If they are interested in interacting with other children, these interactions are likely to be unsuccessful because they don't have the behavioural control to wait for a turn, ask for something or listen to an answer. They also are likely to quickly become dysregulated when things do not go their way. These behaviours make them unpopular playmates and they are often very isolated, with few friends.

Content focus for children with ADHD

For children with ADHD, there is a special focus on the content topics of: doing your best in school, emotion regulation and friendship skills. These three areas address the key skills deficits experienced by most children with ADHD. In the school unit, for the younger children there is a focus on listening, following directions and persisting with a difficult play activity. Therapists use 'persistence coaching' to coach them to stay focused and to keep trying when something is difficult. For older children, there is a focus on concentration, stopping to understand assignments before doing schoolwork and stopping to check and re-check work. All children are taught how to ignore in order to block out distractions. One of the puppets models the concept of ignoring by showing the children that when you ignore, you don't look at or listen to something or someone that is bothering you. Children then practise ignoring a distraction that is made by the puppet, such as whispering into their ears or tapping them on the shoulder. They are praised for using strong 'ignoring muscles'. When real-life distractions occur in the group, children are then prompted to use their 'ignoring muscles' and are praised for doing so.

In the feelings and anger management units, the focus for these children is on emotion regulation. They learn to relax and recognise signs of dysregulation, and to calm down by taking deep breaths, thinking of their happy place and using positive self-talk. In the friendship units, these children are taught specific social sequences for situations such as entering a group of children who are already playing, waiting for a turn, playing co-operatively with a peer, negotiating the decision-making process with other children and using friendly communication skills.

Methods and process for working with children with ADHD

The structure of the group is modified for children with ADHD because of their more limited capacity for sustained attention during circle time and their need for more movement than other children. Therapists introduce more songs, more role-plays and physical activities and more hands-on group activities to keep the attention of the children. If the entire group comprises children diagnosed with ADHD, the two-hour format is revised to include three shorter circle time lessons lasting 10–15 minutes instead of one 20–30 minute circle time lesson. In addition, extra small group activities may be planned. At the end of the session children have 15–20 minutes of coached play time. Toys such as Lego, blocks, play dough and board games are provided, and therapists coach children intensively in their play interactions with each other. If the group consists of children with and without ADHD, the structure is modified to allow those more focused children who want the extra time to continue to work on their small group activity, while permitting the inattentive children to work on a different activity. Nonetheless, special opportunities to move and be engaged – beyond those provided for the entire group – are set up for children with ADHD. For instance, the child with ADHD may be asked to come to the front of the group to hold a cue card, or

be asked to retrieve something for the therapist from the back of the room. The therapist may have the child come and sit on his/her lap for a few minutes (this should be contingent on appropriate behaviour, rather than as a response to off-task behaviour). The child may also be placed in a seat next to the therapist and physical touch (therapist hand on shoulder or arm) may help sustain the child's ability to stay focused.

The child with ADHD may be given slightly more physical space than other children, with visual boundaries used to delineate the space. For example, a masking tape box might be placed around the child's chair and as long as the child is within the tape boundaries he or she would not be required to be seated with both feet on the floor at all times. It may also be helpful to give the child a sanctioned 'wiggle space' to use if it becomes too difficult to stay in the group. This is not a punishment, rather it is a self-regulation space so that the child has an option of a place to go to re-regulate and then come back to the group. This space should also be marked out with a physical boundary and might have nearby a picture of the puppet Wally relaxing, or taking deep breaths, as a signal to remind children of the calm down steps. Another approach is to ask the child with ADHD who is becoming very distracted to go over to an area of the room where there is a 'show me five' hand posted on the wall and to put their hand on the poster to help them regain focus. This 'show me five' hand cue is a signal with a picture for each finger that indicates the following – eyes on the teacher, ears open, mouth closed, hands to self and body quiet.

Therapists are coaching, praising, labelling and reinforcing (with tokens) targeted child behaviours such as waiting, managing impulsivity (eg. remembering to quietly raise a hand rather than blurting out), staying calm, sitting in their seat, concentrating, following directions, appropriately using wiggle space and respecting physical boundaries. At first, therapists notice even very short periods of attention, waiting and calm behaviour, and a child might receive a tangible reward such as a token along with praise for sitting in his or her chair for as short a period of time as 30 seconds. One goal for these children, however, is to help them learn to sustain this kind of attention for longer and longer periods of time. Gradually over the course of treatment, therapists will tailor their rewards, rate of praise and their expectations to extend the children's ability to focus, wait, concentrate and attend. Very young or extremely impulsive children may have difficulty connecting the tokens with a reward given at the end of the two-hour session. For these children there may need to be even more frequent opportunities to earn more immediate rewards such as stickers or hand stamps, which are then traded in for tokens that lead to prizes.

It is important to begin to teach children with ADHD to self-regulate and to use cognitive strategies and positive self-talk. Initially, adult prompting and visual cues are used to achieve this. For example, children are shown a picture of Dina dinosaur concentrating. Under her picture are the words 'stop, look, think, check'. These words are rehearsed out loud with hand motions to accompany each word. Picture cue cards also accompany each word (eg. stop sign, looking eyes, light bulb symbol, and check mark). Children practise an activity requiring concentration, while the teacher, puppets or other children help to remember each of the steps, and the steps are repeated out loud with the picture cues. The child can be provided with a picture cue card of Dina concentrating and this card might be placed on his or her desk at school to remind him or her of the skill she is practising. The classroom teacher is asked to walk by periodically and prompt the child to use the concentration steps by tapping the picture. At the end of a period, the child can be asked to reflect on whether they concentrated and followed Dina's steps. They can be provided with self-praise or coping statements (eg. 'I did it! I'm good at concentrating' or 'I forgot to concentrate this time, but I bet I can concentrate on my next work').

Part of teaching children self-regulation is also about teaching them how to manage their anger when conflict occurs. In the problem solving and anger unit, the precise steps for how to identify a problem and generate possible solutions are taught, modelled and rehearsed. Depending on the age of the child, these strategies will be a combination of behavioural and cognitive techniques. For example, specific behaviours that children learn to manage anger are taking three deep breaths, counting to 10 and practising making their bodies tense and relaxed. Cognitive strategies they learn range from simple statements such as 'I can do it, I can calm down' to more complex cognitions such as 'I'm feeling angry because my sister took my truck, but I'm going to be strong and ignore her. Then I won't get in trouble and I'll prove I can control my anger'. Cognitive strategies involve thinking of happy thoughts or places, giving a compliment to yourself or telling yourself that feelings can change and even though you are angry now you will feel better later.

In the friendship unit, the precise steps for learning how to play with another child are taught,

modelled, prompted and practised extensively. First, children watch videotapes of children playing with a variety of toys (blocks, make believe, puzzles, art projects, etc) and in a variety of settings (playground, classroom), and they are prompted by the therapists to notice how the children on the videotapes wait, take turns, and share. One or two of these friendship skills are modelled by the puppet in interaction with the therapist or children. Then, each child practises one or two play skills with one of the puppets and is reinforced for using these behaviours. Next, they are paired up to play with another child (their buddy) and the therapist prompts, coaches and reinforces them for using these friendly play behaviours. Sometimes it is helpful to break up the group by taking pairs of children out of the large group to practise their play skills without the distractions of other children in their peer group. After these dyadic practice sessions, the children return to the group for a circle time lesson focused on learning and practising a particular social skill. Children with significant play delays may need to practise the social skills one-on-one with the puppet before doing this with a peer.

Children with academic problems: language or reading delays

Approximately 30% of children with conduct problems and/or ADHD also have academic problems such as language or reading delays or learning disabilities (Hinshaw, 1992).

Content focus for children with reading or language delays

For children with reading or language delays, all of the tailoring recommendations suggested for improving the concentration skills of children with ADHD will also be helpful. Additional methods and processes for children with reading and language delays are suggested in what follows.

Therapists working with children with language and reading problems will also want to engage frequently in interactive or dialogic reading. This reading style encourages exploration of a book without the sole focus on reading the words accurately. Therapists discuss the pictures with the child by taking turns to label objects, feelings or other aspects of the picture, following the child's lead and interest in the story, and helping the child make up alternative endings to the stories or even act out parts of the story with hand puppets. As children become familiar with particular stories, they may become the storyteller and will read or recite the story back to the therapist. Research has shown that when preschool teachers and parents read dialogically with their children, the children's vocabulary increases significantly (Whitehurst *et al*, 1999), as well as their word recognition and motivation to read.

Methods and process for children with academic difficulties

For these children, the link between written and oral language should be emphasised throughout the curriculum. Each visual cue card that presents a new social, emotional or problem-solving concept has both a picture and a word that describes the concept. Strategies such as asking the children to practise 'reading' the word on the picture by repeating it aloud, pointing to the word as it is said and acting out the word at the same time that it is spoken, all help children with language delays to associate printed words with spoken words. Small group activities can also be chosen that will reinforce particular academic goals. There are many activities involving reading and writing that can be adjusted for children with different developmental levels. Using small group activities that target a particular skill area for a child provides a low-pressure time for children to experience success with academic activities that may be difficult for them at school because therapists can provide extra scaffolding to make this learning successful.

Therapists focus special effort on labelling, praising and encouraging academic behaviours and processes for children with learning problems. Raising a hand quietly, concentrating on work, checking something again, correcting a mistake, trying again and persisting with a hard task are all examples of behaviours to reinforce. Cognitive processes are also recognised by therapists. Examples of this are: '*I can see you are really thinking hard about your answer' ; ' When it' s hard to read, you tell yourself, I can do it if I just look at one letter at a time' ; and ' It' s great that you stayed calm and asked for help on that work. Did you tell yourself, I can stay calm even though I don' t know this word?*'. Child-directed descriptive commenting can also support children's language development. In the role of 'academic coach', therapists will describe what the children are doing during their playing interactions. For example, they will describe or label the colours, shapes, sizes and positions (on, under, beside, inside, next to, etc) of the toys they are playing with, as well as name of the pictures, objects and events as they are occurring. This will increase the children's vocabulary as well as their academic concepts.

Collaborating with teachers

It is particularly important for children with ADHD and ODD, whose attention and behavioural

problems interfere with their academic learning, that therapists communicate with the child's classroom teacher. Therapists begin developing their relationships with teachers by asking them during the initial assessment phase to complete standard behaviour inventories regarding the children. They also ask teachers to share their concerns regarding the children in the classroom and obtain their input regarding the specific behaviours they think that the children need help with. Once dinosaur group therapy sessions begin, therapists provide teachers with summaries regarding the goals for each topic being covered in the programme. About half way through the programme, therapists develop behaviour plans for children and outline the strategies they believe are helpful to them. These individual behaviour plans are shared with the teachers who are asked to review them and to contribute their ideas to the goals or strategies proposed for the children. ***Table 2*** provides a sample behaviour plan for a child who has ODD and ADHD and language delays. ***Table 3*** provides a sample session outline for a group with children with ADHD.

Children with autism spectrum disorders

Over the years, we have had experience working with children with Asperger's syndrome and other autism spectrum disorders, who were integrated in both our treatment and classroom Dinosaur School child training groups. However, we have not had sufficient numbers to be able to report specific outcome data on these sub-groups. Anecdotally, we have heard from a number of teachers and therapists who have also adapted the curriculum for these populations that they have experienced success. This section of the article offers some guidelines for adaptations that have been made. However, controlled experimental trials of these IY curricula are needed with these populations to determine their effectiveness.

Content focus for children with autism

Children with autism or Asperger's syndrome have particular difficulty with affective and reciprocal social interactions, such as difficulties reading social cues as well as verbal and non-verbal communication impairments. They may be non-verbal, or simply repeat what others say to them, or have extensive language skills. They may refuse physical affection and make little effort to share enjoyment. They may actively distance themselves from peers and engage in repetitive, stereotypical and isolated play. Since there are large individual differences among children with autism or Asperger's syndrome, individual behaviour plans based on the children's goals will be important guides for implementing the dinosaur curriculum. In general, efforts will be made to reduce some of their excesses of behaviours (repetitive and ritualistic behaviour and aggression) and to increase their social interactions. The emphasis for these children is on the feelings, friendship and communication units of the programme.

In the feelings unit, children first practise noticing feelings by looking for visual cues (eg. 'What does someone's face look like when he is happy? How do his eyes look? How about his mouth?'). Children look at pictures and videos with no sound to try to name the feelings. They also look at the puppets, the therapists and their peers to try to name and observe what feelings they are having. Mirrors are used so that they can practise showing their own feeling faces. Next, the children learn to identify feelings by listening to sounds and voices. This time, children practise closing their eyes, listening to people talking and trying to identify the feeling just based on the auditory cues. Once children have learned to identify feelings from voices, they practise using their own voices to let someone else know how they are feeling. In particular, we focus on modelling and practising expression of positive feelings and affect to others because of their importance in promoting relationships.

Children with autism have difficulty making friends because of their impairment in expressing positive affect (they do not show smiles or positive expressions), their inability to take the point of view of another child's feelings, and their impaired or delayed language and play skills. Studies have indicated that they have impaired symbolic play (eg. doll-related and pretend play), engage in less diverse play and do not initiate social interactions at the same frequency as children with typical development. For this reason, therapists engage in child-directed play interactions during small group activities using 'emotion coaching' and a high level of affectively rich content (smiles, eye contact, laughter). In addition, therapists set up small group activities that involve socio-dramatic or symbolic play, puppets and role plays as a way to practise events in one's life, social roles and rituals (eg. using a doll house and dolls to act out telephone calls, making dinner, getting ready for school, getting dressed in the morning, going to the dentist or using puppets to practise asking a friend to play).

In the friendship unit, the precise steps for learning how to play with another child are taught, modelled and practised extensively (as described above in the section for children with ADHD). For

Table 2 Sample behaviour plan for Frank

Targeted behaviour	Occasion	Desired behaviour	Proactive strategies and reinforcers to use	Consequences of misbehaviour
1. Fidgety or impulsive at circle time. Is often distracted or off-task (distracting others in the circle, standing up at inappropriate times, leaving the circle).	Circle time	To stay seated, engaged and regulated during the entire circle time.	Seat him near a teacher and, if necessary, in his/her lap. Use touch and backrubs to keep him engaged. Praise a calm body, staying in seat, paying attention and listening. Use small incentives frequently when Frank is sitting quietly (sticker, hand stamp, biscuit). Eg. '*Frank you are sitting and listening, you get a hand stamp.*' Keep the content as varied and engaging as possible. Frank has most difficulty with verbal content. He really enjoys puppets, music and other visual learning. Offer him chances to participate and help. Delineate an alternative area (eg. tape out a box at the back of the room with a book in it) that Frank can choose to go to if he does not want to stay in the circle. '*Frank, you have two choices: you can sit with us in circle, or you can sit quietly in your box.*'	If Frank gets up and leaves the circle, briefly ignore him while trying to make the circle more interesting and see if he comes back on his own. If not, give him the two options. If he does make an appropriate choice (either circle or box), use a warning for a time out. Frank can be very disruptive during time out, so a plan should be in place ahead of time for monitoring and managing his time outs.
2. Frank is usually engaged in parallel play. He has difficulty sharing toys with other children on his own.	Play time	To be able to play	Most of Frank's interactions are likely to be parallel play. Encourage prosocial behaviours (asking, sharing, turn taking). Praise Frank for sharing if he is playing next to another child with similar toys. If Frank wants something that another child has, provide him with the words to ask and then praise him for using words. Model sharing: '*Frank, I'd like to share this car with you. Can you say, please can I have it.*' Model asking: '*Frank, could I use your train for a minute. I will give it right back*.' Currently all Frank's play interactions will need to be coached by an adult.	N/A
3. Frank often gets frustrated when he doesn't get his way in play situations. This may happen partly because it is difficult for him to express himself in words.	Play time	To stay calm when frustrated. To be able to use words to let others know what he wants. To get help from a teacher if he can't resolve a problem with a peer.	Coach Frank to use his words and stay calm. Remind him of calm down strategies (take three deep breaths, pretend to blow out a candle). Try to catch him right when you see he is beginning to be frustrated. At that point, provide him with words to express his frustration. For example, '*Frank, tell him that you are playing with that right now*' or '*Frank, say please can I have that truck*'. Praise him for using his words and for staying calm. If his request resulted in the outcome he wanted, praise how well he solved his problem by using his words. If his request was denied, praise him for staying calm and try to redirect him to another activity or coach him to wait until it is his turn.	If Frank is too dysregulated to be able to listen and respond to coaching, he (or the other child) may need to be moved to another area until he has had time to calm down.
4. Frank is often non-compliant to commands or following established routines.	Any time	To follow directions the first time that he is asked to do something. To ask for help if he doesn't know how to do what is being asked.	Get Frank's attention before giving a command –go near to him, look him in the eye. Give simple, one-step commands and praise ANY compliance. Limit commands to those that are necessary. Give Frank two positive choices, eg '*Frank, you can play with the blocks or with the trains*'. If Frank is non-compliant, evaluate what you've asked him to do and make sure that it is broken down in a way that he can easily follow the directions	Let Frank know what will happen when he complies, and when he doesn't comply. Eg. '*If you clean up now, then you will be able to have your snack.*' '*If you do not clean up, you will need to take a time out.*' If necessary, follow through with a brief time out.

Table 2 (continued) Sample behaviour plan for Frank

Targeted behaviour	Occasion	Desired behaviour	Proactive strategies and reinforcers to use	Consequences of misbehaviour
			without getting overwhelmed. Give warnings well before transitions so that Frank is prepared. Give him a little more time during a transition and have an adult walk him through the transition. Make sure that Frank is aware of what activity is coming after the transition so that he knows what to look forward to.	
5. When Frank is frustrated or dysregulated, he may become aggressive and hit other children or adults	Anytime that he is upset	To express his frustration with words.	Use all the above strategies for helping Frank through play interactions with other children and for coaching him through times when he needs to comply. At a time when Frank is calm, let him know that if he hits or hurts another person he will need to take a time out to calm down.	Give Frank an automatic time out if he hurts another person. Ideally, this time out should only last 2–3 minutes, but Frank should be calm at the end of the time out. If he is upset or dysregulated, wait for him to be calm, then end the time out.

Table 3 Sample group session for children with ADHD

Activity	Time in minutes
Coached play time as group gathers	10
First circle time	20
Small group activity	10
Snack	15
Second circle time	20
Small group activity	10
Coached play time	15
Counting chips	10
Closing compliment circle	10

children with autism, these sessions are expanded – according to children's play goals based on their developmental abilities – with additional vignettes and activities so that over time, their repertoire of play skills becomes more complex to include other behaviours such as giving compliments, making a suggestion or agreeing with a suggestion. Eventually the children's play moves from repetitive parallel play to dyadic play with one child, and eventually to play with several children, as well as learning the skills needed to join in or initiate play with others.

In addition to teaching children how to respond to other children in play interactions, these children need help with self-initiating social interactions with adults or children. Examples of self-initiated interactions include asking a question, inviting someone to play, showing someone a toy or pointing to an object. Children will be prompted to initiate an interaction and reinforced when they do this. For example, children may be prompted to ask '*What's that*?' or '*Where is it?*' and then reinforced for asking a friendly question. In the friendship unit, children are taught five specific social skills steps needed to initiate an interaction, since studies suggest that children with autism initiate infrequently. For instance, if a child wants a turn on the swing (or to play with a group who are already playing), he or she would be coached to (a) stop and watch, (b) give a compliment, (c) ask for a turn, (d) listen to the answer and then (e) either wait for a turn or accept the refusal and use another solution (perhaps get an adult). These steps are practised repeatedly in role plays using visual cue cards to prompt each of the steps. If children are not spontaneously using the new initiation behaviours, then the therapist or puppets can prompt a rehearsal of the behaviours.

Undoubtedly these children's play deficits are also related to their language and communication difficulties. In the communication unit of the programme, the children learn – again through the same process of modelling, guided practice and coached practice with another child – how to ask questions to get to know a friend, how to give a compliment, how to accept a friend's overture and how to be persistent in asking to play with another. Children are paired up with a buddy to practise communication skills. Preferably these pairings include a buddy with normal language development so that the buddy can model developmentally appropriate communication. Children are reinforced for imitating their buddy, and buddies are reinforced for modelling appropriate communication skills. A growing body of research suggests that teaching communication behaviours can also result in dramatic

improvements in the behaviour of preschool children with autism (Koegel *et al*, 1992; Wacker *et al*, 1998).

Methods and process for working with children with autism

Motivating these children to respond is an essential prerequisite to teaching them new skills. In order to enhance motivation of these children, intensive use of reinforcement and rewards is employed for their attempts to respond or initiate an interaction, even if the response is not exactly correct. By reinforcing trying it is hoped that these children will sustain their efforts at interacting or learning something new. Frequently, these children do not spontaneously initiate interaction, and when this is the case they will be prompted by the therapist modelling the precise words to use and then reinforced for their efforts. Moreover, previously mastered tasks are interspersed with new learning of more difficult tasks to ensure that the children stay engaged. In addition, to maximise interest, a variety of choice is provided to allow some selectivity of the particular small group activity. Since children with autism often have very focused interests, these interest areas may be incorporated into the small group activities. For example, a child who is fascinated with trains maybe be encouraged to make a train poster with another child. Preferred activities or topics may also be used as rewards for engaging in the group. A child who is interested in a particular toy may earn chances to play with this toy between other group activities. In order to promote generalisation of the skills being learned, children are given opportunities to try to self-manage in a variety of settings (eg. playground, lunch room, bus). For example, in the playground they can use the problem-solving solution cards to decide on a solution to a conflict situation. Playground teachers and monitors are trained to prompt and reinforce the use of these skills in these less structured settings. Eventually, these prompts will be faded out to see if they are produced more spontaneously.

As with the other populations, the child training curriculum is only one part of an intervention approach. A comprehensive intervention will always involve parent training to help parents understand how to coach and reinforce the child's learning at home. This will be crucial to help children generalise their skills to other settings and relationships. It is ideal to offer the child programme at the same time as the parent intervention so that parents learn how to support their child's newly acquired skills. In addition, this provides parents and child therapists a chance to co-ordinate treatment plans. However, services that set up combined interventions will need adequate staff to deliver both of these interventions at the same time.

Summary

It is increasingly recognised that evidence-based interventions need to clearly identify what aspects of the evidence-based therapy are core for all populations and how programmes can be adapted or tailored according to individual needs and goals without affecting programme fidelity. In particular, there is a need for more research evaluating the effectiveness of evidence-based interventions for use with young children with a variety of mental health problems. In this article, we have shown how the Incredible Years child dinosaur emotion, social and problem-solving programme can be adapted to treat multiple presenting problems. Children who present for treatment with conduct problems are likely to be experiencing a number of other developmental problems that contribute to their behavioural difficulties. In order to provide comprehensive and effective treatment for these children, it is important that these comorbid issues are addressed.

Therapists delivering the programme must be very familiar with the basic content, methods and process before making adaptations. They should understand the rationale for presenting each content unit, as well the behavioural principles that are important for working therapeutically with children (eg. frequent positive attention for behaviours that they would like to see increase and minimal attention for behaviours that they would like to see decrease). With this in mind, the therapist, in conjunction with the parents and classroom teachers, can set individual behavioural goals and develop a behaviour plan for each child in the group. Central to this treatment model is the idea that while a specific set of skills is taught in a specific order, the way in which the skills are taught, the level of sophistication with which they are presented, and the amount of time spent on each content area must depend on each child's behavioural and emotional needs, as well as on his or her developmental level. In this way, the programme can be used as a comprehensive treatment to provide children with the skills to cope with many different situations and circumstances.

Summary of policy and practice implications

- There is a need for more research evaluating the effectiveness of evidence-based interventions for use with young children with a variety of mental health problems.
- Evidence-based interventions need to identify clearly what aspects of the evidence-based therapy are core for all populations and how programmes can be adapted or tailored according to individual needs and goals without affecting program fidelity.
- Young children with ODD diagnoses frequently have many comorbid problems and interventions must address these needs as well as the primary diagnoses.
- Research suggests that combining child intervention with parenting interventions results in higher effect sizes for treatment outcomes for diagnosed children.
- Combining typically developing children with diagnosed children in treatment may be useful for providing appropriate peer models for diagnosed children. Typical children may benefit from increased understanding and empathy towards children with developmental difficulties.

Author note
This research was supported by the NIMH 5 R01 MH067192.

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