The Incredible Years Parent, Teacher, and Child Intervention: Targeting Multiple Areas of Risk for a Young Child With Pervasive Conduct Problems Using a Flexible, Manualized Treatment Program

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Young children who present for treatment with oppositional-defiant disorder (ODD) and conduct disorder (CD) frequently exhibit these symptoms across settings and often show comorbid symptoms of attention-deficit/hyperactivity disorder (ADHD) and/or internalizing symptoms such as anxiety or depression. Parent training programs to treat these children must be flexible and comprehensive enough to address these issues. This article outlines a case in which the Incredible Years Parent, Teacher, and Child Training programs were used to treat a young boy, John, with ODD. His problems were pervasive and occurred at home, at school, and with peers. In addition to the ODD symptoms, John exhibited symptoms of ADHD as well as significant anxious and depressed behaviors. This case study outlines how a multimodal, manualized treatment can be applied flexibly to attend to individual family needs and address issues of comorbidity.

THE INCIDENCE of oppositional-defiant disorder (ODD) and conduct disorder (CD; key predictors of adolescent delinquency, substance abuse, and violent behavior) in children is alarmingly high, with reported rates of early-onset conduct problems in young children as high as 35% for low-income families (Chambless & Hollon, 1998; Webster-Stratton & Hammond, 1998; Webster-Stratton, Hollinsworth, & Kolpacoff, 1989). Parent training has been recognized as one of the most effective approaches to preventing and reducing conduct problems (e.g., Brestan & Eyberg, 1998). However, parent training is often perceived as a narrowly focused intervention that focuses exclusively on increasing child compliance and reducing aggressive behavior at home. While many parents of young children with conduct problems seek help because of noncompliant and aggressive behavior at home, our data with well over 600 children (ages 4 to 7) diagnosed with ODD or CD suggest that 50% to 60% of these children also show clinically significant problem behaviors with teachers and peers (Webster-Stratton, 1990). In addition, as many as 50% of children described as aggressive and disruptive are also comorbid for attention-deficit/hyperactivity disorder (ADHD; Barkley, Guevremont, Anastopoulos, DuPaul, & Shelton, 1993; Lahey & Loeber, 1997). Lastly, children who exhibit high levels of externalizing (aggressive, oppositional) behaviors also tend to show high levels of internalizing (anxious, withdrawn) behaviors (Achenbach, 1991a). In our sample of children presenting with conduct problems, 34% of children who scored in the clinical range on the externalizing subscale behaviors of the Child Behavior Checklist (CBCL; Achenbach, 1991a) also scored in the clinical range on internalizing behaviors (the CBCL is a standardized, parent-report measure of child behavior problems that has been shown to discriminate between clinic-referred and nonreferred children). Thus, the majority of children who receive treatment for ODD/CD also exhibit difficulties in other areas. As a consequence, treatment for these children must be comprehensive and tailored to specific client needs. The parent training component of treatment must be broadly based and flexible enough to help families cope not only with aggressive and noncompliance behavior at home, but also target individual goals for children who are anxious, socially isolated, rejected by peers, or hyperactive.

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Comprehensive and broadly based parent training, such as Webster-Stratton's Incredible Years Program, is an important starting place for treating children with conduct problems, and will result in clinically significant improvements for two-thirds of children. However, approximately one-third of children treated with this parent training program (and others) will continue to have diffi-

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culties with school and peers (e.g., Funderburk et al., 1998; Webster-Stratton, 1990). The addition of child social skills and problem-solving training to this parent training program (Webster-Stratton & Hammond, 1997) improved long-term child outcome at home and observations showed improved positive conflict management with peers compared to children who received only parent training. The combination of parent and child training, however, did not impact children's noncompliant and aggressive behavior in the classroom, according to teacher reports. When teacher training was added to the treatment plan, observations in the classroom indicated significant decreases in aggressive behavior with peers at school compared with classrooms with no teacher training (Webster-Stratton, Reid, & Hammond, 2001). These data indicate that for young children whose behavior problems are pervasive (i.e., with parents, teachers, and peers), parent training will be most effective when offered in combination with teacher and child training. This type of comprehensive treatment plan targets multiple risk and protective factors for children with conduct problems across settings and attempts to effect change in all arenas of the child's experience.

Each program consists of over 200 videotaped vignettes of common situations faced by parents, teachers, or children. Vignettes show effective and ineffective ways of handling these situations.

The Incredible Years Programs

Each of the three Incredible Years parent, child, and teacher training programs used with the family described in this article have been empirically validated in randomized control-group studies for use with children (ages 4 to 7) with conduct problems (Brestan & Eyberg, 1998; Webster-Stratton, in press). The series consists of group-based training programs for parents, teachers, and children. Each program consists of over 200 videotaped vignettes of common situations faced by parents, teachers, or children. Vignettes show effective and ineffective ways of handling these situations and provide the framework for group discussions on how to handle common problems. In addition to the vignettes, each program contains detailed treatment manuals with session-by-session checklists, group-leader scripts, program "principles" to highlight, homework materials, books, and practice activities. Although all three programs are manualized, and strict adherence to treatment protocol is important, leaders are trained in a collaborative and problem-solving process that stresses the key therapeutic principle of using the particular goals, issues, and circumstances of each group member to fit the curriculum into the particular context of each family or classroom (for a detailed description of the collaborative process, see Webster-Stratton & Hancock, 1998).

The Parent Program

The parent program is held weekly for 2 hours and lasts 22 to 24 weeks. Groups generally contain 12 to 16 parents. The program consists of topics including child-directed play, encouragement, praise, tangible reinforcement, monitoring, ignoring, limit setting, natural and logical consequences, and time-out. In addition to learning cognitive behavioral principles, parents are helped to understand and accept individual differences in their child's temperament, attention span, needs for attention, ability to regulate emotions, and how their child's unique "wiring" will determine particular parenting approaches. Material on anger management, mood regulation, working with schools and teachers, academic success, communication, problem solving with adults and children, and encouraging children's positive peer relationships is also covered. The videotaped vignettes are used by the group leader to "trigger" parent discussions, problem solving, and role-plays of common situations in the group. The groups are led in a collaborative format whereby the leaders present material and provide structure to the discussion, while parents set their own goals and extract parenting "principles" from the material presented. Additionally, parents are given weekly homework consisting of reading and behavioral assignments to practice with their children. Parents self-monitor this homework by committing to particular goals they want to accomplish during the week.

The Teacher Program

Similar in format to the parent program, the teacher program is taught in 4 day-long sessions spaced throughout the fall and winter of the school year. Teachers of children involved in our clinic are invited to attend the training (to date, approximately 90% of teachers have agreed to participate). The teacher program consists of topics such as building positive relationships with students, strategies to promote parent-teacher collaboration and parent participation, the importance of teacher praise and positive attention, proactive strategies to prevent problems, using tangible reinforcement, decreasing inappropriate behavior with limit-setting and time-out, and classroom-management approaches designed to increase children's prosocial and problem-solving skills. As with the parent program, the teacher program is offered as a collaborative venture between the group leader and the teachers. Role-plays and discussion are used to illustrate

new concepts. Teachers are seen as the experts and are encouraged to use each other as resources for solving difficult problems in the classroom. With the group leader's guidance, teachers help each other to make changes at the classroom level as well as implementing individual behavior plans for the target child. Outside of the training days, our clinic therapists observe the target child in the classroom, meet with the teachers individually to develop behavior plans, and facilitate meetings with the parents, teachers, and other school personnel. At the end of the school year, our clinic therapist works with the parents and teachers to develop a transition plan to document successful strategies for the child's next teacher.

The Child Program: Dinosaur School

The Dinosaur Social Skills and Problem Solving curriculum is delivered to the children in the evenings while their parents are participating in the parent group. The groups consist of six to seven children and are led by two therapists. The program contains topics such as school rules, doing your best in school, feelings, problem solving, anger management, making friends, and teamwork. As with the parent and teacher programs, the program content is illustrated through videotaped vignettes that children watch and discuss. In addition, the Dinosaur Program uses child-size puppets to discuss and role-play content with the children. Learning is enhanced by activities, games, colorful cue cards illustrating key concepts, and homework activity books. A token economy system is used whereby children earn chips for good behavior, active participation in discussion, and prosocial behavior with the other children in the group.

Case Example

Intake Information

Sarah and Ben were referred to the Parenting Clinic by their school psychologist because of difficulties at home and at school with their 6-year-old son, John. Although John was just beginning first grade, he had a substantial reputation at the school for his aggressive and oppositional behavior in the classroom and on the playground. These behaviors had been evident when John was in kindergarten and had increased in intensity when he entered first grade. At the time that the Smiths came to the clinic, his teacher had approached his parents and told them that she did not believe her classroom was an appropriate place for John. John was regularly being sent to the principal's office and had also been asked to leave school early on at least two occasions because of his aggressive behavior.

In addition to these problems at school, Sarah and Ben were concerned about his behavior at home. Both parents described John as extremely volatile. He would frequently "lose control of his behavior" and engage in extended temper tantrums during which he would call his parents names, refuse to comply with any requests, and engage in aggressive or destructive behavior. Both parents described feeling helpless to change John's behavior once it reached these proportions. They reported that their parenting style was usually to talk and reason with John in problem situations, but felt that this merely escalated his behavior. They also had tried a number of different discipline strategies (e.g., time-out, loss of privileges), but felt that John was unresponsive to their efforts. They were often at a loss as to what events had triggered the tantrums and described John as having a "Jekyll-and-Hyde" personality. They were quick to describe John's strengths as well as his difficulties. During his good times, they reported that he was a generous, loving, charming child with a good sense of humor. John had been assessed by a psychologist prior to coming to the clinic and had been diagnosed as having numerous symptoms of ADHD, but was just below the threshold warranting formal diagnosis. Prior to coming to the Parenting Clinic, Sarah and Ben had enrolled John in a 10-week social skills program recommended by their school counselor, but saw no change in his behavior as a result of the group.

Teachers are seen as the experts and are encouraged to use each other as resources for solving difficult problems in the classroom.

In addition to the difficulties of managing John's behavior, Sarah and Ben were quite concerned about the effect that his difficulties were having on his self-esteem. During the year prior to the intake, John had begun saying that no one liked him and that he was the dumbest kid in his class. They also perceived him as depressed and anxious about school and his lack of friends.

The Smiths are a middle-class Caucasian family. Both parents are college graduates and both work (Ben full-time and Sarah part-time). They had been married for 13 years and both reported a strong and positive marital relationship. They also have a daughter who was 8 years old at the time of the intake and had no significant behavior problems. At the time of the intake, neither parent reported any mental health issues, although Sarah had a history of depression. The Beck Depression Inventory (Beck, Steer, & Garbin, 1988) and the Dyadic Adjustment Scale (Spanier, 1976) confirmed normal scores for depression and good marital satisfaction. John's difficulties, however, were putting a significant strain on their family's functioning. Both parents felt that John's problems were their main focus, to the exclusion of other activities and

Table 1
Baseline, Posttreatment, and 1- and 2-Year Follow-Up Assessments

	Baseline	Immediate Posttreatment	1-Year Follow-up	2-Year Follow-up
Mother Report				
Eyberg Prob.[a]	18	11	9	4
Eyberg Intensity	139	118	112	116
CBCL Ext.[b]	71 (98%)	66 (95%)	63 (90%)	58 (79%)
CBCL Int.	61 (86%)	57 (76%)	46 (34%)	43 (24%)
CBCL Attention	63 (90%)	60 (84%)	60 (84%)	57 (76%)
Father Report				
Eyberg Prob.	21	14	7	9
Eyberg Intensity	155	126	117	107
CBCL Ext.	72 (99%)	70 (98%)	71 (98%)	66 (95%)
CBCL Int.	71 (98%)	49 (46%)	53 (62%)	53 (62%)
CBCL Attention	60 (84%)	57 (76%)	63 (90%)	51 (54%)
Teacher Report				
TRF Ext.[c]	78 (100%)	62 (88%)	68 (96%)	71 (98%)
TRF Int.	60 (84%)	51 (54%)	57 (76%)	56 (73%)
TRF Attention	68 (96%)	62 (88%)	67 (96%)	75 (99%)
Classroom Observation				
Ratio of Teacher Praise to Criticals	1.5	7.75	—	—
Satisfaction[d]				
Mother	—	6.5	6	—
Father	—	6	5.3	—
Teacher	—	5.7	—	—

[a] Eyberg Child Behavior Inventory (Robinson et al., 1980).
[b] Child Behavior Check List (Achenbach, 1991a): *T* scores and percentiles.
[c] Teacher Report Form (Achenbach, 1991b).
[d] Treatment Satisfaction measure: 7-point scale (7 = *very satisfied*).

interests. They felt that they no longer had control over their family and were worried that John's behavior was on an irreversible trajectory. They were perplexed by their inability to help John, since they both felt they had strong parenting skills and they had little difficulty with their daughter.

See Table 1 for a summary of key information on John's behavior. Note that in addition to John's externalizing behaviors, his internalizing and attention scores on the parent and teacher CBCL were elevated at intake. John's scores on the Eyberg Child Behavior Inventory (ECBI) were also in the clinical range (Robinson, Eyberg, & Ross, 1980). The ECBI is a 36-item behavioral inventory that provides a total problem score (number of behaviors parents endorse as problematic) as well as an intensity score for those behaviors (how frequently they occur on a 7-point scale). Problem scores of 16 and intensity scores of 142 correspond to the 90th percentile for this measure.

Our school observer visited John's classroom on four occasions and coded him in two structured and two unstructured periods using the MOOSES coding system (Tapp, Wehby, & Ellis; see Figure 1 for observational data). The observer noted that John had great difficulty concentrating. During both structured observations, John was disengaged for the majority of the time (crawling under desks, wandering around the room). During the unstructured observations (on the playground or in the lunch room), John was aggressive with other children on multiple occasions. The observer's impression was that in the classroom the teacher had given up on John. She ignored all his off-task behavior unless he was overtly disruptive or aggressive, at which point she reprimanded him or asked him to leave the room. She seemed to have stopped requiring anything of him academically.

The Smith family was observed in their home for an hour on two occasions using the DPICS-R coding system (Robinson & Eyberg, 1981; Webster-Stratton, 1989; see Figure 1 for child data and Figure 2 for parent data). During both observations our observer rated John's behavior as very challenging. He was noncompliant to 79% of his parent's commands, and was engaged in ongoing smart talk, name-calling, and whining. The coder summary report noted the following:

> Sarah and Ben are intelligent, thoughtful, considerate parents, but nothing they do is working. They encourage conversation and opinions from the children, but John consistently responds by saying they are dumb or stupid. They attempt to discuss his feelings and are completely bamboozled when his response is defiance and noncompliance. It is an awful situation that the parents keep feeding into. He cries over real or imagined hurts and the parents are all over him with comfort and questions. The minute they leave, he stops. His sister gets very little of their time because John is the center of their universe. He is controlling the household with his negative behavior. There are no negative consequences for John's behavior.

Treatment

Treatment began in October, following the assessment period. John and his parents came to the clinic each week for 2 hours in the evening. During that time John attended the child group with five other children (three boys and two girls, ages 4 to 7) and his parents attended the parenting group with the parents of those children.

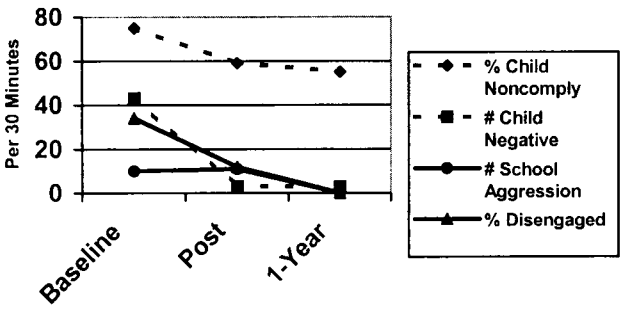

Figure 1. Child behaviors observed at home (dashed) and at school (solid) at baseline, posttreatment, and 1-year follow-up. Percent noncomply = percentage noncompliance to parent commands at home. Number child negatives = frequency of child whining, crying, smart talk, and aggression at home. Number school aggression = frequency of aggressive behaviors to peers or teachers. Percent disengaged = percentage of time that child was disengaged at school.

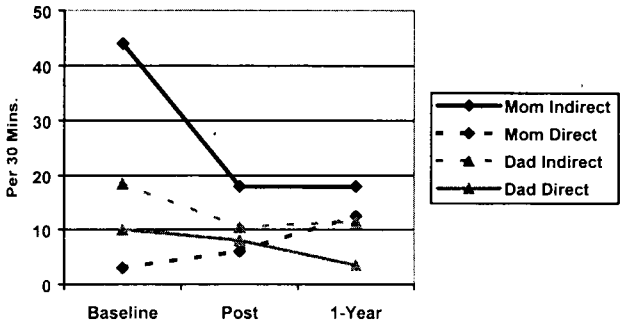

Figure 2. Number of direct (e.g., "Pick up your toys") and indirect ("Wouldn't it be nice if your toys were picked up") parent commands observed at baseline, posttreatment, and 1-year follow up.

Parent group. During the initial group, parents described their child and their reasons for coming to the clinic. The parents in this group seemed to form an immediate bond with other parents around the common issues of aggression, noncompliance, and school problems. Many of the parents, Sarah, in particular, described how isolated she felt as a parent of a "problem child." She felt that they could no longer socialize with their friends because John was not able to behave appropriately. She felt judged by other parents and was beginning to feel that she was a "bad parent" because nothing she did worked with John. After the group, Ben privately expressed relief about the other parents in the group. He said, "I can see that this is a group of good, committed parents. They are a lot like we are and are dealing with similar problems." He had been afraid that a parenting group would consist of parents who were clearly parenting badly and that he and Sarah would feel out of place. Sarah and Ben expressed their goals for John primarily in terms of his happiness and self-esteem. Although they clearly wanted home life to be smoother, they wanted most for him to be successful in school, to learn to regulate his emotions, and make friends with other children.

Sarah and Ben were active participants in the parenting group. They added thoughtful reflections to the group discussions and were able to generalize new material to their own situation. They consistently completed homework assignments. They were also able to respond to other parents in an understanding and helpful way. They came to the group with many strengths, and the other members of the group trusted their feedback and opinions. They were also able to see the humor in some of the difficult situations that they found themselves in with John and shared that perspective with other parents.

Since both parents already had many positive interactions with John, the initial topics on play and praise were not difficult for them. They did note that they enjoyed having the structure and the goal of spending focused time with John each day and noticed that he seemed to become more relaxed with them during the regularly structured play times. They struggled somewhat with how to respond to him when he became negative during play sessions, but were able to incorporate differential attention, distraction, and ignoring to redirect his play.

The topics and limit-setting units were more challenging for the Smiths. Both were accustomed to reasoning with John when he was misbehaving. As noted by our observer during the home visit, this provided John with considerable attention for his misbehavior. Observations indicated that Sarah gave a high number of vague, indirect commands (more than 1 per minute) and few clear, direct commands. She seemed uncertain and tentative about limit setting. Both Sarah and Ben intellectually understood the principle of using ignoring when John was annoying or verbally abusive and time-out when he was aggressive. However, they had some initial difficulty implementing these strategies. They had tried using time-out but had always given up partway through the process because of John's aggressive and destructive behavior. John was very persistent with his whining and tantrums, and both parents needed support and encouragement to stick to their discipline plans. For Sarah, this involved teaching her to use calming self-talk (e.g., "I can stay calm, I can handle this") and reframing strategies (e.g., "He will feel safer when he learns there are predictable limits"). With Sarah, in particular, John frequently swore and called her names, which she found difficult to ignore. When she did ignore, he would also cry and yell that she didn't love him and would become so upset that she worried about whether he would be okay. She was inclined to catastrophize the situation and worry that

John's behavior was irreversible and that he was on the path to becoming a delinquent. Sarah practiced changing these negative thoughts by substituting coping thoughts such as, "He knows that I love him, he's just saying that to get my attention"; "If I keep ignoring this time, next time he'll know that I mean business"; "We can change this behavior"; "John is only 6 and if we help him now, he won't become a delinquent."

With encouragement from the group, the therapists, and several role-plays they managed to successfully complete several lengthy time-out sequences with John. There was a marked shift in their self-confidence after this point.

Ben issued fewer commands and was less affected by John's name-calling and tantrums, but he had difficulty ignoring John's destructive behavior during the tantrums and during time-out. The group discussed with him the long-term benefits of continuing to follow through with a time-out even if it meant needing to repair damage that John caused during time-out. They also helped him to problem-solve ways to make sure that John was safe even when he was being destructive during the time-outs. With encouragement from the group, the therapists, and several role-plays where Sarah and Ben took turns being John and themselves, they managed to successfully complete several lengthy time-out sequences with John. There was a marked shift in their self-confidence after this point. Although John continued to have very difficult days, they felt more equipped to handle his behavior at home. They also noticed that the frequency of these very intense tantrums decreased markedly.

The topics on communication and problem solving with each other were, for the most part, review for Sarah and Ben. They did remark, however, that since most of their energy had been focused on John, they had not taken as much time to talk together about other issues. They used this time to catch up with each other on other life issues. As with the play units, they commented that they appreciated the assignment to spend focused time with each other on specific problem-solving exercises. Both noticed that as their lives became too busy, they tended to let the play sessions with the children as well as their time with each other slip. When they did this, they found that they were in "reaction mode" with each other and with John. When they were able to turn this around and plan the time to play with the children and talk to each other, they felt more proactive and in control of their family time. With the encouragement of the group, Sarah and Ben also scheduled some evenings together away from the children. They also decided that when the parent group was over, they would continue to go out together on the night that the group had been held.

Working with the school and teacher training. Although Sarah and Ben progressed relatively easily through the parenting program in terms of their skills at home and their interactions with John, they were experiencing significant conflict with the school. Even after John's behavior began to improve at home, it continued to worsen at school. His teacher was repeatedly requesting that he be removed from her classroom, and John was so unhappy at school that it became a battle just to get him onto the bus in the mornings. Sarah and Ben had been called into the school on numerous occasions because of John's behavior. In one instance at recess, John was digging in the dirt with an open paper clip. When the playground assistant requested that John give her the paper clip, he refused and waved it at her. The incident was written up describing the paper clip as a weapon. Since the school had a no-tolerance policy, the school planned to suspend John for 3 days. Although Sarah and Ben had excellent interpersonal skills, their relationship with John's teacher and with the school principal had become quite adversarial. The Smiths reported that whenever they met with the principal and the teachers, they felt personally attacked, and felt responsible for defending John, even though they agreed that his behavior had been unacceptable. Particularly in the paper clip incident, they felt that if a similar event had occurred with another child, it would have not been handled so severely. In our conversations with the school, it was clear that the teacher and principal were frustrated with the Smiths, with John, and with the difficulty of dealing with John's aggressive and noncompliant behavior on a day-to-day basis. In addition, parents of other children were reluctant to allow John to associate with their children because of his aggressive behavior.

The typical sequence of our treatment program is for the parent and child groups to meet for the first month and then to begin the teacher training after we have established relationships with the families and have worked with the child. In addition to the four scheduled days of teacher training, our therapists meet with parents and teachers to develop behavior plans and deal with school issues. Two to three meetings of this type are built into the treatment protocol, but, if necessary, more meetings are added in special circumstances such as this (all extra meetings are documented in our therapy records). It quickly became clear that earlier intervention with the school and teacher would be necessary with John. After the incident with the paper clip, a school meeting was set up with the therapist, the teacher, the principal, and Sarah and Ben. The therapist rehearsed with Sarah and Ben

the importance of beginning the meeting with an acknowledgment of the work that the teacher and school had done on John's behalf. They also agreed to share some of the difficulties they were having with John at home. Lastly, they rehearsed a nonconfrontative way to request that the school consider an alternative to suspension. With the therapist at the meeting to support them, they felt comfortable acknowledging that they knew that John was a difficult child to manage. This helped to establish a bond with the teacher, who had been feeling as if John's parents blamed her for all the difficulties that John was having. The therapist also helped discuss with the principal that sending John home for misbehavior could actually backfire and be reinforcing for John since he felt so negatively about being at school. Together, the teacher, principal, and parents agreed that for aggressive behaviors, John would be given a brief time-out in the classroom or the office or would lose the privilege of using the classroom computer. The therapist encouraged everyone to think of the process of making John successful in this classroom as a long-term goal with many small steps. At that meeting the teacher and the Smiths began to set up a behavior plan to increase home-school communication and to focus on small, positive goals for John's behavior in the classroom.

John's teacher attended teacher training when it began in November. Although she participated actively in the training sessions, she and the Smiths continued to report that the situation at school had not improved. It began to seem that John had established such a negative reputation in that classroom in the first few months of school that it was hard for his teacher and his peers to view him in a positive light. Another school meeting was set up to discuss the continued difficulty, and it was decided that John might be more successful in the other kindergarten classroom in the school. Moving a child to a new classroom is quite unusual in our program, but seemed to be the best option in this particular situation. Prior to moving John to the second classroom, a meeting was set up with the old and new teacher, John's parents, and the therapist from the clinic. A transition plan was discussed so that John would begin in the new classroom with a behavior plan in place. This plan focused on a few positive behavioral goals with frequent reinforcement, a "wiggle space" for times when John was having difficulty sitting still, and a back-up time-out plan for severe negative behavior. John had been participating very successfully in the child Dinosaur groups at the Parenting Clinic, so feedback from the clinic child therapist was incorporated into the plan. John was able to earn breaks for successfully completing manageable parts of his seatwork. Because it was difficult for him to sit still for long periods of time, he was also given sanctioned reasons to move around the classroom. The therapist also worked individually with the new teacher to make up the content that she had missed during the first teacher training meetings. The new teacher agreed to attend the subsequent teacher training sessions.

This classroom switch worked extremely well for John. His new teacher was able to begin on a more positive note with John. His behavior continued to be difficult, but she had the support of the principal, the therapist at the clinic, and Sarah and Ben, so problems were addressed as they occurred. Peer issues were also addressed immediately, and his new teacher made a concerted effort to introduce John to the class in a positive light. As part of his behavior plan he was able to earn chances to assist other children (an activity that had proven to be very reinforcing to him in our child Dinosaur group at the clinic). On the playground, John was initially limited to activities in a smaller, well-supervised area, and through appropriate behavior was able to earn the privilege of expanded recess.

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During the remainder of the year, there were several additional incidents that required Sarah and Ben to meet with the teacher and the principal. For those meetings, the therapist met with Sarah and Ben at the clinic prior to the school meeting and discussed a strategy with them. Then they attended the school meetings themselves and worked with the school to set up a plan to deal with the problems. This increased their confidence in their ability to deal successfully on their own with the school issues. By the end of the year, the principal, teacher, and Sarah and Ben had an effective, collaborative relationship. When our therapist attended the last meeting to discuss a transition plan for the next year, Sarah and Ben needed little help to negotiate the best placement for John's second-grade year. Altogether, the therapist attended two initial meetings at the school and the transition meeting at the end of the year. Therapists from the Parenting Clinic also called John's teacher during the year to check on his behavior plan and update her on the curriculum presented to John in the Dinosaur group. Although the timing of these meetings was earlier than our usual protocol, the number of meetings was well within the usual range for our other families. The therapist spent slightly more time on phone consultations than for families where school issues were not the main concern.

Child Dinosaur social skills and problem-solving group. John was initially resistant to the idea of coming to the child

groups. His negative experience with school made him extremely reluctant to participate in any activity that seemed remotely like school. He reported that he hated the children at his daytime school and did not want to meet any new children at night. In addition, because of his attentional difficulties, participating in a 2-hour group after a long day in the classroom was a challenge.

During the first several sessions, the child group leaders allowed children to discuss their feelings about coming to the groups. The leaders had the puppets model that they, too, had been scared or mad when they first came to Dinosaur school, but that they soon started to like the group, and that they made good friends. After this initial processing, the therapists ignored John's complaints about being in the group. Rather, they focused on praising and giving tokens for any appropriate behavior that he exhibited. They quickly noticed that while he was reluctant to volunteer answers or participate on his own, if he was asked to help another child with an answer or a project, he quickly became involved. Initially, John sought attention from the other children in the group by being disruptive and inappropriate. The other children were taught to ignore this inappropriate behavior. John was also put in charge of helping to monitor other children's friendly and positive behavior. This provided him with an opportunity to receive attention and positive approval from the other children. Children were taught to compliment things that they liked about the other children, and therapists repeatedly pointed out and reinforced every instance of friendly behavior they observed. After four sessions, John began to report to his parents that he liked Dinosaur school. Two of the other boys in the group became friends with John, and they began to have some play dates after school. From this point on, John was consistently positive about coming to the group and his parents reported that he seemed happy about a group peer activity for the first time in his life.

While he was reluctant to volunteer answers or participate on his own, if he was asked to help another child with an answer or a project, he quickly became involved.

A second issue for John during the child groups was difficulty sitting and attending for more than a few minutes at a time. (In this particular group, three children had been diagnosed with ADHD, and John had borderline symptoms, so modifications made for John were also used for the other children.) The therapists arranged the format of the group such that children had frequent opportunities to change activities and move around. After watching each videotaped vignette, therapists would lead a brief discussion with the puppet and then would have children get up and role-play the situation. They continually interspersed sedentary activities with more active rehearsal and hands-on learning to engage the children. John was reinforced for attentive behavior, but the therapist also ignored considerable wiggling and movement, if he was engaged in the lesson. John was also allowed to leave the group and go to a "wiggle space" if he was unable to sit still. Unlike time-out, this was not a punishment, and John could participate in the group discussions from the wiggle space as long as he appropriately raised his hand. At first therapists prompted him to use the wiggle space, and eventually he began to learn to recognize when he needed a break from sitting still. As long as the activities changed frequently and the therapists monitored John's attention level and need to move around, they were able to keep him engaged and on-task. When reviewing tapes of the sessions, John's problem behavior frequently occurred if he had been sitting for longer periods of time without a break. If a therapist managed to redirect and re-engage him when he first became restless or off-task, the sequence of misbehavior could be diverted fairly easily.

Summary of treatment. John's behavior improved at home first as Sarah and Ben began to use more effective limit setting, combined with frequent positive interactions. There continued to be explosive incidents throughout the treatment period, but they became less frequent, and Sarah and Ben were confident in their ability to handle the problems. The Dinosaur child group quickly became a reinforcing activity for John, and he made some of his first friends in the group. His parents reported that he was proud of these friends and proud of his ability to help them. This was in sharp contrast to his negative feelings about peers and school at the beginning of the year. The school situation was most difficult for this family. The change in the classroom placement along with some initial work in helping the parents and school to work together for John (instead of blaming each other for the difficulties) led to a much smoother school experience for John. As at home, John's difficult behavior and explosive episodes at school continued, but were reported to be less frequent and less intense. In addition, the school and the teacher felt capable in their ability to handle the behaviors and work collaboratively with John's parents to set goals and modify his behavior plan as needed. It is worth noting that a classroom change, such as this one, is rare in the families who participate in our treatment. Our first goal is almost always to make a current classroom situation work for the child and the teacher. However, in cases where a classroom switch is determined to be most beneficial to the child, the goal of the treatment then becomes to make the transition as smooth as possible.

Posttreatment

All observations and reports were collected again immediately posttreatment (6 months after the initial assessment, and 1 month prior to school ending) and 1 and 2 years later when John was in grades 2 and 3 (see Tables 1 and Figures 1 and 2). Overall, John showed fewer behavior problems following treatment, and these changes maintained at the follow-up assessments. On the ECBI, John's behavior was in the clinical range at pretest and in the normal range at posttest and follow-up. On the CBCL, according to parent report, John's scores decreased across time points. It is clear from the scores, however, that he continued to have higher rates of externalizing problems (particularly at school) than other children his age. It is notable that his internalizing CBCL scores dropped to within the normal range following treatment. John's scores on the Attention subscale of the CBCL dropped according to parent report, but remained high on the teacher report. It is also notable that Sarah and Ben's stress scores related to parenting issues dropped substantially following treatment, reflecting their reports that although John continued to be a challenging child, they now felt they had the skills to manage his behavior.

The home observations reflected a much different picture than those at pretest. The average number of negative behaviors (whining, crying, yelling, name calling) that John displayed dropped from 43 at pretest to around 3 at posttest and follow-up. In addition, the observer's report reflected a different atmosphere. Overall, Sarah and Ben issued fewer commands, and Sarah, in particular, drastically reduced her use of indirect or vague commands. John was still noncompliant approximately 60% of the time, but this was a reduction from baseline, and Sarah and Ben followed through when John was noncompliant. During one visit, John was given a time-out for noncompliance. John complained and called his mother names, but she ignored and calmly followed through with the time-out. When John returned from time-out, he initially pouted, but received little attention for the pouting and quickly rejoined the conversation in a positive manner. This time the coder's impressions of the visit were, "These parents enjoy spending time as a family and are very involved in their kid's activities. Sarah and Ben appear to have the art of ignoring down. John made negative comments at the start of each visit, but these comments disappeared when he received no attention for them. These parents appear to have good control over both children."

The posttreatment school observation also showed a different situation than the pretreatment observation. The observer reported that John was somewhat restless and inattentive during the two circle times, but that the teacher ignored the misbehaviors and re-engaged him in the discussion. During seatwork, John finished his work and went to the teacher to receive a sticker. During recess, John was actively engaged in playing with other children. At one point, the playing became rough as John and three other children began tossing rocks into the air (although not at another child). A recess assistant intervened and John and a friend were sent to a different part of the playground, where they began to dig a hole. At another recess, he played kickball with friends.

Follow-up Contact With the Family

Although their treatment ended 3 years ago, Sarah and Ben have continued to stay in touch with their therapists at the Parenting Clinic. Over the past 3 years, John has continued to be challenging at home and at school, but his behavior in both settings is more manageable. Sarah and Ben report that John's difficult times frequently coincide with times when their schedules are busier than usual and/or they have stopped being as consistent with positive discipline and limit setting. At these times, they make an effort to sit down together and problem-solve the situation. They almost always feel capable of making the changes they need to in order to turn the negative cycle around. Occasionally they consult with their therapist about a difficult situation, but in these instances they have usually already come up with a reasonable plan of action. There have been two to three major incidents at school in the past 3 years. Each time, Sarah and Ben have arranged a meeting with the school and have felt capable of handling the situation on their own. They are on very good terms with John's teacher and the school principal and are comfortable working together with them to plan John's education.

Sarah and Ben's stress scores related to parenting issues dropped substantially following treatment.

At the 1-year follow-up, when John was in second grade, his parents reported that he had been evaluated for special education because of his continuing school difficulties. He had an Individualized Education Plan with behavioral goals and received resource room instruction for two 40-minute periods a week. He was also occasionally sent to the resource room if his behavior was unmanageable in the regular classroom. His parents also reported that he had begun taking Imipramine for a diagnosis of Sensory Integration Disorder. At the 2-year follow-up, John was still receiving resource room assistance and was continuing to take the medication.

John is involved in group activities for the first time and is enthusiastic about Boy Scouts and baseball. He has friends at school and in the neighborhood. He reports that he likes school and likes his teacher.

Summary

Young children presenting with ODD/CD frequently exhibit these problems across settings (home, school, peers). In addition to oppositional and aggressive behaviors, they frequently display symptoms of ADHD and higher than normal levels of anxiety and/or depression. Manualized treatments that have the flexibility to address issues in all the problem areas can be extremely effective for these children. The above example is a case where the Incredible Years Parent, Teacher, and Child programs were used with a child presenting with pervasive externalizing behavior problems as well as some symptoms of ADHD and elevated internalizing symptoms. This child, family, and school received the same content as other parents participating in our groups. In each area, however, the therapist focused the treatment on the issues that were most salient for this case. In this way, the therapist was able to tailor the manualized treatment to the individual situation, with a successful result for the family.

In addition to the individual support provided by the therapists, the group aspect of the treatment was also helpful for this family. Being part of a group of other parents and children with similar issues provided support and confidence. These personal connections with the other families helped to remove some of the stigma and guilt that Sarah and Ben felt because of their difficulties with John. Group training can also help parents to become more independent in their problem solving (rather than depending solely on the therapist). Sarah and Ben actively participated in the buddy-calls during the group and frequently called other parents for support when they were first implementing time-out. Even after the group ended, they continued to socialize with other parents and also used them as resources when problems came up. For John, the other children in the Dinosaur group provided some of his first positive peer relationships.

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