

Parent Training Through Video Modeling and Structured Group Discussion

Behavioral parent training is a potent treatment for child conduct problems, as discussed in Chapters 6, 9, and 10. For some therapists, though, the challenge of becoming a behavioral expert and finding time to structure individual interventions, one family at time, can discourage efforts to try behavioral approaches – particularly under the productivity pressures of managed care. Fortunately, there is a cost-effective approach that relieves therapist burden to some degree, and has unusually strong empirical support. The approach uses videotaped illustrations to convey behavioral principles through observational learning, one of the most efficient ways to build skills.

The most thoroughly tested video modeling approach has been developed by Webster-Stratton (e.g., 1981a,b, 2001) and her colleagues. In the parent component of their Incredible Years Training Series, a therapist shows brief videos of parent-child interactions to groups of mothers and fathers and leads discussions on themes illustrated in the videos. In this chapter, we describe some of the videos, some of the themes, and some of the evidence on treatment effects.

The Incredible Years BASIC Parent Training Program: Conceptual Basis and Procedural Overview

Advantages of teaching parents child behavior management skills were discussed in Chapter 9. Teaching parents via video illustrations may offer further advantages. One is that the video approach employs modeling, a highly efficient form of learning that outpaces, for example, the trial and error process involved in operant conditioning (see e.g., Bandura, 1971, 1986). The video-guided approach is also more engaging for many parents than didactic learning in a classroom format, or being required to read a book and take a test on it. The advantages of a video-guided approach seem obvious for parents who do not read or who may have relatively little

formal education. However, the Webster-Stratton program has been found to work well across a broad range of parent education and intelligence. Another strength is that the video material is the same at every presentation, which ensures significant uniformity across therapists and settings. Such uniformity may help limit the impact of variations in therapist training, orientation, style, and skill. Finally, and notably in an era of managed care, video modeling is cost-effective; it limits expensive therapist training time, and therapist intervention time, in ways that cost-conscious mental health administrators will appreciate.

Although observational learning is one part of the conceptual basis for the treatment, other theoretical perspectives have been influential as well. Building on Bandura's (1989) self-efficacy theory, Webster-Stratton trains therapists to work as collaborators with parents, rather than as teachers or dispensers of advice; the collaborative approach is thought to enhance parents' "efficacy expectations" – that is, the conviction that they can successfully change their own and their child's behavior.

Cognitive-behavioral theory is also highly relevant, as therapists work with parents to identify and modify unproductive cognitions (e.g., "I'll never be an effective parent," or "My child is impossible to control.") or to reframe distressing events (e.g., a difficult child's demands can be construed as "testing limits" or "moving toward independence").

In their approach to parent training, Webster-Stratton and her colleagues share basic goals with those who train parents directly through didactics and discussion – that is, to reduce inappropriate child behavior and increase appropriate, prosocial behavior. The skills Webster-Stratton and colleagues try to inculcate in parents are also similar to the skills more traditional parent training approaches aim to teach. However, unlike those who use traditional behavioral parent training, Webster-Stratton capitalizes on the efficiency and other advantages of observational learning, and she combines this with the social support potential of the parent group format. She and her colleagues have developed multiple programs. We will focus here on a particularly well-researched series of 10 videotaped programs in which adults and children act out various interactions in brief vignettes. This series, called *The Incredible Years BASIC Parent Training Program* includes 250 vignettes, most one to two minutes long, each illustrating a behavioral principle and its implementation in parent-child interaction. The tapes are usually shown to parents of 3–8 year-olds, in groups, for 12 sessions or so, with the vignettes used to both model appropriate parent behavior in response to child problems and to stimulate group discussion.

Webster-Stratton's BASIC program has been applied primarily to youngsters in early childhood through early elementary school. There are both empirical and practical reasons for such a focus. As noted previously,

the evidence on developmental pathways (e.g., Loeber, 1991; Patterson, DeBaryshe, & Ramsey, 1989) suggests that "early starters" are the most at risk for serious long-term conduct problems. One popular early starter model involves oppositional and defiant behavior in the preschool years, progressing to aggressive and devious behavior (e.g., lying, stealing) in middle childhood, and leading to property crimes and violence in adolescence (see Lahey, Loeber, Quay, Frick, & Grimm, 1992). Early starters account for a disproportionate share of delinquent acts in adolescence, and some evidence suggests that the primary developmental pathway for serious conduct problems in adolescence and adulthood is laid down during the preschool years (see Campbell & Ewing, 1990; Loeber, 1991).

All this evidence suggests that, if one must make a choice as to what age group to focus on for intervention, the preschool through early elementary years may be a particularly wise choice. Practically speaking, the use of video modeling does require that a choice be made, because the young models must be of some age, and effective observational learning is apt to require similarity between the modeled situation and the situation faced by the learner. Videotapes with young child models probably would not be very useful to parents of disruptive adolescents.

So, the evidence on developmental pathways into serious conduct problems has led to a focus on parents of preschool through early elementary-age children. Observational learning theory and research has led to the idea of video modeling for parents. And self-efficacy theory and cognitive-behavioral principles have informed the particular approach used in working with parents.

In the BASIC program, groups of 10–14 parents meet with a therapist for 13–14 weekly two-hour sessions. Parents view a series of video vignettes showing other parents dealing with their children in a variety of situations, sometimes successfully, sometimes not. These videos are used to stimulate discussion of basic behavioral principles. Parents practice the principles in homework assignments, some of which include tracking their children's behavior to look for changes resulting from new parenting methods. Over the series of sessions, four themes are addressed: constructive use of play, using praise and reward effectively, setting and enforcing limits, and handling misbehavior.

The Incredible Years BASIC Parent Training Program: In Brief

Designed for Parents of children ages 3–8 who have conduct problems

Number of sessions 12–14

Session length 2 hours

Session participants Therapist with groups of 10–14 parents
 Theoretical orientation Observational learning, operant,
 cognitive-behavioral, relationship, group support

Treatment steps:

1. *Constructive use of child-directed play.* Therapist uses video vignettes and role-plays to focus parent discussion on constructive use of child-directed play skills to help build children's self-esteem and self-confidence, help children handle boredom, avoid power struggles with peers, improve language skills (including emotion language) and problem solving, and cope with frustration.
2. *Effective use of praise and reward.* Using other videos, role-plays, and guided discussion, therapist teaches parents ways to use praise and tangible rewards to increase the frequency of specific, desirable child behaviors. Parents are helped to generalize principles of praise to other relationships such as partners and teachers.
3. *Limit-setting.* With videos, role-plays, and discussion, therapist helps parents learn basic rules for effective limit-setting – for example, limit commands to the ones that really matter, make them clear and concise, fit them to child's maturity level, don't insert a barb, and use distraction to enhance compliance.
4. *Handling misbehavior.* Videos, role-plays, and discussion focus on dealing with child misbehavior through preventing it, strategic ignoring, time-out, logical and natural consequences, and problem solving.

Other features, present throughout the steps . . . Intervention individualized through parent goal-setting and self-monitoring, solution-focused assignments with identification of personal barriers, notes to/from therapist in parent folders, home assignments, and therapist phone calls to parents at home; peer support comes through a support group and through "buddy" calls at home.

Classified by Task Force Well established (See Brestan & Eyberg, 1998)

Key resources for potential users . . . Webster-Stratton, C. (2001). *Leader's Guide, the Parents and Children Series: A Comprehensive Course Divided into Four Programs*. Seattle, WA: University of Washington. Webster-Stratton, C., & Reid, M. J. (2003). *The Incredible Years Parents, Teachers, and Children's training series: A multifaceted treatment approach for young children with conduct problems*. In A. E. Kazdin & J. R. Weisz (Eds.), *Evidence-Based Psychotherapies for Children and Adolescents*. New York: Guilford.

Incredible Years BASIC Parent Training Program: Treatment Procedures

The BASIC program consists of 12–14 weekly sessions, each about two hours long. In each session, the therapist meets with a group of 8–12 parents, shows a series of about 15 one- to two-minute video vignettes, each depicting a parent-child interaction of some kind – typically some problem behavior by the child followed by a parental response. After each vignette, the therapist asks parents for their reactions to the situations and events, including their ideas as to how the problem shown in the vignette should be solved. The therapist's role includes some direct teaching, some reframing and refining of ideas proposed by the parents, and extensive use of role-plays to illustrate points and procedures.

Promoting parent identification with vignette models, individual goal-setting, home assignments. An important goal is to bridge the gap between the specific structure and content of the vignettes, on the one hand, and the often diverse backgrounds, situations, and problems represented by the parent participants, on the other. To assist in this process, the vignettes have been constructed with diversity in mind. The tapes show parents and children of differing ages, cultures, socioeconomic backgrounds, and temperaments. The intent is to help parents perceive at least some of the models as similar to themselves and their own children, thus to promote identification and a perception that the taped material is personally relevant. Beyond the diversity of the tapes, therapists work to help parents make the treatment personally relevant. At the beginning, parents are asked to identify specific goals for themselves and for their child (i.e., behaviors they want to see more of and less of). The therapist works to help each parent move toward these goals and to monitor progress over time. Parents are asked to read portions of the Webster-Stratton book, *The Incredible Years*, and also to apply some of what they are learning to their interactions with their children at home. This is one form of the home assignments parents are given each week; for example, they might be asked to read (or listen to audio-tapes) about limit-setting or time-out, and try the procedure with their child.

Promoting communication between therapist and individual parents: folders, weekly evals, phone calls. The therapist takes several steps to promote communication with individual parents as a complement to the group sessions. First, each parent is given a folder, in which the therapist places personal written notes to the parent, including feedback on the previous week's home assignment, plus praise (and sometimes stickers or candy) for achieving a special milestone or accomplishment. Each week, as parents arrive at the group meeting, they place in their folder the written work they have done for the week's home assignment, and they retrieve the therapist's folder entries written for them. Each parent also completes an

evaluation form for each session, which gives the therapist a window into how the parent responded, and whether there were problems that warrant a follow-up phone call. The therapist tries to call each parent every other week, to check in, inquire as to how things are going, and nurture the relationship.

Collaborative approach to intervention. Therapists are trained to adopt the role of collaborator with parents rather than expert who tells parents what to do. So, for example, during discussions of vignettes and role-plays, the therapist asks open-ended questions, actively solicits parents' ideas, and tries to facilitate group problem solving. Debate is encouraged, and parents who disagree with the therapist on some point are urged to express their views. When parents' session evaluations suggest a problem, it is the therapist's job to change in response to the feedback. In these ways, and by having parents set and monitor their own goals, procedures are designed to support the development of self-efficacy and discourage excessive dependence on the therapist, who, after all, will not be available for long.

Mutual support by parents. The therapist also engineers mutual parental support as much as possible. Parents are urged to bring a spouse, partner, other family member, or good friend to the sessions, to provide ongoing support. Each parent is also assigned a buddy, a group member who will agree to call during the week to check on how the home assignment went. Buddy assignments shift from time to time, to give parents varied experiences of giving and receiving support. The group as a whole devotes significant time to discussing ways they can be a source of strength and help for individual members, particularly when those members are feeling tired, stressed out, or unable to cope. Finally, the parent groups are encouraged to continue meeting as support groups after the formal treatment program has ended.

Tapes show parents doing it "right" and "wrong." An important aspect of the treatment experience is that the tapes show parent models both *doing it right* and *doing it wrong*. The "wrong" tapes are intended to help stimulate problem solving and discussion by parents in a way that would not be likely if parents were simply shown the right answer. In addition, Webster-Stratton has been influenced by the literature suggesting that coping approaches to modeling – that is, showing models who need to learn how to cope, and illustrating how such learning can happen – are often more beneficial than mastery modeling, in which the models simply do everything right from the outset (see discussion in Webster-Stratton, 1981b).

Do's and don'ts of using the videotapes. Therapists try to pace vignettes evenly throughout the session, and to ensure that a discussion follows each vignette. Key points are highlighted through role-plays, three to four per session. The therapist may do the first role-play, aiming for humor by exaggerating bad parenting behavior, such as yelling orders to a child from behind a closed door (in which case one can't tell whether the child

heard, understood, or obeyed), and then asking the group for better ideas. In fact, in the first parent role-play, parents may be told, "OK, do it the worst way possible," to help reduce pressure and add humor to the situation.

Contents of the BASIC Parent Video Program. The BASIC parent program contains 250 vignettes, covering four core parenting skill domains. Content of the first two domains – *play interaction* and *reinforcement skills* – was derived from important work by Hanf (1970) and Robinson and Eyberg (1981) on parent-child interaction. Content of the last two components – *setting limits* and *handling misbehavior*, including the use of effective problem-solving techniques – was derived partly from the family interaction and parent training research of leaders like Patterson (e.g., 1982; see Chapter 9) and Forehand and McMahon (1981; see Chapter 10), and partly from research by D’Zurilla and Nezu (1982) and Spivak, Platt, and Shure, (1976) on enhancing problem-solving skills. Here we summarize the four components.

1. *Play interaction.* The first set of video vignettes (25 vignettes, 36 minutes) focuses on the importance of adult attention during children’s play, and on ways parents can use child-directed play to help their children develop imagination and creativity, build self-esteem, handle boredom, and learn to avoid power struggles with peers. A second set (22 vignettes, 35 minutes) illustrates ways of playing and talking with children to promote language development (including feeling or emotion language) and problem-solving skills, help children deal with frustration, and make learning enjoyable through play. One video vignette, for example, shows a parent working on a peg board with her son:

"OK, that’s a tough one. You’re doing a good job. [Child struggles with the wrong square on the wrong peg.] How about this? Let’s find two more pegs. See if it fits here, Darren. [He tries it, as suggested.] How can you make that one fit? Turn it around. Good job. Try it again, it will fit. Good for you, that was a hard one!" (Webster-Stratton, 1989, *Play, Part 2: Helping Children Learn*, p. 24)

2. *Using praise and rewards.* A second set of vignettes teaches parents effective ways of using praise and tangible rewards to enhance child growth and adjustment. As for praise (26 vignettes, 25 minutes), parents are taught to be discriminating and planful, identifying the specific child behaviors they want to see more of (e.g., sharing, complying with requests, doing chores, doing homework, being kind to someone), and praising those specific behaviors. For their homework assignment, parents pick out one such behavior in their child, increase their rate of praise for that behavior, and track changes in the frequency of the behavior. The therapist cautions against common pitfalls, such as saving praise for only perfect behavior, which may send an unfortunate message to the child. Parents are also taught how to give praise – that is, immediately after the desired behavior, with labeling so the child is clear what the praise is for, directly and with

enthusiasm (smile, eye contact, excitement in the voice), combined with pats and hugs, and in front of other people where possible.

On the subject of tangible rewards (15 vignettes, 15 minutes), parents are shown several ways to reinforce desirable behavior in their children. For example, one vignette shows how to use unexpected rewards.

The scene. Luke's mother enters the kitchen as he is putting away the dishes.

MOTHER: Luke, I really appreciate you helping me by putting away the dishes so nicely. Since you've been so helpful, what would you like to have for dessert tonight that's your favorite?

LUKE: (with enthusiasm) Apple pie!

MOTHER: OK.

(Webster-Stratton, 1989, Praise and Rewards Program, Part 2: Tangible Rewards, p. 5)

After viewing the video, parents and therapist discuss the special value of the surprise reward (e.g., very salient for the child), and what is especially effective about the mother's approach (e.g., she combines the reward with praise, and she is very specific about what behavior is being rewarded). Models also illustrate how to set up and use star and chart systems (e.g., start simply, with a single behavior as the focus) and how to design procedures to fit the age and maturity level of the child (e.g., use star charts for younger children, point systems for older ones).

3. *Effective limit-setting.* The limit-setting component comes in three parts. The first is a set of rules for how to set limits (34 vignettes, 30 minutes). One rule is not to overdo; limit-setting commands should be used only for issues that really matter. Having too many rules and commands makes it difficult for children to keep track, and hard for parents to follow through consistently. Videotapes illustrate the problem by showing parents giving unnecessary commands during such activities as board games, coloring, and cookie baking – commands about child behavior that does not matter in the least, such as where to put the cookies on the cookie sheet. The tapes also illustrate the need to be clear and concise in giving commands to children, and to avoid commands that are not appropriate for the maturity level of the child. Consider this example of a mother's comments in a vignette showing milk being spilled by her preschooler:

"Oh, Denise, you're spilling your milk. Oh, my! Well, here, why don't you wipe that up.... Use the towel. [Denise tries, but some milk spills on the floor.] Denise, be careful – you're going to spill that milk. Look what's happening here, Denise. You better watch out!" (Webster-Stratton, 1989, Effective Limit Setting, Part 1: How to Set Limits, p. 13)

Denise tries to comply, but her mother's correcting and criticizing comments lack the specificity Denise needs, and the task itself may simply be beyond a preschooler's capacity in the first place.

Other vignettes focus on the need to give the child alternatives to prohibited actions, rather than just saying "No," and on the need to be aware of which child behaviors are being rewarded by attention. In one scene, for instance, a mother is reading, while her son plays with rubber puppets. Suddenly he bites the mother on the arm with the coyote puppet; here is what happens next:

Mother says, "No, I don't want the coyote to eat me, let the coyote eat some other animals. [Mother turns back to her magazine and reads; the boy takes the puppets and starts biting puppet animals.] (Webster-Stratton, 1989, *Effective Limit Setting, Part 1: How to Set Limits*, p. 23)

In this vignette, mother gets credit for clarity in limit-setting, and for suggesting a behavioral alternative rather than simply saying "No;" but she rewarded the prohibited behavior with attention, and she ignored her son when he obeyed her. Thus, the vignette shows both pros and cons, which become grist for the mill of parents and therapist in their postvideo discussion.

Parents are also cautioned about the tone of their limit-setting. Commands that include a barb can be counterproductive. "Jake, will you sit still for once in your life," carries a critical implication about Jake's usual behavior. This may make Jake feel incompetent, defensive, or angry, and it may thus make him less likely to obey.

Another set of video clips illustrates ways to help children accept limits (19 vignettes, 15 minutes). One approach is to follow a prohibition with distraction, as in, "OK, turn off the TV ... and let's see what other toys there are here." Other vignettes illustrate ways to avoid arguments about rules and commands; examples include involving the child in joint problem solving (where to park the bike when we put it away) and simply ignoring a child's inappropriate or combative responses.

A third set of vignettes shows ways to deal with noncompliance (9 vignettes, 13 minutes). For example, when Mom asks Max to hang up his coat, and he ignores her, she waits five seconds and then says, "OK, Max, you didn't do what I asked, so you have to go to time-out now." If Max says, "No, I'm hanging it up now," Mom lets him hang it up, but then says, "That's six minutes for arguing."

4. *Handling misbehavior.* The fourth component, handling misbehavior, is also presented in three sets of vignettes. The first set (14 vignettes, 17 minutes) involves avoiding and ignoring misbehavior, and using differential attention. Here is an example of ignoring:

THE SCENE: Dad is making dinner when his 10-year-old son enters.

LUKE: Dad, can I go over to Jimmy's house?

FATHER: Not now, Luke. It's almost time for dinner.

LUKE: But I'm not hungry. Why can't I play with Jimmy? (The father does not respond. Then Luke begins to hang on his father's arm and plead.) Please, please.

FATHER: (continues to ignore Luke's pleading and begging until Luke walks away unhappily) Want to help me decide what to have for dinner?

LUKE: Yeah.

FATHER: How about Swedish pancakes? Mom will love that. (Luke eagerly becomes involved in helping his father plan dinner.)

(Webster-Stratton, 1989, *Handling Misbehavior*, Part 1: Avoiding and Ignoring Misbehavior, p. 12)

A second series of video clips on handling misbehavior focuses on time-out and other penalties (31 vignettes, 35 minutes). In one clip, 12-year-old Derek refuses to get with the program, but his father clearly knows what to do:

THE SCENE: Derek stubbornly refuses to go to Time Out.

FATHER: Derek, go to Time Out.

DEREK: (angrily) You and your dumb old Time Outs. I'm not going!

FATHER: (calmly) That's six minutes.

DEREK: (sarcastically) Oh . . . where did *you* learn how to count?

FATHER: (calmly) That's seven minutes.

DEREK: (continues to protest) I don't wanna go. I don't have to!

FATHER: Eight minutes. (The father picks up the newspaper and begins to read it. A few minutes later he looks at his watch.) That's 10 minutes now, Derek. If you don't go to Time Out right now, you're going to lose your TV privileges tomorrow, and that means you're not going to be able to watch the big game.

DEREK: (protests) That's not fair.

FATHER: (calmly) Forget the game tomorrow. You've just lost your TV privileges.

DEREK: (starts to go to Time Out) But I was just going to go.

(Webster-Stratton, 1989, *Handling Misbehavior*, Part 2: Time Out and Other Penalties, pp. 19-20)

Here, father does all the right things, using time-out and backing it up with loss of privileges for arguing. He stays remarkably calm and

matter-of-fact throughout the interaction, even when Derek insults him ("Where did you learn how to count?"). The father's calm demeanor deprives Derek of the reinforcement of emotional attention, prevents escalation of Derek's noncompliance into an argument, and adds quiet power to Dad's parental authority.

The final set of video illustrations in this last section of the BASIC program involves handling misbehavior by preventing it in the first place (7 vignettes, 11 minutes). In one scene, an eight-year-old girl runs into the kitchen to tell her mother about her friend Colleen, who is teasing and calling her names. Mom asks, "What do you think you can do about it?" Her daughter mentions hitting Colleen. Mom asks, "... will that make things better or worse?" Worse, her daughter admits, because Colleen and her parents will get mad. Then the two discuss tattling on Colleen to her parents, and the daughter agrees that this would not work so well, either. Mom presses on, "So what else could you do? What do you think would be best for you?" Her daughter replies, "Ignore her and play with someone else." Mom says, enthusiastically, "Good idea! Let me know how that all works out." (Webster-Stratton, 1989, *Handling Misbehavior*, Part 3: Preventive Approaches, pp. 11-13).

The vignettes, and discussions of each, are complemented by parent handouts, and by practice assignments in which parents try the procedures at home, and track the results. Parent groups discuss these take-home assignments and troubleshoot any problems encountered at home. This helps parents fine-tune their learning, and it promotes a climate of group support that is so important to the Incredible Years philosophy. Of course, the process also helps therapists track whether parents have caught the concepts and mastered the skills.

Other Incredible Years Video Programs Developed by the Webster-Stratton Group. The BASIC parent program addresses core parenting skills that are thought to have a major impact on child outcomes, and particularly on whether children develop serious and enduring conduct problems. Additional Incredible Years programs have been developed to attend to other risk factors associated with child problems. For example, the ADVANCE program for parents focuses on such skills as personal self-control (e.g., how parents can control their anger and reduce their depressive, angry, or blaming self-talk), communication skills (e.g., constructive approaches to dealing with spousal conflict), problem-solving skills (esp. for interpersonal problems), and generating personal social support (e.g., how to ask others for support and help). Another series, called SCHOOL, focuses on the things parents can do to enhance their children's development of academic skills (e.g., how to provide homework structure and support, how to use teacher conferences to the best advantage). A Teacher Training Series is designed to help teachers enhance classroom management skills, promote students' social competence, reduce peer aggression, and build

parent-teacher partnerships. Finally, the Incredible Years Child Training Series, including the Dina Dinosaur Curriculum, uses videos and exercises to teach children social skills (e.g., friendship, teamwork, helping), problem solving (including anger management), and adaptive classroom behavior (quiet hand up, compliance, concentrating, thinking before acting, cooperating with peers and teachers). These additional programs have been supported in randomized trials (see Webster-Stratton & Hammond, 1997; Webster-Stratton et al., 2001a,b; Webster-Stratton & Reid, 2003), with an emphasis over the past decade on treatment that combines the BASIC and ADVANCE programs. However the most extensive research to date has been devoted to the BASIC parent program. It is to that research that we now turn.

The Incredible Years BASIC Parent Training Program: Outcome Studies Testing the Effects

Webster-Stratton's parent training program is one of the best-researched in the field, with at least seven randomized trials testing its impact. As with virtually all evidence-based treatment programs, Webster-Stratton's has evolved across successive trials; thus, early tests involved somewhat shorter versions of BASIC than later tests. Among the outcomes of interest in these studies have been parental attitudes, parent-child interactions, including parents' use of various disciplinary and behavior management methods, and of course, the frequency of child conduct problems. We turn now to the outcome evidence.

BASIC (short form) versus no treatment. In the initial trial (Webster-Stratton, 1981a,b, 1982a,b), which was focused more on prevention than treatment, 35 mothers of 3–5-year-olds (66% boys; ethnicity not reported, but the article implies exclusively or predominantly Caucasian) were recruited through flyers announcing a parent-training program. The mothers, who averaged 33 years of age and four years of college, were randomly assigned to receive either a four-session (two hours per session, one session per week) version of BASIC or to be waitlisted until two weeks after postintervention data had been collected. The tapes and discussions focused on effective play techniques, limit-setting, ways to handle misbehavior, and communication and feelings.

After the intervention group had finished the program, several outcome measures showed them faring better than the control group. Behavioral observations (30 minutes videotaped in a playroom) indicated that BASIC mothers showed more positive affect and less dominating and nonaccepting behavior toward their children than did parents in the untreated group. Mothers in the intervention group also reported fewer and less intense behavior problems in their children. Children of the BASIC mothers showed correspondingly less negative affect, less submissive behavior, and more

positive affect than did children of control group mothers. BASIC and control group mothers showed fewer differences in parental attitudes, although the BASIC group did show a trend toward greater confidence; and on a consumer satisfaction survey, all of the mothers who had received BASIC reported that they were "very positive" about the program and perceived positive changes in themselves and their children. Notably, when the control group mothers were later given the BASIC program, most of the positive changes seen in the original intervention group were replicated; and a follow-up assessment showed that most of the behavioral changes noted for mothers and children in coding of their interactions at posttreatment were either maintained or improved one year later.

BASIC group versus individual one-on-one (nonvideo) therapy. In a second trial, Webster-Stratton (1984) compared the BASIC group approach to a non-video individual treatment approach, with parents of 35 3–8-year-olds (71% boys; 43% having a history of reported abuse; ethnicity not reported) who showed serious oppositional behavior in such forms as chronic defiance, aggression, and tantrums. After recruitment and screening, parents were randomly assigned to (1) a nine-week session (17 hours) version of BASIC, carried out with groups of 8–19 parents; (2) a nine-week session (16 hours) program of individual therapy involving parent, child, and therapist; or (3) a waiting list. The individual therapy program was designed to resemble BASIC in a number of ways. The first four weeks of each were devoted to training in interaction skills, a la Hanf and colleagues (Hanf, 1970; Hanf & Kling, 1973; see Chapter 10), and the last five weeks focused on teaching parents specific techniques for behavior management.

However, the manner of training differed markedly across the two groups. Unlike BASIC, with its combination of videos and group discussion, the individual treatment placed the therapist in sessions with each parent and target child alone. During these sessions, the therapist modeled appropriate parenting skills, then the parent role-played these skills with the child while the therapist, stationed behind a one-way mirror, provided direct supportive and corrective feedback to the parent via a bug-in-the-ear device. A particular advantage of the individual therapy approach was that, in addition to teaching the general skills covered in BASIC, therapists were also able to focus directly on each target child's specific behavior problems and coach each parent via the bug in appropriate responses.

This individual treatment may seem an unusually strong comparison condition to pit against BASIC. Indeed it was! In fact, while the BASIC and individual therapy groups outscored the waitlist group on multiple parent-report and home observation measures of parent and child behavior at posttreatment, none of these measures showed a significant difference between the BASIC and individual therapy group, either at the end of treatment or at a one-year followup.

Does this null finding represent a failure of the BASIC program? No. Remember that BASIC was superior to a waitlist control condition on multiple measures of child and parent behavior; it clearly worked better than no treatment. Remember, also, that individual treatment is much more expensive to deliver than group treatment. Total therapist time was 251 hours for the entire individual therapy group, but only 48 hours for the BASIC video group. Thus, at one-third the cost in therapist time, BASIC produced benefits essentially equivalent to individual therapy. From a cost-effectiveness perspective, this study offers substantial support for the BASIC program.

One other notable feature of this study (Webster-Stratton, 1984) is that it employed a sample that was different from, and arguably more at-risk than, the sample used in the first trial. Parents in that initial trial (Webster-Stratton, 1981a,b, 1982a,b) were college-educated, middle and upper socioeconomic status, mostly married, highly motivated to seek out parent training (75% had done so previously), and nonclinical in the sense that they were recruited through flyers rather than referred to the clinic; and their children evidently did not have very severe behavior problems. Parents in this second clinical trial were generally low in socioeconomic status and educational level and predominantly single parents; they showed a high prevalence of child abuse, and their children's problem levels were above the 95th percentile on national norms. The fact that the BASIC program produced markedly better outcomes than waitlist, on multiple measures, with such a sample, is encouraging evidence that the program benefits can generalize to more at-risk parents and children.

BASIC versus video-only versus group discussion-only. The third clinical trial (Webster-Stratton et al., 1988; Webster-Stratton et al., 1989) was a dismantling study. It tested whether the full BASIC package of videos plus therapist-led group discussion is more efficacious than (1) merely viewing the videotapes, with no therapist and no group discussion, and (2) group discussion covering the BASIC topics and skills, but with no videos. The sample included parents of 114 3–8-year-olds (69% boys; ethnicity not reported), referred because of noncompliance, aggression, and oppositional behavior. Home observations prior to the study showed that the children averaged almost one noncompliant behavior per minute. The parents were a heterogeneous group in socioeconomic status and income level, and they reported high rates of alcoholism or drug use in the immediate (40%) and extended family (61%); 13% of the mothers reported some involvement with Child Protective Services, and 31% reported significant depression (scores above 10 on the Beck Depression Inventory). Some 57% had been referred to the project by professionals, with the remainder self-referred.

Parents were randomly assigned to either a waitlist condition or one of the three alternate treatment approaches. In the video-only treatment, parents came to the clinic weekly for 10–12 self-administered sessions (most lasting about one hour); a secretary set them up with a room and that week's

set of videotapes, which parents viewed at their own pace, reviewing tapes if they wished. By the end, the video-only parents had seen the same videos as the BASIC group, but with no input from a therapist and no group discussion. Parents in the group discussion-only treatment came to the clinic weekly for 10–12 two-hour sessions. They met in groups of 10–15 parents, led by a therapist, who directed a group discussion of the same topics and skills featured in the BASIC video series, but without any videos.

Outcome assessment included parent-report measures of child problems, home observations of parent and child behavior conducted by trained observers, teacher reports on the children, and a consumer satisfaction questionnaire. Compared to parents in the waitlist condition, parents in all three treatments reported significantly less spanking by parents, fewer child problems, and more child prosocial behaviors; and home visit observations also showed better mother, father, and child behavior in treated than untreated families. Where there were differences among the three treatments, they generally favored the BASIC group that had received both videos and therapist-led group sessions; for example, the full BASIC program outperformed the single-component treatments in increasing mothers' and fathers' praise to their children, reducing mother's reports of parenting stress, and generating good session attendance, low dropout rates, and consumer satisfaction with treatment.

However, one of the most striking findings was the absence of treatment group differences on most of the outcome measures! These findings held up rather consistently at a one-year follow-up assessment (see Webster-Stratton et al., 1989). Overall, the study results suggest that both components of the BASIC package – that is, the videotapes and the therapist-led group discussions – can be efficacious when used alone, if they cover the same issues and skills addressed in the BASIC program. The full BASIC package, with videos plus group discussion, was somewhat more beneficial than the separate components alone, on a few measures but not on most.

Testing individually administered BASIC videos, with and without therapist consultation. In the dismantling study we just discussed, the least expensive of the three alternative treatment methods was clearly the video-only approach in which parents viewed the videos alone. This approach required only a bit of secretarial time to hand parents the videos and situate them in a viewing room. Across all the outcome measures employed, this simple approach fell short of the full BASIC package (i.e., videos plus therapist-led parent discussion groups) on only a handful of measures. This finding led Webster-Stratton (1990) to explore the possibility of enhancing the impact of this highly cost-effective video-only approach. Her strategy: pairing solo video watching by parents with modest amounts of therapist consultation. In Webster-Stratton (1990), parents who viewed the tapes alone were told they could call the therapist any time they liked over the 10 weeks of video

viewing, and they were scheduled for two one-hour individual sessions with the therapist, one midway through the program (after the play, praise, and tangible reward parts) and one at the end (after the limit-setting and discipline parts).

The sample consisted of families of 43 3–8-year-olds (79% boys; ethnicity not reported), all referred for misconduct, in this case misconduct persisting more than six months. Some 26% of the mothers reported experiencing spousal abuse, 42% reported substance abuse in the immediate family, and 14% had had prior involvement with Child Protective Services because of child abuse reports. The participating parents (all 43 mothers and 26 fathers) were randomly assigned to either (1) a video-only condition like that of the Webster-Stratton et al. (1988, 1989) dismantling study described earlier, (2) the video + therapist condition described in the previous paragraph, or (3) a waitlist control condition.

At posttreatment, compared to the waitlist group, mothers in the two treatment groups reported significantly fewer child behavior problems, less use of spanking, and lower parenting stress levels; and home observation data showed that treated mothers showed more positive affect with their children. Comparison of the two treatments showed only two significant differences in outcomes – that is, families in the video plus therapist condition, compared to those in the video-only condition, showed fewer no-opportunity maternal commands (i.e., commands to which the child is given no chance to respond) and less child deviance in home observations. Other measures, even consumer satisfaction, showed no significant difference between the two treatment approaches. So, like the dismantling study discussed earlier, this study found beneficial effects of merely having parents view the tapes alone, plus some modest incremental benefits of adding a small amount of therapist consultation.

Testing BASIC + ADVANCE. In a later study, Webster-Stratton (1994) tested whether adding the ADVANCE program, discussed earlier, might enhance the impact of the BASIC program, by addressing the parents' ways of handling stress. Recall that the ADVANCE program teaches parents to cope with interpersonal stress via improved communication, self-control, and problem-solving skills. The potential value of such adjunctive training was suggested by Webster-Stratton's analysis of her own data from 218 families, showing that the most potent predictors of child deviance at long-term followup were marital distress and lack of a supportive partner. This 1994 study was designed to test whether addressing such stressors through the ADVANCE program would strengthen the impact of the BASIC program.

To structure this test, a sample of 78 3–8-year-olds (74% boys; ethnicity not reported) was assembled; the children in this sample had not only been misbehaving for six months, but all met criteria for a DSM-III-R diagnosis of oppositional defiant disorder or conduct disorder. The full sample received the standard BASIC program, with the full set of videos and therapist-led

discussions. After completing BASIC, half the parents were randomly assigned to the ADVANCE program. When ADVANCE was completed, outcomes were assessed in both the BASIC-only and the BASIC + ADVANCE groups.

Did ADVANCE make a difference? Yes, on some key measures. Families in the combined program showed significant benefits in the areas of parental problem-solving, communication, and collaboration skills, in consumer satisfaction (and treatment attendance), and in the number of prosocial solutions their children proposed on a problem-solving test. However, adding ADVANCE did not enhance parents' self-reports of marital satisfaction, anger, or stress levels, nor did it reduce either parent reports or observer reports of child deviant behavior at home. So, the various outcome measures presented a mixed picture. And those findings that did show beneficial effects of adding ADVANCE may be difficult to interpret, because the add-on study design meant that the combined treatment group received about twice as much treatment time as the BASIC-only group. However, the outcomes that did show benefits of adding ADVANCE were regarded as particularly important by the Webster-Stratton group, and their subsequent research has heavily emphasized combining the two programs.

BASIC versus eclectic mental health center treatment. In a particularly timely study, given current interest in taking evidence-based treatments into practice settings (see Weisz, in press), Taylor et al. (1998) compared the standard BASIC program with the kind of treatment that would otherwise be available in a community clinic. In doing this, they also provided a test of the usability and impact of the video approach in representative clinic practice. Wasn't this done in the clinical trials just reviewed? Perhaps not very fully, at least according to the list of illustrative clinic therapy characteristics discussed by Weisz et al. (1992, 1993, 1995a). As Taylor et al. (1998) note, in those earlier trials, "... the program was offered in a university laboratory, rather than a clinic," "... treatment was delivered to a homogeneous group," "... The therapy was offered by the program developer or by assistants under her direct supervision," and all of them "had small therapy caseloads of [similar] clients" (p. 223). This is certainly not a criticism of those prior studies, because their intent was not to provide a test in a fully representative clinical practice setting. Nonetheless, it is appropriate for clinical practitioners to ask whether the BASIC procedure (and other evidence-based treatments as well) can produce beneficial effects in a representative service-oriented community clinic, with clinic staff therapists leading the groups, and with clientele consisting of families referred to the community clinic. It was this question, in part, to which the Taylor et al. study was directed.

In addition, the study was designed to answer a comparative question: How would the BASIC program fare relative to the usual treatment provided in this community clinic? This question goes to the heart of what many want to know about empirically tested treatments – that is, whether

such treatments will lead to better outcomes than those already achieved via current treatment procedures, or usual care. The Taylor et al. study tackled this question as well.

As in the previous clinical trials, the Taylor et al. sample was limited to parents of 3–8-year-olds, parents who had contacted a community clinic regarding child conduct problems or difficulties in parenting. There were 108 children (74% boys; ethnicity not reported), all living in Canada, where the mental health center was located. Families deemed appropriate for waitlist placement were randomly assigned either to a waitlist, to BASIC (with therapist group leaders who had been thoroughly trained, in part by Dr. Webster-Stratton), or to the usual treatment of the clinic, which was an eclectic mixture of approaches including “ecological, solution-focused, cognitive-behavioral, family systems, and popular press parenting approaches” (Taylor et al., 1998, p. 229).

Results showed that both BASIC and usual care generated reports of significantly fewer child problems than the waitlist condition on multiple parent-report measures, although a teacher-report measure and some parent measures did not show such differences. When BASIC and usual care were compared, the two parent-report measures of child problem behavior (of six) that showed a significant difference favored the BASIC program. The BASIC program also generated higher consumer satisfaction ratings.

Interpretation of the findings is complicated somewhat by the fact that the participants were partially recruited through physicians and school principals (i.e., not all spontaneous call-ins), the fact that BASIC parents received a larger average number of therapy contact hours than the usual care parents, and the absence of direct observations of parent or child behavior. Still, the overall pattern of findings is certainly consistent with two important conclusions: (1) the BASIC program does appear to have been useable and effective in a community clinic setting, and (2) BASIC generated better outcomes and higher levels of consumer satisfaction than the usual care provided in that setting, on at least some measures, and none of the measures showed usual care to be superior to BASIC.

British clinic test of BASIC effects. In another application of the treatment program in a clinical practice context, Scott et al. (2001) tested BASIC with parents of children referred to any of four local mental health service programs in England for treatment of antisocial behavior. The children, ages 3–8 and 75% boys (ethnicity not reported) were above the 97th percentile on interview-assessed conduct problems, compared to population norms. At the beginning of the study, children were assigned in blocks (not randomly but using an unbiased assignment strategy) to either a waitlist condition or the BASIC program; videos were dubbed into English accents. Treatment was delivered by therapists of multiple disciplines who held regular jobs in the service settings, and who had received training in the program over a period of three months. After the program, parents in the treatment

condition had shown marked improvements in parenting behavior; with the ratio of praise to ineffective commands tripling from pre- to post-treatment. By contrast, parents in the waitlist group showed change in the opposite direction. The children of treated parents also showed marked reductions in conduct problems, falling to within the normal range on the interview assessment, whereas children in the waitlist group showed no improvement.

Summary of the clinical trials evidence. We have reviewed seven outcome studies testing the BASIC program. Together, the studies offer rather consistent evidence of beneficial effects. The BASIC program is associated with improved parent-child interactions, reduced parental reliance on critical and violent forms of discipline, and reduced child conduct problems. The full program, including therapist-led parent discussion groups, has the strongest support, but there is evidence of benefit when parents merely view the videos alone, and when therapist-led discussion groups cover the topics of the BASIC program without any videos involved. When parents view the videos alone, therapist consultation may help a bit; and when BASIC is combined with the ADVANCE program described earlier, there appear to be increments in benefit associated with helping parents address stressors in their lives. Recent evidence from Taylor et al. (1998) and Scott et al. (2001) suggests that the BASIC program can work well when it is taken out of the university and used in community clinic settings by staff therapists.

Research on Webster-Stratton programs other than BASIC. Webster-Stratton and her colleagues have also carried out studies of her programs that complement the BASIC parent training program. Findings on the benefits of multiple-parent programs (BASIC + ADVANCE) have led the Webster-Stratton team to make the combination of BASIC + ADVANCE + SCHOOL (22–24 sessions) their core treatment program for parents of children referred for conduct problems. Studies have also tested the programs for children (see Webster-Stratton & Hammond, 1997; Webster-Stratton et al., 2001) and teachers (see Webster-Stratton & Hammond, 2001), and evidence (reviewed by Webster-Stratton & Reid, 2003) suggests that the child training and teacher training programs may add significantly to the impact of parent training. A case study (Reid & Webster-Stratton, 2001) illustrates ways to combine components of the various programs, a strategy that may be particularly important for children whose problems show up in multiple settings, not just at home.

What about Sal? Applying the Incredible Years BASIC Parent Training Program

Thinking about Webster-Stratton's video modeling approach in light of the case of Sal highlights several issues. First, Sal's age and the severity

of his conduct problems place him beyond the usual range of the BASIC program, which is designed for parents of children in elementary school or younger, and for less entrenched and less dangerous behavior than Sal's. The level of difficulty and the intransigence of Sal's current style remind us of the literature on developmental pathways, noted at the beginning of this chapter. Sal's case is consistent with research suggesting that basic building blocks of serious conduct disorder are often in place by early elementary school (see Campbell & Ewing, 1990; Loeber, 1991), and that "early starters" are particularly at risk for serious long-term conduct problems (see e.g., Loeber, 1991; Patterson et al., 1989). Sal has had a poor relationship with his mother since his preschool years, and she is now almost completely ineffective in managing his behavior. Might Sal's mother be more effective with him now if she had had early training via the BASIC program? This seems a real possibility. We will develop the idea here, describing how the BASIC program might have been applied when Sal was a first grader and already showing disobedient and disruptive behavior.

Sal's mother seeks out a therapist when Sal is six, after the first progress report and parent-teacher conference of his first grade year. Learning from Sal's teacher that he is disobedient and disruptive in class, and that he is aggressive toward peers, scares her. The behavior in school sounds a lot like what she has seen at home, and this tells her that Sal's problems are spreading, that they are more than just normal mother-child conflict. The therapist agrees that the problems are significant, and that the time is right for intervention. She invites Sal's mother to join a parent training group that is about to begin, and to bring her husband along as well.

The odds of getting her husband in are slim to none, Mom thinks, but the therapist is very persistent, even going to the extent of calling Dad at home to ask about his perspective on Sal, then calling again to invite him to the first session "just to see if you think it might help." The therapist knows that the BASIC program can be helpful even if only mothers do the program, but that effects show better long-term holding power if fathers (or grandparents, or others in the family who are close to the child) join in (Webster-Stratton, 1985). Together, the therapist and Sal's mother wear Dad down. He grudgingly agrees to come to the first meeting, saying he'd like to find a way "to make the kid less of a pain in the butt." To his surprise, he quickly learns to appreciate the therapist's respectful, collaborative approach. He has never liked having so-called experts tell him what to do, but this therapist doesn't do that. She seeks his opinions, listens closely when he speaks, and follows up with occasional phone calls. Although Dad warms up to the therapist's collaborative approach, he is still not consistent in attending the group meetings. The therapist is ready for this problem. For each session Dad misses, the therapist either schedules a make-up session or sends Mom home with videos covering the key skills, and the job of discussing each vignette with Dad.

In their first meeting with the parent group, Sal's parents get acquainted with nine other parents – four couples and one single mom, all with children ages 5–7. As the other parents describe the difficulties they are having with their children, Sal's mother breathes a sigh of relief. At least she is not the only parent who faces these difficulties, and who feels the need for expert help. After a get-acquainted discussion, the therapist tells the parents that she expects to have 14 weekly meetings, all lasting about two hours. She also explains that the meetings will not be like a class in school, with lots of lecturing and note-taking. Instead, most of each meeting will involve short videotapes of parents and children, followed by discussions. Sal's mom and the other parents like this idea; it sounds more interesting than what they had pictured.

Using Play to Teach Skills and Build a Relationship. The first set of skills the parents learn about are positive skills – ways to encourage their children to do good things. As a first step, the therapist has the parents focus on ways of using play activities to build child skills and self-esteem and strengthen the parent-child relationship. Sal's mother is impressed by the videos that show parents helping their children learn to solve problems that arise in play – from peg board pieces that don't fit to conflict with playmates. She realizes that much of Sal's misbehavior, including his explosive temper, grows out of frustration over problems he can't solve. She also learns, through the videos and discussion, that she can help Sal build problem-solving skills through a gentle, supportive style of play that models patience and encourages creativity and perseverance. The idea that this may also improve her relationship with Sal has a lot of appeal. She knows the relationship needs help.

At home, she tries to use the gentle, narrative style she has seen modeled in the parent meetings. First, because Sal is fascinated by cars, she buys a simple model kit – a plastic car that she and Sal can assemble together. As they work on it and encounter problems, she tries to maintain the patient, encouraging style she has seen modeled in the videos. Here is a sample of their interaction:

SAL: (frustrated) This wheel won't go here!

MOM: Gee, you're right. I thought it would fit, too. Is there a different place for it?

SAL: Well, maybe. But where?

MOM: Maybe it could go here, or here – which one do you think is right?

SAL: I think here. (tries it, and it does fit) Hey – it works!

MOM: Great job, Sal. You figured it out! (high fives)

Through interactions like this, Sal's mom models patient perseverance for her son, she encourages him to try different options when he encounters a problem, she offers guidance but avoids taking over the task, and she praises him when he perseveres and succeeds. In addition to helping Sal build skills, these shared play and problem-solving experiences are also strengthening the mother-son relationship in ways that may pay important dividends, especially as Sal matures and the problems he confronts grow more complex. The therapist has told parents they can think of this as a bank account, one they can build up through positive interactions, and then can withdraw from when problems arise and discipline is needed.

Sal's mom also uses what she learns in the parent group to help Sal deal with a second type of situation that often leads to problems – peer conflict. As an example, when Sal has 6-year-old Evan (the son of Mom's parent group buddy) over for a play date, a shouting match erupts.

SAL: (pushing Evan) Go home. I don't want to play with you.

EVAN: (crying) Me neither. I want to go home.

MOM: Hey guys – what's the problem?

(Both boys shout at once. Sal wants to play outside. Evan wants to play a video game. Neither boy will budge.)

MOM: Well, this sounds like a problem we can solve. If Evan wants a video game, and Sal wants to play outside, what could we do to be fair? (Both boys are silent.) Is there a way for both of you to get some of what you want?

EVAN: (after a long pause) We could do both things?

MOM: What do you think, Sal? How about that idea? Video game for a while, and then play outside for a while?

SAL: (reluctantly) OK.

MOM: Alright, guys – nice work! I think you two have solved the problem. You did such a good job, you get a reward – how about some ice cream while you do the video game?

SAL AND EVAN: (in unison) Yeaaaaah!

Here again, Sal's mom models a calm, problem-solving approach, and she provides the guidance two 6-year-olds need while avoiding the trap of completely taking over. In fact, she coaches the boys from the sideline throughout their play date, using other skills learned in the program. She describes their friendly behaviors such as waiting, taking turns, and helping each other; and she comments on how they are working as a team and on how much they seem to be enjoying being with each other. As in the video example, she praises and rewards the boys for successful problem solving. The praise and reward are crucial, as she has learned in another component of the parent program.

Effective Use of Praise and Reward: Catching Sal Being Good. The parent meetings that focus on praise and reward make a strong impression on Sal's mom. She realizes that her style of parenting has been mostly negative; she has criticized (and sometimes punished) Sal for his misbehavior, but she has been quite passive in response to his good behavior. She has been fairly consistent in criticizing Sal for breaking household rules, but when he has played quietly or done a chore without complaining, she has most often been silent (afraid to break the spell). This style of parenting, the therapist explains in one of the meetings, can lead to increased misbehavior; children learn that they gain little by behaving appropriately, and they gain attention by misbehaving. The way to increase good behavior is to make it rewarding. Prompted by the therapist, Sal's mom decides that a key part of her job description needs to be "catching Sal being good," and then praising and rewarding the good behavior.

The parent meetings make it clear that using praise and reward effectively involves much more than simply dispensing a lot of each. A critical part of the process is deciding what specific kinds of positive behaviors are to be targeted. As an experiment, the therapist asks all the parents to pick one child behavior they would like to see more of, and to increase their rate of praise for that specific behavior. Sal's mom chooses washing hands after using the toilet. She learns that to make her praise most effective, she needs to (1) give it within 5–10 seconds of the desired behavior; (2) label the praise, so Sal will know what he did that made Mom so pleased; (3) be direct and enthusiastic; (4) add pats and hugs; and (5) do the praising in front of others, if possible. She also learns not to reserve praise for only perfect performance, but to look for reasonable approximations, even if they have to be prompted a bit. Clearly, proper praising is more complicated than she ever realized. So, she studies her notes carefully after the parent meeting, and then she waits for the right moment. It comes before dinner the following evening, when the three of them are sitting down at the table. Sal jumps up to run to the bathroom. The toilet flushes, and the door opens immediately.

MOM: Sal, remember what we do after flushing the toilet? (she prompts Sal)

SAL: I did! (Mom looks away from Sal, says nothing) Oh yeah – I forgot. Just a minute. (returns to bathroom and washes hands; returns to table)

MOM: Good, Sal. Thank you for washing up (not waiting for perfection, but rewarding a reasonable, prompted washup; giving labeled praise, immediately after the desired behavior). Your dad and I like it when you wash up. (praising in front of a third party)

SAL: (smiles, looks down shyly)

MOM: My smart boy! (enthusiastic, and with direct eye contact; she reaches out and hugs him, magnifying the praise by adding physical affection) . . . and how nice and clean your hands smell (sniffs the soapy smell)!

SAL: (sniffs his hands, smiles) Yeah – smells good.

Mom briefly considers adding, “Next time, don’t make me ask you to wash,” but she remembers that the therapist cautioned parents not to mix praise with criticism, even implied criticism. One of the videotapes the parents watched showed how adding a statement such as “Next time, do it this way . . .” can undermine the positive effect of praise. So she decides not to add the “Next time” comment. Instead, she figures she can just watch for a time when Sal washes without a prompt, and then she can give enthusiastic, labeled praise for washing without being asked. Good job, Mom!

As the themes of praise and reward are developed further in the parent sessions, Mom expands her agenda to include more specific positive behaviors by Sal: brushing his teeth before school and before bedtime, putting his dirty clothes in the hamper, and – importantly – obeying parents. To help make these behaviors rewarding for Sal, the therapist suggests the use of a star chart, in addition to the usual procedures for praising good behavior. Each time Sal does one of the desired behaviors on Mom’s list, she gives him a star to stick on the chart (labeled “Sal’s Stars”). The consequences of good behavior are thus expanded. Whenever Sal has earned seven stars, he gets to choose a prize from a grab bag of small toys and stickers Mom has put together. Each time Sal shows one of the desired behaviors, she looks directly at him, gives him labeled and lively praise, hugs or pats him, and gives him a star to put on his chart. Each time he gets his seventh star, the praise escalates, and the grab bag ceremony is carried out.

With her growing skills in the use of praise and reward, Sal’s mom sees a real difference, both in her behavior and in Sal’s. She has become much more of a strategist, setting goals for Sal’s behavior, and ensuring that he receives positive consequences when he attains those goals. Just as the therapist suggested, when Sal’s consequences for good behavior grow more positive, so does the frequency of his good behavior. Not surprisingly, the overall tone of their interactions has grown much more positive and loving. Of course, the specifics of what Mom does will need to evolve over time. The same praising comment will lose some of its sparkle with repeated use, and the grab bag of goodies will be less thrilling with increasing familiarity, and as Sal matures. So, ways of praising Sal will need

to change from time to time, and the menu of star rewards will need to be revamped, eventually including certain valued privileges (e.g., TV or video game time). Nonetheless, Sal and his mom both have made real gains, and they have established a relationship in which she has a significant positive impact on his behavior.

Setting Limits and Giving Commands. Although things are better than before, and Sal's mother feels more in control than she has in years, there are still times when she feels she has little leverage with Sal – times when he does what he wants regardless of what she tells him. She has an idea as to why this may be the case. In the parent discussions, and through the video illustrations, she comes to realize that her general lack of confidence spills over into the ways she gives Sal directives and commands. She often gives directives in vague ways that make it hard for Sal to be sure what she wants. As one simple example, she sees Sal and herself illustrated in this video of a son and his father:

FATHER: Derek, your bike is still in the yard!

DEREK: (irritated) So?

FATHER: You know better than that.

DEREK: (angrily) Better than what?

She has had very similar interactions with Sal, in which she complains to him about what he has done without saying specifically what she wants him to do (e.g., without saying, "Put your bike in the garage."), and in which Sal has grown angry at her, in just the way Derek does in the video. She realizes that she has also weakened her effectiveness with Sal by making two other command errors discussed in the parent group meetings: (1) *"Let's" commands* (e.g., "Let's put the video game away now."), which falsely imply that she is going to help; and (2) *Question commands* (e.g., "Want to put your video game away now?"), which imply that it's up to Sal to decide. She resolves to try to make her commands very clear and direct, to see if this changes Sal's responses. She quickly learns that simple, declarative commands, such as "Sal, put your video game away now," work noticeably better than her old, obfuscating instructions.

Several other tips on effective use of commands also prove helpful. Mom learns not to let her irritation show up in barbed commands, such as "Eat with your mouth closed – not open like a pig." She learns to offer alternative behaviors when forbidding some activity (e.g., telling Sal that he can't watch TV, but he can look at his comic books). She learns to help Sal

anticipate good consequences of compliance by using When/Then commands (e.g., "When you put your toys away, then you can go outside."). She learns not to get drawn into the Why game, by letting Sal badger her into justifying every command. She also learns to use her newfound skills in praising and rewarding each time Sal complies with a command. In the past, she had viewed Sal's compliance (when it happened) as the end of the episode; she now realizes that each episode of command-comply should end with a positive consequence for Sal.

Reducing and Responding to Sal's Misbehavior. Even children whose parents are very skilled behaviorally sometimes misbehave. So, all parents need skills in how to respond to misbehavior. Sal's mother finds the skills she learns in the final part of the parent program to be especially useful in dealing with her son, who is widely recognized as a handful.

Strategic ignoring. One of the most useful skills she learns is a deceptively simple one: strategic ignoring, sometimes combined with distraction. Sal sometimes gets it into his head that he simply must have something, such as ice cream. When his mom refuses, he pleads, and the pleas escalate to shouts. In the past, she has responded by explaining her reasons, or bargaining for a compromise, or even crumpling under the pressure and giving in to Sal's demands – all of which helps to explain why his demanding style has gotten out of hand. With the benefit of the parent meetings and the very helpful videos, she adopts a new strategy for dealing with Sal's demands, as reflected in the following episode.

SAL: (after dinner) Hey, Mom, I want some ice cream for dessert.

MOM: (looking directly at Sal) No, Sal. You've had enough sweets today.

SAL: No I haven't. I'm hungry. Give me some ice cream!

MOM: (immediately turns away from Sal and walks to another area of the kitchen)

SAL: (follows Mom, and says with rising volume and pleading tone) I'm really hungry. I've got to have ice cream! (continues pleading, continues following her, grabs her arm and pulls her toward the refrigerator)

MOM: (continues to ignore Sal, busies herself in the kitchen, and then, when Sal has been quiet for a moment, says . . .) "Hey, want to make some popcorn and play checkers?"

SAL: Sure. I bet I'll win!

Here she ignores the unwanted behavior of a very persistent son, then shifts him to another track through the skillful use of distraction. Clearly, Sal's mom is learning some useful skills.

Time-out. Another important skill she hones in the training program is the use of time-out. She has tried time-out prior to the parent program, of course, but she discovers that she has not done it in the best possible way. One problem: she has always presented time-out as punishment, and always when Sal was upset and she was angry with him. The therapist explains to parents that time-out should actually be explained to the child, in a more positive way, and at a time when the child is behaving appropriately. When this happens, the parent should explain that time-out is a way of helping the child learn not to do certain things that are unacceptable; it is also a way to help the parent avoid getting angry and help the child calm down. The parent needs to be clear about what specific behaviors will lead to time-out, where the child will go during the time-out, and how long the time-out will last. Sal's mom decides that (1) hitting and (2) refusing to obey after three requests will both lead to time-out, so she explains this to Sal. She tells him that he will need to go to the time-out chair she will place in the hallway, and that his time-outs will last six minutes (one minute for each year of age, the therapist suggests).

In the parent discussion during this phase of the training program, parents come up with lots of problems they have encountered in using time-outs, and some of these sound familiar to Sal's mom. One is that the child may simply refuse to go to time-out, or may insist on arguing about it. If this happens, the therapist suggests first ignoring the child's protests to see if they subside; if ignoring does not stop the behavior, then the parent should tell the child that one more minute has been added to the time-out. If the refusal or protests continue, parents should add additional minutes, one at a time, until nine minutes has been reached. At that point, parents should tell the child that further refusal will lead to a loss of some valued privilege, such as TV time, or an upcoming play date with a friend.

Sal's mother listens attentively, makes notes on her parent handout, but remains skeptical. However, when Sal comes home from school the next day, she sits down with him before there has been time for any misbehavior. While both are calm and relaxed, she explains the rationale and procedures for time-out. To her surprise, Sal listens attentively. He seems to be interested in hearing about time-out from this new perspective, one that sounds more like solving a problem than it does like punishment. It is three more days before she actually has to use time-out. When she does, she soon discovers that Sal hasn't given up testing limits. The occasion is Sal's refusal to take his plate to the sink after dinner. He refuses twice, his mother reminds him of the time-out rule, but he then refuses a third time. Then the following exchange ensues:

MOM: OK, Sal, remember what I said about time-out. If you disobey me three times, you have to go to time-out. Go to the time-out chair now. (pointing to it) You have to stay there six minutes.

SAL: No! It's not fair, and I'm not going!

MOM: OK, I'm adding another minute. You now have to stay for seven minutes. (Sal stays put.) OK, now it's eight minutes. (Sal puts on his angry face, stands fast.) OK, now nine minutes. (Still no movement by Sal.) Sal, you now have to stay there for 10 minutes.

SAL: No way!

MOM: Sal, if you don't go now for 10 minutes, there's no TV for you tonight. Understand? (Sal doesn't budge) . . . Well, Sal, you've lost your TV for tonight.

SAL: (hangs his head, begins walking to the time-out chair.) OK, but it's not fair. (sits down)

MOM: (ignores his comment and follows through with loss of TV for the evening.)

This exchange makes a believer out of Sal's mom. She is amazed to see that the procedures taught in the parent group actually work with Sal, albeit after considerable resistance on his part. Certainly, she is not home free, and there is a good deal more to be learned and done. She needs to work with Sal on developing good problem-solving skills, to prevent his erupting in anger when things don't go his way. She also needs to assess whether Sal's improvement at home is generalizing to his behavior at school. If not, she will need to work out a collaborative plan with Sal's teacher. However, the parent group discussions, the illustrative videos, and the therapist's insights have helped Sal's mother sharpen her parenting skills in some very important ways, and Sal's behavior is already showing encouraging changes.

Of course, all this assumes that the parenting skills taught in the BASIC program, if learned when Sal was a preschooler, might have made a big difference in his behavior as a 13-year-old. We cannot be sure in any specific case, but the evidence reviewed earlier is consistent with this idea. Indeed, Sal's behavior at age 13 might be seen as an illustration of why many in the field favor a "stop it before it multiplies" approach to conduct problems in early development.

Troubleshooting: Common Treatment Problems and Recommended Solutions

The Webster-Stratton program has an impressive track record with families like Sal's, but experts in the program acknowledge that problems can

arise, some involving parents' behavior in the group meetings, and some involving the interplay between parents and therapists.

- *Parents who push the therapist's buttons.* Sometimes parents in the groups manage to say and do things that rub their therapist the wrong way. Parents may show a lack of interest in treatment ("I'm only here because I was forced to come."), express skepticism toward the program ("What makes you think that would work with my child?") or the therapist ("You don't understand what it's like because you are not a refugee like I am."), or claim the intervention is nothing new ("I'm already doing all these things . . ." sometimes followed by "... and they don't work."). An important part of the therapist's job is to forge a positive connection with each group member – even the more difficult ones – perhaps finding grains of truth in what they say and focusing on those grains, and ideally finding some attributes or accomplishments for which genuine praise can be offered. Where this proves especially difficult for a particular therapist, a cotherapist may do the heavy lifting of relationship building with particular parents.
- *Group process issues.* Because the intervention format is a series of group meetings, process issues familiar to many group therapists are likely to surface. These may include parents who dominate the discussions or keep them focused on their own issues, parents who say things in ways that make the other group members dislike them, and even marital discord that gets expressed in the group context. To address such process issues, therapists need to be confident enough in their group management skills to set clear ground rules and enforce them consistently. Arranging for speaking turns with time limits may make sense when one or two group members are monopolizing air time. A separate discussion with the angry couple may be needed to emphasize that the group needs to focus on parent-child interaction issues, and that couple conflicts need to be dealt with outside the group. The therapist's challenge is to be nice, but not so nice that group management needs are ignored.
- *Therapist discomfort with role-playing and other group leader expectations.* Therapists are expected to make extensive use of role-playing in the parent group meetings, but some are not so comfortable in role-plays. Therapists are expected to model core elements of good parenting that they are helping parents learn – differential attention, and enthusiastic praise, for example – but not all therapists are comfortable doing such things in their interactions with adults. For such therapist difficulties supervision and consultation can be helpful, with session videotapes used to examine trouble spots and the supervisor and therapist brainstorming various solutions together. Perhaps role-plays can be designed in ways that do not make the therapist uneasy, and perhaps the therapist

can find ways to be encouraging and support parents' successes without dispensing praise that seems awkward, infantilizing, or insincere. In general, supervision is intended to bridge the divide between therapist characteristics and capacities, on the one hand, and expectations that go with the therapist's role, on the other.

The Incredible Years BASIC Parent Training Program: Scientific Issues

The work of Webster-Stratton and colleagues builds on the power of modeling in ways that go well beyond most parent training treatments for conduct problems. It is an intriguing application of social learning theory to the challenge of inducing observational learning in parents. Of course, the therapists who work with parent groups also apply operant principles, especially social reinforcement, to enhance learning of new behaviors. The process is intended to help parents, in turn, make effective use of operant principles with their own children to increase prosocial behavior and reduce disobedient, disruptive, and otherwise inappropriate behavior. Do the procedures work? Evidence on the core program, BASIC, is quite positive thus far, and findings on other training programs in the Incredible Years series are also encouraging.

The evidence has rather consistently shown that BASIC produces positive changes in parent behavior and reductions in child conduct problems, both as reported by parents, and (to a somewhat lesser extent) as recorded by trained observers during home visits. This has been especially true in comparisons of BASIC to waitlist control groups but also true to some degree in more challenging treatment versus treatment comparisons. Studies have shown evidence of clinical significance, in that families receiving BASIC, relative to those not receiving BASIC, (1) showed parent reports of more normal range functioning and less clinical range problem scores by children on standardized measures, and (2) were less likely to request additional therapy for child behavior problems at follow-up assessments. Child behavior ratings tended to hold up over time, as assessed at follow-up, but study designs that assign waitlist groups to treatment after the posttreatment assessment do lose the opportunity for clear-cut treatment versus control comparisons at followup.

The overall research portfolio shows an admirable blend of designs and methods, and an interesting variety of control and comparison groups. Control groups have ranged from no-treatment waitlist to individual therapy to usual care in the clinic, the latter a particularly valuable point of comparison. One study (Webster-Stratton, 1984) showed no difference on any outcome measures between BASIC and individual therapy (covering the BASIC topics), but even that finding was impressive in that the cost-effective BASIC program required less than a third of the total therapist time required for individual therapy.

Webster-Stratton and colleagues have endeavored to ensure that the treatment works with a range of client families, from middle-class college grads to low-income, low-education parents. The study array has included add-on designs testing proposed methods of enhancing treatment effects (e.g., by adding the ADVANCE program to BASIC), and a dismantling design in which comparison groups received separate components (i.e., video only, and therapist-led discussions only). The results of the dismantling study (Webster-Stratton et al., 1988, 1989) and its sequel (Webster-Stratton, 1990) raise the intriguing question of whether the full BASIC package, with videos and therapist-led parent group discussions, is actually necessary to generate respectable treatment benefits. While therapist contact added some benefit, on at least some measures, the effects obtained by simply having parents come in and view the tapes were striking, and a bit disquieting from the perspective of one who both does therapy and trains therapists! The findings of these two studies certainly deserve followup in future research; we need to discern the optimal role for therapists in video-guided parent training.

Tests of the BASIC program have encompassed a broad range of parent and child characteristics along such dimensions as socioeconomic status, educational level, presence versus absence of child maltreatment, and severity of child problems. This should make possible a systematic search for predictors of treatment impact, and Webster-Stratton (e.g., 1992a) and colleagues have begun that search, focusing on both posttreatment and follow-up outcomes. In some of the research, children showing the poorest outcomes tended to come from families characterized by marital distress, single-parent status, parental depression, lower socioeconomic status, and higher levels of life stress. Interpreting such findings is complicated by the fact that such factors may also predict poor outcome in untreated families. In the future, applying methods that have been developed specifically for zeroing in on moderators (see e.g., Baron & Kenney, 1986) may add importantly to the knowledge base, helping us discern the boundary conditions within which the intervention can be expected to work well.

Another useful goal for future research is identification of outcome mediators. The suggestion by Webster-Stratton (1994) that "... causal modeling work is needed to explore the direct and indirect links between marital processes, parent's personal adjustment, parenting skills, and child adjustment" (p. 392) suggests that understanding the change processes that account for BASIC treatment effects may be a part of her group's agenda. If so, the information gain could be quite substantial.

Another useful direction for research will be the study of generalization of treatment effects to child behavior in settings outside home, where the contingencies parents have learned to use are not in place. Generalization of benefits to new settings has been a problem for most behavioral child and

adolescent treatments. Tests of the BASIC program thus far have made only rather gingerly attempts to assess child behavior in preschool and school settings, and with somewhat mixed results. However, the Webster-Stratton group appears to be taking a different tack than most investigative teams have. Their approach to generalization, which may be very wise, has been to complement parent training with training of teachers and children, as discussed earlier. The idea seems to be that if we want behavioral treatment effects to be evident in out-of-home settings, we need to extend the training to individuals in those settings. Early evidence (e.g., Webster-Stratton & Reid, 1999) suggests that this view may be right on target.

The Incredible Years BASIC Parent Training Program: Clinical Practice Issues

From a clinical practice perspective, major advantages of the Webster-Stratton approach include its readiness for clinical use, its natural appeal to parents, and its very low dropout rate. Because the core content of the treatment program is inherent in the sequence of videos, the program is, to a certain extent, self-teaching; this means that, even though therapist training is certainly needed for optimum use of the BASIC program, the time required to reach proficiency is apt to be less than with most manualized treatments. Training programs are increasingly available for therapists (see next section). The video approach clearly has an inherent appeal to a generation of parents reared on television, and the combination of videos and therapist-guided group discussion has been rated very high on consumer satisfaction measures used by Webster-Stratton and colleagues.

A common practitioner concern is that the samples used in clinical trials do not look like the cases they themselves treat in practice, raising questions about the relevance of the treatment to their usual cases. Such concerns may not be so worrisome in the case of the BASIC program, given the broad array of families seen in the trials to date. Samples have ranged from predominantly middle- and upper-socioeconomic status, college-educated parents whose children showed relatively modest problems (e.g., Webster-Stratton, 1981a,b) to high-risk families with low-socioeconomic status, low-education single parents, high rates of substance use and child abuse, and very serious child conduct problems (e.g., Webster-Stratton, 1984; Webster-Stratton et al., 1988, 1989). Two studies (Scott et al., 2001; Taylor et al., 1998) have included families referred to local community mental health services. The evidence base supporting the BASIC program certainly seems to encompass many of the kinds of families likely to be seen in everyday clinical practice.

Therapist time to administer the full BASIC program appears quite manageable, even in an era of cost cutting. Although the full program can involve up to 14 two-hour sessions, the sessions are for relatively large groups

of parents, which creates considerable efficiency in average therapist hours per case. There may be a certain comfort in findings indicating that, in the extreme case, simply having parents view the videotapes alone (with no therapist guidance and no parent group discussions) can be quite helpful (Webster-Stratton et al., 1988, 1989), and that adding just a few hours of therapist consultation can further enhance the benefits of individual parent video-viewing.

The fact that the tapes lend such consistency and structure to the treatment program nicely addresses a major concern that many have about manualized treatments – that is, that differences among various therapists in the ways they administer the treatments will lead to departures from the precise approach that has been tested in clinical trials. In BASIC, the combination of standard videotapes, all shown in a fixed sequence, with manualized discussion questions, prewritten parent handouts, and parent homework assignments, helps to ensure more consistency and standardization than in perhaps any other evidence-based treatment for child problems.

An important boundary condition is that the materials and procedures tested thus far are not designed for parents of youngsters beyond age 10. Omitted from the tapes, for obvious reasons, are such adolescent issues as sexuality, association with dangerous peers, dealing with physically dangerous confrontations, and drug and alcohol use. As originally intended by Webster-Stratton, the objective of the program is to cut short the development of conduct problems early in life. In cases where such problems have developed and extended into the middle school years and beyond, other treatment approaches are likely to be needed.

Webster-Stratton's approach is subject to a constraint that applies to all parent programs: It requires motivated parents who are willing to invest considerable time attending sessions, doing homework, and answering questions over the phone. However, the video and group discussion approach is probably more inherently engaging, and more likely to reach parents regardless of their reading level and despite variations in therapist skill and experience, than a number of alternative parent training approaches. Because the videos and discussions keep things lively and interesting, parents who have only marginal interest may be more likely to continue participating than would otherwise be the case (but see Webster-Stratton, 1984, showing no difference in parent consumer satisfaction between individual parent therapy and the BASIC program).

In this section we have focused on parent and therapist perspectives, but another important perspective in the clinical practice domain is that of those who organize and fund services – clinic administrators, managed care representatives, and payors. For this group of stakeholders, programs like Webster-Stratton's should have genuine appeal, combining cost-effectiveness, measurable client benefit, and a high level of consumer satisfaction.

How to Find Out More about The Incredible Years BASIC Parent Training Program and Other Webster-Stratton Programs

An overview and discussion of BASIC and other video-guided programs for parents, teachers, and children by the Webster-Stratton group can be found in a recent chapter by Webster-Stratton and Reid (2003). A leader's guide to the video course has also been prepared (Webster-Stratton, 2001). Webster-Stratton's (1992b) *The Incredible Years: A Troubleshooting Guide for Parents of Children Ages 3–8 Years* (Toronto: Umbrella Press) serves as a text for the parent program; the book is available in audio form, for nonreaders. The actual video series and a variety of supporting materials can be obtained by contacting The Incredible Years, 1411 8th Avenue West, Seattle, WA 98119 (phone 888-506-3562) or by going to the website, www.incredibleyears.com. The site includes detailed information on available video series and supporting materials (e.g., books, audiotapes, stickers, magnets, puppets), upcoming workshops and other training opportunities in various locations, and certification requirements and procedures for becoming a group leader in the parent, child, and teacher programs.