PRACTICUM

A PROBLEM SOLVING, GROUP THERAPY APPROACH: SOCIAL-EMOTIONAL COMPETENCY ENHANCEMENT FOR LATENCY AGE CHILDREN

BY

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A PROBLEM SOLVING, GROUP THERAPY APPROACH:

SOCIAL-EMOTIONAL COMPETENCY ENHANCEMENT

FOR LATENCY AGE CHILDREN

BY

KAREN HOLYK

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF SOCIAL WORK

ABSTRACT

A therapy group was conducted to target latency-age school children who had been identified by parents and school personnel as displaying deficits in social and emotional competency skills. The nature of difficulties were such that they were determined to impede phase and age appropriate psychosocial development hindering various aspects of the child's social and emotional life. Intervention with the children was designed to facilitate the growth and development of more adaptive ways of dealing with affective expression and social interaction, utilizing a cognitive behavioral, problem-solving approach.

Parallel systems intervention was an integral component of overall treatment objectives. Parent and school collateral involvement was implemented in an attempt to enhance generalization of newly acquired competency skills being learned by the children to the home and school environment.

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Acknowledgments

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INTRODUCTION

The development of social and emotional competence in young children is an area that has attracted much attention in recent years. The notion that stress reactions and coping abilities are directly related to children's current and future development, adjustment, and physical well-being is well documented (Asher, 1986; Caplan, 1992; Coie, 1992; Denham, 1993; Nousiainen, 1992; Strauss, 1989). It is reported in the literature that children who manifest social deficits may suffer other related difficulties such as poor academic achievement, delayed cognitive and emotional development, poor or nonexistent peer relations, and social withdrawal in later childhood (Denham, 1993; Nousiainen, 1992; Strauss, 1989; Waldrop, 1975). Moskowitz, Ratatori, and Helsel (1983) investigated the social behavior of students who were both aggressive and withdrawn and reported that social difficulties persist over time, and that these children demonstrated social skill deficits which placed them at risk for later social-emotional maladjustment.

Other retrospective studies have shown that socially impaired children may also make poor life adjustments as adults. Robins (1966) reports that poorly adjusted children manifest a higher incidence of adult alcoholism, antisocial behavior and are more vulnerable to a host of psychiatric disturbances. Roff, Sells, and Gordon (1972) report that poorly adjusted children are more likely to experience difficulties both as children and adults in lowered self-esteem, adolescent and adult deviancy, and diminished cognitive performance. Conversely, children who are socially competent have demonstrated superior academic achievement and meaningful interpersonal adjustment later in life (Barclay, 1966; Cohler, 1987; Short, 1992).

The children that participated in this practicum displayed a diverse range of behaviors that the literature suggests put them at potential risk for future psychosocial maladjustment. Although difficulties varied for each child, common to each was, low self-concept, few or nonexistent peer relationships, self-reported shyness that incumbered significant interactions both with children and adults, and lack of self-confidence. Additionally, each child identified feeling lonely resulting in feelings of inadequacy and helplessness.

The remainder of this practicum report is devoted to detailing the approaches used in the specific intervention with the children and families in terms of enhancing skills in the area of social and emotional competency.

Organization of the Practicum Report

This practicum report will detail the various treatment modalities used with the children/families of this study. They included a cognitive-behavioral problem-solving approach, group psychotherapy, and parent-training. What follows is an elaboration of the identified problem based on current research in the field; an understanding of normal child development in order to provide the reader with a developmental basis in which to understand the latency-age child's relevant developmental tasks; play and its significance to children in this phase of development; group therapy approaches; theory and the practical application of a cognitive-behavioral problem-solving approach; application of the treatment approaches, and finally, an evaluation of the outcome of the intervention.

Practicum Objectives

The primary objective of this practicum was to initiate a therapy group with latency-age school children who had been assessed as having difficulties which impeded their phase appropriate psychosocial development. Intervention was designed to facilitate the growth of more adaptive ways of dealing with affective expression and social interactions.

Of equal importance, was the implementation of a parallel group for the parents. The objective of the parent's group was to maximize the probability of their child's newly acquired social-emotional competency skills being generalized into their broader environment. Additionally, intensive contact with school collaterals was instrumental in addressing generalization on newly acquired skills within the school setting.

Implication for Social Work

Experience with child and adult victims of abuse, has been the basis of this writer's work for more than a decade. An integral component of work conducted with this client population, has been an attempt to increase their life satisfaction by helping them learn how to cope with the complex systems in which they live. This sometime means attending school meetings to devise plans that empathically meet the traumatized child's needs, meeting with extended family to build a web of support around a client to buffer her in times of crisis, or advising a woman who is experiencing domestic violence about how to access a phone vital to her safety from a Provincial Welfare worker. A broad range of "ecological" interventions are available to the creative therapist who is sensitive in understanding that clients present with problems where a multitude of variables may be effecting them; and in turn can be effected. Understanding the relatedness of the individual to her larger system is the basis for all social work practice.

An ecological approach to social work intervention looks at the transactions that take place between individuals and their environments (Germain, 1972). This approach of viewing individuals, avoids the dichotomizing of person and situation, focusing on the reciprocal influence individuals have on their environment, and the influence the environment exerts on the individual (Germain, 1972; Lehmann, 1990). Problems within this paradigm of understanding human behavior are not viewed as "pathology" or disturbances of the self, rather they are redefined as "problems in living" and are considered "adaptive" responses to difficult life situations (Germain, 1972; Lehmann, 1990).

Viewing problems as a consequence of living in complex systems, forces the caseworker to broaden her conceptualization of the problem and subsequent intervention strategies. Intervention from an ecological approach concerns itself with enhancing or modifying the quality of transactions between the individual and her environment (Germain, 1972; Lehmann, 1990). This requires the helper to be sensitive to how intervention will create change in

another part of the system and where other levels of simultaneous intervention might be useful in viewing the person in situation (Lehmann, 1990; Salzinger, et al., 1980). The ultimate goal of treatment in the context of an ecological treatment plan, is that the "professionals" involvement is at some point replaced by the individual's natural helpers in her system (Lehmann, 1990; Salzinger, et al., 1980).

Keeping in mind the importance of understanding the child in the context of an ecological paradigm, this practicum was designed to provide group intervention for children which focused on enhancing their social-emotional competency skills. Social competency training and its relevance to the practice of social work is apparent in that it provides the individual with an invaluable personal and social paradigm for survival and adaptation in the enhancement of social functioning or transactions that take place in her environment.

In response to the reciprocal influence intervention would have on each of the parts of this system, and to address important concerns about the support and maintenance of competency skills that would become the responsibility of the child's natural helpers following termination, parallel intervention was implemented with parents and teachers.

The practicum experience provided this writer with an experience in developing and implementing a preventative model of intervention that viewed the child in relation to her ecological system of individual, family, social, and cultural environment.

Specific Educational Goals

1. To increase my knowledge and skill in conducting brief family/social assessments.

2. To increase my theoretical and practical knowledge about group therapy with children and their parents.

3. To increase and enhance knowledge about latency-age children's psychosocial development.

4. To increase and practice my clinical skills in working with the child's system to enhance the impact of this type of intervention.

PROBLEM ELABORATION

Work in the area of social-emotional competency has grown out of the "pathology" research which has informed us that childhood social adjustment is a predictor of psychosocial adjustment in adolescence and adulthood (Caplan, 1992; Cavell, 1990; Coie, 1992; Levy-Shiff, 1989). Predictors of future maladjustment include poor or nonexistent peer relations, social withdrawal, aggression, anxiety, and depression (Cavell 1990; Dodge 1983; Strauss 1989). Of these variables, it would appear that peer relations, attainment or the converse lack of them, plays a crucial role in predicting the future mental health and life satisfaction of a child (Caplan, 1992; Cavell, 1990; Coie, 1992; Taylor, 1989). Given the research that suggests peers play an imperative role in the emotional health of a child, peer relations and how they are effected by a child's social functioning has become an increasingly important area of study.

Importance of Peers in Social-Emotional Development

Each of the children who participated in this practicum had significant difficulties in the area of peer relationships. This area of discussion was therefore relevant to the understanding of childhood maladjustment. Just how important peers are in the psychosocial adjustment of a child is highlighted in the following discussion.

Certain psychological characteristics appear to be important when considering what influences a child's popularity. Primarily, social sensitivity or the ability to accurately perceive and comprehend the behavior, feelings, and motives of one's peers appears to correlate with high quality interpersonal relations (Dodge et al., 1986). General characteristics of "unpopular" children include, being disagreeable with peers; they are not as likely to have an explanation for their behavior; they cannot suggest alternative behavior when disagreeing with a peer; they are more likely to persist in disagreements which often escalate resulting in rejection or neglect by peers (Caplan, 1992; Cavell, 1990; Levy-Shiff, 1989).

Putallaz and Gottman, as taken from Grunebaum and Solomon (1987), suggest that these behaviors are indicators of the child's self-doubt, their insecurity, and anxiety. Grunebaum and Solomon (1987) state,

> "Self-esteem and peer relationships are such interconnected phenomena that the self-evaluation may be viewed, in large measure, as the inner experience of esteem in which one is held by one's peers. The ability to have successful peer relations, which validates one's sense of personal worth, depends on positive self-esteem." (p. 475)

Deprived of interaction with peers, children lack the contact by which social skills are learned and practiced. Without these skills, children are more likely to become isolated leading to the greater probability of maladjustment in school achievement, delinquency, and future psychopathology (Coie, 1992; Dodge et al., 1986; Levy-Shiff & Hoffman, 1989; Strauss et al., 1989).

Approach To Social Incompetence

Professionals from a wide discipline base including, child guidance, social work, psychiatry, psychology, and education have been interested in the study of social competence as an area of preventative mental health because of its focus on an individual's health, strengths, and resiliency (Cohler & Anthony, 1987; White, 1959; Zigler & Phillips, 1961). Subsequently, how to define "social competence" has been the subject of much debate in the literature (Anderson & Messick, 1974). Despite the divergent conceptual differences inherent in the varied professional ideologies and experiences, all tend to agree that social competence entails effective interpersonal functioning within social contexts (Cavell, 1990; Dodge et al., 1986).

In response to these concerns, competence training to promote adaptive behavior and mental health have developed. Approaches are generally "competence promotion" programs which are designed to enhance personal and interpersonal effectiveness and are largely problem-solving oriented

(Caplan et al. 1992; Dobson, 1988). They are designed to "instruct" a child on the acquisition of positive interpersonal skills (Cavell, 1990; Matson & Ollendick, 1988; Spivack & Shure, 1976).

Jahoda (1953) was one of the first theorists to identify a problem-solving process as a positive mental health approach. Later, D'Zurilla and Goldfield (1971) elaborated on Jahoda's approach and emphasized "how" or the operationalized aspects of problems solving. However, it was Spivack and Shure (1974, 1976) who provided one of the earliest comprehensive problem-solving treatment models which remains at the core of many of the competence programs designed to target the amelioration of problems related to social incompetence.

A central tenet in their work is,

> "...disturbed individuals suffer from a cognitive deficiency in their ability to solve interpersonal problems, and that this deficiency results in difficulties with others and brings on failure when confronted with important life situations." (Spivack & Shure, 1974, p. 43).

They assert that interpersonal cognitive problem-solving skills play a critical role in the adjustment of a child. According to these authors, an inability to successfully resolve daily problems leads to failure of important personal or interpersonal task resolution. This results in lowered self-esteem, frustration, feelings of hopelessness, and impaired peer membership (Spivack & Shure, 1974).

Much of the work conducted with children today in relation to social competency training has been borrowed from Spivack and Shure's proposed problem-solving model. For the sake of clarity, aspects of the problems-solving model will be discussed in the section entitled "Group Therapy With Children."

The current literature in the area of social competence has begun to address the issue of generalization of skills, an area that was not discussed in the earlier problem-solving approaches (Caplan et al, 1992; Dobson, 1988). Recent research suggests that teaching specific problem-solving behaviors is not sufficient in mitigating difficulties in the

area of social competence (Caplan et al., 1992). Durlak (1983) asserts that the combination of social competency, or problem-solving training and "domain-specific" application of that training are the variables that account for the effective resolution of psychosocial difficulties. In conjunction with providing the child with opportunities to practice and apply learned skills to relevant life situations, equally important is the inclusion of parents or immediate caregivers either in the treatment of the child or as recipients of training in separate parent groups. This type of intervention appears to correlate with successful long-term treatment generalization making this model compatible with an ecological approach to intervention (Caplan et al., 1992;Dobson, 1988; Dodge et al., 1986).

CHILD DEVELOPMENT

This portion of the literature review will provide the reader with a general overview of the physical, intellectual, emotional, and social development of the latency-age child. Despite their importance and contribution to the field, it is beyond the scope of this practicum report to incorporate discussion regarding the multitude of perspectives relevant to child development. Those theories that were most relevant to the children of this practicum, all eight years of age, will be presented to provide the reader with contextual framework of, "who" the child is at this point in her development. An understanding of child development also plays a crucial role in the assessment of childhood difficulties and subsequent appropriateness or relevance of a particular method of intervention.

Latency

The children who participated in this study were all eight years of age. This period of child development is referred to as "middle-childhood" or latency with its onset being somewhat arbitrary. Latency begins at approximately

age six and ends when the child is around twelve years or when she reaches "puberty".

Physical Development

During middle childhood, the body undergoes change in both structure and function. Children become taller and heavier. Girls typically outgrow boys. There is a decrease in fatty body tissue and an increase in bone and muscle development.

Perceptual motor development is refined, creating greater control over motor responses (Lefrancois, 1983; Williams & Stith, 1980).

The child in this phase of physical development moves away from tactile-kinesthetic sensory dominance to one of visual dominance as a way to relate and modify motor activity (Lefrancois, 1983). The child at the beginning of this period is learning skills such as throwing a ball, skipping rope, and running (Lefrancois, 1983; O'Connor, 1991). The end of this developmental phase is heralded in by dramatic physical changes and is referred to as "pre-pubescence".

Intellectual Development

Intellectual development refers to the child's capacity to link those things learned previously with those that they are learning, and to mentally organize the vast accumulation of knowledge (Lefrancois, 1983; Williams & Stith, 1980).

One of the primary tasks of middle childhood is to organize and apply the knowledge that has been accumulated over the life-span. It is a time of mastery of basic skills such as reading, writing, and math. More sophisticated communication begins to develop and becomes the predominate mode by which a child understands and responds to her world. The child's thinking is less self-centered and self-serving which allows for the taking-on of another's point of view (Lefrancois, 1983; Mussen, 1970; Zigler et al., 1982).

The child of seven or eight is moving away from thinking that is dominated by senses and intuition or the "pre-operational" phase of intellectual development (Lefrancois, 1983), towards thinking that is dominated by logical and

concrete cognitive processes that are dictated by logic and rules. This stage is referred to as concrete operations (Lefrancois, 1983; Piaget, 1952, 1967; Williams & Stith, 1980).

Concrete operations is characterized by logical thought, use of mental operations of classification, seriation, hierarchical arrangement, and the emergence of schema of reversibility. Mental activities in this phase of development are dependent largely on perception (Piaget, 1952, 1967).

Strommen et al. (1983) refer to this period of intellectual development as one where the mind becomes more "systematized". For instance, a child of six is able to pick a bunch of the same type flowers, but could not classify them. Between the age of seven and eleven, the child can classify according to shape, size, and color. This also is the onset of what Piaget refers to as "reversibility" (Piaget, 1952, 1967).

Reversibility accounts for the child being able to watch her own mind manipulating thoughts and to understand that there is logical consequences that follow. However, this ability is not fully developed until the child nears the end of the concrete operation period at age eleven (Lefrancois, 1983; Piaget, 1952, 1967; Strommen et al., 1983).

Piaget's schema of intellectual operations was important to this study. For the method of treatment to be effective, it was important for each child to have the capacity to logically think through situations and be able to reverse her thinking to resolve dilemmas that were an inherent part of intervention.

Emotional Development: The Origins of Social Behavior

Many theorists including, Erikson, Freud, Piaget and others have made important contributions to our understanding of the child's emotional development. However, for the purpose of this practicum, this writer will focus the discussion on attachment theory developed by Bowlby (1971, 1973) and Ainsworth (1989). These authors assert that the root of psychological adjustment (or

maladjustment), can be traced back to secure (or insecure), attachment to the primary caregiver. Hartup (1989) argues that social competence emerges mainly from experience in close relationships. Understanding the origin of relationships and how they develop was central to both understanding the problem identified in this report and targeting important intervention areas.

What evolves from a secure attachment has been cause for much debate in the literature. There is evidence that good adaptation to this early developmental task predicts competence in other tasks that lie ahead throughout the life span of an individual. Studies show that children with a secure attachment are more competent at problem-solving tasks, are more ingenious in their play, their affect is more positive, they are more cooperative with peers resulting in enhanced competence with peers (Arend, Grove, & Sroufe, 1979). Attachment, from this perspective, appears to be the origin of all social behavior.

Attachment

According to Bowlby (1971), attachment is a biologically based bond with a caregiver which serves as a survival function of protection, especially in stressful periods in the child's life. It is through the use of the secure base, the parent, that the child begins to feel safe enough to explore her environment with competence (Bowlby, 1971). The beginnings of social responsiveness commence at birth. Smiling and crying are social responses that are dependent on interactions. Gerwitz (1972) states,

> "... crying brings about an interaction between mother and child. It is through such constant interactions and commerce between a particular adult (usually the mother) and the child that mutual links are woven and strengthened over the first few months. As these links become enduring and permanent we call them attachment." (p. 128).

Initially the baby has no specific preference for an individual adult. She can be quite content with the care of anyone who is meeting her needs to be fed and nurtured. In the last quarter of her first year, the

infant's preference for her primary caregiver is observable (Bowlby, 1971; Lafrancois, 1983; Mussen, 1970; Zigler et al., 1982). She can show great delight in her caregiver's presence and unhappiness in her absence. Attachment is facilitated by the development that the object of her desire, the caregiver, exists even when she is out of sight. This is referred to as "object permanence" (Ausubel et al., 1980; Bowlby, 1971, 1973; Mussen, 1970; Wood, 1973).

If all goes well and the child has had a quality, secure attachment as she develops, the intensity and the frequency of attachment behavior decreases. The child no longer depends solely on the primary caregiver for all her needs and begins to function more independently. Language develops which facilitates involvement with other partners. Language also facilitates greater cognitive foresight which allows the child to build a mental picture that bridges herself and the caregiver (Ainsworth, 1989; Ausubel et al., 1980; Wood, 1973).

Attachment is transformed into a "bond" which does not require the constant proximity of the caretaker but rather is a result of the trust that has evolved in the context of the relationship. This early attachment and subsequent bond

evolves into later life attachments. Attachment theory asserts that the early infant/caregiver relationship sets the stage for all subsequent relationships throughout the life cycle and is believed to be at the core of psychological adjustment (Ainsworth, 1989; Ausubel et al., 1980; Bowlby, 1971, 1973; Mussen, 1970).

Social Development

The greatest change to occur for the child in early middle-childhood, is the widening of her social world. This is a period of development that entails movement away from the family as the child's primary reference group to one where peers, friendships and school life predominate (Lefrancois, 1983; Strommen et al., 1983; Williams & Stith, 1980). Peers begin to assume greater importance, while adults lose their exclusive position in the child's life. It is the period when, for the first time, the child becomes truly social.

Additionally, the child is also being exposed to "other" adults and their "rules" which requires her to modify much of what she has learned in her primary reference group, her family (Lefrancois, 1983; Zigler et al., 1982).

Functions of Peer Relations

Peer means equal. Involvement with peers is the onset of children experiencing relationships that do not have authority as a component. The child learns about being a follower and how to be a leader within the context of an equal relationship without the constraints of authority. Being involved with peers makes her aware of and sensitive to others and what matters to them, creating a social perception (Lefrancois, 1983; Williams & Stith, 1980; Zigler et al., 1982). Children learn social accommodation to others from involvement with peers.

This involvement helps them understand how they differ from others and how they must cope with or accommodate those difference in order to fit into their new social world (Lefrancois, 1983).

Peers provide a forum for play, a forum for physical and cognitive skill acquisition, and emotional support (Zigler et al., 1982). Much of the child's identity and self-validation is drawn from her peer group which serves the

important function of challenging a child's perception about herself in the process of membership where peer evaluation is constantly a component of these relationships (Lefrancois, 1983; Strommen et al., 1983; Zigler et al., 1980).

Friendships

Friendships constitute a more intimate form of social contact. Friendships are characterized by a continuous and typically positive form of interaction. As quoted out of Lefrancois (1983) , Sullivan (1953) describes the importance of friendships as being,

> "...of paramount importance in the life of the child. Not only do they provide the child with intimacy, encouragement, and support, but they might also be importantly involved in the development of the capacity to form meaningful and lasting emotional relationships in adulthood" (p. 346).

Friendships in early middle-childhood are characterized by concrete, self-centered relating that evolve into relationships of mutual support and reciprocity (Strommen et al., 1983; Zigler et al., 1982). For instance, a child of

six would identify a friend as someone that likes them because they will play, while a ten year old would identify a friend as someone that helps in difficult situation and likewise would do the same for that friend.

Involvement with friends often serves the function of providing a child with gratification of playing with another child who may have the same interest. Friendships can be an enormous source of support and are a fundamental part of a child's social development. (Lefrancois, 1983; Williams & Stith, 1980; Zigler et al., 1982).

The School

Despite the importance of this institution on the developing child, there has been very little research conducted in the area of its "emotional" impact on the child. Apart from teaching children basic fundamental skills, schools demand that children be exposed to and interact with a wide variety of individuals, peers and adults. It permeates and shapes every aspect of the child's social and

emotional development. Lefrancois (1983) refers to the school as a "monolithic culture machine" stating,

> "There is virtually nowhere for frightened first graders to run, their parents have abandoned them ...they are far away from home and children here are alone. They have discovered that the world stretches beyond the circle of home and family, that it is necessary to adjust to this world, and that adjustment is sometimes painful" (p. 348).

Teacher expectations and preference play a crucial role in the developing identity and socialization of the developing child. Taylor (1989) found evidence concerning teacher preference as a predictor of later peer status in children of early elementary school years. Her longitudinal study found that teacher preference for children in kindergarten to grade one made a substantial difference in the prediction of a child's acceptance or rejection by peers in grades two and three even after controlling for prior levels of peer rejection.

It would appear that understanding a child in the context of her school culture, would be imperative when assessing and intervening on her behalf.

Play

Latency age children typically are involved is what is referred to as cooperative play (Zigler et al., 1982). This sort of play is usually organized around a theme where roles are defined by playmates which offers the child a forum for social interaction which facilitates social competence (O'Connor, 1991).

Children's play was an important developmental consideration in the practicum. Therefore, the following section will be devoted to discussing the phenomenon of latency age children's play in more detail.

In summary, it is important to state that no one theory on child development can fully explain why children develop the way they do. This writer attempted in her selection of theory to address important areas that were identified in the literature as relevant to the problem being studied.

An example is the discussion of attachment theory. The literature in the area of social and emotional competence strongly argues that "competence" is associated with a quality attachment in early childhood (Arend, Grove, & Sroufe, 1979; Carson, 1992; Hartub, 1989). Bowlby's (1971, 1973) theory clearly describes when attachment begins, how it develops, and how this attachment is transformed into other, more social relationships. However, his theory does not attempt to include broader social factors such as socio-economic, cultural, or gender related issues in the explanation of why attachment is "secure" or "insecure".

Understanding child development within an ecological paradigm requires that one be critical of "traditional" child developmental theories which are not sensitive to other factors such as socio-economic status, family developmental stage, gender, and cultural beliefs (Germain, 1972; Lehmann, 1990; Salzinger, 1980).

PLAY IN MIDDLE CHILDHOOD

Play Defined

Although the phenomenon of child's play is well documented throughout the literature, there is no definition that takes into account every aspect of the multidimensional and dynamic activity of play; or a consensus that there is one. Like other areas of psychological study, play has been an easier phenomenon to observe than it has been to explain and define. However, investigators in this area agree that a child's play is important to psychosocial development (Erikson, 1977; Gottfried & Brown, 1986; O'Connor, 1991; Piaget, 1969; Schaefer & O'Connor, 1983).

Despite the difficulty in defining play in absolute terms, there is consensus that play has several common characteristics (Levy, 1978; O'Connor, 1991; Schaefer & O'Connor, 1983). Although not exhaustive, they include:

1. Play is intrinsically motivated with play occurring for its own sake rather than from external demands or reinforcements.

2. The activity rather than the outcome or the consequence of the activity is the focus of the child play behavior.

3. Play involves active involvement of the child.

4. Play has no particular purpose or goal.

5. Pleasure and gratification are often a characteristic of play.

Writers in the field agree that child's play is a serious endeavor which serves a function in the development of biological, social and psychological growth of the child. As Piaget (1969) states,

> "Practically every form of psychological activity is initially enacted in play. From the senses that predominate the infancy period throughout the remainder of the emotional, intellectual and social growth of the child, play activities make a significant contribution to the development of the evolving child." (p. 73)

Erikson (1977) believed that play was a serious activity whose function was to offer a medium to organize and master an existence in the social world which was a life long endeavor. Erikson (1977) stated, "...the human propensity to

create model situations in which aspects of the past are re-lived, the present, re-presented and renewed, and the future anticipated occur through play." (p.44).

Functions of Play

Functions of play vary with the age and socioemotional stage of development of the child. Functions as detailed in O'Connor (1991, pp. 7-8) include:

1. Biological Functions: This includes basic physical skill acquisition, coordination, exploration of senses, increasing body awareness.

2. Intrapersonal Function: Attends to needs of a child when experiencing period of isolate activity, mastery building in her environment, fantasy provoking, competence building in relation to objects, master conflict through symbolism.

3. Interpersonal Function: Practice of separation/individuation. Acquisition of social skills through interaction that requires cooperation.

4. Sociocultural Function: Medium of social acculturation and role acquisition.

Interpersonal functions of play were most relevant to the developmental phase of the children of this practicum and therefore will the basis for the following discussion.

Interpersonal or social play is the medium through which peer interactions take place for children. Singer and Singer (1977) suggest several major benefits of social play of children. They include:

1. Development of greater self-awareness and a sense of control over the environment.
2. Development of emotional awareness.
3. Development of sensitivity to others.
4. Expansion of roles develop in new social situations which is the result of the broadening social context of the child.

Play also serves a socioemotional function of allowing a child relative freedom from negative consequences of actions vis-a-vis peers or parents while learning social rules (Gottfried & Brown, 1986).

Play progresses thorough various stage-related phases beginning from early object manipulation to engaging in object relationships. First are actions with real objects to actions with imaginary objects, from sensorimotor to more abstract forms of play such as pretend play, from self-

centered play to play that includes others and from solitary to social interactive play (Erikson, 1977; Gottfried & Brown, 1986; Karger, 1982; O'Connor, 1991; Piaget, 1969). Play and the progression it follows, are integrated activities that are not mutually exclusive of one another but fluid movements throughout the child's development.

Cooperative Play

Although play in the developmental period of middle childhood is largely characterized by interactive play, children still engage in fantasy play. However, fantasy play begins to disappear and is substituted with play that is most relevant to the child's development at this time, which is typified by social interaction among peers (Lefrancois, 1983; Piaget, 1969; Zigler et al., 1982).

Cooperative play is characterized by interaction between two or more children and usually entails the use of rules and role assignment (Lefrancois, 1983). Much of what children play in early latency entails the use of games with rules.

Schaefer and O'Connor (1983) suggest that games with rules serve the purpose of providing the child with, "...the means by which a child tries out activities and social roles and comes to terms with objects and people in his or her environment." (p. 175). The function of social play, as eluded to in O'Connor's (1991) typology of the functions of play, is to provide the child with "a myriad of social skills" (p. 8). Skill acquisition includes: reciprocity, cooperation, understanding rules or norms, and skills of interaction that extend beyond the protected home environment which engender social and emotional competence (Cavell, 1990; Levy, 1986; O'Connor, 1991).

As presented in the literature, children's play in this phase of development is a dynamic multidimensional phenomenon that serves a multitude of purposes in the ongoing psychosocial development of the child.

Play therapy approaches are extensively documented in the literature. However, given that play as a treatment modality was applied in the context of a group, this will be discussed in the following section on group therapy.

GROUP THERAPY WITH CHILDREN

Overview

Group therapy with children was first developed by S.R. Slavason at the Madeline Borg Child Guidance Institute in 1934. This new form of therapeutic work was referred to as Activity Group Therapy or AGT (Kaplan & Sadock, 1993). The position of Slavason was that aberrations in a child's behavior were the result of negative life experience. Subsequently, the abhorrent behavior could be mediated by "corrective" experiences in a therapeutically controlled environment by the therapist interpreting the child's "deviant" behavior (Kaplan & Sadock, 1993; Schiffer, 1984).

Because interpretative group psychotherapy with children was often an inappropriate form of treatment with latency-age children, Slavason and other investigators in the field began to develop a therapeutic model of group treatment that took into account both activities, typically play, and verbal analytical interventions (Kaplan & Sadock, 1993; Schaefer, Johnson, and Wherry, 1982; Schiffer, 1984). In the

revised group therapy model, the therapist avoided confrontation and interpretation and the fundamental position was that the "cure" in group psychotherapy resulted from corrective experiences with therapist and peers in a clinically controlled environment (Gazda, 1968; Kaplan & Sadock, 1993; Schiffer, 1984).

Present psychotherapy groups for latency-age children are usually small, planned, structured, and designed to treat problems child members have in common (O'Connor, 1991; Schiffer, 1984; Yalom, 1970, 1975, 1985). O'Connor (1991) argues that when working with young children, the therapist must be careful in addressing the developmental needs of the child such as the need for nurturance by an adult, the therapist. Consequently, groups designed to address the psychological needs of the latency-age child usually have four, and no more than six child members (O'Connor, 1991; Schiffer, 1984).

Rationale for Group Work With Children

Psychotherapy groups for children offer the opportunity for purposefully created, closely observed, and skillfully guided interpersonal interaction (Alonso & Swiller, 1993; Schaefer Johnson, & Wherry, 1982; Schiffer, 1984). The aim of group work is always twofold: the power of the collective is invoked to help individuals cope with or overcome personal problems, while the individual is simultaneously required to find satisfying and effective ways of fitting in and contributing to the group's overall aims (Budman, 1987; Grunebaum & Solomon, 1987; Kaplan and Sadock, 1993; Toseland & Rivas, 1984). Groups can address a variety of human problems such as distorted perceptions of others, communication, inadequately discharged affects, stereotyped behaviors, impulsive action, and alienation (Alonso & Swiller, 1993; Scheidlinger, 1982; Toseland & Rivas, 1984).

There are a number of psychosocial benefits afforded children in the context of group psychotherapy. One of the primary assets of group work with children is its replication of several already ongoing developmental tasks

which include: mastering the diminishing dependency on parents to one of a more independent state, and learning skills essential to the conduct of social life which takes place in relation to one's peers (Alonso & Swiller, 1993; Caplan et al., 1992; Schaefer, Johnson, & Wherry, 1982; Yalom, 1975).

Groups also provide children with an opportunity to share common problems and concerns without the stigma of being negatively identified by peers. Problems are addressed in a safe, responsive environment allowing the child to re-experience and work through difficult problems without the risk of exposure and harm (Borg & Bruce, 1991; Budman, 1987; Kaplan & Sadock, 1993; Schiffer, 1984). Additionally, groups provide a place to master stage-specific developmental tasks and foster cohesion, creating a sense of belonging which has the potential of fostering new, competent behavior (Schiffer, 1984; Toseland and Rivas, 1984).

Curative Aspects of Group Psychotherapy

Yalom (1970) conceptualizes the major curative aspects of group psychotherapy as interpersonal learning in relation to ones peers, catharses of the problem, cohesion, commonalty of the problem, and altruism (Yalom, 1970, 1975). In his review, the corrective experience takes place in assembling a group that becomes a symbolic family. This allows for conflicts that engendered the dysfunctional behavior to be recapitulated and corrected as they are "relived" correctly in the group or symbolic family context (Yalom, 1975, p. 15). Yalom (1970, 1975, 1985) asserts that through relationship building and restoration behavior change begins to occur.

Alonso and Swiller (1993) attempted to isolate curative elements of group psychotherapy. They include:

1. Vital enactment of the characterological dilemmas of the members.

Members own their problems, they are an integral construct in their character. These difficulties and the resulting distress is not simply recounted in the group, but rather enacted and experienced in the context of the group. The group provides a forum for its members to learn how others perceive them and how perceptions of the self are possibly distorted in the context of the self. The group provides its members the opportunity to observe and experiment with appropriate/inappropriate or healthy versus dysfunctional methods of interaction in an attempt to find one's "unique potential".

2. Exposure and the resolution of shameful secrets.

The authors suggest that "exposure" is universal in groups. Exposure in groups allows for an opportunity of relief in the process of finding out that "peers" have similar fears, secrets, distresses and that one can be empathic when they are exposed. Resolution is a process of empathic interpersonal involvement with peers who become concerned for the other person and their own well-being.

3. Support around the universality of the member's wishes, fears, and distress.

4. Reintegration of split-off aspects of the self.

As the split-off and unconscious parts of the self emerge in the group, they can be viewed first in the mirrored response of the others and finally take on the scale of ordinary human failings, capable of being dealt with, forgiven, and resolved.

(pp. xxii-xxiii)

In summary, "healing" in group psychotherapy, is believed to be the consequence of corrective emotional experiences that occur in the context of the therapeutic relationships occurring at both therapist and members level. It is through enactment of the difficulty or problem in a responsive environment that allows healthier perceptions about the self to develop.

Major Theoretical Approaches

Psychoanalytic

Groups that employ psychoanalytic techniques are typically used with adolescent children as they rely heavily on insight and interpretation as the primary mode of healing. Unlike the Activity Therapy Groups that were typical in the 1930's, it is well known today that young children who have not cognitively developed formal operational thinking do not benefit from insight oriented therapies (Schaefer, Johnson, & Wherry, 1982; Schiffer, 1984).

Psychoanalytic groups are usually long-term in nature, often running over the course of several years. The behavior of an individual group member is often the focus of the therapist's intervention. The group itself is considered to represent a "symbolic family" acting as a catalyst to bring forth unresolved "libidinous", or instinctual drives, and aggressive tendencies from a member's family of origin. (Kaplan & Sadock, 1993; Schiffer, 1984).

The therapist role within this treatment paradigm is to interpret, reflect, and confront behavioural distortions. This is done by using transference and countertransference reactions as a guide about when and how to intervene. Insight into the "deviant" behavior is viewed as the primary method of change (Riesler & Kraft, 1986; Schaefer, Johnson, & Wherry, 1982; Schiffer, 1984).

Behavioral/Social-Learning Theory

Any behavioral perspective is organized around the role of learning in human behavior (Coleman, Butcher, & Carson, 1984; Lazarus, 1971). A primary assumption in any behavioral model is that the subject of study is the behavior itself and not, like in the psychoanalytic model, an underlying, intrapsychic process (Kendall & Hollon, 1979; Ollendick & Cerny, 1981). Psychopathology is believed to be the result of not having acquired the skills and "competencies" necessary for day-to-day living and that the individual has learned faulty coping patterns that are maintained due to some form of reinforcement (Coleman, Butcher & Carson, 1984, p. 640).

A core feature of behavioural models is that the treatment approach is always grounded in scientific methodology (Gholson & Rosenthal, 1984). Child behavior therapy is based on factual, observable, countable behavior with interventions being developed to decrease undesirable observable behavior (Kendall, 1984; Ollendick & Cerny, 1981).

In an attempt to explain the conditions that elicit and/or eliminate learned responses or the stimuli, a number of behavioral models have evolved which include, classical conditioning, operant conditioning and the social learning model.

The classical conditioning model is often referred to as Pavlovian conditioning or respondent conditioning where a given behavior is learned in association with a stimulus (Coleman, Butcher, & Carson, 1984).

The operant conditioning model, also referred to as Skinnerian conditioning, emphasizes the active role of the "organism" and that behavior is a function of its consequences in obtaining rewards or satisfaction (Coleman,

Butcher, & Carson, 1984). Toseland and Rivas (1984) indicate that this approach is often used in group work using tokens and positive comments or praise as the vehicle to obtain desired group behavior.

The social learning model developed by Bandura (1969) is the most commonly used behavioural approach today (Coleman, Butcher, & Carson, 1984). It is considered a vicarious learning process whereby behaviors are learned as a result of observing a model's performance of the target behaviour (Coleman, Butcher, & Carson, 1984).

When conducting behavioral groups with children a combination of these approaches is commonly employed. The therapist role is one of modeling appropriate behavior, providing appropriate reinforcement for appropriate behavior or attempting to extinguish inappropriate behavior. Because of the intense and direct focus on specific behaviors, rather that changing personality characteristics, behavior therapy groups are usually short-term in nature (Schiffer, 1984).

Cognitive Behavioral Approach

Cognitive behavioral approaches grew out of the belief that behavioural models were too mechanistic. Investigators felt that they did not take into account intrapersonal variables such as motivation, affect and human cognitive processes (Coleman, Butcher, & Carson, 1984; Toseland & Rivas, 1984). Much of the current cognitive behavioral theories have evolved from the social learning model (Kendall, 1984, 1986).

Cognitive-behavior theory attempts to re-evaluate important private inner perception and self-states that mediate behavior. The emphasis is on the effects of thought on human behavior and the reciprocal effects of behavior, cognition and affect playing a role in maladaptive responses by the individual. Behavioural maladaption is believed to be caused by dysfunctional automatic thoughts which influence the individual's behavior as well as that individual's mood. The impact the thoughts have on the individual's behavior and later responses either perpetuates

the dysfunctional behavior or is the juncture where the problem can be terminated. (Gholson & Rosenthal, 1984; Kendall, 1986). Cognitive behavioural therapies are designed to target both cognition and behavior change providing an opportunity to rethink and learn about distortions that evolve from the cognitive process (Freeman et al., 1990; Kendall, 1986).

Cognitive-behavioral groups offer unique opportunities for their members. Presenting problems are presumed to be social-interactional and the presence of other individuals in the group context allows for the practice of new social-interactional skills to take place with their peers in a safe, nurturing and protected environment (Coleman, Butcher, and Carson, 1984; Freeman et al., 1990; Kendall and Hollon, 1979). In addition, the group provides important feedback about how behavior effects its members, either positive or negative, with confrontation by peers being the most effective method of change. (Kaplan & Sadock, 1993; Schiffer, 1984).

Cognitive Behavioural Techniques

The focus in cognitive behavioural therapies is always on the present. This does not mean that early life experiences are unimportant. Rather, it is unnecessary to extensively explore past issues when the focus of attention is on present behavior and problem amelioration (Coleman, Butcher, & Carson, 1984; Kendall, 1986; Ollendick & Kraft, 1986).

Utilizing techniques generated by operant conditioning which suggest that behavior is a function of its consequences, a host of reinforcement techniques can be discussed within the cognitive behavioural approach. If the consequences increase the probability of future occurrences of the behavior, they are considered to be reinforcing (Coleman, Butcher & Carson, 1984). Positive reinforcement is accomplished by applying a positive stimulus; negative reinforcement involves withdrawal of a negative stimulus. Non-reinforcement, whereby a behavior goes unnoticed and followed by no consequence, leads to the extinction of the behavior.

Another reinforcement is that of differential which refers to applying a positive reinforcement for the desired behavior and ignoring undesirable behavior. Self-reinforcement refers to a process where the client praises herself, or engages in a pleasurable activity which is self motivated. This increases adaptive functioning and is often implemented after the client resists the negative behavior (Coleman, Butcher & Carson, 1984; Kendall and Hollon, 1979).

Therapist Role

Functions of the cognitive behavioural therapist include, being able to organize the group, orienting the members to the group, building group cohesion, monitoring the behaviors determined to be problematic, evaluating the progress of the treatment, planning for and implementing specific change procedures, modifying group attributes to enhance the treatment process, and establishing transfer and maintenance programs for behavioral and cognitive changes occurring in the group (Kaplan & Sadock, 1993; Kendall, 1984, 1986).

Therapeutic methods typically employed by the group therapist include modeling, role playing, and the use of contingencies to reinforce the behavior (Dobson, 1988).

Of these methods, modeling is one of the most powerful techniques in the behavior therapies (Kaplan & Sadock, 1993; Kendall, 1986; Lazarus, 1971). Modeling conveys coping methods, both by therapist and peer, in an active form where desired behavior and problem-solving can be observed (Kendall, 1986).

Role-playing provides the child with a performance-based learning experience. Role plays typically involve the therapist and child. However, the literature indicates that to increase effectiveness, inclusion of peers and simulating real-life experiences is desirable for optimal outcome (Gholson & Rosenthal, 1984; Kendall & Hollon, 1984).

Behavioural contingencies are necessary to reinforce the learning of new cognitive and behavioral skills (Kendall, 1986). They include socially rewarding phrases from the therapist, assignments that occur outside the session designed to enhance and reinforce treatment goals, and items such as stickers when appropriate social behavior occurs (Coleman, Butcher & Carson, 1984).

A Cognitive Behavioural Approach to Therapy: The Problem-Solving Approach

Intervention programs based on facilitating competence-enhancement and social-skill training often rely on a problem-solving approach when addressing children's problems (Caplan et al., 1992; Matson & Ollendick, 1988; Ullmann & Krasner, 1969).

Caplan et al. (1992) state,

> "Competence training to promote adaptive behavior and mental health is one of the most significant developments in recent primary prevention research. In general, social competence promotion programs are designed to enhance personal and interpersonal effectivenesses and to prevent the development of maladaptive behavior through (a) teaching students developmentally appropriate skills and information, (b) fostering prosocial and health-enhancing values and beliefs, and (c) creating environmental supports to reinforce the real-life application of skills." (p. 56)

Investigators in the field assert that interpersonal cognitive problem-solving skills play a critical role in the adjustment of a child. A child's inability to successfully resolve daily problems will result in failure of important personal and interpersonal task resolution. As discussed in the introduction section of this report, this results in lowered self-concept, frustration, feelings of hopelessness, and impaired membership in the peer group (Anderson and Messick, 1974; Asher & Dodge, 1986; Carson, 1992; Coie et al., 1992; Spivack, Platt, & Shure, 1976; Spivack & Shure, 1974, 1980).

Spivack, Platt and Shure (1976) suggest that there are distinct cognitive skills that are crucial to the adjustment of the child. They include:

1. Sensitivity to interpersonal problems.
2. Ability to generate alternative solutions to problems.
3. Articulating a concise means to carry out the proposed solution.
4. The ability to understand the consequences of one's actions.
5. The ability to understand the causes of one's behavior, feelings, and motivations, as well as those of others.

Spivack, Platt, and Shure (1976) propose that treatment designed to "reorganize" thinking in these areas, will transform social relationships. They assert that when a child is capable of differentiating and comparing other's feelings in relation to his or her own, different types of interaction occur due to the increased cognitive processing capacity which enables the emergence of more competent interactions. Most problem-solving competency enhancement interventions incorporate to some degree, the five cognitive structures put forth in Spivack and Shure's problem-solving model (Dlugokinski, 1989; Durlak, 1983; Kendall, 1984, 1986).

Generalization of Treatment

In reviewing the literature on outcome studies of the cognitive behavioural approaches one becomes aware that in the short-term specific gains are often achieved (Caplan, et al., 1992 Cavell, 1990; Dobson, 1984). However, studies to determine generalization of the treatment approach often result in findings that suggest the treatment did not produce long-term effects (Dobson, 1988).

Variables believed to hamper generalization include lack of overlap or similarity to the social context of the child's life and a lack of consideration or exclusion of relevant individuals in the child's social system, usually the parent(s) (Caplan et al., 1992; Dobson, 1988; Kendall, 1984, 1986).

Systems theory is a metatheory which provides a way of viewing living systems in terms of relatedness. Systems theory examines discrete entities by affect and affectedness rather than specific characteristics (Borg & Bruce, 1991; Stein, 1974). The study of the problem is not seen as linear, rather there is a process of interactional, circular themes that involves the total system identification and their connectedness and the properties that emerge when the collection of the components are coupled together (Borg & Bruce, 1991; Levine & Fitzgerald, 1992; Stein, 1974). According to systems theory a child's behavior must be understood in terms of the interactions between that child and other relevant social systems (eg. family, school, community, culture).

The idea that a child's parents should be an important consideration when working with children is not new. Slavason (1956) argued that the parental involvement at some level of the child's treatment had a significant impact upon its effectiveness.

Recent research to support this position was undertaken by Parmenter, Smith, & Cecic (1987). They conducted short-term therapy groups for school-aged children who were referred for treatment as a result of emotional and behavioural problems. They concluded that the simultaneous use of group therapy for the individual child and parallel group treatment for the parents provided the opportunity for treatment goals to be generalized. They found that at the end of the program that "significant positive" change had occurred in over 80 percent of the children. This change was maintained five years later when they conducted a follow-up study (Parmenter, Smith, & Cecic, 1987).

Group Dynamics

The final topic to be discussed in this section involves group dynamics. Group dynamics refers to the way one goes about understanding group life, how members interact among themselves and the leader, and the structure and development of the therapeutic group (Alonso & Swiller, 1993; Toseland & Rivas, 1984).

Group As A Whole

One of the first social scientists to view group processes as interrelated elements and devise a metatheory for human behavior within the context of the group, was Kurt Lewin (Toseland & Rivas, 1984). Borrowing from systems theory, Lewin (1951) conceived of the group as a dynamic whole that was different from the sum of its parts; each equally as important and having definite properties of it own. This idea was a deviation from the long-standing belief that members in a therapy group were simply an aggregate of group behavior (Toseland & Rivas 1984).

Current discussion in the literature on group as a whole focuses on how individual group members who compose the collective, interact and their relations and transactions impact the group (Kaplan & Sadock, 1993).

Stages of Group Development

There a variety of ways in which group stages are described throughout the literature. For the purpose of this discussion, group development will be discussed in terms of pre-planning, beginning, middle and ending or termination phases.

Pre-planning is considered an important phase in group therapy. It is the period when all work that is directed at planning the group takes place (Toseland & Rivas, 1984). Considerations in this phase include: group population or client inclusion (or exclusion), composition and size of group, group purpose and objectives, duration and frequency of the group, and location (Borg & Bruce, 1991; Ettin, 1992; Toseland & Rivas, 1984).

Yalom (1975) asserts that the most important factor in a group's pre-planning or organizational phase is determining if the problem being treated in the context of the group is relevant to the client, and whether the client is motivated to change. Groups where these variables have not been taken into account have been found to be less successful (Yalom, 1975, 1985).

For children, developmental considerations such as age, gender, and the size of the group are important factors to consider when planning a group. Such planning ensures that their social and emotional needs are met in the context of the group (O'Connor, 1991; Schiffer, 1984).

The beginning stage of group therapy is often characterized by intense feelings of anxiety and tentativness as members get to know one another (Alonso & Swiller, 1993; Kaplan & Sadock, 1993; Toseland & Rivas, 1984). Toseland & Rivas (1984) state that focusing on certain objectives in the beginning phase of treatment are essential to the successful outcome of the group. These objectives include, facilitating acquaintances, clearly stating purpose of the group, providing an atmosphere of empathic reciprocity between members and leader, goal setting, contracting and helping members to be motivated to work in the group.

The middle stage of treatment is often preceded by what is referred to in the group therapy literature as a "storming stage" (Kaplan & Sadock, 1993; Toseland & Rivas, 1984). A storming period refers to a phase in group life where conflict is at a peak. This is typically heralded in by calm or cohesion by members which is essential to a group's maintenance. This phase is typically where the majority of group work is done which is the result of deepening emotional ties or cohesive membership (Toseland & Rivas, 1984).

The ending or termination phase is often characterized by a resurgence of group anxiety at the prospect of losing intimate interpersonal ties (Toseland & Rivas, 1984). Also, during termination the therapist processes what tasks have been accomplished and actively works at decreasing the attractiveness of the group and helps a child generalize the new behavior to external settings (Borg & Bruce, 1991; Kaplan & Sadock, 1993; Toseland & Rivas, 1984).

Group Norms

As therapeutic groups develop and become cohesive, group norms or "social control" evolve (Toseland & Rivas, 1984). Group norms refers to, "...shared expectations and beliefs about the proper and appropriate ways to act in a social situation." (Toseland & Rivas, 1984, p. 67). Norms are in fact the rules which regulate group behavior and are developed out of the expectations of individual members about what is or is not appropriate behavior. Toseland & Rivas (1984) suggest that to fully understand how a group exerts social control, members' roles and status must be considered.

Roles are defined as the shared expectations about how members function within the therapeutic group. Roles emerge as authorship as they are associated with various activities. A common role that occurs in almost any group is that of a "specialist" who takes on the a leadership role (Kaplan & Sadock, 1993). Assignment serves the function of ensuring certain, often vital functions are carried out in a way that the group finds acceptable. A member's role often defines how each member behaves in the group.

Status refers to a member's ranking in the group which often is assigned due to how they are perceived by members. Status as a variable of social control is conceptualized by the sanctions the group develops to handle deviation. Toseland & Rivas (1984) suggest that a member's status functions as social control by members vying for positions which usually cause members to conform to the norms set-forth by members.

For instance, a " medium-status" member will conform to group norms either to retain their status or in an attempt to gain a higher position of status within the group (Toseland & Rivas, 1984).

Group Cohesion

Yalom (1985) emphasized the importance of the development of group cohesivness as a variable to successful group therapy outcome. Cohesivness involves identification with the leader, members, goals and values of the group (Yalom 1975).

Yalom (1985, 1975) asserts that feelings of belonginess in groups can facilitate the growth and development of group attendance, stability, individual expression and exploration, and the integration of previously unacceptable aspects of the self. Promotion of cohesion is considered one or the most important tasks of the group's leader because of its importance to the success of group outcome (Kaplan & Sadock, 1993; Yalom, 1985).

Communication and Interaction

Understanding communication and interaction patterns is important in group work as it is through these processes that the group develops, tasks are accomplished, and assessment of important intervention areas occur (Kaplan & Sadock,

1993; Kendall, 1984, 1986; Toseland & Rivas, 1984). Communication and interactional styles may be, (a) vertical or maypole with the leader as the primary focus for communication and interaction with group members; (b) triangular, with the a leader-centered focus and two members who consistently interacting with the leader; (c) horizontal which does not include the leader and is referred to as "authority-denying"; and (d) circular or "round robin" which refers to the group process occurring among both leader and members (Kaplan & Sadock, 1993; Toseland & Rivas, 1994).

It is desirable for the group to evolve to the point where communication and interaction occurs among all members. This style of interaction often reflects a strong emotional bond and trust among members providing a cohesive atmosphere where the therapeutic goals are more likely to be achieved (Kaplan & Sadock, 1993; Toseland & Rivas, 1984).

As a result of mutual interest and emotional bonds that occur naturally in the group, subgroups begin to develop (Toseland & Rivas, 1984). Subgroups serve an important function of creating "dynamic tension" which is essential in

group work (Toseland & Rivas, 1984). However, subgroups can become problematic when individual members' attraction for other members outweighs the attraction for the group as a whole.

Subgroups can be classified by the formation of dyads, triads, or cliques among members (Kaplan & Sadock, 1993). Subgroups also can be classified by members who are isolated from the group as a whole. These individuals are referred to as the group's "scapegoat" or "isolate" (Toseland & Rivas, 1984). Scapegoats tend to receive negative attention from group members whereas isolates do not interact with group members (Toseland and Rivas, 1984).

Understanding the patterns of communication and interaction allows the group therapist to develop intervention strategies in an attempt to modify dysfunctional styles of relating by modelling more appropriate and functional adaptation.

PRACTICUM METHODS, PROCEDURES, AND EVALUATION INSTRUMENTS

Overview

This practicum focused on latency-age children and their families, social-emotional competency training, group therapy with the child and her family, and work with collaterals within the child's school setting. The evaluation instruments were designed to elicit relevant social data from the children's families and their teachers, measure behavior change of the children, identify changes in the children's self-esteem, identify changes in parental self-esteem, and elicit feedback from the children, parents, and teachers about the impact of treatment. Of interest to this practicum was whether a competency based treatment approach which involved the child, her family, and school collaterals, could effect change in psychosocial areas in which the child/family expressed difficulties.

Setting

The setting was Morse Place School located in the River-East School Division in north-east Winnipeg. Morse Place is a public school which recently merged elementary and junior high grades. Children who attend Morse Place range in age from five to fourteen years.

The room that was used in the practicum was a very large, sunny room that more than adequately met the needs of the therapy group. Its spaciousness allowed for active play to occur. Other functional aspects of the room included a sink, shelves that allowed for easy storage of play materials, a chalkboard, a table and chairs, and ample space on the walls for the children to hang pictures they drew.

Play material was chosen to facilitate social interaction and cooperative play among members. In addition, each of the children was asked in the pre-planning phase of the group what, if any, play items they would like to have provided for their use throughout the duration of the group's life.

The following was provided for the group's use:

1) art materials: crayons, water paints, large drawing paper, construction paper, glitter, macaroni, markers, and tape

2) music: tape player, children's tapes and tapes that each child chose to bring from her home

3) board games

4) jumping ropes

5) balls: soccer ball, mitts and tennis balls

6) puppets and puppet prop

Clients

The client population was composed of four latency age female children who had been identified by their school counselor as candidates for competency training. Each of these children presented with a range of difficulties that were felt to compromise psychosocial functioning. Two children were identified as aggressive, or acting out children. Two were identified as quiet and withdrawn. What each had in common was significant difficulty interrelating which was considered by parent(s) and school personnel to interfere in both adult and peer relationships.

In accordance with the literature that strongly suggests that for long-term treatment gains to occur when treating children, a parallel parent's group was developed to provide parent training designed to stimulate and enrich skills their children were learning by addressing important issues raised earlier with respects to understanding the child in the context of her ecological system (Dobson, 1984; Germain, 1972; Lehmann, 1990; Parmenter, Smith, & Cecic, 1987; Salzinger, et al., 1980).

Personnel

Clinical supervision was provided by Diane Hiebert-Murphy, of the Faculty of Social Work. Weekly individual meetings occurred in the pre, beginning, middle and post phases of this practicum.

Duration

This practicum began in October 1993 and ended in December 1993. Follow-up evaluation occurred in February 1994.

Procedures

A discussion of the theoretical approach that was chosen for this practicum was detailed earlier in the Group Therapy chapter. Therefore, only a brief description will be presented to highlight important aspects of the treatment model. Specific intervention was drawn from Exercises For Enhancing Emotional Competence Manual (Dlugokinski, 1989). This manual presents a problem-solving approach to enhance social and emotional competency skills specifically with latency age children. Treatment is presented in four phases of competency building. They are (a) recognition and acceptance of feeling states, (b) relaxation as a means to prevent automatic release of feelings, (c) thinking about alternative actions or solutions, and (d) implementing the solution (Dlugokinski, 1989; Spivack & Shure, 1974, 1980). Presentation of the competency manual material constituted the first half hour of the hour devoted to the children's treatment.

The remainder of the children's group hour was designed to elicit social interactive play where competency skills could be applied to actual experiences under the careful observation of peer and therapist, which facilitated immediate feedback when instances of conflict arose. This typically took the form of play such as games or physical activity like dodge ball or hide-and-seek.

The format for the parent's group was designed to provide information and insight about their children's difficulties, their progress in treatment, to model similar, albeit more sophisticated problem-solving skills, and to provide a supportive environment to discuss the consequences of child behavior change on the family system and generate ideas on how to manage difficulties that might arise.

Evaluation

Measures were selected to enhance assessment about change that occurred in relevant areas over the course of treatment. The evaluation process consisted of pre and post administration of instruments. Follow-up evaluation was

implemented three months following termination of the group in an attempt to determine if intervention had a long-term impact. At each evaluation juncture (pre, post, and follow-up), children, parents, and teacher(s) were involved in this process.

Instruments

The Achenbach Child Behavior Checklist (CBCL).

The CBCL is a broad based parent-report standardized measure which offers a detailed and discriminate child behavior profile from health/pathology (Achenbach, 1991) (see Appendix A). It highlights important intervention areas and measures changes in behavior once treatment is implemented.

This 118 item scale has been standardized on 2300 children ranging from ages four to sixteen (Lehmann, 1990). Test-retest reliabilities are supported by a mean test-retest r =.87 for the scales designed to assess competency and .89 for problem scales. The construct validity of the CBCL is supported by the correlates of CBCL scales, and its association with scales on the Conners' Questionnaire (1973)

and the Quay-Peterson (1980) (Achenbach, 1991). Criterion validity is supported by the CBCL's ability to discriminate between referred and nonreferred populations of children after demographic effects were considered (Achenbach, 1991).

A score of 70 or above on the CBCL indicates the child experiences clinically significant behavioural difficulties (Achenbach, 1991).

The Child Behavior Checklist-Teacher's Report Form (TRF).

The TRF is a standardized 116 item measure designed to obtain teachers' understanding of their pupils' adaptive functioning (Achenbach, 1991) (see Appendix B). The TRF provides a means in which a particular child's school functioning can be compared to the functioning of normative samples of peers. It also can be used to compare how other school and/or home sources perceive the child's functioning.

Test-retest reliability of the TRF (over a mean interval of 15 days) is supported by a mean $\underline{r}$ = .90 for academic and adaptive scores and .92 for scores in the problem scales. The content validity of the TRF is supported by its ability to discriminate between demographically matched referred and nonreferred pupils. The criterion validity of the TRF is supported by the quantitative scale scores which discriminate between referred and nonreferred pupils with demographic effects considered (Achenbach, 1991).

A score of 70 or above on the TRF indicates the child experiences significant behavioural difficulties (Achenbach, 1991).

Index of Peer Relationships (IPR).

The IPR is a 25 item, self-report standardized measure designed to assess the extent, severity or magnitude of peer problems of the client (Hudson, 1982) (see Appendix C). This measure can be used to globally assess peer problems or to assess more refined peer reference group difficulties.

Excellent internal consistency of the IPR is indicated by a by a mean alpha of .94. The validity of the IPR is supported by excellent know-group validity, which can significantly distinguish between clients judged by themselves and their therapist as having (or not) peer difficulties (Hudson, 1982).

According to this measure, a score of 35 or above indicates that the child has significant difficulty in the area of peer relationships (Hudson, 1982).

Index of Parental Attitudes (IPA).

The IPA is a 25 item, self-report standardized measure designed to measure the extent, severity, or magnitude of relationship problems between parent-child as perceived by a parent (Hudson, 1982) (see Appendix D).

Internal consistency is indicated by a mean alpha of .97. which indicates excellent internal consistency. Validity of the IPA is supported by it excellent known-group validity which significantly distinguished between a client's perception of relationship problems matched with that of the therapist.

According to this measure, a score of 30 or above indicates that the respondent perceives that the parent-child relationship is problematic (Hudson, 1982).

Piers-Harris Children's Self-Concept Scale (PIERS).

The PIERS is an 80 item, self-report questionnaire designed to aid in the assessment of the self-concept of children and adolescents (Harris, 1984) (see Appendix E).

Test-retest reliability coefficients for the PIERS range from .42 (interval of eight months) to .96 (interval of three to four weeks) with mean test-retest reliability of .73 (Harris, 1984). The content, criterion-related, and construct validity of the PIERS has been supported by research that the PIERS reflects a relatively stable set of self-attitudes in referred and nonreferred client populations (Harris, 1984).

Items of on the PIERS are answered "yes" or "no".
For interpretation of the score (see Appendix E).

Parenting Sense of Competence (PSOC).

The PSOC is a 16 item, self-report questionnaire designed to measure parenting self-esteem. It assesses both self-efficacy as a parent and the satisfaction derived from parenting (Johnston & Mash, 1989) (see Appendix F).

Normative data for the PSOC was obtained from 297 mothers and 215 father of four to nine year old boys and girls. In mother-father pairs (N = 208) significant positive correlations were found that support the PSOC. Total score (r = .32. $p<.001$).

Based on the findings reported in Johnston and Mash's (1989) study, scores in this report were interpreted by comparing to the normative sample means of 64.19 and a standard deviation of 10.48.

Just About Me (JAM).

JAM is a seven item, self-report questionnaire designed to assess a child's perception about his or her current emotional status (Dlugokinski, 1989) (see Appendix G).

Higher scores (with a maximum of 14) indicates that the child feels more competent in managing his or her emotions.

Playing On The Slide/The Soccer Game (POTS) (TSG).

POTS is a pre-intervention, self-report measure designed to aid the therapist in understanding the child's ability to recognize affective states and responses to them in relevant childhood situations (Dlugokinski, 1989) (see Appendix H).

TSG is the post-intervention, self-report measure designed to aid the therapist in understanding how affective states and responses have changed over the course of treatment (Dlugokinski, 1989) (see Appendix I).

Higher scores (with a maximum of three) indicates that the child is more capable of identifying affective states and responds in an appropriate fashion to an emotionally charged play situation.

Children's Feedback Questionnaire (CFQ).

The CFQ is a ten item, post-intervention, self-report measure designed to provide the therapist with information about what the child felt was beneficial from their participation in "Emotional Competency Training" (Dlugokinski, 1989) (see Appendix J).

Higher scores (with a maximum of 17) indicate that the child found the program useful.

The Client Feedback Form.

Client feedback was obtained from the child (see Appendix K for post evaluation, see Appendix L for follow-up evaluation), the parent(s) (see Appendix M for post-evaluation, see Appendix N for follow-up evaluation), and the teachers (see Appendix O for post-evaluation, see Appendix P for follow-up evaluation). Each evaluation measure was designed to assess client satisfaction and allow for opinions to be expressed about how individuals who participated in this practicum found the intervention to be useful.

APPLICATION OF THE TREATMENT APPROACH

Overview

I worked with a total of four families. Two of these families were traditional two parent families, one was recently blended and one family was a single parent family. None of the families had been actively seeking treatment on behalf of their child. Each was initially identified by the school counselor as a potential candidate for competency training. The counselor approached the families of each child asking if they were interested in a therapy group designed to enhance social and emotional competency skills.

Within this report all of the names and some of details of sociodemographic information about the families have been changed to preserve confidentiality.

Pre-Planning Process

Pre-planning is considered an important phase in group therapy. It is the period when all work that is directed at the group planning process takes place (Toseland & Rivas, 1984). Considerations in this phase include, group

population and appropriate client inclusion, composition and size of group, group purpose and objectives, duration and frequency of the group, and location (Toseland & Rivas, 1984. Yalom (1975) asserts that the most important factor in the group's organizational phase is that the problems being treated in the context of the group are relevant to the client. Another important inclusion factor is that the client be motivated to change. Groups where these variables have been taken into consideration have proven to be more successful than groups where they have not (Yalom, 1975, 1977).

For children, age, gender and size of group are important factors to consider to ensure that their social and emotional developmental needs are met (O'Connor, 1991; Schiffer, 1984).

During the pre-planning phase, the Morse Place School administration was approached to determine if they were interested in the proposed treatment. They indicated they had a client population that met the practicum inclusion criteria of early latency age children who had demonstrated

long-term difficulties in competent interrelating. A second consideration was that the parents of the children would be willing to participate in a parallel group as part of their child's overall involvement.

Permission was granted by the superintendent of River East School Division, Mr. George Wall to implement treatment (see Appendix Q).

Child and parent client screening was initially conducted by the school counselor who introduced this writer and her practicum proposal to them. I then contacted each parent to discuss the proposed intervention, its rationale, and emphasized the importance of their involvement in the parent group. Written consent was obtained from the parent to then contact each child individually at the school to determine their appropriateness for group (see Appendix R). Once they were deemed an appropriate candidate, each child was informed about the purpose of the group, asked if they had any questions and given the opportunity to either become a member of the group or decline.

I then returned to the homes of each of the children and gathered social history, administered pre-evaluation measures and obtained written consent for their child's membership in the group and to consult with school personnel (see Appendix S). Meeting again with the parents provided an additional opportunity for parents to address any questions or concerns that may have not been discussed earlier. This procedure was replicated with each of the children in private interviews.

Each child was again approached about their desire to become a member of the group. Pre-evaluation measures were administered to each child at this point.

I also met individually with the two teachers to gather information about their observations and impressions of their pupils and to administer pre-evaluation measures.

At the end of this information gathering process, I had learned a great deal about the children and their families. The following section will provide the reader with an overview of the information that was gathered with respect to the children and families who participated in this practicum.

CASE SUMMARIES

The findings of the practicum will be presented by first providing individual child/parent psychosocial information. This was obtained from the Health And History Form (see Appendix T), Social Demographic Information Form (See Appendix U) evaluation measures, and individual contact with the families prior to the onset of intervention. This is followed by a discussion of the treatment process as it relates to the three groups that constitute this practicum report: the child, the parents, and collateral meetings with the teachers.

Susie

Susie, age eight, lived with her mother, Laurel, younger brother, Roger age six, and sister, Molly, age one and one half. This family lived in a low income housing development in the River East School Division. Laurel was not employed throughout the time of my involvement. However, in the past she had worked in various paid positions and was in the process of seeking employment. Laurel left a violent

relationship with Susie and Roger's father when Susie was three years old. Laurel reports that she was quite depressed throughout much of her daughter's formative years as a result of the violence she endured in this relationship.

When Susie was five years of age, Laurel became involved with a man she dated for approximately three years. He is the father of the youngest child in the family. Laurel described her partner's treatment of Susie as one that was verbally abusive. When I first met Laurel, it appeared that she did not understand the consequences of her partner's abusive behavior or that of Susie's father on her daughter's emotional well-being. Developing a supportive relationship that allowed for insight into the negative consequences of the violence they experienced became the essence of my work with this family.

Presenting Problems

When I spoke to the school counselor about this child as a potential candidate for group, he indicated that Susie had a variety of difficulties that had been observed over the course of her school life. School personnel described her as

defiant, aggressive, and moody. The school also reported that Susie experienced difficulty in all areas of interrelating, both with adults and peers. Her teacher indicated that she had no friends, and referred to her as a "loner". She indicated that Susie's negative, disruptive behavior interfered in classroom functioning.

Susie initially described her life, as one fraught with loneliness which appeared to perpetuate feelings of desperation and longing for peer validation. Susie did not understand why other children did not want to play with her which resulted in utterances such as, "They won't play with me because I am stupid and ugly." She did not attribute lack of friendships or peer affiliation to her aggressive, alienating way of relating with other children.

Observations:

Parent

Laurel presented as a very lonely individual who lacked social supports. She welcomed my involvement, indicating that contact with another adult would offer her some relief from the isolation she felt in being a single mother. Laurel

felt that her two previous abusive relationships had emotionally depleted her, compromising her ability to empathically parent Susie throughout her formative years. She also thought that her current difficulty in finding employment, was the result of lingering feelings of inadequacy that she attributed to her two previous relationships and the lack of "energy" that was an inherent part of her life as a single parent.

Susie

From the onset of involvement, I was aware of the intensity of difficulties Susie encountered on a daily basis both at home and school. Everyone that I spoke to initially reported that they found her disruptive behavior "intolerable." I observed her completely isolated from peers, she had no friends. Susie indicated that the only "true friend" she had was the "T.V."

To address the issue of informed consent, I cautioned Laurel about the potential effects the group would likely have on her daughter. I felt that the group would awaken dormant emotions for Susie which would necessitate a strong

support system to rally around Laurel and her family. I proposed therapy beyond the termination of the group and intense school involvement as the possible result of her involvement in the group. She agreed that we would assess the appropriateness of such a plan throughout the course of our working relationship.

Intervention

I saw Susie for a total of 16 group therapy sessions.

Aside from Laurel's regular attendance at weekly parent meetings, we agreed that individual meetings in her home would be beneficial in supporting this family. Much of our time was spent in exploring the impact of past violent events on Laurel and her children.

Our individual work focused primarily on the painful aspects she and her family had endured as a result of previous family violence which included lowered economic status, isolation, and feelings of inadequacy and responsibility that Laurel held for the abuse they had

experienced. This opened up painful avenues of responsibility and guilt that she was somehow responsible for her previous partners' violent behavior. However, as our relationship deepened, there was a growing sense on her part that I would be empathic to her life experiences and not blame her for the actions of others. This facilitated an eagerness on her part to understand more about the consequences of family violence and how it had effected her family.

Laurel began initiating conversations that were designed to elicit information about what I felt her daughter's current emotional needs were with respects to parenting. I encouraged her to find resolutions that she felt would be appropriate, in an attempt to empower her.

Laurel's growing sense of competency was also evident in her participation in the weekly parent group. Initially, she had been quite reserved in relating to members. However, as the group developed she became an outspoken leader providing important insight to other members who were more reluctant to discuss intimate information about parent/child difficulties.

As the practicum neared the end, I began to discuss how we should consolidate what had taken place over the course of our involvement. I observed Laurel distancing herself from the intimacy that had developed and our discussions lacked the depth and vibrancy that had been evident before. I brought this to Laurel's attention, which resulted in us talking about how difficult loss is for her and its association to painful events that have occurred in her life.

Laurel agreed that transfer of support was essential beyond termination. In an attempt to provide continued support to meet her family's needs, I referred the case to The Child Guidance Clinic for continued parental support. In addition, the school counselor resumed a supportive role with Susie until a referral for individual/family therapy was made. It is my understanding that the individualized therapy began with this family approximately six weeks following termination of group.

Valerie

Valerie, age eight, lived with her mother, Kathy, father, Steve, and younger sister, Rachel, age five. They lived in a comfortable home in the Morse Place catchment area. Both of Valerie's parents were employed in professional careers. This family was quite active in their community with the majority of Valerie's socialization with other children taking place with members of their Church.

Presenting Problems

The school identified this child as a potential candidate for competency training because she was withdrawn, isolated, and appeared unhappy much of the time. Her teacher described Valerie as a child who had difficulty concentrating in class, was often restless, appeared confused most of the time, was disobedient, disturbed other pupils in class, and lacked self confidence which she felt impaired her ability to function autonomously. She reported Valerie paired with other children which served the purpose of providing her with models about how to conduct herself both academically and socially.

Valerie's parents described their daughter as "hyper" which they described in terms of her constant nail biting, inability to concentrate, and fidgeting. They also reported being concerned about her shyness which they felt compromised her ability to socially interact and be assertive in instances that would be appropriate. They also expressed a concern about Valerie's perceived need to be "perfect".

Valerie presented as quite anxious upon meeting me. She could not maintain eye contact and physically withdrew to areas on the other side of the room. She would not allow me to ask interview questions, which resulted in my asking her if she wanted to play tag. Following our game, Valerie calmed enough for me to proceed with the interview.

She reported "hating" school and stated that she always felt "bored". Valerie described herself as "shy" and indicated that she had "only" two friends at school which she attributed to her shyness.

Observations

Valerie's parent's seemed to experience difficulty allowing her to be an autonomous individual. If Valerie expressed difficulties occurring outside the home, they would attempt to rectify the problem instead of instructing her on how to do this on her own. For example, when she expressed being unhappy at school (this occurred almost daily), their response would be to phone her teacher and ask her to intervene (calls ranged from one to three a week at the beginning of my involvement). The very protective nature of their involvement with Valerie appeared to result in her feeling ineffectual in most situations, especially school where a fair amount of autonomous behavior is required in most instances.

Over time, I became aware of how exhausted this family was in terms of the multiple roles they were engaged in during this stage of family development. Both parents were professional individuals in the midst of developing their respective careers. I believe, in many of the situations I observed, their attempts to intervene on Valerie's behalf was

how they adapted to the limited time they had in their roles as parents. The struggles that I observed, usually related to instances where time constraints were an important consideration in the way they responded.

Intervention

I saw Valerie for a total of 16 group therapy sessions. I encouraged Valerie's parent's to call when difficult situations arose. This family however, was quite adept at learning more effective ways of coping at parenting meetings and did not feel a need to consult with me on an individual basis. I observed a heightened awareness by her parents about the benefit of allowing Valerie more autonomy. This speaks highly of this family's ability to adapt, especially in light of their hectic schedules where "doing" things for Valerie would have been easier.

Mandy

Mandy is an eight year old girls of aboriginal descent. Together with her mother, Kelly, and father, Stew, Mandy lived in the East Kildonan community that was serviced by Morse Place School. This family resided in a two bedroom

apartment and were in the process of looking for larger accommodations due to the upcoming birth of their second child. When I first met this family, the mother was working full time in a semi-professional position and the father was completing a degree at a community college. Towards the end of my involvement, Stew was working full-time in a professional position.

Presenting Problems

Mandy was described by school personnel as a child who had no friends. Her teacher described her behavior as threatening and cruel to other children which often resulted in her being isolated from peers in an attempt to protect others from harm. Mandy (who was in the same class as Susie) was also viewed by her teacher as a disruption to the normal functioning of the class because of her aggressive behavior.

My first meeting with the family to ascertain if they felt the group was appropriate for their daughter was chaotic. Mandy, who was present, was so disruptive and intrusive that I suggested we arrange another meeting time.

Prior to leaving, Mandy insisted that she be allowed to become a member of the group. Her mother agreed that she could. For our second meeting, Mandy's mother made arrangements for her daughter to visit with a relative which offered us some privacy. Mandy was described by her parents as inattentive, restless, clingy, and constantly in need of adult attention. They also expressed concern that Mandy appeared to lack the skills to successfully make and sustain friendships. In addition, the parents expressed their frustration about how difficult it was to manage Mandy's behavior stating, "We don't know how to handle her when she is so demanding, so we usually just let her do what she wants."

When I first met Mandy in private, the first thing she brought to my attention was the fact that one of her eyes was green and the other was brown. I later came to understand this behavior as a measure, on her part, to point out what she perceived to be her "faults" in a attempt to ward off insult or injury to her self-esteem. Quite unlike the interview that took place in her home previously, this contact was qualitatively different. I provided very clear,

firm, yet nurturing boundaries for her behavior from the onset. This allowed me the opportunity to observe a very different child than the one described by the school and that I had observed earlier in the home.

Mandy described her current school life as one fraught with loneliness and confusion. Much like Susie, she did not understand how her behavior alienated others. Quite the contrary, she perceived her attention seeking behavior (which was quite aggressive) as a means to gain others attention; much like she did in my presence at her home earlier. Mandy described "hating" school and indicated that she day-dreamed for most of her school day. She reported not having any friends either at school or home indicating that her playmates were cousins that were much younger than herself.

Observations

The school counselor had been involved with this family a year earlier when they approached him requesting assistance in learning how to manage Mandy's increasingly difficult and demanding behavior at home. He had assessed a need for them to assume a more assertive parenting role which he felt

would facilitate a relinquishment of Mandy's power in the family. He instructed them in parent-training techniques for a short time. I tend to agree with the counselor's hypothesis. It appeared that Mandy's parents had difficulty setting limits on her behavior. However, this needs to be understood in the context of this family's cultural and family of origin background. As described by the parents, a fairly relaxed style of parenting had occurred for both of them in their families and within the native communities in which they grew up. The parents also described their primary reference group as that of their extended family which they report tended to isolate Mandy from learning about reciprocal relationship outside her immediate family. Therefore, it was important to be culturally sensitive throughout the intervention process to these issues and the impact they had on my observations and involvement with them.

I observed Mandy as disruptive, intrusive, and she constantly violated the personal boundaries of others. All of the family's activities appeared to revolve around her needs and desires which limited the opportunity for her to learn self control. This compromised her ability to

interrelate in a world where delayed gratification and taking in another's perspective is imperative in reciprocal relationships.

Much like Susie's mother, this family saw my involvement as a way to solve their child's difficulties. They expressed a growing concern that they did not know how to cope with Mandy's behavior.

Intervention

I saw Mandy for a total of 15 group therapy sessions. She missed one session to travel with her parents to visit family who lived out of town. Besides regular attendance at parent meetings, two meetings with the mother and one with the mother and the father occurred over the course of my involvement. Meetings were initially set-up to gather social history and follow-up data. However, I also used this opportunity to model for the parents a more effective style of managing Mandy's behavior when is became disruptive, to address concerns they had expressed about their growing frustration in parenting her.

In terms of modelling appropriate behavior, when Mandy would disrupt a discussion that was taking place between her parent(s), I would ask her to wait until I finished talking with them, stating that it was inappropriate to talk while others did. Another example occurred when Mandy attempted to give me items to take when I left. I pointed out that her mother or father needed to make that decision. Following, Mandy asked permission from her parents to give me an item which resulted in a transfer of parental power and negotiation about decision making to them.

Diane

Diane, age eight, lived with her mother, Harriet, her new step-father, Murphy, and older sister, Rhonda, in a comfortable side by side home in the community of East Kildonan. This is a black family where the mother, had earlier immigrated from Jamaica and met and married Diane's father in Canada. They later separated and divorced when Diane was approximately four years of age. When I met Harriet, she had recently re-married. Both Harriet and her current husband worked in semi-professional positions.

Harriet described her relationship with Diane's father as one filled with violence. She indicated that Diane never experienced direct violence at the hands of her father, but observed both physical and emotional abuse that was directed at her and her daughter Rhonda. When Diane was approximately age four she left this relationship. Alone and isolated in Canada, she made the difficult decision to send Diane and Rhonda to Jamaica to stay with extended family until she could find employment and suitable housing for them. Harriet also reported that she was emotionally depleted and needed time to "heal" from the violent experience her family had endured.

One year later, Harriet flew to Jamaica to be reunited with her children. She described being "horrified" at seeing her children. Harriet showed me pictures of Diane before leaving for Jamaica, and one following her return to Canada. In the later picture, her physical stature appeared withered and she looked despondent. Harriet later learned that had been physically abused by a teacher in Jamaica. In retrospect, she feels that the long separation and the physical assaults resulted in her daughter's depleted state upon her return.

Harriet had recently re-married when I first met the family. She indicated it had taken her a long time to "trust" again because of the violence she had endured in her first marriage. Harriet described Diane's relationship with her new step-father as "good" and felt that her new husband was a good father. I was also sensitive to the fact that being minority members in the culture impacted on this family in a number of ways. Harriet often described experiences that ranged from finding it difficult to find employment as a female black woman , to feeling intimidated in a predominantly white community. She reported that this had resulted in some of the isolation that occurred for her family, and thought that it contributed to her daughter's withdrawn behavior both at school and in terms of lack of involvement with children in the neighborhood.

Presenting Problems

Diane was the first child to be identified by the school as a potential candidate for the group. Diane's teacher reported that she had a variety of learning difficulties that required intensive resource assistance. She was also

described by her teacher as having difficulty concentrating. She appeared confused, was self-conscious and guarded, extremely shy and timid, and was very slow and lethargic in all the activities in which she participated. Her teacher knew of only one individual with whom Diane played; who was equally as shy and the only other black female child in the school. She often was teased by peers because of lags in development, both academic and physical, and because she was a black child.

Initially, Diane's mother was quite tentative in suggesting that her daughter had any difficulties. However, she did feel that her daughter was shy, but only with others outside the home. At the beginning of our involvement, she attributed her daughter's withdrawn state as part of her personality.

When I first met Diane she was so soft-spoken that I could not hear anything she said. When I asked her questions, she looked at the floor, hid her face, or turned away from me entirely. In order to proceed with the interview, I asked her if she would draw pictures with me.

This appeared to alleviate some of the anxiety and allowed the interview to proceed. Diane described herself as "shy". She indicated that school was a frightening place for her because the other children teased her and she felt isolated from her peers.

She also reported that she was afraid at school because she had been "hit" at school when living in Jamaica and said she was frightened this would happen again.

Observations

It was important to view Diane's current difficulties in the context of her family's status as a minority, that they were a newly formed step-family, and to understand how multiple traumas had compromised her social, emotional, and physical development.

Harriet indicated that Diane had suffered with childhood asthma since infancy which had been life threatening at times. Diane had learned that rapid or exerted body movement could bring on an attack. In addition to life threatening

medical concerns, Diane's early life experiences have been characterized by paternal alcohol abuse, and witnessing her mother and sister being physically and verbally assaulted. She consequently experienced the loss of both parents in her formative years. It is likely that her separation from her mother for a year and the physical abuse that occurred during this period of time, had a negative impact on her which is evident when viewing the picture of her physical stature and demeanor upon her return to Canada.

I concluded from my understanding of the family that Diane had been subjected to repeated childhood trauma, both emotional and physical, and as reported by her mother experienced isolation due to her minority status which compromised her ability to feel competent in many aspects of her life.

Intervention

I saw Diane for a total of 16 group therapy sessions. Two individual contacts occurred with Harriet in her home. Although these meetings were intended to gather social history information and data for the evaluation of the

practicum, they also provided a forum to discuss the multiple traumas of Diane's young life and possible consequences.

General information about the consequences of childhood trauma were discussed. Harriet was quite interested in this topic and soon began talking about how emotionally depleted she felt following the termination of her relationship with Diane's natural father.

As our working relationship deepened and a level of trust developed, she discussed being shy as a child and how it had interfered in various aspects of her life. This opened up avenues for us to discuss how this could also effect the quality of her daughter's life. Harriet became quite interested in what she could do to intervene on her daughter's behalf. I approached her queries by addressing specific problem areas that I had observed for Diane and encouraged Harriet to come up with possible solutions. In collaboration with her, the following areas were discussed. They included, encouraging Diane to be expressive and assertive in a variety areas in her life, to help Diane

become involved in play activities that emphasized body movement and interaction with others, and activities that required social interaction with peers such as a community baseball team.

I also talked with her about how I had observed Diane's isolation from classmates due to her involvement in Resource and encouraged Harriet to continue advocating to have more of the work done in her classroom whenever possible.

GROUPS

Overview

The following discussion will describe where the child and parent group's took place, how the level of involvement by the school impacted on the groups, group size and composition, observations about the groups, and finally concluding remarks about how treatment impacted on the families of this study.

Physical Environment

The treatment room used for both the child and parent groups was a very large rectangular shaped room with windows at both ends. It was equipped with sink, shelving, tables, chairs, chalkboard, locked storage units and was large enough to accommodate the busy activity that occurred in the children's group.

School Involvement

I believe my prior involvement in this community as a Child & Family Services worker had a tremendous impact on the both the ease with which this practicum was implemented and its outcome. I was well known in this community and to the staff at Morse Place School. The mutual trust and respect that was a component of my working relationship with the administration at Morse Place School, greatly diminished the amount of time that it took the staff to accept my presence in their school. The staff were cooperative and always asking if I needed their assistance.

There were a variety of practical advantages of conducting the group within the school. One of the most important factors was that it facilitated attendance in the children's group. Administration and school personnel contact were readily accessible, virtually eliminating the back-and-forth calling that would have occurred. It also allowed for weekly meetings to take place with the teachers to discuss the children's various needs and intervention strategies. For the parents, the familiar location was central to their homes which decreased driving time.

The children's group experience itself was greatly enhanced by the fact that it occurred in their natural day-to-day setting. This provided the opportunity to observe and intervene in the real life experiences occurring for the child's life outside the group.

An example occurred very early on in the children's treatment when I was invited by members to join them on the playground for recess. This allowed opportunities for direct observation and intervention to occur. It also provided opportunities to play with the children which facilitated a more rapid therapeutic alliance because I was viewed as a "companion" rather than an authority figure.

Group Size and Composition

The children's therapy group was a small, homogeneous group composed of four eight year old female children, all in grade three. Each of the children presented with long term maladjustment problems that had persisted over the course of several years. Susie and Mandy presented with aggressive, acting-out behavior. Valerie and Diane presented with

behavior as shy and withdrawn. Despite differences in their behavioural presentation, common to all four children was an impaired ability to interrelate which interfered in their psychosocial development.

Yalom (1983) asserts that homogeneous groups offer an advantage when the emphasis is on support or on symptomatic relief when a group is run over a short period of time. This is largely due to the fact that the group "gels" quickly, the attendance rate is usually higher, members tend to be more cohesive and offer almost immediate support, and there is less conflict resulting in a more rapid relief of "symptoms" (Yalom, 1985). Due to the identified criteria of group participation, members in homogeneous groups are more quickly able to exchange pertinent experiences. This expedites collective influence of support. Another important consideration is that the group be small enough that it can meet the dependency needs of latency age children which are still great (O'Connor, 1991).

Group Description

The children's group was a time limited, cognitive behavioral problem-solving therapy group which ran a total of eight weeks, twice weekly for a total of 16 sessions. The length of each session was 60 minutes. Following the first session, I was invited to participate at recess which extended the amount of time spent with the children by 20 to 30 minutes each session.

The first 20 to 30 minutes of each session was devoted to a pre-planned, structured exercise from Exercises For Enhancing Emotional Competence (Dlugokinski, 1989). (I will refer to this manual from this point on as, The Competence Manual or the Manual to simplify material for the reader.) The Manual focuses on a story called, "The Turtle Story". The story focuses on two child turtles, one female and one male, who encounter various difficulties in their daily lives and "how" they attempt to resolve them with the assistance of a wise old turtle who challenges them to "feel" and "think" their problems through.

Exercises highlighted various aspects of the problem solving approach which included, (a) accepting ones feelings, (b) relaxing to avert the release of negative emotions, (c) generating solutions that are helpful and relevant to the problem, and (d) acting on them. A companion workbook was distributed to each child to complement the lessons being learned each session, this encouraged active participation by the children in the therapeutic process.

Session by session content material from the Competence Manual is presented in the Appendix section of this report for reader simplification. (see Appendix V).

Following the structured portion, sessions were designed to provide members with social interactional experiences in order to allow difficulties to be resolved in a safe, nurturing environment with the therapist guiding members through the problem-solving approach. Beyond the protected life of the therapy room, opportunities were presented for out-of-group intervention while on the playground and in the hallways of the school.

Group Process

For the purpose of this project, group process and its evolution is understood as emerging and evolving from the continual interplay between the individual which is defined as the groups discrete members; interpersonal defined as the collective of related members who have a certain order or arrangement; group as a whole which is the collective (Kaplan & Sadock, 1993; Pfeifer, 1992). Group therapy literature has various ways of talking about group phases which were described earlier in this report. They include, pre-planning, beginning, middle and ending or termination phase (Kaplan & Sadock, 1993; Toseland & Rivas, 1984).

For the purpose of the report, observations about the children's group will be presented in the phases described above. Discussion will include observations of the group, as well as individual member. Finally, comments from teacher and parent are included where their observations were relevant to what was occurring in the group in a particular phase of group treatment.

Beginning Phase

Children's Group

The first session began by introducing "round robin" discussion about who we were as individuals and who we might become as a group. Also, the purpose of the group was discussed in terms of finding new and more effective ways of dealing with problems that occurred in their daily lives.

What typically took place in the beginning when children wanted to communicate, was the raising of hands. I asked the members if they could find other ways to speak. This was met with squeals of delight by the children who immediately set-forth on the task of deciding how to proceed in what became the group's first experience in problem solving.

To provide a sense of structure and boundaries, I informed the group that the only rules I would impose, were ones that would keep them emotionally and physically safe. I asked if anyone had a rule they felt was important. Each child offered what appeared on the surface as rather silly

rules (which defied the conformity that is highly valued in a school setting) such as, "If you want to stand on the table you can". Another said, "If you don't want to sit, you don't have to." At the end, we had effectively established a fairly relaxed, non-threatening format of treatment, where decisions were made by members. We decided that members could be who they wanted to be in the group, and do what they wanted (even if that meant standing safely on top of a table to defy conformity) when they wanted as long as they did not hurt themselves, or others. There was a level of comfort with the "no" rules policy, knowing that group norms would develop and keep the group safe.

Norms, or the rules governing behavior, were developed by the group and fairly well established by the fifth or sixth session. Well beyond the "artificial" rules prescribed in the first session, the norms in the group evolved from struggles between its members, their status in the group and the intolerance of certain behavior by members.

Valerie and Mandy quickly became highly valued members. Their positions brought with them the power and authority to develop most of the rules of conduct. These included, reciprocity among members in play activities, a hierarchy of leadership was not tolerated, sub-groups that could not be dispersed for the good of the group were not tolerated, and emotionally laden disclosure usually resulted in a member being shunned.

My leadership in this phase was one characterized by "benign" authority. As the designated leader, I was often looked to for direction, but had little power to challenge the "group resistance" that was taking place. The first sessions were characterized by intense, anxious play activities and a denial by members that the group had assembled due to problems they held in common.

Despite my attempts to make the content material appealing, members resisted this format of treatment. I modified the goal of introducing exercises in an attempt to develop a therapeutic alliance by connecting and interacting

with members through their play. Throughout the development of this alliance, I actively applied the problem-solving approach to the difficulties that were occurring in the formation of this group.

Eventually members settled and became interested in the material. I observed the group "calming" in relation to Valerie and Mandy persistently urging the other members to participate in learning process. This was the onset of the beginning of the Middle Phase of treatment which the literature indicates is characterized by an observable calming by members (Toseland & Rivas, 1984).

Individual Child

Valerie - Observations:

Valerie's initial presentation in group was that of a shy, timid, withdrawn who was overwhelmed by the lack of structure and control. She agreed to participate in activities and games that she did not want to play. A difficulty that persisted throughout the group, was Valerie's

isolation from members in the larger social context of the school. She had not know any of the members prior to the onset of group (unlike the other three children who were classmates), which made integration into the group more difficult for her.

From the outset, Valerie appeared quite anxious. She persistently attempted to leave the group early, had difficulty attending to exercises, and would often withdraw from group activities and engage in isolated activities such as drawing. When the group was involved in exercises from the Competence Manual, Valerie became an important and valued member in the group. She was looked to for guidance and direction because of her astute problem-solving capabilities.

An example of how Valerie was esteemed by her peers for her problem-solving capabilities occurred when the group was playing the game "Sorry". To precipitate conflict so observations could be made about the children's capacity to resolve problem situations, I had purposely taken one piece from a set of four that is necessary for each player. The group members began arguing about who would be the child

to play with three rather than four game pieces. Valerie suggested that they all play with three, reducing the mounting conflict. When situations such as this arose, I reinforced the capacity of members to competently problem-solve and to identify how this might apply to what they were learning in the group.

Despite initial reservations about involvement in the group, Valerie become a group leader and a member of the only dominant subgroup with Mandy. This subgroup provided the girls with a sense of stability when the group became chaotic. When the group was most disruptive, they retreated into activities on their own. This subgroup evolved into a friendship. To my knowledge, Valerie and Mandy are the only two children who continued their friendship beyond the group.

Diane - Observations:

Diane's initial presentation was that of a shy, withdrawn, child who physically withdrew from the group as a means of self-protection. Her body movements were lethargic and slow moving. Invitations to join the group were often met with blank stares or a further removal from the group.

Comments would be directed to other members to invite Diane to join. This appeared to entice her, but she would withdraw when feeling overwhelmed or challenged. After four or five sessions there was a notable shift in the way Diane interacted with group members.

Over time, Diane began to assert herself in situations where she had not before. She became more capable of remaining in the group, even when conflict occurred. Despite her growing assertiveness, Diane never became a high status group member. However, as group cohesivness developed, I observed members' respect grow for her. This was most obvious when other children challenged her which resulted in members attempting to protect Diane.

Mandy - Observations:

Mandy initially presented in the group as clingy, dependent, whiney and unable to tolerate contact with other members. Attempts at interpersonal involvement with peers overwhelmed her and she often isolated herself from group activities.

Towards the end of this phase Mandy grew to positively interact with peers. She participated more and her I observed a level involvement with them that was highly cooperative. Due to the reciprocal relationship between Mandy and Valerie, she began to learn essential relationship skills. Their developing friendship began to stretch beyond the group to the school playground.

Susie - Observations:

Susie initially presented in the group as loud and demonstrative, her behavior overpowering the group. She indiscriminately disclosed personal abusive life experiences to members who had difficulty understanding the nature, scope, and motivation behind the abuse. She was physically and verbally aggressive with members. She cheated in games and constantly confronted members when they challenged the growing authority she had by virtue of the fact they were scared of her.

I began to intervene by asking members to express how her behavior made them feel. Eventually, her peers began to directly confront her inappropriate behavior.

By the beginning of the middle phase of treatment, members had grown intolerant of Susie's behavior and would not allow her to deviate from their expectation that she be fair. Her behavior often resulted in her being shunned or scapegoated by members. This was a period in Susie's treatment that brought with it a painful emotional awakening. Susie's behavior shifted from an aggressive style of relating to one that was passive and submissive to members. She often appeared sad and confused. Both her mother and teacher reported a dramatic decline in aggressive behavior to noticeable dysphoria.

Middle Phase

The middle phase of treatment in group therapy, is where the bulk of therapeutic work is done (Toseland & Rivas, 1984). It is often preceded by a "storming stage" which is characterized by a high degree of chaos or disorder among members of the group (Kaplan & Sadock, 1993; Toseland & Rivas, 1984).

At the beginning of this phase, there was a dramatic decrease in group disruption resulting in a whirlwind of purposeful activity. This allowed many of the group goals to be addressed. Members were attentive to the structured portion of sessions. Throughout this period, members challenged one another by applying many of the constructs of the problem-solving approach when difficult situations arose. This suggested that members felt relatively safe, facilitating a growing sense of belonginess among member who now interrelated with ease.

In this phase there was also a shift in how the group utilized me as a leader. I was viewed as the "wise woman" who, much like the wise old turtle in the "Turtle Secret", helped children cope by imparting guidance from afar. Throughout this phase, the group functioned quite autonomously, distributing a fair amount of power among the peer leaders, Valerie and Mandy.

Another event that heralded the middle phase of group life was the active member participation of Valerie. Earlier, Valerie's mother expressed concerns about her daughter's unhappiness in the group. To prevent Valerie from

dropping out of the group, I assessed her as needing more individual time with me. As a result I met with her on two occasions prior to sessions for 15 minutes. We talked about her discomfort and I attempted to elicit solutions that she felt could benefit her. With Valerie's permission, I told members that Valerie was struggling in the group. As I had hoped, they responded by expressing their feelings about her leaving and strongly encouraged her to remain a member.

I was constantly assessing what exercises from the Manual would best meet member needs. As I grew more comfortable with the material and felt more competent as a group leader, modification of the material occurred in order to provide situations where members could actively participate and address situations they felt were important. An example of how exercises were modified occurred in Exercise 10, "Learning About Thinking" This exercise is designed to help children learn "how" to think, rather than "what" to think. The Competence Manual suggests that children look up the word "think" and conceptualize solutions to a problem posed in the Turtle Secret story. Instead, I asked the children to tell me what they though the word

"think" meant. I then asked if they would like to reverse roles and become the instructor writing as many solutions to the problem that they could generate on the blackboard while I observed. Members conceptualized a variety of options about how to think through and resolve the same situation, while instructing me, their pupil, how to implement the solutions.

A number of events that took place during the middle phase of treatment capture the essence of the group and its cohesive functioning. Diane's birthday fell in one of the months that the group took place. I informed the group of her birthday and asked them to comment on how it should be acknowledged. An entire session was devoted to acknowledging members feelings about being left out of a birthday celebration. This process resulted in members chosing to resolve their feelings by having a party to honor of each of them. We spent the next session delegating tasks among members about how to proceed with plans they had for the party. Because of the cohesive nature of the group in this phase, this two session problem-solving process took place almost entirely by members.

The power of corrective peer experience that evolved as a result of the group's cohesive nature is captured in an incident that occurred as the members were walking down the hall to the therapy room. On a number of occasions Mandy and Susie had talked about their siblings. Mandy expressed her distress about the upcoming birth of a new sibling. Susie, overhearing this indicated to Mandy that the way she "dealt" with her younger sister was by "pretending" that she was not really there. A conversation ensued with Mandy confronting the dysfunction inherent in this style of coping if used persistently. However, she informed Susie that if she felt "too awful" at times in relation to her sibling, she would resort to the suggestion put forth by Susie. There were many similar corrective peer experiences such as this one that occurred in the hallway to and from session.

While most of the interventions planned and implemented addressed group issues and difficulties, individual group members had special needs which necessitated planning to occur at and individual level. An example of individual planning occurred with Diane. Diane typically walked slowly and methodically everywhere we went. I used the opportunity that the hallway presented in challenging her to a race to

and from the therapy room. On other occasions I noticed much of her recess she missed due to spending inordinate amounts of time tieing her shoes. I challenged her to "practice" tieing her shoes before our next session indicating we would have a contest to see who could be on the playground first. Diane was the first child on the playground the following session.

The playground also became a rich and rewarding intervention arena. There were many instances where conflict with non-group members occurred allowing direct, real life intervention to occur. For example, during ball play on the playground, Diane, who had difficulty catching the ball, was teased because of her poor coordination. When asked to apply her newly learned problem-solving skills, Diane was able to confront the child who teased her. Later, I saw this child encouraging Diane to play ball with her so that she could "teach" her how to do it.

I also observed friendships occurring for both Diane and Mandy with other children who joined in our play. Eventually, I became less involved in playing directly with the children, and was delegated the role of observer of

their play activities. Towards the end of treatment, I often was able to walk off the playground, unnoticed by the members, as they played with other children.

Individual Child

Valerie - Observations:

Valerie entered the middle phase with feelings of ambivalence about her membership in the group. Following individual intervention, I observed Valerie lingering at the end of sessions. Following one session, she poked her head back in the play room insisting that we "hurry up" because she wanted to walk back to the classroom with us. From that point on, she remained with the group until we dispersed at recess. However, Valerie increasingly became drawn to the prospect of playing with us at recess and eventually joined us.

Valerie's behavior underwent a rather dramatic transformation during the middle phase of group. She became demonstrative and assertive. She demanded that she be first and told members what they were going to do. Her status was

high which allowed her a fair amount of unchallenged power and control in the group. I mirrored to the group that Valerie appeared to dictate what they would do with their time. Members began to correct the power imbalance by directly confronting the inappropriateness of her behavior in relation to their needs and wants.

Valerie's mother and father began to report at the parent's meetings that she had become more assertive at home as evidenced by challenging the rules.

Diane - Observations:

Diane became more assertive. She was quite immature in relating her needs to the group. Diane would stomp up to a member she was irritated with and say, "I don't like what you are doing. I want to be first." Not only did she articulate her dissatisfaction at the situation, she began to physically push her way into the group. Members directed their comments about the inappropriate nature of her behavior and she would re-attempt to enter the group until she was satisfied with the outcome. During this time, Diane became more integrated

in the group. It began with a joke she told (a rather funny one), about a "fart". Members literally fell to the floor in laughter. I observed that whenever she felt threatened by what was occurring in the group that she would re-tell the joke resulting in renewed intimacy among members.

Diane's teacher described a dramatic change in her behavior in this phase. She reported that Diane had become physically demonstrative in class. She would raise her hand (this had not happened before), want her opinions heard, and at one point wanted her teacher to listen to a story she had been reading in silence. Diane's teacher reported she went to the front of the class to read her classmates the story.

Diane's mother reported that Diane was more assertive at home and that she appeared more interested in participating in neighborhood activities.

Mandy - Observations:

Mandy appeared more content. Her demands for individualized attention almost disappeared. She became a more positive member and made concerted attempts to befriend Valerie. She no longer physically distanced herself from the conflict that arose in group activities, but became an active participant in resolving problems when they arose.

Mandy's teacher reported that Mandy become more capable of participating in small groups with very little conflict. She also observed Mandy spending time with two children from other classrooms on the playground.

Mandy's mother described the changes she observed in affective terms such as, "contentment" and "happiness". She also observed a notable difference in Mandy's ability to share with other children. She also reported that during this phase of treatment, that feelings of parental frustration began to diminish. She attributed this to Mandy's decreasing needs for constant attention.

Susie - Observations:

Susie's plunder from a position of power and dominance in the group brought forth waves of aggression and sadness. Susie was often scapegoated and at best was minimally tolerated by members because of her behavior and expression of feelings that they could not understand. If she could not contain her behavior, members would simply leave and begin to play somewhere else.

Susie's teacher reported that behavior in the classroom became increasingly difficult to both manage and tolerate.

At home, Susie's mother reported that she was becoming increasingly "clingy", "needy", "dependent," and "sad". I attempted to explain her daughter's current behavior as an awakening from a very shut-off damaged part of her self which brought with it tremendous emotional anguish. She was also becoming increasingly aware of the degree of isolation she held in relation to her peers and how her behavior alienated children. Susie told me on many occasions that she realized her behavior was difficult for other children to tolerate. Despite her awareness, she often felt frustrated in her renewed attempt to befriend children.

Ending: Termination Phase

The primary task in the termination phase of group therapy is to help its members consolidate the work that has been done in the group (Kaplan and Sadock, 1993; Toseland and Rivas, 1984). This is done by assisting in decreasing the attractiveness of the group for members while at the same time helping the client generalize newly acquired skills and changes outside the group (Toseland & Rivas, 1984; Yalom, 1985.) Another important consideration, especially in children's groups where clients are dependent on others for virtually all of their needs, is to consciously build in a web of support (Kendall, 1984, 1986; Kernberg & Chazan, 1991; Matson, & Ollendick, 1988).

With five therapy sessions left, the issue of termination was explicitly addressed to allow ample time for issues and concerns to be processed. I introduced termination by reviewing what I had observed the group accomplishing over the course of treatment. I pointed out the group had evolved from a phase filled with conflict, to its present functioning which was characterized by comfort and ease in the way members interrelated.

Sessions that followed were characterized by a resurgence of anxiety that is common in this phase of treatment (Kaplan & Sadock, 1993; Toseland & Rivas, 1984). The group refused to participate in discussion presented from the Manual and I observed a return of frenzied and chaotic play activity that dominated the first sessions of the group.

Susie reverted to an overtly aggressive and verbally assaultive style of relating, projecting the pain of termination onto members of the group by calling them names, and by deliberately throwing objects such as balls towards members who were engaged in an activity. Valerie assumed an ambivalent position often stating that coming to group "interfered" with her school work and would depart from the group early.

Diane reverted to physically withdrawing from group activities and became quite clingy and dependent on me requesting that I help her with very minor tasks that she was quite competent of doing on her own.

Mandy withdrew from the group as she had in the beginning of treatment and wanted constant reassurance that I would attend each session to the end.

Members coveted my involvement with them. Children who were usually welcomed when we were on the playground, were explicitly told that they could not play with us.

With three session remaining, members began to settle. I observed a rather expedient return to the cohesion that was evident prior to the onset of discussing termination. The group again functioned with a high degree of harmony and autonomy, operating fairly independently of me. This allowed for the identification and processing of feelings of loss surrounding the termination of the group. I began these sessions much in the same way I did in the beginning phase of treatment modelling therapeutically relevant self-disclosure. I indicted I was sad that we would say good-bye soon and that I had come to care very much for each of the children.

Eventually, we talked about each member's feelings regarding termination. Common to all member's was the fact that the group had been very special for them and that they "felt" like very special people while in the group. I asked what they thought they had gained from their involvement in the group with each member's response varying.

Valerie said that she had learned to make "better" choices for herself in terms of resolving problems. Diane said that she felt the group had provided her with the opportunity to learn how to assert her rights. Mandy thought she had learned how to "share" because of her experience in the group, and Susie felt that she now "got along better" with other children.

When asked how they would like to say goodbye, each of the children insisted on another party. Members decided that they each wanted to invite friends from the school to their party; the very children by whom they had been shunned in the past.

Decorations were made. Invitations were sent out to their guests. I was diplomatically assigned the task of purchasing the refreshments. During the next three sessions, members made decorations while we spoke about saying goodbye and discussing what they had learned as individuals and as members of a group.

Two important incidents took place toward the end of the group which allowed me to conclude that the children had, at that point, learned how to problem-solve difficult situations with a large degree of skill and sensitivity.

Prior to one of our last sessions, Mandy had called Diane names. Diane presented in session as dejected and sad and almost immediately began to cry. She withdrew to a corner that had safely harbored her during the worst storms in the life of the group and wept. When I approached Diane, she explained what had happened. Both Valerie and Susie attended to Diane saying that they were sorry that her feelings had been hurt. They immediately went to seek out

Mandy, who by now looked very intimidated, scolding her for hurting Diane. They openly confronted Mandy saying, "What are you going to do to fix-it?" Mandy slowly approached Diane apologizing.

Another example occurred following a particularly difficult session when Susie had been quite hostile towards other members. At the following session, members enquired why she had been upset. She indicated that she was being taunted on the way home from school and that this made her, "mad at the world." Members empathized with her situation and then offered a host of solutions on how they thought she should attempt to resolve this difficulty ranging from asking for teacher assistance to walking home with friends who would protect her.

Parent's Group

The parent group of this project was formed to address the fact that children live in family systems. These systems acculturate children, instilling values which are decisive in how the child perceives and relates to the world. Any maintenance of behavior change on the part of the child, requires support in the context of the family system for generalization of treatment gains to occur (Dobson, 1988; Parmenter, Smith, & Cecic, 1987; Kendall, 1986).

Parent group goals were developed to complement therapeutic work being done with the children. The focus in the parent's group was to closely align them with the therapeutic process that was occurring in the children's group in an attempt to increase the likelihood of integration of therapeutic gains being supported by the family system. Parents were asked what they felt would be important goals in for the parent group. Goals were developed in conjunction with the parents in an attempt to address parent/child needs and areas assessed to by important by this writer.

They included:

1) To promote treatment alliance and provide a forum for active participation in their child's treatment.

2) To provide a forum to discuss child behavior changes, and concerns they may have related to them.

3) To provide educational information about normal childhood development.

4) To provide educational information about the competency, problem-solving approach being used in the children's group in order to empower parents in the use of this model with their child.

Setting

The parent group took place in the same room that was used for the children's group. Refreshments were served at the beginning of each session in an attempt to facilitate an atmosphere of comfort and ease in our gathering.

Using the same room the child members used enhanced the parents' understanding of the nature of the work being done with their child because they could easily observe play and visual material that was being used in the group. Viewing the material offered a natural forum for parents to be

inquisitive about what was happening in the children's group. It also proved useful in alleviating the initial anxiety that predominated the beginning of each session, by temporarily averting attention away from members interacting with one another.

I initially contracted with parents in the pre-planning phase to meet on a weekly basis for eight weeks. Each family indicated that attendance was dependent upon work schedules and child care arrangements. After careful consideration of each family's scheduling needs, we decided to hold the meetings in the evening to facilitate attendance and participation. Two school social-evening events and one parent-teacher meeting occurred during this time. As a result, three sessions were cancelled because it was difficult for members to commit to alternative dates. In total, there were five parent meetings which lasted one to two hours, depending on parent interest.

Group Size and Composition

This was an involuntary, heterogeneous group that had assembled to address family systems issues. Membership and attendance changed from week to week as a result of child care arrangements and other commitments made by members.

Parent Group

When I approached parents asking what type of group they envisioned for themselves, they all expressed an interest in a relaxed, non-structured format that would allow relevant issues to be discussed as they arose. The discussion that follows is session by session observations from the parent group which is proceeded by general comments.

Session One

In attendance at the first session were Steve, Harriet, Kelly, and Laurel. Initially, the group was quite apprehensive. I reintroduced myself to the group and spoke generally about my background in relation to working with

children and their families. I concertedly attempted to "de-mystify" the therapeutic process by reiterating the importance of their involvement providing a brief overview of an ecological approach to child intervention.

Following, I observed a level of comfort and ease among members. Each member openly confided in one another about a variety of difficulties they encountered as parents and how they attempted to resolve them. There were a number of occasions when members asked my opinion. My response was to return the question to the group in an attempt to model a collaborative problem-solving approach. I was also attempting to avert being thrust into a position of authority which would have interfered with the peer consultation I observed occurring. The remainder of the session followed this style of collaborative interacting among members. I reinforced both the style of interrelating that had occurred and the ease with which it had occurred to members. Members appeared surprised when I commented that we had talked for almost two hours. Members lingered as they left, casually talking with one another.

Session Two

The following week, membership varied with Kathy, Laurel, and Kelly in attendance. I observed a resurgence of anxiety. I attempted to alleviate it by again providing a brief history of my background for our new member, Kathy. Each parent asked to be up-dated about their child's progress in the group. This provided an opportunity to discuss a variety of issues related to their child's progress including, how problems may have developed, how they are maintained, what appeared to be working in regards to specific approaches in the children's group, and how parents and teachers could become involved in individualized planning. This form of inquiry became the norm at the beginning of each parent meeting that followed which required me to be in the role of psychoeducator for the remainder of parent meetings.

Session Three

In attendance this session were Laurel, Kathy, Steve, Kelly and Murphy.

Murphy began the meeting by requesting information about the purpose of the parent group. Following a brief discussion about relevant child and parent group information, Murphy described to the other parents the positive changes he had observed in Diane, attributing them to her involvement in the group. I took this opportunity to identify salient points in Diane's progress, emphasizing how plans that had been formulated by both her teacher and parents enhanced what was occurring in the group. This precipitated discussion among parents who openly discussed how they viewed and experienced their child's behavior changes.

Towards the end of this session, parents appeared excited and wanted information about how to proceed with plans at home to enhance the gains that were made. I attempted to turn their questions back for members to consult with their peers. Members appeared to be uncomfortable with this approach. I pointed out areas where I believed intervention might be useful for a child and asked the parents if they could provide ideas to address them.

At this session, I introduced the idea of inviting the teachers to our last meeting reiterating the importance of continued support from the child's system once the group terminated. The parents welcomed this idea, and I was affectionately chastised for not including them at each of the meetings.

Session Four

Attendance again changed with Steve, Laurel, Harriet, and Stew present on this evening. With the introduction of a new member Stew, I observed a resurgence of anxiety that occurred each week when membership varied. I believe members had grown weary of having to accommodate new members which resulted in a lack of interest in member communication throughout the session.

In preparation for the ending of involvement in the children's group, I introduced the topic of termination. I discussed how I believed this would impact on each child and in turn parents expressed interest about how to respond to feelings of loss they each indicated their child would have in relation to the group ending.

This session was short, approximately 50 minutes. Members grew weary as we discussed the topic of "endings". Each expressed that their family's involvement (either child and/or parents) in the program had been helpful and that they found discussing ending their participation difficult.

Session Five

All the parents attended the last session. With the teachers present, parents openly expressed their satisfaction with the intervention, reporting discriminate, observable changes. Parents openly asked the teachers if they had observed similar changes. Their observations were affirmed by the teachers.

I asked what level of involvement parent/teacher might feel was necessary following termination. In response, I observed parents and teachers discussing the importance of remaining in contact with one another. In response to earlier requests by parents and teachers, I distributed a three page, typewritten condensed copy of the competency, problem-solving approach that was used in the children's

group and emphasized its continued use at home and school. I then reviewed what I thought had taken place throughout the tripartite intervention, and how powerful I believed the parents and teachers involvement had been to the outcome of the children's treatment. I extended my gratitude for their commitment of my practicum and invited them to phone if I could be helpful to them in the future.

Discussion

Overall, the group appeared to provide members with important information about their child's emotional difficulties and the important role they played in the maintenance of healthier (or negative) interactional styles. I viewed my primary role in the group as one of a "psychoeducator". Being consistently thrust into this role inhibited the development of intimate peer relationships from developing among members, changing the collaborative consultation among peers that was evident in the first session to a more structured, leader-centred format.

Cohesion never developed among members. I observed the function of my role as "expert" as one that served to buffer the group from the difficult task of accommodating new members from week to week. Despite my concerns that the group had not met the parent's needs, common responses in parent feedback forms was to report that their involvement in the group had allowed them an opportunity to understand their role in the maintenance of healthier (or negative) interactional styles of their child and tangible ways in which to intervene.

Alternative ideas about how parent-training based on the limitations of this practicum experience, are detailed in the "Conclusion" section of this report.

Teachers Meetings

Working with the teachers developed quite by accident. I found it necessary to speak to both teachers following the first child group session. Realizing that these meetings would bear important relevance in the lives of the children in the group, I requested we do this weekly. We met in this

fashion for seven weeks which proved to be a rich intervention area. It allowed each of to discover new things about each child. I was able to learn things about a child and her behavior in the context of classroom, and the teachers reported that our meetings offered them an experience to gain insight and understanding about their pupils' emotional difficulties. Jointly, we conceptualized intervention plans on behalf of each child that resulted in enhancing the quality of their life in the school setting.

Valerie's teacher was concerned about her inability to function autonomously in the classroom. She suggested, and later provided Valerie with opportunities to become the designated leader in small group activities to address her inability to assert herself with peers.

I mentioned to Diane's teacher observations about how vibrant and assertive she became following physical exertion which appeared to facilitate feelings of mastery for her. A proposal to concentrate Diane's individual programming (she was intensely involved in resource) to be more activity based and less isolated from her classmates resulted from our meetings.

For Mandy, helping her teacher understand this child's negative way of relating in the context of her family experience, enhanced her ability to empathize with her. Mandy's teacher told me on a number of occasions that she had difficulty "liking" her. Over the course of my involvement she indicated that she had grown to "like" Mandy, which she reports changed the way she related to her which became more positive over the course of my involvement.

Another area that was addressed at our meetings was that Mandy was often removed from the small group of children with whom she sat because of her disruptive behavior. Based on observations that Mandy was capable (when given the opportunity) to conform to peer demands, I suggested that Mandy be allowed to struggle in these groups rather than be removed. I also suggested that when it become necessary for her teacher to intervene, that she direct her concerns to Mandy's peers in the form of a question. An example being, "Gee, I see that Mandy is bothering so and so..." She then directed the children in the group to enforce more appropriate behavior when instances such as this occurred. Mandy's teacher reported at both post-evaluation points, that

she was fitting in reasonably well with peers and there had been a definite decrease in her disruptive behavior. She also reported that Mandy was making friends with children at school.

The difficulties Susie experienced dominated conversations. Susie's teacher indicated that in her twenty some odd years of teaching she had never experienced as many negative feelings about a pupil as she was with Susie. I attempted to frame Susie's alienating behavior in the context of her abusive life experiences. I attempted to explain her behavior in terms of the cultivation of a variety of survival techniques (one being fear of intimate involvement) that she developed to protect her fragile sense of self.

I suggested that when she became overwhelmed by Susie's behavior to take a "time-out" and not get pulled into the invisible negative interaction at which Susie was so proficient. I reiterated the importance for Susie to experience significant adults (of which she was one) as empathic. This, in practical terms, meant decreased isolation from the class which required a fair amount of

planning on her teacher's part. Susie's teacher developed a number of intervention plans which were meant to make her feel special. She would often spend individual time with her over recess either reading or playing a game.

Despite her efforts, Susie's teacher often felt frustrated because Susie did not appear to respond to the time and devotion she exerted. I reiterated that change would be slow and often appear contrary to her efforts because of Susie's fear of intimate involvement.

Conclusions: Valerie and Parents

Valerie' behavior altered dramatically over the course of treatment. She became more assertive and withdrew less. This resulted in increased positive affective states.

The parent system underwent some change as well with the parents indicating that they saw the benefits of shifting their style of parenting from a close interdependent one, to one that allowed for autonomous activity for Valerie. I believe the changes that occurred for Valerie are closely related to the change in the parent(s) ability to modify their style of parenting. The parents reported toward the end of their involvement in the group that they were attempting to parent in a way that allowed Valerie more autonomy. This in part, might account for the observed positive changes as reported by the parents at follow-up.

Conclusions: Diane and Parents

Diane's behavior underwent a dramatic transformation over the course of treatment. She became physically more active, more assertive, and an active participant in the world around her.

The involvement by relevant individuals, especially in this case, was essential to the gains this child made. Concerted efforts by her teacher, and resource teacher in identifying and implementing plans in areas where she was vulnerable, accelerated Diane's progress.

The parents also made concerted efforts to become more actively involved in the pursuit of intervening on their daughter's behalf. Diane's step-father provided a useful role model in the home on assertive behavior and helped Diane understand the benefits of "sticking-up" for her rights. In addition, working with the mother helped her understand Diane's extreme withdrawn states as the consequence of a numbers of variables which included childhood trauma, resulting in an active participation on behalf of her daughter following intervention.

Conclusions: Mandy and Parents

Mandy's involvement in the group largely effected her ability to engage in reciprocal relationships both with peers and adults. Her home environment, where she was an only child and where her parents attended to many of her demands without exception, had compromised her ability to interrelate in a way that was satisfying to others. As a result, Mandy was often alienated from others.

Unfortunately, Mandy's parents found it difficult to be more involved individually with me due to time constraints. However, at parent meetings they were quite interested in learning more effective ways of parenting Mandy to alleviate the frustration they felt towards her when she became demanding.

Conclusions: Susie and parent

The group offered Susie the opportunity to explore very painful aspects of her life. As a result, her aggressive and disruptive behavior decreased proportionately to the profound sadness she began to experience. For the most part, treatment was a screening process for this child and family to be referred for the ongoing, long-term psychotherapy to address areas of family violence and its consequences.

Involvement with both the teacher and mother, was essential in this case. I was amazed at the extent and magnitude of involvement Susie's teacher was committed to once she was able to empathize with her. The mother also dramatically changed her view of Susie once she understood the impact of her life experiences. She became attentive and nurturing, allowing for the much needed mothering that she had alienated herself from for many years. The mother also became visibly more involved in Susie's life and began to assert herself on behalf of her child.

RESULTS

Attempting to prove "cause" and "effect" was not a consideration in selecting measures to demonstrate that change had occurred. As noted in an earlier section entitled "Implications For Social Work", within an ecological paradigm of understanding human behavior, change is considered to be the result of the interplay of a number of variables, some have been discussed throughout this report. Intervention was only one of the multitude of variables that could potentially explain the changes that will be described in this section. The measures used in this practicum were meant to offer an objective link in integrating research with practice. However, it became evident when interpreting scores from measures, that the most valuable form of evaluation became the self-report measures and observations made by the parents and teachers who participated in this practicum.

The remainder of this section will provide the reader with results from a host of evaluation instruments that were chosen for this practicum and administered pre-, post-, and follow up (see the Evaluation section for descriptions of

the measures). Measures where scores best represent change will be presented in Tables for reader clarification. They include the Child Behavior Checklist, Teacher's Report Form and Piers-Harris Children's Self Concept Scale. Results from measures to assess enhanced competency will be presented by describing change when this occurred. I will then attempt to describe and briefly discuss the impact intervention had on the families that participated in this practicum and common findings as reported by the children, parents, and teachers. Results from the Index of Peer Relationships, Index of Parental Attitudes, and Parenting Sense of Competence scale did not provide evidence for the effectiveness of this practicum. These results will be addressed in the "General Comments" at the end of this section, in terms of the limitation of their use in this practicum.

Valerie - Report

The response on the CBCL indicates that Valerie's behavior falls well within the range that is considered normal by this measure. However, there is a slight shift from internalizing to externalizing behavior when the scores are divided between the two subscales. (See Table 1.)

Table 1

Summary of Scores

Child Behavior Checklist (CBCL)

and

Teacher's Report Form (TRF)

	Pre-Int.	Post-Int.	Follow-Up
VALERIE			
CBCL			
T-Score	57	55	60
Internalizing	49	43	50
Externalizing	43	50	53
TRF			
T-Score	62	57	62

Note: A T-Score of 70 or above is considered clinically significant (Achenbach, 1991).

The PIERS shows a consistent positive upward trend in the respondents perceived sense of self-worth. (See Table 2.)

Discussion

It would appear that the areas most effected by the child intervention are those of affect and competency. In the assessment phase, Valerie was identified by both her parents and teacher as being a child that was despondent and unhappy, particularly in the school setting. It appears that the impact of Valerie's participation in the group in conjunction with her parent's involvement in the parallel parent-training increased her sense of competence which is reflected both in the measure of self-concept and an observed steady and consistent increase in her ability to identify and address her feeling states and competently resolve difficult situations. One's sense of self-confidence, or self-regard is closely linked to affective states. In Valerie's case, it would appear that the group acted as a catalyst for her to explore feelings, which initially were negative and anxious, resulting in enhanced competence.

Table 2

Summary of Scores

Piers-Harris Children's Self-Concept Scale

	Pre-Int.	Post-Int.	Follow-Up
VALERIE			
T-Score	50	58	62
DIANE			
T-Score	43	62	63
MANDY			
T-Score	53	64	68
SUSIE			
T-Score	53	50	29

Note. Score interpretation:

Total T-Score	Descriptor
Greater than 70	Very much above average
66-70	Much above average
61-75	Above average
56-60	Slightly above average
45-55	Average
40-44	Slightly below average
35-39	Below average
30-34	Much below average
Less than 30	Very much below average

In terms of parent self-report, they state on the Parent Feedback Form that positive child behavior change had persisted up to the follow-up evaluation point. Asked if they felt intervention had been beneficial for their family, Valerie's mother responded, "The most useful thing was that you helped me stand back and see Valerie in a different light. You helped me understand what would be important to change in some of the ways in which we treated her. I think it helped her a lot because she is a lot happier these days." This supports observations made over the course of intervention. As Valerie became more assertive in challenging her parents' authority, I observed a growing awareness on their part about the benefit to her well being in allowing her more autonomy.

Diane - Report

The results on the CBCL and TRF suggest that there were no behavior problems as perceived by the parent and teacher. (See Table 3.) This seemed inconsistent with observations of Diane which suggest that she had a variety of experiences that compromised her psychosocial development. I concluded from my assessment of Diane that she had been negatively

Table 3

Summary of Scores

Child Behavior Checklist (CBCL)

and

Teacher's Report Form (TRF)

	Pre-Int.	Post-Int.	Follow-Up
DIANE			
CBCL			
T-Score	56	56	58
Internalizing	0	0	0
Externalizing	0	0	0
TRF			
T-Score	58	50	53

Note: A T-Score of 70 or above is considered clinically significant (Achenbach, 1991).

effected by earlier traumatic life events. I believe Diane's mother has coped with feelings of responsibility for her daughter's earlier experiences, by minimizing the extent of her daughter's difficulties which may have affected responses on the CBCL.

The TRF also is inconsistent with observations of Diane. Responses suggest that Diane's teacher perceives her to function competently within the school setting. In part, I believe this can be explained by understanding the high value schools place on a pupil's compliance and conformity. Her teacher often commented how wonderful it was having a child like Diane in her classroom because she did not create any problems. Another plausible explanation for the response on the TRF, is the general lack of understanding in most professional fields about the extent to which internalizing disorders can compromise a child's psychosocial adjustment resulting in their exclusion from services to target the problem.

The PIERS initially reflects a rather devalued sense of self-worth. (See Table 2.) However, there is a dramatic positive upward trend at both post- and follow-up periods, suggesting a growing sense of self-worth and competency over the course of the group that was maintained to follow-up three months later.

Discussion

Tracking behavior change with the CBCL and TRF was limited because of the responses. The child's self-report however, clearly indicates some benefits from the intervention.

Diane's growing sense of competency is reflected in the PIERS and measures to assess increased competency in problem solving. Feedback forms completed by the parent and teacher confirm behavior change in the area of self assertion. My own observation of Diane, concurs with the responses by parent and teacher. She became increasingly more self-confident which appeared to result in a more assertive style of relating with others.

Diane's parents reported on the Feedback Form that parent intervention was useful in helping them understand current difficulties in the context of multiple childhood trauma. They reported that they implemented many of the suggestions that were collaboratively developed to meet Diane's developmental lags and reported the many of the gains she made in the group were maintained to follow-up.

Mandy - Report

The overall response on the CBCL indicates that Mandy falls within the range of behavior that is considered normal by this measure. (See Table 4.) However, when separated out from the internalizing and externalizing behavior, pre-intervention responses show high externalizing behaviors on the subscales of "hyperactivity", "delinquency", "aggressiveness", and "cruelty".

What occurs post-intervention is a decrease in externalizing behavior and an increase on the subscale that measures internalizing behavior. This suggests that intervention may have challenged her

Table 4

Summary of Scores

Child Behavior Checklist (CBCL)

and

Teacher's Report Form (TRF)

	Pre-Int.	Post-Int.	Follow-Up
MANDY			
CBCL			
T-Score	69	71	66
Internalizing	60	70	52
Externalizing	69	61	60
TRF			
T-Score	61	57	59

Note: A T-Score of 70 or above is considered clinically significant (Achenbach, 1991).

aggressive style of relating which, over the course of intervention as reported by parent and teacher, was substituted by a more cooperative style of interrelating.

The PIERS reflects a steady positive upward trend which suggest this child's self-concept was positively effected by the intervention. (See Table 2.)

Discussion

It would appear that child intervention provided important skills in the area of positive, reciprocal interrelating with a set of her peers. This is reflected in a decline in aggressive behavior on the CBCL and an increase in popularity among her peer group as reported by parent and teacher. Mandy reported in the Child Feedback Report That her involvement in the group offered her the opportunity to learn how to "share" and get along with other children. She indicated that life satisfaction has increased and that much of the loneliness described at assessment has abated in light of new friendships.

In terms of parent involvement, comments on the Parent Feedback Form are strikingly similar to those of the other parents involved in the practicum. They state that their involvement in the parent group provided them with information about their daughter's current difficulties and how to better meet the challenges of parenting her.

Susie - Report

The response on the CBCL at each evaluation point indicates clinically significant behavior problems. (See Table 4.) Pre- and post-intervention evaluation reflect symptoms of an externalizing nature. However, at follow-up a shift from externalizing to internalizing symptoms occurred.

The TRF at pre-intervention reflects clinically significant problems as reported by her teacher. (See Table 5.) At post-and follow-up evaluation, scores reflect behavior that is considered normal by the standards set-forth in this measure.

Table 5

Summary of Scores

Child Behavior Checklist (CBCL)

and

Teacher's Report Form

	Pre-Int.	Post-Int.	Follow-Up
SUSIE			
CBCL			
T-Score	76	71	83
Internalizing	74	72	75
Externalizing	80	78	77
TRF			
T-Score	72	63	62

Note: A T-Score of 70 or above is considered clinically significant (Achenbach, 1991).

The PIERS initially reflects a perception of self worth that this measure would suggests is "average". (See Table 2.) However, over the period of evaluation, the respondent's sense of self-worth declines dramatically. This corresponds with observations reported by parent, teacher and this writer in which an erosion of aggressive defenses was replaced by feelings of worthlessness and supported by the shift of behavior noted above on the CBCL from externalizing to internalizing.

Measures designed to assess competency suggest a growing awareness of affective states and competency in problem-solving difficult situations. However, in the follow-up portion of evaluation, Susie's ability to maintain a degree of competency had eroded which is closely linked to the decline in self-concept that the PIERS has measured.

Discussion

Of the four families that participated in this practicum, this one experienced the most difficulties. As a result of treatment needs continuing beyond the termination of the practicum, this family was referred for

individual/family therapy for the mother and child. Therefore, follow-up scores must be interpreted with some caution as psychotherapy began prior to this time.

The dramatic shift in the child's behavior suggests that intervention at the child, parent and teacher level challenged her psychological defenses. This resulted in a dissipation of aggressive behavior which was replaced with feelings of sadness and confusion; a more accurate portrayal of her internal state. In the mother's case, it is interesting to note an increase in parenting efficacy, as both reported by her and was my observation, as she became more aware of her daughter's difficulties and subsequent needs. This speaks highly of her strengths and ability to empathize which is consistent with my observation of her throughout the time of my involvement with this family.

In the Parent Feedback Form, the mother indicated that her involvement in the intervention provided her important insight in relation to understanding her daughter's difficulties in the context of childhood trauma. She

reported that this facilitated a more empathic style of parenting her. As she stated, "You have made a special bond and confidence occur between Susie and myself."

General Comments: Common Findings

The Child Behavior Checklist (CBCL) was sensitive to changes from one scale to the other in the case of Valerie, Mandy and Susie. For Valerie, there was a slight shift from internalizing, or withdrawn behavior to that of a more outgoing assertive presentation. For Mandy and Susie there was again a slight shift, but this time from externalizing or aggressive and disruptive behavior, to that which was reported by peers in the group, parents, and teachers, as a more cooperative and pleasing style of relating. These observed shifts in behavioral style, suggest that the goal of enhancing a more cooperative style of relating may have been addressed during the time they were involved in the group.

By far the most surprising finding in terms of the evaluation measures selected for this practicum, is reflected in the pre- and post- evaluation of self-concept in the PIERS. (See Table 2.) One's self-esteem is a fairly stable psychological construct that evolves as the child develops. Subsequently, integration of new beliefs about self takes substantial time and re-organization before actual change occurs. Perhaps what this measure has assessed, in the case of Valerie, Diane, and Mandy, is a sense of competency and omnipotence that members felt as a result of intense and intimate involvement in a competence enhancement group designed to increase feelings of mastery and self-worth in conjunction with parents and teachers becoming more empathically involved with the children.

For Susie, the results suggest that multilevel intervention eroded psychological defenses, resulting in a painful awareness on her part, of a highly debased sense of self which is supported by parent and teacher observations.

Common to child self-reports was that their involvement in the group helped them learn new and more effective ways to cope with difficult life situations. Each reported that they felt less isolated and subsequently less "lonley". I had been told by each of child in the assessment process that they found school difficult, each stating that they "hated" it. Although I neglected to ask this question in the Feedback Form, I did at follow-up. Each child stated that school was either "ok" or that they now "liked" it. Given their previous sentiments on this matter and that a good deal of their life is spent at school, it is important to note the change and that they each attributed this change to the learning that occurred for them in the context of the group.

Parent and Teacher Feedback Forms all indicated that gaining insight into the child/pupils' emotional difficulties facilitated more empathic responses toward the child. They reported that information gained in the

group/meeting facilitates how they relate and respond to their child/pupil in a variety of situations that they find beneficial to the child and themselves.

Valerie, Diane and Mandy's parents all reported that their child is more competent in peer relationships and said that friendships either increased or were enhanced since involvement in the group. This is supported by teacher observations.

As noted earlier, there were three measures administered to the families that participated in this practicum that were not reported in this section. These measures included The Index of Peer Relationships (IPR), The Index of Parental Attitudes (IPA), and the Parenting Sense of Competency (PSOC). Each of these measures did not reflect that change occurred. This was contrary to observations by this writer and self-reports by parents and teachers. It is difficult to determine in advance if measures will be sensitive to change, especially in single-subject designs. Despite their appropriateness in relation to the problem being studied, and their success in doing so in other

areas, in this practicum they did not appear to be sensitive to change. This will be elaborated on in the "Conclusion" section of this report.

CONCLUSIONS

In concluding this report, I will detail the learning that occurred for me throughout my experience as a group therapist and describe what I believe were the limitations of the practicum.

As a private practitioner who had never worked with groups prior to this experience, I found that the therapeutic effectiveness for the clients involved in the group nothing short of amazing. Directly observing the unfolding and integration of many human stories at once and viewing the curative power of the collective was a privilege. Observing the group as it developed increased my awareness of the interpersonal dimensions of health and pathology, as well as the impact of the system on the intrapsychic experience. The culmination of my experience has deepened my conviction about the importance of providing children and families preventative mental health services; much like the one detailed in this report.

There are a number of limitations of this intervention that are important to consider in the overall evaluation of this practicum.

1. Parent involvement was involuntary. The consequences of this ranged from an observed resistance to engaging in the group process to difficulty in individual consultation when it would have been beneficial for the child/family. Possible solutions to buffer the potentially negative impact might include contracting with parents about stable and consistent membership, extending the number of sessions to facilitate engagement and cohesivness among members, and providing a more structured parent-training group format. I also believe that providing parents with a comprehensive understanding about the impact they have on the development and amelioration of problems before the group, may have decreased expectations that I, as the therapist, was the primary change agent.

2. There were times when the extent and magnitude of a child member's difficulties resulted in her needs not being met in the group. An example is Susie's disclosure of abusive life experiences, which the group could not

comprehend resulting in her temporary dismissal from group activity and invalidation of her feelings. Ideally, I believe problems in this area could have been minimized by careful assessment of client compatibility in the pre-planning phase of treatment. However, that was not an option in this case. Possible alternative solutions to buffer client incompatibility include enlisting the aid of a co-therapist which would allow a child's needs to be more readily met in difficult situations, and extending the length of the group to enhance intimacy and subsequent empathy for other member's experiences.

3. Despite observations to the contrary, the IPR was not sensitive to intermediate changes in peer relationships that were occurring for the children who participated in this practicum. Given the relevance as cited in the literature about the impact peers have on the emotional adjustment of children, an attempt to link the outcome of this intervention approach to increasingly positive peer relationships became problematic. It may be worthwhile to find measures that are more sensitive to intermediate changes in peer relationships to address the limitation this created within the study.

This was also the case with instruments designed to measure changes for the parents: Parenting Sense of Competence (PSOC) and Index of Parental Attitudes (IPA).

In retrospect, I believe there are two areas that could have potentially enhanced the quality of the application of this approach. The first was touched upon briefly in relation to parental involvement. Many of the limitations noted with respect to the parents' group are due to unrealistic expectations that a "therapeutic" group could be run in such a short period of time. It may be more relevant to provide parent-training by way of educating parents in areas relevant to the issues being addressed if time is limited.

Secondly, planning for the continued needs of children who have experienced long standing difficulties in the area of peer relationships would be useful. The approach detailed in this report provided basic, fundamental skills in this area. However, some form of temporary, adult guided, peer intervention (ideally within the school) where the facilitator is slowly phased-out, would help ensure that interaction skills would be generalized to the child's daily life.

Immersing myself in an area that I had not researched before, and applying this knowledge to the children and families of this study was exciting and professionally enriching. Overall (if one takes into account the limitations of this practicum) I believe this is a powerful, preventative mental health model that serves to empower children and families.

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APPENDIX A

CHILD BEHAVIOR CHECKLIST FOR AGES 4-18

(CBCL)

CHILD'S NAME: _____ DATE: _____

CHILD'S SEX: _____ AGE: _____

GRADE IN SCHOOL: _____

This form filled out by:

Mother Father Other

Your Name _____

Parent's type of work. (Please be specific - for example: auto mechanic, high school teacher, homemaker.)

FATHER'S TYPE OF WORK _____

MOTHER'S TYPE OF WORK _____

Below is a list of items that describe children. For each item that describes your child now or within the last 12 months, please circle the **2** if the item is **very true** or **often true** of your child. Circle the **1** if the item is **somewhat** or **sometimes true** of your child. If the item is **not true** of your child, circle the **0**. Please answer all items as well as you can, even if some do not seem to apply to your child.

Very or Often True . . . . . 2 Somewhat or
Sometimes True 1
Not True 0

0 1 2 1. Acts too young for his/her age
0 1 2 2. Allergy (describe):
0 1 2 3. Argues a lot

(APPENDIX A Cont.)

0 1 2	4.	Asthma
0 1 2	5.	Behaves like opposite sex
0 1 2	6.	Bowel movements outside toilet
0 1 2	7.	Bragging, boasting
0 1 2	8.	Can't concentrate, can't pay attention for long
0 1 2	9.	Can't get his/her mind of certain thoughts; obsessions (describe):
0 1 2	10.	Can't sit still, restless, or hyperactive
0 1 2	11.	Clings to adults or too dependent
0 1 2	12.	Complains of loneliness
0 1 2	13.	Confused or seems to be in a fog
0 1 2	14.	Cries a lot
0 1 2	15.	Cruel to animals
0 1 2	16.	Cruelty, bullying, or meanness to others
0 1 2	17.	Day-dreams or gets lost in his/her thoughts
0 1 2	18.	Deliberately harms self or attempts suicide
0 1 2	19.	Demands a lot of attention
0 1 2	20.	Destroys his/her own things
0 1 2	21.	Destroys things belonging to his/her family or others
0 1 2	22.	Disobedient at home
0 1 2	23.	Disobedient at school
0 1 2	24.	Doesn't eat well
0 1 2	25.	Doesn't get along with other kids
0 1 2	26.	Doesn't seem to feel guilty after misbehaving
0 1 2	27.	Easily jealous
0 1 2	28.	Eats or drinks things that are not food- don't include sweets (describe):
0 1 2	29.	Fears certain animals, situations, or places other than school (describe):
0 1 2	30.	Fears going to school
0 1 2	31.	Fears he/she might think or do something bad
0 1 2	32.	Feels he/she has to be perfect
0 1 2	33.	Feels or complains that no one loves him/her
0 1 2	34.	Feels others are out to get him/her
0 1 2	35.	Feels worthless or inferior
0 1 2	36.	Gets hurt a lot, accident-prone
0 1 2	37.	Get in many fights

(APPENDIX A Cont.)

0 1 2	38.	Gets teased a lot
0 1 2	39.	Hangs around with others who get in trouble
0 1 2	40.	Hears sounds or voices that aren't there (describe):
0 1 2	41.	Impulsive or acts without thinking
0 1 2	42.	Would rather be alone than with others
0 1 2	43.	Lying or cheating
0 1 2	44.	Bites fingernails
0 1 2	45.	Nervous, highstrung, or tense
0 1 2	46.	Nervous movements or twitching (describe):
0 1 2	47.	Nightmares
0 1 2	48.	Not liked by other kids
0 1 2	49.	Constipated, doesn't move bowels
0 1 2	50.	Too fearful or anxious
0 1 2	51.	Feels dizzy
0 1 2	52.	Feels too guilty
0 1 2	53.	Overeating
0 1 2	54.	Overtired
0 1 2	55.	Overweight
	56.	Physical problems without known medical cause:
0 1 2		a. Aches or pains (not headaches)
0 1 2		b. Headaches
0 1 2		c. Nausea, feels sick
0 1 2		d. Problems with eyes (describe):
0 1 2		e. Rashes or other skin problems
0 1 2		f. Stomachaches or cramps
0 1 2		g. Vomiting, throwing up
0 1 2		h. Other (describe):
0 1 2	57.	Physically attacks people
0 1 2	58.	Picks nose, skin, or other parts of body (describe):
0 1 2	59.	Plays with own sex part in public
0 1 2	60.	Play with own sex part too much
0 1 2	61.	Poor school work
0 1 2	62.	Poorly coordinated or clumsy
0 1 2	63.	Prefers being with older kids
0 1 2	64.	Prefers being with younger kids
0 1 2	65.	Refuses to talk
0 1 2	66.	Repeats certain acts over and over; compulsions (describe):

(APPENDIX A Cont.)

0 1 2	67.	Runs away from home
0 1 2	68.	Screams a lot
0 1 2	69.	Secretive, keeps things to self
0 1 2	70.	Sees things that aren't there (describe):
0 1 2	71.	Self-conscious or easily embarrassed
0 1 2	72.	Sets fires
0 1 2	73.	Sexual problems (describe):
0 1 2	74.	Showing off or clowning
0 1 2	75.	Shy or timid
0 1 2	76.	Sleeps less than most kids
0 1 2	77.	Sleeps more than most kids during day and/or night (describe):
0 1 2	78.	Smears or plays with bowel movements
0 1 2	79.	Speech problem (describe):
0 1 2	80.	Stares blankly
0 1 2	81.	Steals at home
0 1 2	82.	Steals outside the home
0 1 2	83.	Stores up things he/she doesn't need (describe):
0 1 2	84.	Strange behavior (describe):
0 1 2	85.	Strange ideas (describe):
0 1 2	86.	Stubborn, sullen, or irritable
0 1 2	87.	Sudden changes in mood or feelings
0 1 2	88.	Sulks a lot
0 1 2	89.	Suspicious
0 1 2	90.	Swearing or obscene language
0 1 2	91.	Talks about killing self
0 1 2	92.	Talks or walks in sleep (describe):
0 1 2	93.	Talks too much
0 1 2	94.	Teases a lot
0 1 2	95.	Temper tantrums or hot temper
0 1 2	96.	Thinks about sex too much
0 1 2	97.	Threatens people
0 1 2	98.	Thumb-sucking
0 1 2	99.	Too concerned with neatness or cleanliness
0 1 2	100.	Trouble sleeping (describe):
0 1 2	101.	Truancy, skips school
0 1 2	102.	Underactive, slow moving, or lacks energy
0 1 2	103.	Unhappy, sad, or depressed
0 1 2	104.	Unusually loud
0 1 2	105.	Uses alcohol or drugs for nonmedical purposes (describe):
0 1 2	106.	Vandalism

(APPENDIX A Cont.)

0 1 2	107.	Wets self during the day
0 1 2	108.	Wets the bed
0 1 2	109.	Whining
0 1 2	110.	Wishes to be of opposite sex
0 1 2	111.	Withdrawn, doesn't get involved with others
0 1 2	112.	Worries
0 1 2	113.	Please write in any problems your child has that were not listed above.

APPENDIX B

TEACHER'S REPORT FORM

PUPIL'S NAME: _____ DATE: _____

PUPIL'S SEX: _____ AGE: _____

GRADE IN SCHOOL: _____

NAME OF SCHOOL: _____

Below is a list of items that describe pupils. For each item that describes the pupil **now or within the past two months**, please circle the **2** if the item is **very true** or **often true** of the pupil. Circle **1** if the item is **somewhat** or **sometimes true** of the pupil. If the item is **not true** of the pupil, circle **0**. Please answer all items as well as you can, even if some do not seem to apply to this pupil.

Very True or Often True 2
Somewhat or Sometimes True..... 1
Not True (as far as you know)..... 0

0 1 2	1.	Acts too young for his/her age
0 1 2	2.	Hums or makes other odd noises in class
0 1 2	3.	Argues a lot
0 1 2	4.	Fails to finish things he/she starts
0 1 2	5.	Behaves like opposite sex
0 1 2	6.	Defiant, talks back to staff
0 1 2	7.	Bragging, boasting
0 1 2	8.	Can't concentrate, can't pay attention for long
0 1 2	9.	Can't get his/her mind off certain thoughts; obsessions (describe):
0 1 2	10.	Can't sit still, restless, or hyperactive
0 1 2	11.	Clings to adults or too dependent
0 1 2	12.	Complains of loneliness

(APPENDIX B Cont.)

0 1 2	13.	Confused or seems to be in a fog
0 1 2	14.	Cries a lot
0 1 2	15.	Fidgets
0 1 2	16.	Cruelty, bullying, or meanness to others
0 1 2	17.	Daydreams or gets lost in his/her thoughts
0 1 2	18.	Deliberately harms self or attempts suicide
0 1 2	19.	Demands a lot of attention
0 1 2	20.	Destroys his/her own things
0 1 2	21.	Destroys property belonging to others
0 1 2	22.	Difficulty following direction
0 1 2	23.	Disobedient at school
0 1 2	24.	Disturbs other pupils
0 1 2	25.	Doesn't get along with other pupils
0 1 2	26.	Doesn't seem to feel guilty after misbehaving 0
1 2	27.	Easily jealous
0 1 2	28.	Eats or drinks things that are not food - **don't** include sweets (describe):
0 1 2	29.	Fears certain animals, situations, or places other than school (describe):
0 1 2	30.	Fears going to school
0 1 2	31.	Fears he/she might think or do something bad
0 1 2	32.	Feels he/she has to be perfect
0 1 2	33.	Feels or complains that no one loves him/her
0 1 2	34.	Feels other are out to get him/her
0 1 2	35.	Feels worthless or inferior
0 1 2	36.	Gets hurt a lot, accident-prone
0 1 2	37.	Gets in many fights
0 1 2	38.	Gets teased a lot
0 1 2	39.	Hangs around with others who get in trouble
0 1 2	40.	Hears sounds or voices that aren't there (describe):
0 1 2	41.	Impulsive or acts without thinking
0 1 2	42.	Would rather be alone than with others
0 1 2	43.	Lying or cheating
0 1 2	44.	Bites fingernails
0 1 2	45.	Nervous, high-strung, or tense
0 1 2	46.	Nervous movements or twitching (describe):
0 1 2	47.	Overconforms to rules
0 1 2	48.	Not liked by other pupils
0 1 2	49.	Has difficulty learning
0 1 2	50.	Too fearful or anxious
0 1 2	51.	Feels dizzy

(APPENDIX B Cont.)

0 1 2	52.	Feels too guilty
0 1 2	53.	Talks out of turn
0 1 2	54.	Overtired
0 1 2	55.	Overweight
0 1 2	56.	Physical problems without known medical cause:
0 1 2		a. Aches or pains (**not** headaches)
0 1 2		b. Headaches
0 1 2		c. Nausea, feels sick
0 1 2		d. Problems with eyes (describe):
0 1 2		e. Rashes or other skin problems
0 1 2		f. Stomachaches or cramps
0 1 2		g. Vomiting, throwing up
0 1 2		h. Other
0 1 2	57.	Physically attacks people
0 1 2	58.	Picks nose, skin, or other parts of body (describe):
0 1 2	59.	Sleeps in class
0 1 2	60.	Apathetic or unmotivated
0 1 2	61.	Poor school work
0 1 2	62.	Poorly coordinated or clumsy
0 1 2	63.	Prefers being with older children or youths
0 1 2	64.	Prefers being with younger children
0 1 2	65.	Refuses to talk
0 1 2	66.	Repeats certain acts over and over; compulsions (describe):
0 1 2	67.	Disrupts class discipline
0 1 2	68.	Screams a lot
0 1 2	69.	Secretive, keeps things to self
0 1 2	70.	Sees things that aren't there (describe):
0 1 2	71.	Self-conscious or easily embarrassed
0 1 2	72.	Messy work
0 1 2	73.	Behaves irresponsibly (describe):
0 1 2	74.	Showing off or clowning
0 1 2	75.	Shy or timid
0 1 2	76.	Explosive and unpredictable behavior
0 1 2	77.	Demands must be met immediately, easily frustrated
0 1 2	78.	Inattentive, easily distracted
0 1 2	79.	Speech problem (describe):
0 1 2	80.	Stares blankly
0 1 2	81.	Feels hurt when criticized
0 1 2	82.	Steals

(APPENDIX B Cont.)

0 1 2	83.	Stores up things he/she doesn't need (describe):
0 1 2	84.	Strange behavior (describe):
0 1 2	85.	Strange ideas (describe):
0 1 2	86.	Stubborn, sullen, or irritable
0 1 2	87.	Sudden changes in mood or feelings
0 1 2	88.	Sulks a lot
0 1 2	89.	Suspicious
0 1 2	90.	Swearing or obscene language
0 1 2	91.	Talks about killing self
0 1 2	92.	Underachieving, not working up to potential
0 1 2	93.	Talks too much
0 1 2	94.	Teases a lot
0 1 2	95.	Temper tantrums or hot tempter
0 1 2	96.	Seems preoccupied with sex
0 1 2	97.	Threatens people
0 1 2	98.	Tardy to school or class
0 1 2	99.	Too concerned with neatness or cleanliness
0 1 2	100.	Fails to carry out assigned tasks
0 1 2	101.	Truancy or unexplained absence
0 1 2	102.	Underactive, slow moving, or lack energy
0 1 2	103.	Unhappy, sad, or depressed
0 1 2	104.	Usually loud
0 1 2	105.	Uses alcohol or drugs for nonmedical purposes (describe):
0 1 2	106.	Overly anxious to please
0 1 2	107.	Dislikes school
0 1 2	108.	Is afraid of making mistakes
0 1 2	109.	Whining
0 1 2	110.	Unclean personal appearance
0 1 2	111.	Withdrawn, doesn't get involved with others
0 1 2	112.	Worries
0 1 2	113.	Please write any problems the pupil has that were not listed above.

APPENDIX C

INDEX PEER RELATIONSHIPS

(IPR)

This questionnaire is designed to measure the way you feel about the people you work, play, or associate with most of the time; your peer group. It is not a test so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows.

1 = Rarely or none of the time
2 = A little of the time
3 = Some of the time
4 = A good part of the time
5 = Most or all of the time

1. I get along very well with my peers.
2. My peers act like they don't care about me.
3. My peers treat me badly.
4. My peers really seem to respect me.
5. I don't feel like I am "part of the group."
6. My peers are a bunch of snobs.
7. My peers really understand me.
8. My peers seem to like me very much.
9. I really feel "left out" of my peer group.
10. I hate my present peer group.
11. My peers seem to like having me around.
12. I really like my present peer group.
13. I really feel like I am disliked by my peers.
14. I wish I had a different peer group.
15. My peers are very nice to me.
16. My peers seem to look up to me.
17. My peers think I am important to them.
18. My peers are a real source of pleasure to me.
19. My peers don't seem to even notice me.
20. I wish I were not part of this peer group.
21. My peers regard my ideas and opinions very highly.
22. I feel like I am an important member of my peer group.
23. I can't stand to be around my peer group.
24. My peers seem to look down on me.
25. My peers really do not interest me.

APPENDIX D

INDEX PARENTAL ATTITUDES

(IPA)

This questionnaire is designed to measure the degree of contentment you have in your relationship with your child. It is not a test, so there are not right or wrong answers. Answer each item as carefully and accurately as you can by placing a number beside each one as follows:

1 = Rarely or none of the time
2 = A little of the time
3 = Some of the time
4 = Good part of the time
5 = Most or all of the time

1. My child get on my nerves.
2. I get along well with my child.
3. I feel that I can really trust my child.
4. I dislike my child.
5. My child is well behaved.
6. My child is too demanding.
7. I wish I did not have this child.
8. I really enjoy my child.
9. I have a hard time controlling my child.
10. My child interferes with my activities.
11. I resent my child.
12. I think my child is terrific.
13. I hate my child.
14. I am very patient with my child.
15. I really like my child.
16. I like being with my child.
17. I feel like I do not love my child.
18. My child is irritating.
19. I feel very angry toward my child.
20. I feel violent toward my child.
21. I feel very proud of my child.
22. I wish my child was more like others I know.
23. I just do not understand my child.
24. My child is a real joy to me.
25. I feel ashamed of my child.

APPENDIX E

Piers-Harris Children's Self-Concept Scale

(PIERS)

Directions:

Here are a set of statements that tell how some people feel about themselves. Read each statement and decide whether or not it describes the way you feel about yourself. If is **true or mostly true** for you, circle the word "yes" next to the statement. If it is **false or mostly false** for you, circle the word "no." Answer every question, even if some are hard to decide. Do not circle both "yes" and "no" for the same statement.

Remember that there are no right or wrong answers. Only you can tell us how you feel about yourself, so we hope you will mark the way you really feel inside.

1. My classmates make fun of me
2. I am a happy person
3. It is hard for me to make friends
4. I am often sad
5. I am smart
6. I am shy
7. I get nervous when the teacher calls on me
8. My looks bother me
9. When I grow up, I will be an important person
10. I get worried when we have tests in school
11. I am unpopular
12. I am well behaved in school
13. It is usually my fault when something goes wrong
14. I cause trouble to my family
15. I am strong
16. I have good ideas
17. I am an important member of my family
18. I usually want my own way
19. I am good at making things with my hands
20. I give up easily
21. I am good in my school work

(APPENDIX E Cont.)

22. I do many bad things
23. I can draw well
24. I am good in music
25. I behave badly at home
26. I am slow in finishing my school work
27. I am an important member of my class
28. I am nervous
29. I have pretty eyes
30. I can give a good report in from of the class
31. In school I am a dreamer
32. I pick on my brother(s) and sister(s)
33. My friends like my ideas
34. I often get into trouble
35. I am obedient at home
36. I am lucky
37. I worry a lot
38. My parents expect too much of me
39. I like being the way I am
40. I feel left out of things
41. I have nice hair
42. I often volunteer in school
43. I wish I were different
44. I sleep well at night
45. I hate school
46. I am among the last to be chosen for games
47. I am sick a lot
48. I am often mean to other people
49. My classmates in school think I have good ideas
50. I am unhappy
51. I have many friends
52. I am cheerful
53. I am dumb about most things
54. I am good-looking
55. I have lots of pep
56. I get into a lot of fights
57. I am popular with boys
58. People pick on me
59. My family is disappointed in me
60. I have a pleasant face
61. When I try to make something, everything seems to go wrong
62. I am picked on at home
63. I am a leader in games and sports
64. I am clumsy

(APPENDIX E Cont.)

65. In games and sports, I watch instead of play
66. I forget what I learn
67. I am easy to get along with
68. I lose my temper easily
69. I am popular with girls
70. I am a good reader
71. I would rather work alone than with a group
72. I like my (brother) (sister)
73. I have a good figure
74. I am often afraid
75. I am always dropping or breaking things
76. I can be trusted
77. I am different from other people
78. I think bad thoughts
79. I cry easily
80. I am a good person

APPENDIX F

BEING A PARENT

(PSOC)

Listed below are number of statements. Please respond to each item, indicating your agreement or disagreement with each statement in the following manner.

If you strongly agree, circle the letters **SA**
If you agree, circle the letter **A**
If you mildly agree, circle the letters **MA**
If you mildly disagree, circle the letter **MD**
If you disagree, circle the letter **D**
If you strongly disagree, circle the letters **SD**

1. The problems of taking care of a child are easy to solve once you know how your actions affect your child, an understanding I have acquired.

2. Even though being a parent could be rewarding, I am frustrated now while my child is at his/her age.

3. I go to bed the same way I wake up in the morning - feeling I have not accomplished a whole lot.

4. I do not know what it is, but sometimes when I'm supposed to be in control, I feel more like the one being manipulated.

5. My mother was better prepared to be a good mother than I am.

6. I would make a fine model for a new mother to follow in order to learn what she would need to know in order to be a good parent.

7. Being a parent is manageable, and any problems are easily solved.

(APPENDIX F Cont.)

8. A difficult problem in being a parent is not knowing whether you're doing a good job or a bad one.

9. Sometimes I feel like I'm not getting anything done.

10. I meet my own personal expectations for expertise in caring for my child.

11. If anyone can find the answer to what is troubling my child, I am the one.

12. My talents and interests are in other areas, not in being a parent.

13. Considering how long I've been a mother, I feel thoroughly familiar with this role.

14. If being a mother of a child were only more interesting, I would be motivated to do a better job as a parent.

15. I honestly believe I have all the skills necessary to be a good mother to my child.

16. Being a parent makes me tense and anxious.

APPENDIX G

Children's Self-Report
Pre- and Post-Test

Name _____

Date _____

Just About Me
(JAM)

Directions: The following statements are about ways we might feel or things we might do. After each statement, circle the answer that is most like you. Circle only one answer for each statement.

1. When I get upset, I do things without thinking.	every day	once a week	once a month
2. When I am unhappy, I do things to help myself feel better.	every day	once a week	once a month
3. I feel sick or get headaches or stomachaches.	every day	once a week	once a month
4. I feel that I like myself.	every day	once a week	once a month
5. I feel like I can't think for myself or make good choices.	every day	once a week	once a month
6. I am proud of the work I do.	every day	once a week	once a month
7. I feel like I'm in trouble.	every day	once a week	once a month

APPENDIX H

Coping Inventory
Post-Test

Name: _____

Date: _____

Playing On The Slide

(POTS)

Imagine that you were playing on a slide with other children. As you were climbing the ladder, you tripped and fell on the ground. Then another child about your size came up to you and said, "You're stupid, you can't even climb the ladder."

Write some of the things you think you might be feeling.

Write some of the things you might do next.

APPENDIX I

Coping Inventory
Pre-Test

Name: _____

Date: _____

The Soccer Game

(TSG)

Imagine that you were playing a game of soccer or kickball with other children. When the ball was kicked to you, you missed it and fell down. Then a child about your size came up to you and said, "You're dumb, you can't even kick the ball."

Write some of the things you think you might be feeling.

Write some of the things you might do next.

APPENDIX J

CHILDREN'S FEEDBACK QUESTIONNAIRE

(CFQ)

Directions: Read each of the following questions and put a check next to the statement which best describes your answer.

1. Do you feel the Turtle exercises have helped you recognize your feelings?

___ I recognize my feelings a lot more often than before.

___ I recognize my feelings somewhat more often than before.

___ I recognize my feelings no more often than before.

2. Do you feel the Turtle exercises have helped you accept you feelings?

___ I accept my feelings a lot more than before.

___ I accept my feelings somewhat more than before.

___ I accept my feelings no more than before.

3. Do you think the Turtle exercises have helped you learn to pause to think about your feelings and options before acting automatically?

___ I am not any more able to pause and think about options.

___ I am somewhat more able to pause and think about options.

___ I am much more able to pause and think about options.

4. Have you learned to be able to relax yourself through some of the Turtle exercises?

___ No, I am not able to relax myself.

___ Yes, I am now somewhat more able to relax myself.

___ Yes, I am now very able to relax myself.

APPENDIX J (Cont.)

5. Have the Turtle exercises helped you think of more options to help yourself when you are not feeling well?

___ I am much more able to do this.

___ I am somewhat more able to do this.

___ I am no more able to do this.

6. Are you now more able to choose options that will help you and not cause you more trouble?

___ I am no more able to do this.

___ I am somewhat more able to do this.

___ I am very much more able to do this.

7. Did you find what you learned in the Turtle exercises to be helpful to you?

___ I found it very helpful.

___ I found it somewhat helpful.

___ I found it not helpful at all.

8. How often did you find yourself using the Turtle secret to help yourself?

___ I never used it.

___ I used it once or twice.

___ I used it about once a week.

___ I used it every day.

9. I think the most helpful thing I learned in the Turtle exercises was...

APPENDIX K

CHILDREN'S FEEDBACK FORM

(Post-Intervention)

1. What did you like about the play group?

2. Were there things you did not like about the play group? What were those things?

3. Are there things you learned in the play group that have helped you solve problems in school and at home? What are they?

4. What was the most helpful thing you learned from the play group?

APPENDIX L

CHILDREN'S FEEDBACK FORM

(Follow-Up)

1. Are there things that you learned in the play-group that you still use or you find helpful?

2. One of the things we worked hard on was how to solve problems. Do you feel that are better able to solve problems both at home and at school because of the things you learned in the play group? If so, give me an example of a problem you recently solved.

3. How about that feelings stuff we talked so much about. Do you know how your feelings make you act now? If so give me an example.

4. Is there one thing you learned in the play-group that you still use or find the most helpful when you have a problem? if so, what is it?

5. How about friends. You told me when I first met you that you were lonely sometimes. Has this changed for you?

APPENDIX M

PARENT FEEDBACK FORM

(Post-Intervention)

I am interested in your opinion about my work with your child. Please answer all of the questions and make additional comments if necessary.

I. INVOLVEMENT WITH CHILD:

1. Was my involvement with your child helpful? Please comment.

2. What, if any, behavioral changes have you noticed that are different since my involvement with your child?

3. Have you noticed an increase in your child's ability to solve problems in areas of her life where she had difficulty prior to my involvement? If so, what areas?

4. What, if any, changes have you observed in your child's friendships. Is she making new friends or becoming more involved in preexistent ones?

5. Comments or suggestions:

APPENDIX M (Cont.)

INVOLVEMENT WITH PARENT:

1. Was my involvement with you helpful? Please comment.

2. Do you feel that you can positively participate in reinforcing your child's' newly acquired problem-solving skills based on the content of the material that was shared in the parents' group? Please comment.

3. Was the group format helpful or did it hinder participation for you?

4. Comments or suggestions:

APPENDIX N

PARENT FEEDBACK FORM

(Follow-Up)

FAMILY:

1. Has your child continued to use some of the skills acquired in the play group? If so, what are they. (Please be as specific as possible, ie. competent problem-solving ability in difficult situations, acquisition of new friendships or enriched friendships with previously existent friends.)

2. Have there been any additional changes in your child's behavior since we last spoke (either positive or negative) that you feel can be attributed to her involvement in the play group? If so, what are they?

3. A number of months have past since my involvement with your child, do you feel that her involvement in the play group has had long-term effects in the way in which she identifies and solves problems? Are their other effects that you feel can be attributed to her involvement with the group? If so, what are they?

4. Has the information I shared with you and your involvement in the parent-group had any long lasting effects or consequences, positive or negative? (ie. the way in which you problem solve with your child, understanding your child's behavior.) If so, what are they?

5. I am very interest in additional comments or suggestions that you may want to discuss. If you have any, please feel free to write them here.

APPENDIX O

TEACHER FEEDBACK FORM

(Post-Intervention)

I am interested in your opinions regarding my involvement with your student. Please answer all of the questions and make additional comments or suggestion if necessary.

1. Overall, do you feel intervention has been helpful to the student. If so why?

2. What, if any, behavior and/or emotional changes have you noted in the student following my involvement?

3. Was my contact with you helpful in understanding the nature of your student's difficulties?

4. Has my contact with you changed the way in which you relate to the student? If so, how?

5. Does the child appear less withdrawn or isolated from their peer group? Does she appear more capable to relate to others?

6. Has your student displayed in increased ability to solve problems in relation to school related tasks and social situations since my involvement? If so, how?

7. Has the student's parent changed the way in which they request your help on behalf of their child? If yes, how?

8. Additional comments, suggestions, opinions.

APPENDIX P

TEACHER FEEDBACK FORM

(Follow-Up)

1. Do you feel that your student's involvement has had long lasting effects? If so, what? (Please be as specific as possible. ie. problem-solving competency, friendship acquisition, ability to relate with peers in a meaningful way, etc.)

2. Have there been any significant behavioral changes since we last met? (positive or negative). If so, what are they? Please be as specific as possible.

3. Have there been changes in your student's school programming based on our previous conversations about her needs or those that you have implemented as a result of what you perceived as her needs? If so, what are they? (ie. involvement with school counselor, academic reorganization.)

4. Has your student's parent(s) intensified their involvement with you since we last spoke. If so, what circumstances, if any, warranted the involvement?

5. Are there any general observations that you can offer me about the usefulness the intervention your student took part in? If so, what are they?

6. I am interested in you comments, suggestions or opinions. If there are any, please detail them here.

APPENDIX R

PERMISSION FOR CONSULTATION

I _____ , give my permission for
(name of parent or guardian)

Karen Holyk to consult with: Morse Place School, her Committee, Dr. Joe Kuypers, Diane Hiebert-Murphy, Ms Ruth Lehmann, regarding my child.

Signed: _____
(name of parent or guardian)

Witness: _____

Date: _____

Address of parent or guardian:

_____

_____

Phone Number: Home _____

Work _____

APPENDIX S

PERMISSION FOR INVOLVEMENT IN THERAPY GROUP

I, _____ , have had the nature of the therapy group described to me and I give my permission for my child to become involved in it. I understand I have the right to withdraw my child from the group for any reason. If I choose to withdraw my child from the group, I agree to discuss this decision with Ms Holyk prior to my doing so.

Signed: _____
(name of parent or guardian)

Witness: _____

Date: _____

APPENDIX T

Health & History Form

Child's Name _____ Family Name_____

Form Filled Out By _____

Please describe the current female parent:

Natural Mother ___ Step-Mother ___ Foster Mother ___

Live-In Partner ___ Other: _____ No Female Parent ___

Please describe the current male parent:

Natural Father ___ Step-Father ___ Foster Father ___

Live-In Partner ___ Other: ___ No Male Parent ___

Family History

Rows 1-7: Please put a yes (y) or no (n) for each answer and indicate family member(s) who experienced problem. If you don't have information on a specific item put a question mark.

1. Received counselling or therapy before.
2. Been psychologically evaluated before.
3. Attempted suicide before.
4. Mental illness in the family.
5. History of drug or alcohol abuse.
6. History of problems with the law.
7. Long term physical illness or handicap.
8. Significant family separations.

APPENDIX U

Social Demographic Data Sheet

In order to better help us understand your child, please answer each of the following questions about your child and family. When describing your child, please think about his/her behavior during the past month. Please try to answer each question. All information will be kept confidential. Select only one answer for each question.

1. You are the child's:

   a. Mother
   b. Father
   c. Stepmother
   d. Stepfather
   e. Other, (specify)

2. Education: (circle one)

   a. None
   b. Grades 1 - 4
   c. Grades 5 - 8
   d. Grades 9 - 12
   e. Technical or Vocational Training
   f. University Education

3. Are you currently:

   a. Married
   b. Living as married
   c. Separated
   d. Divorced
   e. Widowed
   f. Never married

4. Please list the people living in your home:

Name	Age	Relationship to you

APPENDIX U (Cont.)

5. The following questions ask you to describe your life as you now see it. Circle the best answer to each question.

a. Are there adults you know whom you could call for help if you really needed it?

Yes No Not Sure

b. If you needed to leave town quickly, is there someone whom you would trust to look after your house and belongings?

Yes No Not Sure

c. If you had to leave town quickly, is there someone you trust to look after your children?

Yes No Not Sure

d. Have you engaged in social activity with other adults outside your home in the last:

24 Hours Week Month

e. Have you engaged in a social activity inside you home in the last:

24 Hours Week Month

f. Have you talked with an adult who cares about you, and your care about, in the last:

24 Hours Week Month

g. Most of your contacts with other adults are initiated:

1. By you
2. By others
3. Sometimes by you and sometimes by others

h. Are most of your contacts with other adults:

1. Positive, supportive or pleasant
2. Neutral, neither positive or negative
3. Negative, conflictual or aversive

6. Sometimes significant events in a child's life are important in understanding their behavior and emotional reactions. Following is a list of events. Please read through the list **two** times. As you read through the list the first time, place a (*****) in Column 1 beside any event which has occurred in your child's life in the past year.

If any of the events listed were stressful to your child and occurred in the past year, place an (**X**) in Column 2.

Column 1 (*)		Column 2 (X)
_____	Death of a parent	_____
_____	Serious injury/illness to child	_____
_____	Serious injury/illness to parent	_____
_____	Serious injury/illness sibling	_____
_____	Change of school	_____
_____	Family moved to another hour or apt.	_____
_____	New person joined the family	_____
_____	Family income significantly decreased	_____
_____	Divorce or separation	_____

APPENDIX V

SESSION CONTENT MATERIAL

Session 1

Exercise 1 & 2 - The Turtle Secret

Objective: To introduce the four basic steps of competence training. Story and workbook were distributed. Children were encouraged to take story home to read with parent.

Session 2

Exercise 3 & 4 - Feelings Have Names

Objective: Helps children identify and accept their feeling states.

Session 3

Exercise 5 - Body Changes, Common Personal Feelings

Objective: Helps children identify and increase awareness of how feeling states are related to body changes.

Session 4

Exercise 6 - Tying Feelings to Situations

Objective: Helps children identify situations that arouse specific emotions.

Session 5

Exercise 7 - Learning To Pause And Relax

Objective: Learning to relax in order to delay the release of immediate negative emotions.

(APPENDIX V Cont.)

Session 6

Exercise 10 - Learning About Thinking

Objective: Helps children learn "how" to think through situations.

Session 7

Exercise 11 - Deliberation On Positive Emotions

Objective: Helps children identify positive emotional experience and how to use this in their lives.

Session 8

Exercise 12 - Developing Independent Thinking: I

Exercise 13 - Developing Independent Thinking: II

Objective: Helps children identify "how" to think and take responsibility for their behavior.

Session 9

Exercise 16 - Identifying Unpleasant Emotions

Objective: Helps children identify unpleasant emotions.

Session 10

Exercise 17 - Important Steps In Problem Solving

Objective: To foster independent thinking and problem-solving skills and potential consequences of action.

Session 11

Exercise 17 - Important Steps In Problem Solving
(Continued from previous session)

(APPENDIX V Cont.)

Session 12

Exercise 25 - Bridge Building

Objective: Enhancement of problem-solving skills presented in Exercise 17.

Session 13

Exercise 26 - Ralph Heads For Trouble

Objective: To enhance integration of the problem-solving approach.

Session 14

Exercise 30 - When Can The Turtle Secret Be Useful

Objective: Provides a review of coping skills learned throughout the group and how they can be incorporated in the child's daily life.

Session 15

Exercise 30 - When Can The Turtle Secret Be Useful
(Continued from previous session)