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Social Skills Group Therapy For Children With Emotional And Behavioral Problems

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SOCIAL SKILLS GROUP THERAPY FOR CHILDREN WITH EMOTIONAL AND BEHAVIORAL PROBLEMS

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Introduction

Children's Intensive Services (CIS), on Bacon Street in Pawtucket, Rhode Island, is part of Gateway Healthcare, Inc., a non-profit behavioral healthcare agency. CIS offers home-based intensive therapies and case management services for children at risk of psychiatric hospitalization or out-of-home placement. The agency provides psychiatric evaluations, case management, and intensive family, group, and individual therapy for their clients. Funding for the agency is received through a variety of different sources depending on the type of health insurance of each client. Some clients pay for treatment with private health insurance. Most clients, however, use a combination of RIte Care, which is the state funded health insurance for Rhode Island children whose parents do not have access to private health insurance, and funding from the Rhode Island Department of Children, Youth, and Families (DCYF) to receive treatment. The agency has two psychiatrists on staff to ensure that psychiatric evaluations are provided to every client. The agency also has many licensed clinicians and case managers to provide case management and intensive family and individual therapy for clients. The one area that could be improved at CIS is the provision of group therapy. When this research began in 2006, the agency only offered two groups. One was an art therapy group for all clients of the agency, and attendance for this group was not mandatory. The other group available was a closed group for teenage male clients.

Shulman (2006, p. 268) discusses that it is common among social workers to fear leading groups. This fear may be one of the reasons that only a few groups exist currently at CIS. Shulman describes that one origin of this fear comes from the social worker feeling that he or she would be out-numbered by a group of clients, and his or her work

would judged by many clients all at one time. The complexity of groups and potential negative feedback from a group are among other concerns that social workers have about facilitating group work. Another issue that may impede groups at CIS is transportation for clients. Most CIS clients' families work and are unable to provide transportation during the day, or clients' families do not own cars. CIS clinicians and case managers, therefore, often transport clients for treatment, which would be difficult for an entire group.

One of the major potential obstacles that Shulman (2006, p. 279) identifies in group work is the differing interests of each member of the group. The clients of CIS have a dramatic range of behavioral and emotional issues, cultural backgrounds, and age. Some clients may have Attention Deficit Hyperactivity Disorder, whereas others may experience depression or Bi-Polar Disorder. The ethnic and racial backgrounds of the clients are usually Caucasian, African-American, Hispanic or Cape Verdean. The clients range in age from about four years to 18 years of age. Any of these differences in characteristics of the CIS clients could interfere with their ability to identify with each other in order to have a therapeutic effect in a group setting. The criteria for choosing members of a new group at CIS will be crucial to the therapeutic success of a group. The selection of the type of group is also an important consideration in order to serve the CIS clients with the more pressing need for group therapy.

Although many social workers may find the prospect of group therapy frightening, Zastrow and Kirst-Ashman (2004, p. 319) explain that group therapy has many advantages in comparison to individual therapy with clients. One example is that group members receive psychological rewards from helping other group members resolve

their problems. Another advantage is that if a client needs to improve social skills, then a group setting provides the opportunity to test newly learned skills. Group therapy has also been shown to be more likely to change the attitudes of members, if needed, than individual therapy. Shulman (2006) explains that groups can benefit clients when group members share helpful information with one another, challenge one another's ideas, feel supported by others with similar problems, and pressure other members to improve.

Clients are also able to become empowered through the use of social work groups, not limited to just group therapy. The goal of every social worker should be to empower clients, which can also be accomplished with recreation-skill groups, educational groups, socialization groups, etc. (Zastrow & Kirst-Ashman, 2004, p. 315). Children's Intensive Services is a setting, however, where group therapy would be the type of group most beneficial to their clients because they all have emotional and/or behavioral problems, which is usually a requisite of group therapy (Zastrow & Kirst-Ashman, 2004, p. 317). The NASW Code of Ethics (1999, p. 7) requires that "social workers' primary responsibility is to promote the well-being of clients." Social workers, therefore, should advocate for and work to create therapy groups for clients who would benefit from the many advantages of group therapy, not available from individual therapy.

As mentioned, a group therapy setting is an effective way to help clients learn social skills. Sterba and Dowd (1998, p. 17) argue that teaching social skills in itself is an essential part of effectively treating children with mental health disorders. They contend that children develop these problems partly because they have not fully learned the necessary social skills to cope with the problems in their lives. These children have learned inappropriate behaviors and skills in their home environments, which permit

them to get what they want from parents and caretakers. Fraser, Nash, Galinsky, and Darwin (2001) discuss that life experiences build the social knowledge of a person throughout his or her life, especially experiences at home and neighborhood environments, with peers, within a community and society, and with the media. Significant research shows that the children are taught by the media that violence has positive benefits. "Over time, repeated exposure to such messages can result in a belief that takes a prominent position in a child's social knowledge: 'Aggression works'" (Fraser et al., 2001, p. 5). The negative, and sometimes aggressive, behaviors of children with poor social skills are carried over to their outside environments, such as school. Not surprisingly, these children resort to aggressive behavior when their needs are not meet in outside environments. These children need to learn new social skills to allow them to have their needs successfully met in an appropriate manner (Sterba & Dowd, 1998, p. 18-19).

Literature Review

Social Group Work

Group work in a social work context is termed social group work. It is one of several methods that complete the functions of social work when appropriate (Konopka, 1963). "Social group work . . . is a method of social work which helps individuals to enhance their social functioning through purposeful group experiences and to cope more effectively with their personal, group or community problems" (Konopka, 1963, p. 29). Social group work can include therapy groups, but social group work can also be done with individuals who do not need mental health therapy, such as social action groups

(Konopka, 1963, p. 31). In social group work, the group is formed for the purpose of helping the individual members. Northen (1969, p. 13) quotes Somers in describing that social group work appreciates the "potency of social forces that are generated within small groups and seeks to marshall them in the interest of client change." Konopka (1963, p. 39) contends that social group work is based on the theory that no human being is a complete and separate individual, but every person is interrelated with others. Besides basic biological needs, human beings' most fundamental desire is to be loved and be important to someone else. The second theory behind social group work explains that the healthy development of a person is based on appropriate group life during his or her life.

The group process is the essential part of social group work. Konopka (1963, p. 50) cites Marjorie Murphy in defining it as "the totality of the group's interaction, developments and changes which occur in the group's life." After a period of time, a group will become more than the sum of its individual members because a group bond will be formed (Konopka, 1963, p. 60). Northen (1969, p.15) describes Kurt Lewin's group theory that each group member will undergo a process of mutual adaptation to the other members, which he terms "dynamic interaction."

Northen (1969, p. 16) explains Bales' research which indicates that the purpose of groups is to solve a problem, which is achieved when members "either seek or give information, suggestions, or opinions." The group process of solving problems is achieved through sequential phases of social interaction. Northen (1969, p. 17) describes that the interpersonal communication in social interaction of groups is the exchange of meanings and creation of common meanings. "As members of a group exchange feelings

and thoughts, there is a reciprocal and cyclical influence of members on each other" (Northen, 1969, p. 17).

Group Therapy

Group therapy first began in the 1940s (Yalom, 1995, p. xi). The effectiveness of group therapy, both as itself and in comparison to other therapies, is proven by much thorough research (Yalom, 1995, p. 47). There are several features of group therapy that allow a group to be therapeutic. Yalom (1995, p. 5) states that a group can instill hope in group members because it allows them to observe the improvement of other group members. The group also creates a sense of universality for the members because they learn that they share similar feelings and experiences, so they no longer feel alone (p. 6). As briefly mentioned before, Shulman (2006, p. 272) agrees with this group benefit, which he terms the "all-in-the-same-boat phenomenon." Konopka (1963, p. 49) concurs with this idea, which she also calls "in the same boat." A benefit of group therapy that Yalom (1995) mentions, with which Zastrow and Kirst-Ashman (2004) agree, is altruism, which means that is therapeutic for the group members to feel needed by the group.

Yalom (1995) describes many facets necessary for a successful group. Structure should be provided for specialized therapy groups in a "consistent, explicit sequence" (p. 471). He also explains that group members should not describe or detail their pathology to the group because it will become evident to the group members by his or her behavior in the group (p. 28). Yalom describes a six-month study of two long-term groups in which the only variable significantly related to improvement was acceptance (p. 51). He explains that the group facilitator must work to create an atmosphere in the group in which self-expansion is able to occur (p. 55). The first step in the self-expansion of a

person is to participate in self-exploration, which is primarily dependent on a feeling of acceptance from other group members. “Acceptance by others and self-acceptance are interdependent; not only is self-acceptance basically dependent on acceptance by others, but acceptance of others is fully possible only after one can accept oneself” (Yalom, 1995, p. 56).

Shulman (2006) explains that the first sessions of a group will require the group worker to clarify the purpose of the group to the members. In the beginning, the group worker will be viewed by the group members as an authority figure, who some group members will feel the need to test. A code of behavioral rules, called norms, must be created in order to direct the interaction of the group members (Yalom, 1995, p. 109). Shulman (2006, p. 362) argues that the group worker always has two clients in a group setting, the individual clients and the group as a whole. It is, therefore, important for the group worker to monitor the group as a whole and each individual member.

At the end of each group session, Shulman (2006, p. 380) contends that there should be a resolution phase. The group worker should aid the group in “summarizing, generalizing, identifying next steps, rehearsal, and exploring ‘doorknob’ comments.” Shulman (2006, p. 175) defines “doorknob” communication as a significant comment raised by a client at the end of a session so that there is not enough time left to deal with the issue.

Abrams (2000, p. 59) explains that in her study, during the third group meeting, the participants entered into the power and control stage, in which tensions and emotions emerge that may create conflict in the group. It is the role of the group worker to mediate the conflicts in the group (Shulman, 2006, p. 367). Abrams (2000, p. 60) found that a

caring and respectful tone helped her to mediate through the tension during this stage. When other conflicts occurred throughout other group sessions, Abrams (2000, p. 62) found that it was effective to not intervene too quickly. The conflicts were an occasion for group members to develop creative problem-solving skills. She did assist the group by ensuring that the problem was acknowledged and defined. The last group session should have a celebratory theme to acknowledge the work that was accomplished together, such as music and food with group therapy for children. A review of the work done during the course of the group should be discussed as a group (Abrams, 2000, p. 65).

Shulman (2006) explains that individual group members sometimes take on maladaptive roles. Shulman first identifies the scapegoat, who is attacked by other group members verbally or physically because the group is projecting negative feeling about themselves onto the person in this role. The group worker should observe the scapegoat process of the group and then facilitate a group discussion about the connections between the scapegoat and the group (Shulman, 2006, p. 386-394). Another role that may appear is the deviant member, whose behavior deviates from the norms of the group. A group leader must be able to tolerate deviant behavior and look for the underlying message of the behavior (Shulman, 2006, p. 394-396). The other roles that Shulman describes are the defensive member, the quiet member, and the monopolizer.

Group Therapy with Children

Shulman (2006, p. 327) describes that group work with children can be difficult because the children feel as though they are “bad kids” for needing group therapy. If contracting with the children in the initial stages of the group is not done openly and truthfully, it can impede the therapeutic work of the group because the children can feel

anxious. Schiffer (1984) states that group therapy, however, can be an effective therapeutic method for children because it is usually implemented when children are experiencing socialization as an important element of daily life. Children are usually moving beyond the close bond to their families, so therefore, they are more influenced by extra-familial groups (Schiffer, 1984, p. 1). McArdle et al. (2002) performed a 12 week study that tested the use of group therapy for children at risk for emotional and behavioral problems. The improvement of the children was determined using the Teacher Report Form, the Youth Self-Report, and the parent-completed Child Behavior Checklist. Group therapy in this study was found to be better than no intervention, and it was shown to enhance subjective well-being and school adjustment, which they explain corroborates earlier studies of group therapy for at-risk children.

Children often find group work more bearable than individual therapy because it matches where the child is developmentally (Schiffer, 1984, p. 2). Abrams (2000) agrees that children are often quiet with adults, but talkative and noisy with peers. She found that establishing a group of peers allowed the children to be more comfortable. Levinsky and McAleer describe that a group of peers also allows children to "combat feelings of differentness and isolation" (as cited in Abrams, 2000, p. 57). Children are often resistant to discuss their thoughts and feelings in individual therapy due to embarrassment, but groups allow the factor of universalization, which shows the children that they share many similar thoughts and feelings (Schiffer, 1984, p. 228).

In group therapy, children will quickly learn the new role of the adult, which they have never experienced. A group therapist for children should change the norms from children's regular settings to allow them more freedom, although the therapist should

always be available to them if they need help (Schiffer, 1984, p. 3). Abrams (2000, p. 67) expresses that having fewer rules for children in groups can empower children by reversing the power dynamics. Abrams did not have structured punishments in her study, but instead allowed the group of children to collectively decide how to handle situations in which a member is having difficulty behaving. She felt that this also allowed the children to explore their feelings about times when they had perceived adults acting unfairly to them. When they challenged her authority, she searched for the underlying issues, which strengthened the group relationships. Schiffer (1984, p. 16) explains that a group can develop as a "social gestalt" in which the group creates an environment of norms that deter individual children from acting out in the group. Due to the importance of peer acceptance for children, a group can help to raise a child's self-esteem and strengthen his or her sense of identity. These positive outcomes can be supported by "creative accomplishments with arts and crafts media, proficiency in active games and sports, and other activities that have special meanings for latency children" (Schiffer, 1984, p. 17).

The structure and composition of a group for children is an important consideration. Schiffer (1984, p. 8) contends that older children must be in a group with other children and a therapist of the same gender because of their developmental stage. Yet, children who are younger would still benefit from group members of the same gender, but it is not as crucial. Schiffer (1984, p. 19) states that groups should meet for about one hour every week and preferably one and a half hours for older children.

Schiffer (1984, p. 227) describes that in the early experimental years of group treatment, activity-group therapy was found to significantly help children with emotional

difficulties, but it did not eliminate their problems as expected. Activity-group therapy is structured so that children are able to participate in the group without instructions from the group leader, but the therapist is available for help when needed. Activity-interview group psychotherapy was then developed, which consisted of activity as well as discussions of problems led by the group therapist. This type of group was found to be more effective. These discussions are easier for children in groups than in individual therapy due to the factor of universalization. Therapists should have an active role in discussing themes with the group, but only at "psychologically opportune times," so that the children are not threatened (Schiffer, 1984, p. 229).

Social Skills Group Therapy with Children

An essential advantage to all group therapy, according to Yalom (1995) and Zastrow and Kirst-Ashman (2004), is that it allows group members to develop socializing techniques. Yalom (1995) explains that this can range from developing basic social skills to highly sophisticated social skills for long-term group members, such as processing and conflict resolution. The group leader, usually a therapist, can model behavior to the group members, such as methods of communication (Yalom, 1995, p. 16). As mentioned previously, specifically learning appropriate social skills can significantly help children with mental health disorders. Successful social skills also allow children to experience "teacher acceptance, academic achievement, peer acceptance, positive peer relationships, and friendships" (Lane, Menzies, Barton-Arwood, Doukas, & Munton, 2005, p. 18). Grizenko et al. (2000, p. 502) explain that numerous studies show social skills training is successful.

Lane et al. (2005, p. 21) describe a social skills intervention developed in 1991 by Gresham and Elliot that focuses on the five following major social skills: cooperation, assertion, responsibility, empathy, and self-control. In a study of social skills group therapy by Grizenko et al. (2000, p. 504), the following skills were taught: introducing yourself, joining in, knowing your feelings, self-control, dealing with your anger, responding to teasing, and staying out of fights. Fraser et al. (2001) explain that social skills can be improved by enhancing a child's ability to process social cues, which are social actions of other people that can be seen, heard, or felt. Examples of social cues are facial expressions, tone, word choice, and body language. Fraser et al. (2001, p. 3) argue that children should be taught to interpret social cues differently depending on the context of a social situation. They contend that social problem solving should be taught to children in the following six steps: encoding cues, interpreting cues, formulating and refining social goals, searching for and formulating responses to social situations, deciding on particular responses, and enacting or implementing response decisions.

Lane et al. (2005) explain that Gresham and Elliot's social skills intervention included five stages for each of the five previously mentioned social skills. In the first stage called the "tell phase," a social skill is discussed by the group. The next phase involves the children role playing the skill, which is called the "show phase." In the "do phase," the children are asked to define the skill and role play and discuss it again. The next stage involves detailed follow-through and practice activities. Finally, the children are asked to use the skill in contexts beyond the group and discuss their experiences with the group in the "generalization phase."

The social skills intervention used by Grizenko et al. (2000, p. 504) consisted of 12 sessions in which one skill was focused on in a session, which is similar to the intervention described by Lane et al. (2005). The participating children were given snacks during the last ten minutes of each session as a reward for attendance. In the Grizenko et al. (2000, p. 506) study, social skills group were found to be more effective if the children were taught to understand the perspective of the other person involved in the interaction. A group developed by the Arapahoe/Douglas Mental Health Network entitled "I Can Make New Friends" uses role-play, art and educational activities in order for children to learn and practice the social skills involved in forming and maintaining friendships.

A group intervention focused on social skills must first evaluate and then improve social skills (Lane et al., 2005, p. 18). One study had teachers complete a version of Walker and Severson's Systematic Screening for Behavior Disorders to identify the behavior problems of the children. Another study used the *Student Risk Screening Scale* to identify elementary students at risk for antisocial behavior (Lane et al., 2005, p. 19-20). A method of monitoring the progress of the social skills intervention is necessary to determine the success of the intervention. Lane et al. (2005, p. 24) recommend monitoring progress by using teacher ratings, self-report, and through direct observation. In the study by Grizenko et al. (2000, p. 503-505), parents and teachers evaluated behavior and social skills using two questionnaires, the Child Behavior Checklist-Revised and the Matson Evaluation of Social Skills with Youngsters, which were completed prior to treatment, directly after the treatment, and nine months after the treatment. The participating children also were interviewed and completed a self-evaluating questionnaire, the Self Perception Profile for Children.

The clients of Children's Intensive Services (CIS) in Pawtucket, Rhode Island may benefit greatly from the therapeutic advantages that group therapy can provide. CIS, however, does not offer many groups, which could be due to a variety of reasons, such as fear of groups and the difficulty of transporting clients to a group. As a social worker, it is essential to incorporate the theories of social group work when developing a therapy group, such as the theories that state that every person is interrelated with others and everyone's most fundamental desire is to be loved. Some of the most useful aspects of group therapy are the "all-in-the-same-boat phenomenon," acceptance of group members, learning social skills, and group members challenging one another. The structure of the group and roles of the group members are important considerations when conducting a therapy group. Children should be engaged in activities during group therapy. Social skills group therapy is theorized to be helpful for children with mental health disorders, especially children who are physically aggressive. In this type of group therapy, it is effective to teach children the phases of using social skills and using discussion and role-play to understand each social skill.

Method

The type of methodology employed was a mixed methodology combining a one group pretest-posttest pre-experimental design with qualitative analysis of the group process that was intended to produce change. A social skills group was formed of clients of Children's Intensive Services on Bacon Street in Pawtucket, Rhode Island. The group began on Friday, January 26, 2007 and was held every Friday after school, except on two occasions when it was rescheduled due to snow. There were a total of eight sessions. The

group was co-led by this researcher and Cate Gorman, a CIS clinician. The plan for each group session was agreed upon and formulated by the co-leaders of the group, drawing from a variety of group literature and the previous group experience of Cate Gorman. The inspiration for this group came from a male CIS client whose case is shared by this researcher and another clinician at CIS. The client was referred to CIS primarily for his acts of aggression with peers and at home. He has reported not having many friends, and he has difficulty controlling his aggression when he is teased by his peers. It seems that most of his aggressive acts are triggered by his frustration from his lack of social skills, especially conflict resolution. The hypothesis of this study is that the clients who participate in the social skills group will decrease the amount of anti-social behavior exhibited at school, especially in terms of physical acts of aggression, and increase their pro-social behavior at school.

Participants

The social skills group was formed of four male and two female Children's Intensive Services' clients between the ages of eight and nine years. An informational flier was distributed to the staff of CIS in December 2006 to request that their clients join the group. After the six clients for the group were determined, a one page survey was distributed to and completed by the CIS clinicians of the clients to inform the group leaders about the details of each client. Most of the clients of CIS live in the urban city of Pawtucket, Rhode Island. According to the *2007 Rhode Island Kids Count Factbook*, the median household income for families with children in Pawtucket was $33,562 in 1999, which is one of the lowest in Rhode Island. In 2000, about 21 percent of the Pawtucket child population was Hispanic or Latino, about 56 percent of the child population was

white, and about ten percent was black. There were three Hispanic children and three white children in the group.

Methodology

A questionnaire, called The Teacher Questionnaire, was mailed to the teachers of each of the clients in the group at the beginning and end of the group to determine how the pro-social and anti-social behaviors changed, especially acts of aggression. The Teacher Questionnaire utilized is shown in Appendix A. Some of the questionnaire items were based on the Teacher's Report Form for Ages 6 – 18 and the Conners' Teacher Rating Scale, which are forms commonly used by CIS. The Teacher's Report Form and the Conner's Teacher Rating Scale were not used due to their length in order to ensure that the teachers were more likely to complete the questionnaires. The items on the questionnaire specifically targeted anti-social and pro-social behaviors. The items for anti-social behavior are "argues a lot with peers," "cruelty, bullying, or meanness to others," "disturbs other students," "does not get along with peers," "physically attacks peers," "showing off or clowning," and "teases a lot." The items for pro-social behavior are "appropriately helps peers," "comforts and/or compliments peers," "cooperates with peers," "responds appropriately to teasing," "appears happy and calm with peers," "appropriately resolves conflicts with peers," and "gets along with peers." The teacher were asked on the questionnaire to rate how frequently, on a four-point scale from "never" to "very often," the participant partakes in each of the behaviors. Qualitative data on group dynamics and process were also analyzed in order to form conclusions about the group therapy process. Finally, the CIS clinicians of each of the group members were

briefly interviewed after the therapy group was completed to inquire to any changes in the client's social functioning at home and at school.

Data Analysis

On the Teacher Questionnaire, each item rating of frequency was assigned a number so that social scores for each participant could be determined. A rating of "never" is given a zero, a rating of "sometimes" is given a one, a rating of "often" is given a two, and "very often" is given a three. Each group participant received a score for both anti-social and pro-social behavior. The anti-social score was determined by the summation of the items describing anti-social behavior. The pro-social score was determined by the summation of the items describing pro-social behavior. Each group participant, therefore, had a total of four scores because there were the two scores before the group and the two scores at the end of the group. The mean scores of each of these four scores were then calculated. The two mean scores before the group were compared to the two mean scores after the group to determine if the hypothesis that the pro-social behaviors would increase and the anti-social behaviors would decrease was suggested.

Findings and Results

Group Members

There were four male and two female clients in the group, each with their own unique personality and needs to be addressed in the group. All of the names of the group members will be changed to maintain confidentiality. The CIS clinicians of each of the group members were asked to complete a one page survey about their clients before the

group began in January 2007, thus some of the following information was taken from those surveys.

Max was an eight year old, white male client who has a history of physical aggression, such as strangling, towards other children in unstructured environments, especially during recess at school. His clinician was concerned that not only was he very aggressive, but he also lacked many basic social skills and isolated himself from his peers at school. While working with this client, his clinician had discovered that the client was not given the opportunity to socialize with children outside of school. He spent all of his free time playing video games at home, which his mother did not censor. It was determined that the client had been acting out many of the violent acts in the video game to other children at recess when he was feeling angry. During group discussions, video games seemed to be the only topic about which Max enjoyed talking. Noah, an eight year old, white male, was the other male group member who seemed to lack many basic social skills. He had many learning difficulties, so he suffered from low self-esteem. He struggled with making and keeping friends, has some history of aggressive behavior, and became very angry when he lost at games or another child teased him.

Rachel was an eight year old, white female with social skills that were the most highly matured of the group members. Her teacher, however, did report to Rachel's CIS clinician that Rachel sometimes had a tendency to be "bossy" with other children at school. She seemed to greatly enjoy talking and having a leadership role in the group. She was very effective at facilitating compromises during group sessions. Mary was the other female client in the group, and she was nine years old and Hispanic. Mary's personality directly contrasted with Rachel, but the two clients did become friends and

enjoyed spending time together in group. Mary acted extremely shy and anxious in new situations. After an adjustment period, she would act hyper, and would often become overly affectionate with adults around her, such as sitting on their laps and hugging them without permission. These actions seem to be a mechanism to soothe her feelings of low self-esteem, which may be partly due to having many learning difficulties.

There were only two clients in the group who were friends before the group began, Peter and Carlos. They were both nine years old, Hispanic, attending the same school, and neighbors. Peter acted very reserved in new situations, but he became somewhat more outgoing when he adjusted. He did not have any problems with aggression, and he was soft spoken and polite. Other children, however, seemed to be able to take advantage of Peter because he would shy away from conflict. Carlos had an outgoing personality, and he seemed comfortable in social situations. He especially seemed to enjoy laughing and making jokes. He was, however, extremely physically aggressive often at home and sometimes at school.

Qualitative Analysis

The structure of each group session evolved as the group progressed. A consistent structural component of the group is that the group members were always given a snack during the beginning of group, which was necessary because the children were hungry at the end of the school day. The group design began with a thoroughly planned combination of discussions, games, and interactive activities for each group session. For example in the first group session, a few "ice-breaker" games were played while eating snack, group rules were then discussed, brainstorming of group activities was done, a ball game was played, and finally the group members formed pairs and conducted "friend

interviews." It was decided by the group leaders, however, that the group members should be given 15 minutes of "free time" at the end of each group session due to many requests by the participants during the first group to do other activities. The group leaders wanted to allow the group members to freely socialize with each other, which provided a much more productive method for the group leaders to learn about each client's social strengths and weaknesses. This change also helped to create an atmosphere that the group was not a strictly structured environment, to which they may be accustomed at school, but the group should be an engaging and open setting.

Another method of creating the open and engaging atmosphere in the group was the flexibility of the group leaders about the daily plans for the group. For example, the group leaders had an art activity planned in which each group member would be given a blank, large puzzle piece to decorate in a way that represented themselves. After the group members had finished decorating, they would then put all of the puzzle pieces together to symbolize that they are each unique people, but they can all fit together to form a group. After the group leaders had explained the activity to the group, some of the group members requested that they put the puzzle pieces together first and then all draw a picture together, so that it would look like a real puzzle. All of the group members liked this idea, so the group leaders agreed to allow them to attempt it. The activity actually became one of the best opportunities for the group members to learn about compromise. All of the group members had very different ideas for what the picture on the puzzle should be, so there was a lot of arguing initially. They all seemed to realize that they were not making progress, so the group leaders modeled for the group how to compromise by integrating most of their ideas into one picture on the puzzle. The ideas were all written

down, and then the different parts of the picture were delegated to each group member. The puzzle turned out to be something of which the whole group was proud, and it was hung on the wall in the room where the group met.

Another important structural consideration for the group was being sensitive to the amount of physical energy that the clients had on certain days or during a certain time during a session. On some days, the group members were able to focus and actively participate in all the activities that involved sitting. On other days, it became obvious to the group leaders when the group members became overly energetic and had difficulty focusing on the activity, so an active game would then be played to accommodate the group's need to release their physical energy. Yet, it was necessary to keep in mind the goal of the therapy group was teaching the group members to learn to socialize better with peers, so the movement games involved teamwork and working together. For example, a game was played in which the children all worked as a team by hitting a balloon to keep it from touching the ground, but they had to stay seated. They had to, therefore, decide and communicate as a group how to arrange their chairs and other strategies in order to keep the balloon in the air. The group members seemed to thoroughly enjoy this activity, but they all had to learn how to effectively communicate with each other during the game, which took some time.

A final structural consideration that developed later in the therapy group was the use of reading stories to the group members. During snack time for the first few group sessions, the group would discuss the social skills and situations of which the activities in the rest of the group session would facilitate the learning. These discussions were found to be much more meaningful for the group members if they had a story to which to relate

them. The group leaders then decided to read a story to the group during snack time in the beginning of each session, and the group would discuss the story afterwards. First, a story called "The Turtle Story!" by Fraser et al. (2001, p. 58-62) was read to the group in the fifth group session. The story detailed how one of the turtles had difficulty controlling his anger and would fight with other turtles at school. The other turtle felt shy and embarrassed with her peers. Both of the turtles learned that if they felt overwhelmed by a feeling, they could go inside of their shells to relax and think about the best way to act instead of acting on impulse. The group leaders paused at certain points in the story to ask the children questions to keep them engaged in the story and help them relate to the story. Almost all of the group members were willing to share with the group that they related to the characters in the story because they had difficulty managing their emotions at times. This discussion seemed to be the first time that the group members realized that they all shared similar problems, which created some group cohesion because they were "all-in-the-same-boat" (Shulman, 2006, p. 272). After the group leaders finished reading the turtle story, the group members were then asked to act out the story using a turtle puppet, which allowed the concept to accommodate the varied learning styles of the group members. Other stories that were read to the group included *Thank You, Mr. Falker* by Palacco (1998), which is about coping with peer rejection due to learning disabilities, and a story that Carlos wrote in school and wanted to share with the group.

Role-play seemed to be one of the most effective teaching techniques used in the therapy group. Using role-play with the puppet after reading the turtle story is an example of how well the group members learned a new concept. During the last group session, the group leaders asked the group members to describe some of the lessons that they had

learned from the group. One or two group members were able to eagerly describe the lessons from the turtle story. Another important concept that the group leaders had hoped to teach the group was methods to cope with teasing. Yet, the group members did not seem to remember this lesson in the last group session. The reason for the lack of learning of these strategies may have been because they were only taught to the group in discussion. During the last group, therefore, Cate Gorman decided to enhance the learning of the group members by having them role-play the techniques to deal with teasing. The role-play involved two group members performing in front of the group. The children thoroughly enjoyed the exhilaration of being actors in front of their peers. One group member would play the role of the bully and the other person would be teased. The bully would say an insult to the other actor, such as, "Your shirt is so ugly," and the person being teased was instructed to respond, "So?". The group members reacted to the fact that the bully could not think of a "come-back" to that response. Carlos seemed to enjoy the activity and liked the technique, but he argued that he was concerned that he would not be able to use this technique in actual situations because he becomes so angry when he is teased. This created another useful discussion for the group about how to deal with the emotions that come from being teased. Carlos' comment shows that the group was critically thinking about the techniques that were taught during the role-play activity.

It was helpful to be aware of the group roles, described by Shulman (2006), that some of the group members represented. Peter played the role of the quiet member. He was very reserved with the group in the first few sessions, so the group leaders made an effort to give him space to speak to the group in each session. By the end of the group, he was talking and participating as much as the rest of the group members. Max and Rachel

took on the monopolizer roles in the group. They both have controlling and bossy tendencies in social situations that became evident in the group sessions. Max does not have the opportunity often to socialize with other children, so he is accustomed to having control over situations and has never learned to compromise. In the first few sessions of the group, he would begin participating in an activity, but if he could not decide everything about the activity, he would decide not to participate anymore. His CIS clinician warned the group leaders to watch out for this manipulation technique, so they ensured that he did not make all the decisions for the group. He, therefore, became more willing to compromise with the other group members because he realized that the group would not give into his demands if he told them he would quit the activity. He did, however, continue to struggle with this concept throughout the entire group.

Rachel, on the other hand, did have a tendency to want to control the group, but she was much more appropriate in her behaviors. She was very effective at facilitating compromises in the group, which was helpful to the group and modeled a mature social skill to the other group members. Occasionally, she seemed to dominate the group discussions because she loved to talk so much. The group leaders, therefore, learned when to let Rachel know that it was time to let another group member speak. Although the monopolizer in the group can be very frustrating in the group setting, it offers the opportunity to teach the entire group about the importance of compromise. A monopolizer may also be a member who has mature qualities to model to the group, which can be extremely helpful to the group process.

Besides the monopolizers in the group, there were two significant challenges that arose in the group. First, two of the group members with major learning disabilities, Mary

and Noah, did not seem to grasp the lessons taught in group as much as the other group members. Mary sometimes seemed to not understand the topics because her comments in the group discussions did not connect to the topic. Noah, on the other hand, had trouble concentrating on and did not contribute much to the group discussions on social skills. He was more interested in playing the games and participating in the activities in group rather than trying to also learn the concepts. These group members would have benefited more from the therapy group if their learning needs could have been individually met or been in a group specifically for children with learning disabilities. The group leaders did choose to read *Thank You, Mr. Falker* to help Mary and Noah better relate to a discussion and feel as though they could share their experiences with learning disabilities in the group if they chose. They did seem to participate more in discussion after reading this book.

Another challenge in the group proved to be Max's habit of isolating himself from his peers. The goal of "free time" at the end of each session was to allow the group members to socialize with each other in an unstructured setting. Max had become accustomed to isolating himself in those kinds of situations at school, so he chose to do activities without the other group members during free time. He did, however, seek the attention of the group leaders during this time because he felt more comfortable socializing with adults. The group leaders noticed this trend, so they chose to participate in the activities with the rest of the group and did not agree to spend time with him if he isolated himself. Max seemed to respond to this change because he chose to play a board game with another group member in the next group session during free time.

The termination session of the group was well-planned and, therefore, was effective. The group leaders brought ice cream for the group snack to celebrate all of the group member's excellent participation and effort in the group. As stated above, the group reviewed some of the major social skills that had been taught in the group. The group members seemed proud of their ability to describe what they had learned. It seemed difficult for some of the group members to verbalize that they would miss members of the group. Carlos, however, enthusiastically stated that he would miss the group leaders and would like them to join his sessions with his CIS clinician. Max was the member who seemed most unwilling to acknowledge his feelings about the group ending. He said he would not miss the people in the group, and that he had not enjoyed the group. Cate Gorman then reminded Max of many of the activities that he seemed to have enjoyed during the group sessions, especially telling stories to the group, so he then seemed to change his mind. The proposal to have a group reunion a few weeks later during their school vacation was discussed, and each of the group members seemed pleased by the idea.

After the previously mentioned role-play about coping with teasing, a final culminating group activity was implemented in the last group session. The group members were each given a piece of paper on which they wrote their names. They then passed their papers around the table, and they were instructed to write a compliment about that person on the piece of paper. Each group member, therefore, was able to take home a piece of paper with compliments written on it by each of the group members, including the group leaders. The group members seemed excited and gleeful to read their papers, and it hopefully contributed to increasing all of their self-esteem. Max seemed

especially proud of the compliments he received and displayed a huge grin while reading his paper. He may have never received positive feedback from his peers before. The activity also gave the group members practice in giving compliments to their peers, which can prove to be a very helpful social skill.

A change in the group members from the group process, in combination with their individual therapy, seems evident. Carlos' CIS clinician reports that before he was very physically aggressive with his family at home, but after the group had completed, he was no longer showing aggression at home and was acting helpful to his family. His clinician reported that Carlos had told her that he had really enjoyed the group, and that he had learned to share and respect people in group. Carlos' clinician thinks that the group has helped Carlos to learn to think before acting. Max's CIS clinician reported that he is no longer attacking children at recess. His teacher stated that he still tends to isolate himself from his peers at school. His CIS clinician, however, recently took Max to try out an after-school program, and she reported that he thoroughly enjoyed socializing with his peers and interacted appropriately with them, which is a "big step" for him, according to his clinician. Max's mother, however, is still unsure if it is necessary for him to do activities outside of school.

Rachel's improvement is not documented in the quantitative analysis because her teacher was unable to complete the initial Teacher Questionnaire. Nonetheless, her teacher did report that Rachel is no longer being bossy with her peers in school. Noah's clinician reports that she has noticed an improvement in his social skills, but she thinks that he still needs to make more progress in this area. Noah's home environment has a detrimental effect on his behavior. Peter's CIS clinician explained that he is interacting

better with his brother at home, but his behavior is often affected by his relationship with his father. Peter's father will often make promises to spend time with Peter, but the father will not keep the promises, which causes Peter to misbehave at home and withdraw in social situations. Mary's clinician described that Mary did not enjoy the group because she found it too cognitively challenging. Mary's learning disabilities really seem to have hindered her learning in the group. Similar to Max's situation, Mary is also socially isolated from her peers outside of school, so she does not have the proper exposure to socialization, which is necessary to the maturation of her social skills. Her parents are unwilling to allow her to participate in activities outside of school, which is similar to Max's situation. All of the group members seem to have more progress to make in developing their social skills. The group members, however, seem to have improved their social skills, with maybe the exception of Mary, and decreased their anti-social behaviors from their participation in the therapy group.

Quantitative Analysis

A group pretest-posttest pre-experimental design was used to gather the quantitative data about the group. The Teacher Questionnaire was sent to the teachers when the therapy group began and after the group was completed. Rachel's teacher was absent from school for a few weeks during the beginning of the group, so she was unable to complete the Teacher Questionnaire in the time frame requested. It was determined that it may significantly skew the results if a teacher completed the initial Teacher Questionnaire several weeks after the other teachers had completed them, so Rachel is not included in the quantitative results of this research. On Peter's initial Teacher Questionnaire, his teacher did not rate him on a few of the pro-social items. Max's

teacher did not rate him on many of the items on his final Teacher Questionnaire. Their scores would not be comparable to the other group members' scores if a few items were not scored, so this researcher rated Peter and Max on those items with the knowledge of their behavior in the group sessions and with feedback from their CIS clinicians. This researcher decided to include Peter and Max in the quantitative analysis despite the missing items because the sample was small, and Rachel was already not included. This section of the quantitative results, therefore, reflects data collected about only five of the participants in the therapy group.

Mary and Noah were each absent from the group two times, Michael was absent from the first group, and all of the other group members were present at every group session. For the first Teacher Questionnaire, the mean pro-social score for the group participants was 9.0 with a standard deviation of about 4.8. For the final Teacher Questionnaire, the mean pro-social score was 9.2 with a standard deviation of about 6.9. The mean initial anti-social score was 5.0 with a standard deviation of about 4.5. The final mean anti-score was 3.4 with a standard deviation of about 2.6. The scores are displayed in Table 1.

Table 1. The pro-social and anti-social scores before and after the therapy group according to the data collected from the Teacher Questionnaire.

	Pro-social score before group	Anti-social score before group	Pro-social score after group	Anti-social score after group
Max	7	12	8	6
Peter	14	0	16	0
Carlos	7	6	6	6
Mary	3	4	0	3
Noah	14	3	16	2
mean	9.0	5.0	9.2	3.4

The mean pro-social score increased from before the group to after the group, which supports the hypothesis, but it was not statistically significant ($t(4) = -0.21$, one-

tailed p = 0.42). The data from the Teacher Questionnaire show that the mean pro-social behavior did not significantly increase. The pro-social behavior, however, did increase for three of out the five group members included in the analysis, but decreased for two members. The mean anti-social score decreased from before the group to after the group, which supports the hypothesis, but it was not statistically significant ($t(4) = 1.43$, one-tailed $p = 0.11$). The mean anti-social score did decrease for three out of the five group members, and remained the same for the other two members. The trends of the hypothesis were shown to be true, but a significant change in both pro-social and anti-social behavior at school was not shown.

In order to analyze the portion of the hypothesis dealing with decreasing physical aggression, the fifth anti-social item on the Teacher Questionnaire was analyzed, which read "physically attacks peers." The mean score for this item before the group was 0.8 with a standard deviation of about 1.3. The mean score for this item after the group was 0.4 with a standard deviation of about 0.5. Although the score did decrease after the group, the change was not statistically significant ($t(4) = 1.00$, one-tailed $p = 0.19$). The hypothesis that the therapy group would decrease the aggressive behaviors of the group members is suggested, but no significant change is shown. The results of this questionnaire item are shown in Table 2. There were no significant differences between any of the pro-social items or any of the other anti-social items on the Teacher Questionnaire before and after the group.

Table 2. The scores for physical aggression before and after the therapy group according to the data collected from the Teacher Questionnaire for item "physically attacks peers".

	Aggression score before group	Aggression score after group
Max	3	1
Peter	0	0
Carlos	1	1
Mary	0	0
Noah	0	0
mean	0.8	0.4

A significant change in the social scores between before and after the group may have been evident if the final Teacher Questionnaire had been sent a few weeks after the group had ended. The Questionnaires, however, were sent exactly when the group ended due to time constraints, so the social skills learned in group may have shown a greater change a few weeks after learning them and having the opportunity to practice them. Also, some of the teachers who rated the Questionnaires may have quickly completed them without reading the Questionnaire closely. The Teacher Questionnaires for Noah, Peter, and Max have a wide variety of scores given to the different items on the Questionnaire. The Questionnaires, however, for Carlos and Mary only have scores of "never" or "sometimes" for all of the items. It seemed that some teachers may not have been aware of how to rate the pro-social items. For example, Noah received a much higher pro-social score than Carlos, even though Carlos' social skills appeared to be much more mature than Noah's social skills in group.

It is possible that either that different teachers would have rated the Questionnaire differently because they would have different interpretations of the same behaviors or that Carlos' and Mary's teachers did not read the Questionnaire closely. If Carlos and Mary are excluded from the data analysis, there is a significant increase in the pro-social score from before the group to after the group ($t(2) = -5.00$, one-tailed $p = 0.02$). There is

not, however, a significant decrease in the anti-social score from before the group to after the group, with Carlos and Mary excluded ($t(2) = 1.26$, one-tailed $p = 0.17$).

Conclusion

Although no significant change was shown in the social behavior of the group members in the classroom as a result of the group, it does seem that most of the group members had at least a slight increase in their pro-social behavior and a decrease in their anti-social behavior. According to reports from their CIS clinicians, all of the group members improved in their social functioning. Mary and Noah may not have learned as much as the other group members due to their learning difficulties because the group was not tailored to those learning needs. Role-play and using stories as illustrations of social skills seemed to be the two most effective teaching techniques in the group. Creating a flexible and accommodating atmosphere in the group helped to make the group more engaging for the group members. It was found to be helpful to pay particular attention to the group roles that each member represented and the termination session of the group.

Limitations

The quantitative data may not have shown a significant change in social behavior at school for many reasons. First, the Teacher Questionnaire was not formatted like the questionnaires that the teachers usually complete. The Teacher's Report Form and the Conner's Teacher Rating Scale are used by CIS to evaluate the functioning of clients at school, but these questionnaires mostly only have items that describe negative behaviors. Teachers, therefore, may not expect to be asked to rate positive behaviors on a questionnaire, so the group members' teachers may not have realized that they were also

rating positive behaviors and/or the teachers may have had very different interpretations of how to rate pro-social behaviors. Second, the final Teacher Questionnaire was completed by the teachers directly after the therapy group was finished. The effects of the group on the group members may take several weeks or months to manifest and, therefore, then show a significant difference in the social behaviors of the group members. Third, Rachel was not included in the quantitative analysis, so data about Rachel may have changed the results if included in the analysis. It seems that a change in the Teacher Questionnaire tool or the use of another tool to measure changes in social behavior may have been a more accurate test of the hypothesis.

There are many significant factors that hindered some of the group members from improving more in their social functioning from the group. First, many of the group member's home environments had detrimental effects on their behavior, which a therapy group is unable to change. For example, Peter's father's inconsistency in keeping his promises to Peter negatively impacted Peter's social behavior at home and at school. Max and Mary seemed to be overwhelmingly behind developmentally in terms of social skills, so the group only contributed minimally to their development. They need intense interventions at school and after-school in order to help them change their patterns of social isolation and Max's inability to compromise or meet the needs of others. According to Max's CIS clinician, his mother does not want him to join an after-school program or to set limits on his playing of video games. Without control over these factors, group therapy was not able to contribute much to Max's social development. Also, the learning disabilities of some of the group members may have deterred these group members from learning the social skills taught in group.

The therapy group could have been improved in many ways. First, the group had been planned to have eight sessions, and due to schedules of the group leaders, they were unable to extend the length of the group. It took much longer for the group members to complete tasks in group than the group leaders had expected, so there were not enough sessions to cover all of the important social skills determined by the group leaders. Second, the social learning needs of the group members varied greatly. The group would have been able to specifically target the social needs of its members if the members were more similar. For example, some of the group members did not have aggressive tendencies, while others acted physically aggressive often. A group for dealing with only aggressive clients or only shy clients may have been significantly more effective. Finally, changing some of the techniques used by the group leaders in the group may have contributed more to the social development of the group members. The use of role-play proved to be very effective in teaching the group members social skills. Role-play could have been used more in the group to better facilitate the learning of the social skills. Also, the group leaders did not ask the group members to share their own experiences in many of the group discussions. The group discussions may have been more meaningful to the group members if they had more of a realization that they all suffered from a lack of social skills.

Implications

Social workers should be aware that physically aggressive clients may benefit from gaining a better knowledge of social skills in general. Max, for example, only had a social education through video games, where he had learned that violence is the way that people relate to one another. He needed to establish a completely new foundation of his

understanding of social interaction. His lack of social knowledge may have been the cause of his aggressive actions. Also, the information gathered about the influence of parents on the members of the therapy group reinforces the social work value of working with a client's entire family instead of solely with the client. With most of the clients in the group, significant improvement could not be made in the client's social functioning until changes could be made in their home environments. Social workers should pay particular attention to parents who have social isolation tendencies. Both Max's and Mary's parents chose to be socially isolated, which considerably hindered the social skill development of Max and Mary. In addition, teaching feeling management to clients was shown to be effective in the therapy group, particularly with Carlos. He was able to understand the other social skills taught in the group, but he explained to the group that he could not use those skills unless he could first control the impulses from his feelings.

In micro social work practice, clinical social workers should use social skills group therapy to help clients who are struggling socially, especially those who are physically aggressive. Although there are many challenges to implementing a therapy group, the group experience could help improve the social functioning of the client and allow the social worker an opportunity to better evaluate the client's social strengths and weaknesses. The setting of a group allows these clients to realize that they are not the only person with these types of problems. A social skills group is partly educational, so a group is more cost effective than individual work for social education. Furthermore, this type of group provides an opportunity for clients to practice social skills with peers, such as compromise, with the help of professionals, which is not very possible in individual therapy.

Social skills groups may be particularly helpful in schools, where school social workers are aware of which students are having difficulty with socializing with peers. A student's academic performance could be affected by how well they are functioning socially, which may be an incentive for teachers or school social workers to implement teaching social skills to students in general. Violence in schools has become an increasing problem, so social skills education may be an essential factor to helping the children who are acting violent learn to resolve conflicts in an appropriate way. The extreme acts of violence in schools, such as school shootings, are often performed by students who feel socially isolated and turn to violence as an outlet. The school shootings specifically at Columbine High School and, most recently, at Virginia Polytechnic Institute were performed by students who were described as socially isolated. Max is an example of a child who resorted to violence after being socially isolated. Preventing social isolation in schools may significantly decrease violence in schools.

On a societal level, the United States of America has been shown to be one of the most violent countries in the world, with one of the highest rates of murder in the industrialized world (Crime in the United States, 2007). Gang violence is one of the largest contributors to this societal problem. Efforts to teach gangs the advanced social skills of conflict resolution has proven extremely effective in reducing violence, such as the methods used by the Street Workers from the non-profit Institute for the Study and Practice of Nonviolence in Providence, Rhode Island (Smith, 2007). It is difficult for this type of work, however, to receive adequate funding because of the massive cuts to social programs throughout the country. Although the murder rate in Providence has fallen due to the Street Workers, the murder rate is rising in most other cities in the United States

(Smith, 2007). If all children in our society are taught proper social skills, especially conflict resolution, while they are still children, these devastating problems may be able to be at least partly avoided.

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Appendix A

Teacher Questionnaire

Teacher's name:

Student's name:

Below is a list of items that describe students. For each item, please circle the correct number to describe the student's behavior **now or within the past 2 weeks**.

	Never	**Sometimes**	**Often**	**Very Often**
Argues a lot with peers	0	1	2	3
Appropriately helps peers	0	1	2	3
Comforts and/or compliments peers	0	1	2	3
Cooperates with peers	0	1	2	3
Cruelty, bullying, or meanness to others	0	1	2	3
Responds appropriately to teasing	0	1	2	3
Disturbs other students	0	1	2	3
Does not get along with peers	0	1	2	3
Appears happy and calm with peers	0	1	2	3
Physically attacks peers	0	1	2	3
Gets along with peers	0	1	2	3
Showing off or clowning	0	1	2	3
Appropriately resolves conflicts with peers	0	1	2	3
Teases a lot	0	1	2	3

_____ _____

Teacher's signature Date