

**A TIME-LIMITED GROUP INTERVENTION TO
PROMOTE SOCIAL COMPETANCE IN CHILDREN
REFERRED TO A CHILD GUIDANCE CLINIC**

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"Man is born neither devil nor saint. He merely reflects in his behaviour the nature of relationships he has had since the time of his birth, with people who were important to him"

Karen Horney

ABSTRACT

Poor peer relationships and low self-esteem are common attributes of children referred to a Child Guidance Clinic. Peer relationships and self-esteem exert a synergistic effect on one another, both acting as bidirectional sources of stress or support ('protective factors' or 'risk factors'). While positive peer relationships are important for healthy social, cognitive and psychological development, poor relationships in childhood predate adult adjustment problems. In particular, peer relationships and the social bonds that maintain self-esteem play a role in the development, symptomatology, course and outcome of childhood depression. Thus, intervening on the level of peer relationships and self esteem may be an important aspect of a comprehensive treatment programme for children which considers the impact of the broader social environment on a child's psychological development. Literature suggests that cognitively-based 'social-skills training' or 'social-competance promotion' programmes can significantly improve sociometric status and self-esteem, and that groups are an appropriate modality for working with children.

This study described and evaluated an 8 session group intervention which targeted interpersonal relationships through: (i) building self-esteem; (ii) teaching social skills; and (iii) developing interpersonal cognitive problem-solving skills. 2 girls and 5 boys aged 8-9 years with poor peer relationships participated in the intervention. Activities designed to teach circumscribed aspects of relevant social skills formed the basis of the programme, which was applied flexibly in order to meet the changing needs of the group.

In order to evaluate outcome of the intervention, qualitative and quantitative data were collected from various sources and used to support clinical assessments. Individual benefits were assessed by evaluating the response of one child against the background of the group as a whole.

The measures used to evaluate outcome were:

- (i) a 'Party List' - a sociometric technique for collecting data about friendship choices;
- (ii) the Piers-Harris Children's Self Concept Scale;
- (iii) standard semi-structured interviews with class teachers to obtain descriptions of social and academic adjustment and peer relationships;
- (iv) ratings of videotaped sequences of behaviour designed to assess changes in interactive behaviour;
- (v) a clinical assessment of group process (which provided a qualitative assessment of individual and group functioning, and an ongoing evaluation of group process).

In general, statistical measures indicated mildly positive results of variable significance. Qualitative results suggested that the intervention effected variable improvements in self-concept and general adjustment of

all the children, and improvement in the peer relationships of the target child. Teachers and parents expressed positive attitudes to the intervention, and clinically trained research assistants noted distinct positive changes in the behaviour of the target child. The accuracy and conclusiveness of these results was tempered by various problems which are discussed. It could not be concluded that changes noted were due to the intervention alone, or were more effective than any other intervention or than no intervention at all.

Although results were modest, the improvements made by one child were judged to be clinically significant. This type of intervention offered some advantages in that it:

- (i) was relatively cost effective;
- (ii) lends itself to development for use in the community by non-psychologists; and
- (iii) minimizes some of the problems inherent in long-term individual therapy or pharmacotherapy with a child.

It was proposed that this form of intervention might be particularly useful as part of multimodal intervention programme, and may have implications as a preventative intervention technique.

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CHAPTER 1 OVERVIEW

CHILDREN'S PEER RELATIONSHIPS

1.1 THE PREVALENCE OF PEER RELATIONSHIP PROBLEMS

Many of the children referred to a Child Guidance Clinic are reported to have poor peer relationships. In this study, 'poor peer relationships' were defined as 'relationships with same-age peers that (i) were reported to be unsatisfactory by the child or significant others in his/her life (*e.g.* parents, teachers, peers), AND (ii) were characterized by one or more of the following features: rejection or neglect by peers, withdrawal from peers, aggressive or bullying behaviour towards peers, being bullied or teased by peers, absence of intimate (best-friend) relationships'.

This phenomenon has also been observed by researchers in the field of childhood relationships. Hartup (1989:125) notes that "among children referred to Child Guidance Clinics, 30% to 75% (depending on age) are reported by their parents to experience peer difficulties". Goodyer, Wright & Altham (1989) found that 48% of children with emotional disorders showed moderate to poor friendships in the 12 months prior to the onset of symptoms, compared with 16% of matched controls; *i.e.* 11.5 times more often. Achenbach & Edelbrock (1981), in a large-scale epidemiological survey of 1300 clinic-referred and 1300 non-referred children, found that parent reports of poor peer relations alone accounted for 11% of the variance between samples, and parent reports of the amount and quality of their child's peer activities accounted for 28% of the variance (in Bierman, 1987:234).

Thus amongst children presenting for psychiatric help, poor peer relationships are common; a particularly disturbing observation considering the substantial body of literature which suggests that poor childhood peer relations are associated with adult maladjustment.

1.2 THE PROGNOSIS FOR CHILDREN WITH RELATIONSHIP PROBLEMS

Parker & Asher (1987) critically reviewed research in the area of childhood peer relations over the previous four decades and evaluate the empirical support for the premise that poorly accepted children stand a greater chance than others of developing later life difficulties. They report the following associations:

Peer relationships and academic achievement: Studies reveal a higher incidence of earlier peer relationship problems in high school dropouts (46% of males, 14% of females) as opposed to high school

graduates (7% and 4% respectively) and suggest that rejected children are particularly at risk (p.365). Despite controlling for confounding effects (early academic achievement, sex, race, and behavioural reputation) peer status significantly influences later academic adjustment (p.366);

Peer relationships, and juvenile and adult crime: The evidence for a link between early peer-relationship disturbance and later criminality is generally strong, even after several other possible confounding variables are controlled;

Peer relationships and general adjustment: Children with poor peer relationships may have social skills deficits which affect their marital, educational and occupational adjustment in later life, and put them at greater risk for suicide;

Peer relationships and adult psychopathology: Although this link has not been extensively investigated, initial studies suggest an association between poor peer relations and later adult psychopathology. Later pathology is more strongly related to a negative peer-based measure of childhood peer acceptance than to teacher ratings of adjustment, or to physical health, intellectual potential, academic performance, self esteem, or anxiety. "A failure to get along with peers according to teachers... predicted subsequent psychiatric hospitalization among boys" (p.373).

More recent literature continues to corroborate the association between poor peer relationships and psychopathology (Bierman, 1987; Claes, 1992; Dodge, Coie, Petit & Price, 1990; Goodyer, Wright & Althan, 1989; Hartup & Moore, 1990; Hymel, Rubin, Rowden, & LeMare, 1990; Tremblay, McCord, Boileau, Charlebois, Gagnon, Le Blanc & Larivee, 1991). Reisman (1985) found that absent or problematic friendships during adolescence were among the antecedents of such illnesses as schizophrenia and withdrawal disorders (in Claes, 1992). In fact, Claes (1992) endorses the controversial view that absent or conflictual peer relationships predict later psychopathology. Initial statistical measures suggest that "measures of poor peer adjustment are particularly accurate at identifying those children who are actually destined for difficulties but tend to select many children who are not actually at risk (*i.e.* sensitivity is high, but specificity is low)" (Parker & Asher, 1987:376).

1.3 PEER RELATIONSHIPS, SELF-ESTEEM AND ADJUSTMENT

The fact that poor peer relationships are associated with, and may even be predictors of, later maladjustment does not indicate a causal relationship between the two. However, peer relationships mediate development in a number of ways thereby exerting an ongoing impact on adaptive functioning. Poor peer relationships appear to be a source of stress, while positive peer relationships:

- (i) provide an invaluable context for the learning of social, cognitive and physical skills (Claes, 1992);

- (ii) play a role in the socialization of social competence that is different to the role played by parents (Claes, 1992; Hartup, 1989; Parker & Asher, 1987);
- (iii) mediate the development of self-esteem¹ by acting as a mirror against which a child judges his/her own self-worth (Harper, 1978). "The capacity to make... and keep friends is crucial for the development of self-esteem" (Kernberg, Clarkin, Greenblatt & Cohen, 1992:483);
- (iv) act as important sources of emotional and practical support for children particularly when parents are unable to provide this support *e.g.* because of marital problems or parental psychopathology (Belle, 1989; Goodyer et al, 1989; Hartup, 1989; Parker & Asher, 1987). They provide the child with "the opportunity to feel accepted and valued, and know that his preoccupations are normal and shared by others experiencing similar life events" (Claes, 1992:41).

Goodyer, Germany, Gowranskur & Altham (1991) suggest that the link between poor peer relationships and adjustment may be influenced by:

- (i) 'social and direct' effects (*e.g.* the social behaviour of depressed children negatively affects the behaviour of their friends, resulting in friends avoiding contact with a depressed child); or
- (ii) 'cognitive and indirect' effects (*e.g.* the negative thinking state of depression reduces prosocial behaviour necessary for friendship development and maintenance, resulting in the depressed child avoiding social contact).

Each model is inadequate in itself. Theories about the **causes** and **consequences** of low acceptance need to be integrated to account for the fact that some children with poor relationships develop later difficulties while others do not. Any model needs to allow for the operation of a feedback loop where:

- peer rejection leads a child to view him\herself negatively;
- negative self-appraisal influences the child's behaviour and promotes behavioural problems such as withdrawal or aggression; and
- the child's behavioural style affects his level of acceptance by peers, resulting in the child being rejected or neglected.

Puttallaz & Heflin (1990) and Rubin, Le Mare & Lollis (1990) propose models that address these issues (in Parker & Asher, 1987). However, it is not within the scope of this dissertation to elaborate on these models. Suffice to say that the relationship between peer acceptance and adjustment is a complex and dynamic relationship which cannot be simply explained by any single mechanism.

¹ Self-esteem is defined as "the evaluative component of the self-concept" (Schweitzer, Seth-Smith & Callan, 1992:83).

There is evidence of a feedback relationship between self-concept² and peer relationships (Cauley & Tyler, 1989; Joiner, Alfano & Metalsky, 1992; Sroufe, 1989). Although self-concept initially develops out of the primary dyadic (mother-child) and triadic (mother-father-child) relationships (Roopnarine & Honig, 1985), disturbances in these primary relationships are re-enacted in present social relationships, including relationships with peers, which thereby exert an ongoing influence on development of the self-concept (Harper, 1978; Hartup, 1989; Sroufe, 1989; Zabatany, Hartmann & Rankin, 1990). Parker, Barrett, & Hickie (1992:883) suggest that:

"A negative bonding experience may result in the failure to acquire a true sense of self and resilient self-esteem, attributes promoting coping in later life. This greater vulnerability may result in the avoidance of close relationships for fear of intimacy, failure, and/or rejection... (However) the impact of any initial difficulty in the parent-child relationship can be avoided... if the person happens to make a secure attachment at some time"

Both positive peer relationships and self-esteem are important 'protective factors' for children at risk (Karasu, 1992; Rutter, 1985). Ladd (1990:1081) proposes that "of (various) potential sources of support, children's relationships with classmates may be among the most important". Zerkowitz (1989) found that peers were rated second only to mother as a source of nurturance by children [mother 32.6%; peers 25.7%; father 19.6%; siblings 11.6%; others 10%] and she found that children chose to turn to friends and siblings when they felt sad (in Belle, 1989:232). Longitudinal investigations consistently show that the incidence of depression increases almost threefold in the presence of poor self-concept (Brown, 1989:29).

1.4 PEER RELATIONSHIPS AND DEPRESSION

Depression in children is a prevalent and disturbing phenomenon. Kazdin (1990:136) cites a diagnosable disorder in 10% to 20% of clinic referred children. The British Journal of Psychiatry: Supplement II (1991), which is devoted entirely to research on Depression in Childhood, indicates that depression is found in higher proportions of clinic referred children (35.3%) than previously suspected. Recent longitudinal studies indicate that the prognosis for depression in young people is poor (Akiskal & Weise, 1992; Lazarus, 1992), with high rates of recovery but high risk of relapse (Kazdin, 1990:139). Goodyer *et al* (1991:676) note that children suffering from major depression are "at high risk from relapse, and some experience a chronic course which may act as a forerunner of social impairment in adult life", while persistent or relapsing symptoms have been reported in up to 50% of cases. In fact, research indicates that

² Self-concept is defined as "a subject's perception of him or her 'self' viewed as an object" (Schweitzer *et al*, 1992:83).

cognitive, academic and social problems may persist even after symptomatic recovery from depression (Kovacs & Goldston, 1991). Dysthymic disorders last over 3.5 years on average and are often a precursor to Major Depression or comorbid psychiatric disorders (Kazdin, 1990; Kovacs & Goldston, 1991).

Writers looking at depression from a sociological perspective have proposed that depression is in good part a social phenomenon - "the result of complex transactions between the individual and his or her social environment" (Brown, 1989:22). This view is supported by research indicating an association between poor peer relationships and depression. Berney *et al* (1991) investigated different life events commonly associated with childhood depression and concluded that "only poor peer relations are significantly related to depression" (British Journal of Psychiatry:Supplement II:34). Goodyer *et al* (1991, 1989) found that **anxious and depressive disorders are significantly more common in children who report moderate to poor friendships in their own lives, and poor relationships are associated with poor recovery from these disorders.** In their recent double blind, repeated measures, follow-up study of 49 children and adolescents referred to a clinic with anxious and depressive disorders, they found that:

- a documented improvement in maternal confiding relationships and decreased exposure to undesirable life events did not significantly influence the recovery of the anxious and depressed children on follow-up 14 months later;
- no type of desirable or undesirable life event or maternal adversity, before or after onset, exerted an effect on recovery;
- recovery ratings (collected via structured and semi-structured schedules from the child, mother, and trained personnel) indicated that moderate to poor friendships **after** onset were associated with poor recovery especially for children rated **depressed** at follow-up. In fact, "findings show moderate to poor friendships in 88%... to 100%... of cases diagnosed as depressed at presentation and... not recovered at follow-up" (p.680).

Writers from various theoretical backgrounds account for the role of relationships and self-esteem in mediating depression. Psychodynamic theories traditionally propose 'object loss' as central in the aetiology of depression. Enlarging upon this, Sandler & Joffe (1965) equate depression with "losing one's sense of well-being regardless of the cause... thus, the individual's inability to find new sources of gratification or to activate mental representations of earlier satisfactory objects creates susceptibility to clinical depression" (in Karasu, 1992:38); *i.e.* the loss of an inner 'good-enough' object, a sense of self, may mediate depressive disposition. Karasu (1992:39) proposes that depression is founded on "the childhood development of a maladaptive way of bolstering the sense of self". (As this report does not involve a psychodynamically oriented intervention these ideas will not be pursued here).

"Learning theories posit that an individual becomes depressed because inadequate reinforcement is available in their environment" (Rutter & Hersov, 1985:706). Loss of reinforcement can involve both internal sources (self-esteem or sense of self efficacy) and external sources (social relationships), and it is

proposed that loss can give rise to distorted cognitive attributions or learned helplessness which mediates depression (Rutter & Hersov, 1985).

Various models have emerged from this theoretical perspective, *e.g.*:

- (i) Social Skills Deficit models proposes that "an individual becomes depressed because inadequate reinforcement is available in their environment (which)... could arise because of the loss of a person who has provided reinforcements; because of a lack of the social skills required to generate reinforcers; or because environmental changes have reduced their availability" (Rutter & Hersov, 1985:706). For example, Lewinsohn's (1974) reinforcement contingency approach demonstrated that depressed (adult) patients have poor social competence, which is associated with poor social relationships and inadequate social reinforcement; and loss or reduction of reinforcement from the environment may cause and maintain depression (Kazdin, 1990; Stravynski & Greenberg, 1992);
- (ii) Cognitive models, such as Beck's attributional theory of depression, assert that maladaptive cognitive strategies, possibly learned in early relationships, lead to negative views (about self, world, and future) which affect one's interactions with the world and others and lead to depressive symptomatology (Kazdin, 1990);
- (iii) Seligman (1975) proposed that Learned Helplessness³ underlies depression, and "the crux of successful therapy with depressives... is to restore their sense of efficacy" (in Hall & Lindzey, 1978:616).

1.5 THE TREATMENT OF CHILDHOOD DEPRESSION

The research cited above indicates that peer relationships and the social bonds that maintain self-esteem are powerful forces in the development, symptomatology, course and outcome of childhood depression. They have a synergistic effect on one another; they both act as bidirectional sources of stress or support (protective factors or risk factors), and may indicate future adjustment problems. However, therapeutic interventions with depressed children often focus on individual, mother-child, or family techniques. This overlooks the importance of the broader social environment for the acquisition and maintenance of a child's psychological development.

³ Learned Helplessness is defined as "pessimism specific to the effects of one's own skilled actions" (in Hall & Lindzey, 1978:616).

Social learning theory explains human behaviour "in terms of a continuous reciprocal interaction between cognitive, behavioural, and environmental determinants" (Hall & Lindzey, 1978:617). Certain theorists claim that the most effective way to bring about an adequate sense of personal mastery is to induce successful accomplishments **in the actual situation**, rather than some symbolic representation of this (Hall & Lindzey, 1978). These approaches have led to promising therapeutic interventions with adults that stress developing social skills to make the patient more effective in eliciting reinforcement from their environment. In a recent review of several clearly defined, controlled, follow-up studies evaluating the outcome of psychotherapy for moderate depression in adults, Stravynski & Greenberg (1992:411) conclude that "CT (Cognitive Therapy) and social skills training appear to be... clinically worthwhile and enduring, and are equivalent to antidepressant medication but without some of its undesirable effects and problems with compliance". In particular, a 15 session behavioural-cognitive group treatment, which used social skills training and focused on social relationship difficulties, resulted in significant improvement in adult depressed patients. Improvement was maintained on 6 month follow-up and results from the therapy alone were equivalent to therapy plus medication (Stravynski & Greenberg, 1992).

There is a paucity of similar research with depressed children, but initial studies indicate that these models can be extended to childhood depression (Kazdin, 1990). These are outlined in Chapter 2.

CHAPTER 2 INTRODUCTION

Research on broad-based social skills training approaches provided a background for techniques used in this intervention. Some methodological and conceptual issues in evaluating outcome of a psychotherapeutic intervention were considered, and a rationale for measures used to evaluate outcome in this study is offered.

2.1 THE INTERVENTION

2.1.1 Background to the Therapeutic Intervention

"Group work is an especially appropriate modality for working with interpersonal problems" (Toseland & Rivas, 1984:223). Groups:

- (i) have been shown to be more attractive to children than interacting solely with an adult;
- (ii) are cost effective in that they make more efficient use of facilitators time than does individual treatment;
- (iii) encourage social learning by affording multiple opportunities for modelling of effective social skills and obtaining feedback from other children; and
- (iv) offer children the opportunity to practice what they are learning in a 'live' situation (Rose, 1982).

Several studies have found that cognitively-based social skills training programmes can produce significant gains in the sociometric status and self-esteem of children who are among the least liked in their classrooms (reviews in Caplan, Weissberg, Grober & Sivo, 1992; LeCroy, 1982; Oden, 1982; Parker & Asher, 1987; Tremblay, *et al* 1991). One study found that teaching children social interaction concepts (participation, communication, co-operation, and validation-support) led to gains in acceptance that were not only maintained, but increased, at a 1-year follow-up (in Parker & Asher, 1987).

Social skills training efforts have shown positive results from broader approaches which attempt to develop interpersonal cognitive problem solving skills (ICPST). In a review of several interventions, Pellegrini & Urbain (1985) conclude that ICPST can be an effective remediation and secondary preventative technique for children who show signs of social maladjustment. ICPST teaches a set of general coping skills and focuses on developing adaptive thought processes; claiming that such skills readily generalize across behaviours, settings, time, etc. Studies of the preventative power of this strategy indicate that "seventy percent of initially maladapted children were judged to be adjusted following training in kindergarten in comparison to only 6% of maladapted control children" (Pellegrini & Urbain, 1985:28), and 75% of

inhibited youngsters receiving intervention moved into the well adjusted group following intervention compared with 35% of controls (Pellegrini & Urbain, 1985). There was evidence that ICPST mediated the observed changes and that "the impact of ICPST is most apparent when long-term follow-up data are examined" (Pellegrini & Urbain, 1985:34).

Pellegrini & Urbain (1985:35) found that "a wide variety of approaches are effective for teaching ICPS skills to children" (outlined in LeCroy, 1982; Rose, 1982). Of these techniques, positive reinforcement is an especially important means of increasing prosocial behaviour and improving self-esteem; there is extensive documentation linking positive reinforcement from adults to prosocial peer behaviour (Hartup & Moore, 1990). Lewinsohn & Clarke (1984) suggest that improving social skills enables a patient to obtain more positive reinforcement, thereby decreasing depressive symptoms. They claim this is "as effective with adults as individual therapy and more cost effective" (in Fine, Forth, Gilbert & Haley, 1991:79).

The few outcome studies reported with depressed children indicate that interventions which focus on teaching interpersonal skills and problem-solving techniques are more effective than attention-placebo or a waiting list control, but not clearly superior to alternative treatments (Kazdin, 1990). A social competence promotion programme (SCP) has been successfully used with depression (Caplan *et al*, 1992). Fine *et al* (1991) cite research which found that short-term group interventions (8-10 sessions) could effectively reduce depressive symptoms (and global psychopathology) for up to 3 years. They compared the long term efficacy of a (short-term) therapeutic support group (TSG), and a social skills/problem-solving training (SST) group with clinically diagnosed depressed adolescents. Adolescents in the TSG showed greater increases in self-concept and reduction in depressive symptoms immediately post-treatment, BUT at 9 month follow-up both proved equally effective, suggesting that SST has a latent effect.

Based on this literature this intervention followed a time-limited, cognitively-based, social-competence promotion approach which targeted interpersonal relationships and focused on:

- (i) building self-esteem [which has been associated with pro-social behaviour (Cauley & Tyler, 1989:58)];
- (ii) teaching a limited range of social skills; *i.e.* co-operation, sharing, conflict resolution [all of which are related to peer acceptance (Coie & Dodge, 1983; Dodge *et al*, 1990; Hartup, 1989; Kernberg *et al*, 1992; Oden, 1982; Zabatany *et al*, 1990)], and;
- (iii) Interpersonal Cognitive Problem-solving Skills Training ICPST [which increased the social competence of children when taught to them in small groups in schools (Rose, 1982)].

2.1.2 Rationale for the Intervention Techniques used

Peer status has certain behavioral correlates which are specific to a child's sex, developmental level, socioeconomic status, community norms/values/beliefs, etc. In general, research indicates the following correlations for boys during middle childhood:

- (i) **competition** for limited resources is associated with low status (Putallaz & Sheppard, 1990) and low self-esteem (Cauley & Tyler, 1989), while **co-operation** leads to increased acceptance (Dodge *et al*, 1990);
- (ii) **social withdrawal** is related to rejection (Coie & Dodge, 1983; Dodge *et al*, 1990; Hartup & Moore, 1990; Hymel *et al*, 1990) while **social interaction** is related to popularity (Dodge *et al*, 1990);
- (iii) **compromise or conflict resolution** is associated with high social status (Putallaz & Sheppard, 1990); and
- (iv) prosocial behavior that is **self initiated** is more effective than that which is **other initiated** (Cauley & Tyler, 1989).

These behaviours were the focus of training throughout the group.

Key terms involved were defined as follows:

- (i) Peer interaction - "a social relationship between agemates such that they mutually influence each other" (Barlow & Hersen, 1984:112);
- (ii) Co-operation - interaction in which individuals work together to achieve a goal; this might require that they postpone gratification of their own immediate needs to satisfy the demands of mutual play. It includes sharing *i.e.* interaction in which limited resources are apportioned out to the mutual satisfaction of the individuals;
- (iii) Competition - the child pursues his\her own concerns at the expense of another child, and uses power to get or maintain access to limited resources. This includes monopolizing resources *i.e.* access to limited resources (toys, attention, *etc*) is maintained and controlled by one child for the satisfaction of his/her own needs;
- (iv) Conflict resolution - the child attempts to find a solution that partially or fully satisfies the concerns of both\all the children;
- (v) Conflict generation - the child attempts to find a solution that encourages division or disagreement between people.

Children aged 8-9 years were targeted in this intervention as first time referrals to the University of Cape Town Child Guidance Clinic appear to be prevalent at this age. Furthermore, children of this age are expected to become more immersed in a peer-based social world; Hartup (1983) found a 70% increase in peer contact between the ages of 6-9 years (in Belle, 1989). Hartup & Moore (1990:12) suggest that "the early childhood peer group appears to be a good place to begin the task of adapting to egalitarian peer

relations" before social adjustment problems become entrenched. Research on the stability of the self-concept has indicated that "intervention to improve the self-concept would tend to be more successful at the earlier ages when various sub-dimensions of self-concept are more fluid" (Piers, 1976:13).

Rose (1982:56) suggests that the optimal size for such groups is between 4 and 12 children, and Heap (1978:134) claims that groups of about 7 are most cohesive. This group comprised 7 children (5 boys, 2 girls). There are distinct gender differences in the qualitative aspects of children's friendships (Claes, 1992; Goodyer *et al*, 1991). At this age, children's friendships are commonly same-sex relationships with only a 5% occurrence of cross-sex relationships (Hartup, 1989). Research most commonly investigates groups of boys alone; few studies have evaluated interventions with girls. Thus it was against 'conventional wisdom' that this intervention included both girls and boys. This is discussed further in Chapter 5.

Considerable controversy exists about how much structure is useful for treatment groups. Both lack of structure, and overly structured approaches, present problems (for a review see Toseland & Rivas, 1984:151 & 198-200). Lack of structure has been found to increase anxiety (Toseland & Rivas, 1984:199), so this intervention was limited to 8 sessions in an attempt to help structure the groups and contain the anxiety level of the children. Literature supports the appropriateness of this time limit (Moss-Morris, 1990; Toseland & Rivas, 1984). The degree of structure also needs to be tailored to suit the group members and their particular needs; for instance:

"specific, relatively circumscribed problems and goals... can be treated in short-term, highly structured, multicomponent treatment groups at least as effectively, and more efficiently, than in less structured long-term groups"
(Toseland & Rivas, 1984:200).

Toseland & Rivas (1984) suggest that structured formats are appropriate for social skills interventions. This intervention took a **flexibly** structured approach, focusing on relatively circumscribed aspects of some of the social skills relevant to social interaction and self-esteem. Programmed activities and games provided a medium for interaction - an effective way of improving interpersonal skills as well as building group cohesion and ensuring member enjoyment (Toseland & Rivas, 1984). An activity programme was prepared using various social skills training and groupwork literature (*e.g.* Bond, 1986; Hopson & Scally, 1980; Remocker & Storch, 1987), but this was applied flexibly in response to the developing needs of the group.

2.2 THE AIMS OF THIS STUDY

In line with the ideas presented above, it may be necessary and/or expedient to intervene on the level of a child's peer relationships. This study attempted to evaluate the extent to which a time-limited (social competence promotion) group intervention effected:

- (i) actual behaviour change in children *i.e.* were the targeted skills both acquired and utilized in interactions with other children;
- (ii) short-term changes in peer relationships;
- (iii) short- and medium-term changes in adjustment (as measured by changes in self-concept, social acceptance, behaviour, and educational achievement).

The study focused on a child with depressive symptomatology but was not intended exclusively for this problem, particularly considering the difficulty diagnosing childhood depression; children with social adjustment problems often present as depressed (and *vice versa*). The study, carried out in 1990, was thus essentially an 'outcome evaluation', the implications of which are discussed below.

2.3 OUTCOME EVALUATION

2.3.1 General Issues in Psychotherapeutic Outcome Evaluation

There are many problems with outcome evaluation of psychotherapeutic interventions, especially those involving small or single case populations (for more detailed discussion see Barlow & Hersen, 1984; Malan, 1973). Problems seem to focus around the following issues:

- (i) assessment design is often plagued by problems caused by inadequate criteria for selection of patient samples, loosely defined interventions, many variables, poorly defined problems, inadequate control of placebo effect, and unstandardized measurement techniques. Positive results leave one with many questions about what actually caused the change (the intervention itself, the placebo effect, external sources of variance), and about the relative success of one intervention over another. Negative results leave one with just as many questions about whether failure was due to inadequate selection (diagnosis, assessment, referral), inadequate intervention (poor therapist, wrong approach), or inadequate evaluation techniques (could the criteria assess the complexity of psychodynamic change?);
- (ii) psychological change commonly involves diffuse and subtle psychological constructs which are difficult to quantify, and often difficult to change *e.g.* self-concept is, by definition, a relatively stable phenomenon unlikely to be readily altered (Harper, 1978:119);

- (iii) psychotherapeutic outcome studies tend to be caught between clinical relevance or statistical significance (Barlow & Hersen, 1984). Research often fails to contribute significantly to clinical practice (Malan, 1973), and questions are raised about the ethical sensitivity of data collection or whether data collection may be therapeutic in itself.

The outcome of GROUP therapy seems to be particularly difficult to evaluate. Frank (1979:315) notes that:

"as group creatures, humans are highly susceptible to group forces... (and) group methods would appear to be more powerful than dyadic ones... (however) group therapy research involves a forbidding number and complexity of variables that must be taken into account".

However, these problems do not justify the suspension of all attempts to evaluate therapeutic intervention. Clinical observations need to be supported by empirical data. Perhaps outcome criteria need to be designed to do justice to the subtlety of psychodynamic change, and clinical experience needs to be incorporated into research methodology (Malan, 1973). Ideally, research should confirm and refine clinical findings and lead directly to practical applications. In an attempt to address some of these issues:

- (i) qualitative and quantitative data were collected and used to support clinical assessments;
- (ii) data were collected from the child, his\her peer group and his\her class teacher. Since research reveals variable correspondence between peer-, teacher- and parent-based approaches to the assessment of children's peer relationships (Bierman, 1987; Claes, 1992; Goodyer et al, 1991; Parker & Asher, 1987), there is both overlap and diversity in collecting data from different sources;
- (iii) changes in the children were evaluated from social, psychological, behavioural, and academic perspectives.

The cost of using more comprehensive clinical outcome measures is that results may be accused of lacking scientific specificity and rigour. Any one source or method of evaluation is unlikely to provide definitive results, but using various approaches to assessment serves to provide a triangulation technique which helps to corroborate the results.

Group outcome evaluations tend to analyze the MEAN response to an intervention of as many 'subjects' as possible, thereby failing to do justice to the possible significant benefits experienced by an individual patient (Barlow & Hersen, 1984; Frank, 1979). This has led Frank (1979:312) to suggest that:

"instead of continuing to pursue the relatively unrewarding enterprise of statistically comparing the effectiveness of different therapies, we should focus on particular forms of therapy that seem to work exceptionally well

with a few patients and seek to define the characteristics of both the therapy and the patients that lead to this happy result".

The present study incorporates this attitude and attempts to take individual benefits into account while also evaluating group outcome. It is to this end that one child is evaluated in depth against the background of the group as a whole.

2.3.2 Rationale for the Measures used to Evaluate Outcome

A. THE PARTY LIST

The Party List is based upon traditional sociometric¹ measures. A repeated-measures format was used to assess how changes in the child affected the way peers viewed the child. Basically, it entailed the child writing down names of children he/she would like to invite to a hypothetical birthday party. It was assumed that:

- (i) a child would 'invite' those peers whom he/she liked, but not 'invite' those whom he/she disliked;
- (ii) best-friends would be named first, and less favoured peers last;
- (iii) 'neglected' or 'rejected' children would be either forgotten or placed towards the bottom of the list.

The pooled choices would thus reveal the sociometric status of each child. Terms were defined as follows:

- (i) **POPULAR** children are highly liked and rarely disliked; *i.e.* named on most of the lists, and often named towards the top of the lists;
- (ii) **UNPOPULAR** children are "seen by most classroom peers as people they would least prefer to play with" (Roopnarine *et al*, 1985:60); *i.e.* named on few lists and towards the bottom of the list;
- (iii) **NEGLECTED** children are those who are isolated by peers;
- (iv) **REJECTED** children are those who are highly disliked by peers;

Studies confirm the reliability of using peer ratings of social relationships (Biermann, 1987; Kazdin, 1990; Zarbatany *et al*, 1990). Similar sociometric measures display excellent reliability and validity (Asher & Gottman, 1981; Hymel, 1983) and good temporal stability with grade school children over periods of 3-4 years (Biermann, 1987). Feiring & Lewis (1989) used a Party List technique to collect sociometric data

¹ Sociometry is "a research method...defined as the measurement of social relations: it is a technique for collecting data about interpersonal choices, especially friendship choices of group members" (Hallinan in Asher and Gottman, 1981:91).

from both mother and child and found a 65% agreement on children invited (in Belle, 1989). Additional advantages of this technique were that it:

- (i) provided an accessible means of collecting quantitative information about a child's acceptance by his/her peers;
- (ii) could be readily re-administered to provide a follow-up measure which could be **directly** compared to the initial measure;
- (iii) enabled data about one child in a class to be collected through a medium which was familiar to the children, and which could be incorporated into everyday classroom activities without attention being drawn to the targeted child. In this way, it was hoped to avoid a child being 'labelled' during the process of data collection (for a discussion of this ethical problem see Parker & Asher, 1985).

Limiting sociometric nominations to the child's class meant that other aspects of the child's social environment were disregarded (*e.g.* relationships with children in the neighbourhood). However, this is considered a minor limitation since the communities in which these children live tend to show considerable overlap between school and neighbourhood demography (most of the children in a neighbourhood attend the neighbourhood school). In addition, Claes (1992:46) found that "nearly 80% of (children) say that they met their best friend for the first time at school". Thus, limiting data collection to the school environment probably furnished a valid **comparative** estimate of the child's pre- and post-intervention social acceptance.

B. THE PIERS-HARRIS CHILDREN'S SELF-CONCEPT SCALE (P-H)

This self-report questionnaire was designed in 1969 (revised in 1976) to measure the self-attitudes of children aged 8 years and over (Appendix I). It comprises a set of 80 'self statements' (*e.g.* "I have good ideas", "I can be trusted") which must be answered 'Yes' or 'No' by the child. The scoring schedule provides two types of score:

- (i) the Global score - based on a sum of the responses in the positive direction (where a high score is indicative of a favourable self-concept). This can be converted from a raw score into a percentile and stanine score² and can be compared to published norms³;
- (ii) (Revised) Cluster scores - factor analysis indicates that the individual items on the P-H cluster around six sub-scales: Behaviour, Intellectual and School Status, Physical Appearance and Attributes, Anxiety, Popularity, and Happiness and Satisfaction.

Studies confirm the value of using self-report scales with children who "are likely to be better reporters of symptoms related to... internal experience" (Kazdin, 1990:131).

² A Stanine score is a standard score expressed in terms of a 9 point scale.

³ Norms must be used with caution as the P-H has not been adequately standardized in South Africa (or elsewhere).

The P-H was standardized on a diverse population of children (excluding black children) in the U.S.A. in the mid-1960's. Initial research has not shown **consistent** sex, race, socioeconomic status, or age differences (Piers, 1976), but the scale has not been standardized on a South African population. It is most commonly used as a repeat-measures research tool as it is claimed to display good internal consistency and adequate temporal stability on 2 and 4 month test-retest trials even although consistent changes are recorded of up to 5 points more on retest in the absence of treatment (Piers & Harris, 1969). Research in the early 1970's confirmed reliability co-efficients of over .90 for internal consistency and .70 to over .80 for temporal stability over periods of up to 5 months (Piers, 1976). The P-H has adequate construct validity and correlates highly with measures of peer acceptance and rejection; in an extensive 4 year study of developmental processes (including social, familial, parental and individual variables) associated with peer acceptance-rejection, Cox (1966) found that the highest correlation ($r = .61$, $p < .01$) was between peer status and P-H scores (Piers & Harris, 1969). Researchers have also documented appreciable correlations between high P-H scores and good social adjustment in a group of children matched for intelligence (Piers, 1976).

C. TEACHER REPORTS

A standard semi-structured interview was conducted with each child's class teacher in order to obtain: (i) a qualitative description of the child's social adjustment and peer relationships; and (ii) a record of the child's school exam results. To reduce possible bias, information was first collected in a non-directed way from teachers who were unaware of the researcher's interest in peer relationships. Specific information about the child's relationships was collected later using open-ended questions. Biermann (1987:237) claims that of various informants (parents, teachers, peers) "teachers provide descriptions of peer interactions... that correspond most closely to observed social behaviour and peer rated sociometric status". Children's behaviour may vary across home and school settings, so information gathered from teachers can extend or substantiate information from other sources. Thus, teacher reports were a valuable addition to the assessment 'package'.

School exam results were obtained from school records. Academic adjustment is related to high self-esteem and prosocial behaviour (Cauley & Tyler, 1989; Harper, 1978; Purkey, 1970), and depression in children is associated with impaired school performance (Kovacs & Goldston, 1991). Thus, it is assumed that improved academic achievement could indicate improvement in depression, social relationships, or self esteem.

D. VIDEO CLIP

Literature indicates that positive self-initiated social interaction is associated with popularity, while withdrawal and negative interactions are associated with rejection (section 2.1.2). This intervention aimed to improve the quantity and quality of each child's social interaction in the group (assuming this would facilitate improved social interaction outside the group). In order to assess changes in a child's interactive behaviour in the group, video recordings were made and the child's behaviour was analyzed in terms of a

pre-determined scheme (see Chapter 3.3). To minimize bias and increase accuracy, rating was done by 3 independent MA Clinical Psychology students who had been trained in the use of the scoring categories (Appendix III). The **behaviour change** was calculated (rate of behaviour in the final session minus rate of behaviour in the initial session).

E. CLINICAL ASSESSMENT OF GROUP PROCESS

Each group session was analyzed in terms of group process, dynamics, and development (Moss-Morris, 1990). This analysis provided a qualitative assessment of individual and group functioning. Supervision from an experienced group facilitator (i) ensured increased accuracy of this assessment; and (ii) assisted with the ongoing evaluation of group process which is so essential for effective group practice (Anstey, 1983; Toseland & Rivas, 1984).

CHAPTER 3: PROCEDURE

3.1 THE INTERVENTION

3.1.1 The Subjects

Seven children were referred to the group in 1990 following their presentation at a Child Guidance Clinic with a wide range of academic, behavioural and/or emotional problems. In each case, the clinician assessing the child and family noted that the child had peer relationship problems. Children of different sociometric status (rejected or neglected) or with different behavioural correlates (withdrawn or aggressive) were accepted into the group. The children were aged 8-9 years and were of mixed sex, attributed race and socioeconomic status. Some children had received brief alternative interventions but were not in therapy at that time (e.g. one child's family had attended a single feedback session, while another child's family had received 3 sessions of counselling).

The response of one child, Len (whose name has been changed to ensure confidentiality), was assessed in more detail. A full clinical interview and Mental State Examination was conducted by the researcher (then an M1 student) with Len and his family prior to intervention. The interview was watched from behind a one-way mirror by an experienced clinical supervisor who assisted with diagnosis. Psychometric tests (Senior South African Intelligence Scale, Draw-A-Person, Bene-Anthony Family Relations Test, Kinetic Family Drawing, Rorschach) were used to verify clinical impressions. These provided the basis for a pre-intervention assessment of functioning and diagnosis using DSM-III-R criteria (APA, 1987). Kazdin (1990) supports the validity of using DSM-III-R criteria elicited during a psychiatric interview for research with children, and Kolvin *et al* (1991) found that DSM-III-R diagnoses correlated with 3 other widely-used children's depression rating scales (British Journal of Psychiatry:Supplement II, 1991). On the basis of the history and MSE, Len was diagnosed as suffering from Dysthymia - early onset, primary type (DSM-III-R, 1987). A summary of the Case History and MSE is included in Appendix IV and briefly outlined below:

Len is a 9 year old std 1 boy referred with a 3 year history of general scholastic problems (described as "forgetfulness"), crying, irritability, tantrums, and a 6 month history of physical and verbal aggression. Positive features of Len's personal history include: some neurotic symptomatology; a sensitive, quiet, shy personality; a tendency to act out emotions; extreme scholastic underachievement; social withdrawal; and poor peer relationships (he is bullied and teased, his peers apparently 'steal' from him, and he is usually alone). His parents divorced 3 years

ago following his father's arrest. There was considerable marital conflict, substance abuse, violence, and physical abuse. The family live in poor social circumstances. Len's mother works long shifts; she offers inconsistent discipline and nurturance, and is emotionally and physically unavailable to Len. Len appeared afraid of, and very ambivalent towards, his father.

He presented as a slightly-built, passive, avolitional boy who displayed no interest in playing. His quiet, indistinct speech comprised primarily single words or phrases. He made little spontaneous contact and his affect presented as restricted and sad. Results of a cognitive assessment suggested: consistent (high) average intellectual functioning; poor concentration; low frustration tolerance; distractibility. On the Draw-A-Person he scored a 'Mental Age' equivalent to 11 yrs 9 mnths (superior I.Q. range). Projective testing revealed: extreme dependency needs; feelings of deprivation; ambivalence towards Father; feelings of insecurity and inadequacy; depressive tendencies; asponteneity and lowered emotional responsiveness (possibly due to depression); difficulty acknowledging negative feelings and a tendency to act out aggressive impulses.

3.1.2 The Time-limited Social skills Group Intervention

Space limitations preclude detailed specification of the actual intervention so a summarized outline is presented here and further details are included in Appendix V.

The intervention took the form of 8 weekly, 1 hour group sessions following a broad-based social skills training/social-competence promotion approach which was flexibly structured and focused on:

- (i) building self-esteem;
- (ii) teaching some social skills (*i.e.* co-operation, turn-taking, sharing, conflict resolution); and
- (iii) teaching Interpersonal Cognitive Problem-solving Skills.

Two M1 student psychologists acted as co-facilitators, with live supervision from an experienced group therapist.

Activities were set for the children each week; these formed the CONTENT of the group and provided a basis for the learning of such social skills as co-operation, conflict resolution, and sharing. For example, in one activity children learned to use 'voting' and 'flipping a coin' in order to negotiate the planning of a

'funny faces movie' that they were to make using video equipment (see 'funny faces' in Appendix V). In another activity, the children had to share stationery and equipment while making party hats for an 'end of group' party. Facilitators used direct instruction, modelling, shaping and positive reinforcement techniques to help build the children's social skills. Throughout the PROCESS of the group the focus was on promoting social interaction and self-esteem (see 'snake entering game' & 'stars for special people' in Appendix V). Improved self-esteem was as important a goal as actual behaviour change. To help reinforce self-esteem, goals were kept attainable and expectations kept low so that children could have the positive experience of success. The children were given letters at the end of each session which summed up some aspect of that session and reminded them of the forthcoming session.

Facilitating parental involvement in the therapeutic process was considered a vital part of the intervention. Parents were kept informed of their child's 'progress' through brief fortnightly letters (see Appendix VI). In line with strategies used by White and Epston (1989), these letters were used explicitly to:

- (i) support parents and include them in the process of change;
- (ii) alter parents' perceptions of their child by reframing behaviour and personality traits labelled as deficient, and by pointing out the child's strengths and individuality; and
- (iii) suggest to parents strategies for reinforcing their child's self-concept and positive coping mechanisms.

3.2 THE OUTCOME EVALUATION

3.2.1 The Process of Data Collection

Changes in the children were assessed using a repeated-measures follow-up design. Group process and dynamics were assessed during intervention, and outcome measures were collected as shown in Table 1:

Table 1: PROCESS OF DATA COLLECTION

	PARTY LISTS	PIERS- HARRIS	TEACHER REPORTS	VIDEO CLIPS
PRE-INTERVENTION	XXX	XXX	XXX	
INITIAL WITHIN GROUP				XXX
FINAL WITHIN GROUP				XXX
POST-INTERVENTION		XXX	XXX	
FOLLOW-UP	XXX 6 month		XXX XXX 3, 6, 12 months	

NOTE: PRE-INTERVENTION: prior to commencement of the group;
 INITIAL WITHIN-GROUP: during the second session of the intervention;
 FINAL WITHIN-GROUP: during the penultimate session of the intervention;
 POST-INTERVENTION: within 2 weeks after the ending of the group;
 FOLLOW-UP: 3 months to 1 year after the end of the group;

3.2.2 Administration and Scoring of the Measures

A. THE PARTY LIST

The class teacher was given enough identical strips of lined paper for every child in the class. The following instructions for administration of the Party List were given in both verbal and written form during a personal interview:

"Hand the paper out to the children. Ask them to imagine that they are going to have a birthday party but that they can only invite children from their class. Suggest that they make a 'Guest List' by writing down, on the paper, the names of all the children they would like to invite to the party".

Scores were presented in terms of:

- (i) an ACCEPTANCE score which was based on a mean of the ranked position of the child's name on each list and expressed as a percentage;
- (ii) a REJECT/NEGLECT STATUS score based on the proportion of peers who chose not to invite the child at all, expressed as a percentage (*i.e.* [no. who did not invite target child/total no. of respondents] x 100);
- (iii) a favoured status score based on the proportion of peers who listed the child in the top half of his\her list and expressed as a percentage (as with reject/neglect score).

The results were statistically analyzed and presented graphically.

B. THE PIERS-HARRIS SELF-CONCEPT SCALE

The scale was individually administered by the author to each child participating in the group. Questions were read to the child to avoid possible bias caused by children's different reading abilities. 'Global Raw Scores', and (Revised) 'Cluster Scores' were calculated. The results were analyzed statistically and presented graphically. In addition, qualitative observations were made of the children's responses to particular questions on the scale.

C. TEACHER REPORTS

These were obtained by the author during a personal interview with each child's class teacher. Interviews were conducted at the schools at a time chosen by the teacher. Two teachers were reluctant to be interviewed because of work pressure and brief reports were obtained from them telephonically. Notes written from memory immediately following interviews formed the basis for a qualitative assessment. In addition, the results attained by Len in his routine class examinations were obtained from his school (with the consent of his mother, teacher and school principal). Pre-intervention results were compared to post-intervention results and presented graphically.

D. VIDEO CLIP

The children were videotaped while engaged in a set group task (i) during the first session, and (ii) during the penultimate session of the intervention. Each 20 minute 'video clip' was divided into two-minute 'observation' segments, separated by 30 second 'scoring' intervals. These were presented in random order to 3 assistant researchers, who were instructed to watch the target child (Len) and rate his behaviour in terms of the categories outlined below:

'Absence' vs 'Presence' of **interaction**, where:

- (W) indicates absence of interaction (*i.e.* withdrawal). The child does not engage in shared activities either in co-operation or in competition with another child but engages in solitary, unoccupied, or onlooker activity; and
- (I) indicates presence of interaction. This includes making eye contact, and non-verbal 'entry' signals (such as leaning forward into a group) which suggest a desire for verbal or physical contact with another.

'Other-initiated' vs 'Self-initiated' interaction, where:

- (O) indicates other-initiated interactions. These are set up by the other party, or on the suggestion of a third party (*e.g.* a facilitator says "Sam needs the glue, can you pass it to him?");
- (S) indicates self-initiated interactions *i.e.* those which the child enters into spontaneously on his own initiative.

'Negative' or 'Positive' **outcome** of interaction, where:

- (N) indicates negative outcome characterized by: an increase in conflict, competition, division amongst participants; an outcome which is experienced as aversive by one or both participant/s; or an outcome in which none of participants needs have been met; and
- (P) indicates positive outcome characterized by: some mutual satisfaction; a reduction of conflict, or competition; and/or maintenance of interaction, or co-operation.

Behaviour was scored during every 2 minute time period. Thus, (W) was scored only when the child was involved in no interaction at all during the entire 2 minute time period. Rating schedules were provided to ensure ease and accuracy of scoring (see Appendix III), and observers were encouraged to record qualitative observations during the scoring interval. The results were qualitatively and statistically analyzed, and are presented graphically.

E. CLINICAL ASSESSMENT OF GROUP PROCESS

Each group session was videotaped and detailed transcripts were written immediately afterwards. These were analyzed in terms of group process and dynamics. The co-facilitators discussed each group with a supervisor experienced in groupwork and the insights obtained from these discussions were included in the analysis. The author used the written transcripts and analyses to formulate a clinical impression of the progress of the group and its members during the intervention; these are presented in a descriptive format along with the results in Chapter 4.

CHAPTER 4 RESULTS

The results for one child, Len, are presented in full. Results for all 7 children are presented where available and/or relevant. Each child was assigned a letter A to G; Len was assigned letter B.

4.1 THE PARTY LIST

Len's results on the Party List (Table 2 and Figure I) indicate:

- (i) a 12.4% improvement in Len's acceptance by his classmates. A t-test indicates that this difference is non-significant ($t=-1.64$; $df=43$; $p<.05$);
- (ii) a 9.9% reduction in rejection/neglect. A z-test indicates that this difference is non-significant ($z=0.88$; $p<.05$); and
- (iii) a 14% increase in the number of children who named Len in the top half of their lists. A z-test indicates that this is significant ($z=-1.66$; $p<.05$).

Table 2 SOCIOMETRIC SCORES PRE- AND POST-INTERVENTION
CHANGE IN PEER RELATIONSHIPS

	PRE-GROUP	POST-GROUP-	DIFFERENCE	SIGNIFICANCE
'ACCEPTANCE'	30.1	42.5	12.4	NO
'REJECT/NEGLECT'	45.2	35.3	-9.9	NO
'FAVOURED' STATUS	9.5	23.5	14.0	YES

NOTE: A higher score implies greater acceptance or rejection.

Following the intervention, one child named Len first on his list (prior to intervention Len had not been named within the top 5 on any list). This qualitative observation seems to suggest that the intimacy of (at least one of) Len's relationships has improved.

4.2 PIERS-HARRIS CHILDREN'S SELF CONCEPT SCALE" (P-H)

a) Changes in raw scores and percentile scores for the 7 children are shown (Table 3 and Figure II respectively). A t-test for repeated measures indicates a mildly significant improvement in post-

intervention mean scores ($t=4.17$; $df=6$; $p<.05$) although the improvement in individual scores ranged widely (std. deviation = 7.35). The standard error of the P-H is estimated at approximately 6 points ($p<.05$); consequently, individual changes in the global raw scores of less than 10 points should be ignored (Piers & Harris, 1969). This criterion is used to determine the significance of individual scores and indicates a significant improvement in Len's self-concept score on the P-H following the intervention.

Table 3 PRE- AND POST-INTERVENTION RAW SCORE CHANGES IN SELF-CONCEPT

CHILD	PRE-GROUP	POST-GROUP	DIFFERENCE	SIGNIFICANCE
A	34	56	22	YES
B (Len)	34	53	19	YES
C	36	50	14	YES
D	58	70	12	YES
E	50	56	6	NO
F	70	76	6	NO
G	71	73	2	NO
MEAN	50.4	62.0	11.6	YES

NOTE: A raw score of < 40 is considered low in terms of normative values while scores between 46 and 60 are considered average. Norms must be used with caution as the P-H has not been standardized for a South African population and cannot be assumed to be valid for use on a S.A. population, even although initial studies in the U.S.A. indicate non-significant effects for race and social class (Piers, 1976). A higher score implies greater acceptance or rejection.

b) The differences between pre- and post-intervention cluster scores on each of the six sub-scales (Behaviour, Intellectual and School Status, Physical Appearance and Attributes, Anxiety, Popularity, and Happiness and Satisfaction) are presented in Table 4. The greatest improvement was recorded on the anxiety (23%), behaviour (21%), popularity (20%) and happiness (20%) subscales. Len's scores reveal a significant reduction in anxiety on follow-up, and most improvement on subscales measuring his concept of his physical prowess, popularity and happiness.

Len's actual responses on the P-H questions reveal:

- improvement in his mood and lessening of depressive symptoms (*e.g.* in his responses to the questions: "I am often sad"; "I am unhappy");
- improvement in his social adjustment (*e.g.* shown on the questions: "I am unpopular"; "It is hard for me to make friends"; "In games and sports I watch instead of play"; "I feel left out of things");
- an ability to admit real limitations (*i.e.* realistically answer: "I am slow in finishing my schoolwork"; "In school I am a dreamer").

Table 4 PRE- AND POST-INTERVENTION CHANGES IN CLUSTER SCORES

CHILD	FACTOR 1 Behaviour	FACTOR 2 Intellect	FACTOR 3 Physical	FACTOR 4 Anxiety	FACTOR 5 Popularity	FACTOR 6 Happiness
A	43.8%	11.8%	15.4%	28.6%	41.7%	20.0%
B (Len)	25.0%	17.7%	46.2%	50.0%	33.3%	40.0%
C	25.0%	41.2%	15.4%	14.3%	16.7%	10.0%
D	18.8%	11.8%	15.4%	42.9%	41.7%	20.0%
E	12.5%	-11.8%	0	21.4%	8.3%	30.0%
F	6.3%	11.8%	-7.7%	7.1%	8.3%	10.0%
G	12.5%	0	0	0	-8.3%	10.0%
MEAN	20.5%	11.8%	21.1%	23.5%	20.2%	20.0%

NOTE: Figures are derived from the difference between pre- and post-group scores expressed as a percentage of the total possible cluster score $[(\text{post} - \text{pre}/\text{total}) \times 100]$.

4.3 TEACHER REPORTS

Pre-intervention teacher reports confirmed parents' reports that each child had peer relationship problems. Teachers noted: withdrawal; being teased by other children; lack of friends; difficulty mixing with other children; difficulties developing intimate relationships; demanding and dependant behaviour; bossy and domineering behaviour; immature behaviour; aggressive behaviour; refusal to participate in extramural activities; telling tales; and isolated play.

Post-intervention reports revealed an distinct improvement in the social functioning of 4 of the children. Teachers made the following comments: "he seems to be coming out of his shell a bit"; "she is not telling as many tales as she used to, and is not so bossy. She accepts corrections more easily - both from teachers and peers. She is also able to laugh at herself, and say 'oh gosh, I forgot' instead of immediately trying to shift the blame onto someone else"; "He has suddenly got a lot of confidence in himself - he is a different child from last year. He is now playing sport for the school and really seems much more settled"; "He seems to fit in very well now. I can say that he has really changed"; "He is still shy but he interacts VERY well with his classmates"; "Well, he was going through a bad patch last year - becoming a bit asocial... but he fits in better now than he did. He is certainly more assertive, more oppositional even -but for the

CHANGE IN SOCIOMETRIC SCORES Len's Results on the 'Party List'

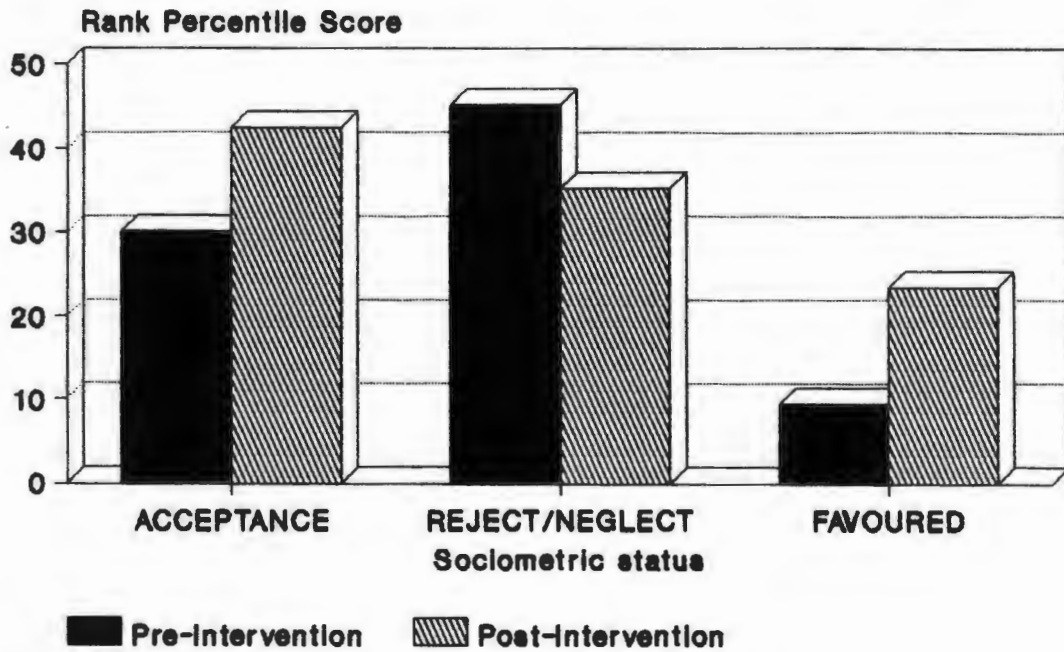


Figure I

CHANGE IN SELF-CONCEPT Percentile Scores on the Piers-Harris

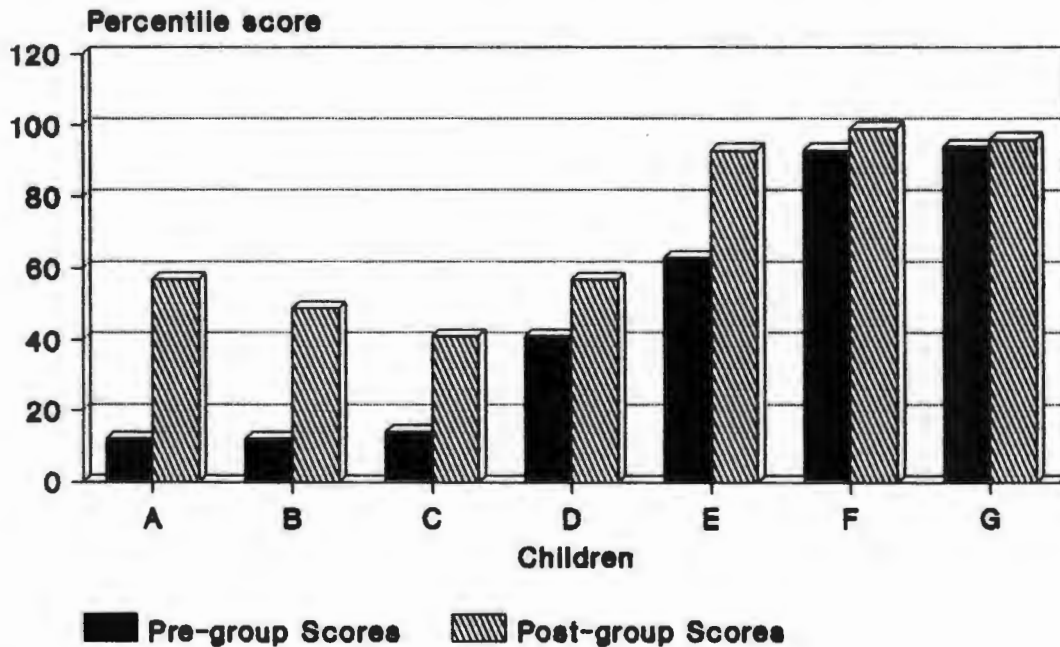


Figure II

better"; "Now he happily interacts with strangers"; "He is still a little withdrawn, but not as bad as he was before. He interacts better - talks more, has more confidence to offer his opinion and will offer information in class".

The new teachers of 2 of the children hadn't known them prior to the group, but reported no ongoing problems ("Socially he has fitted in very well - no problems"). There were no follow-up results for 1 child who's teacher was unavailable at the time of data collection.

Information obtained in interviews with Len's teacher is presented in Appendix II. It reveals that prior to the intervention Len was having scholastic, social and emotional problems, and was withdrawn and crying at school. However, post-intervention the teacher noticed social, emotional, scholastic, and behavioural improvements.

Len's school exam results (Table 5 and Figure III) indicate some post-group improvement in Afrikaans and Maths with a small fall-off in English results. The improvements levelled off in the year following intervention. Len's teacher commented that she was surprised he had passed his end of year exams and been promoted to the following standard.

Table 5 CHANGES IN LEN'S ACADEMIC ACHIEVEMENT

SUBJECT	PRE-GROUP	POST-GROUP	FOLLOW UP 6 Month	FOLLOW UP 1 Year
AFRIKAANS	C	B	A	C
ENGLISH	B	B	C	C
MATHEMATICS	E	C	D	C
TOTAL	C	B	C	C
		Passed Std 1		Passed Std 2

NOTE: Marks given in terms of symbols where A is highest mark.

4.4 VIDEO CLIP

Len's results on the video clip analysis (Table 6 and Figure IV) indicate that between the initial and penultimate sessions his rate of:

- total interactions increased and withdrawal decreased;
- self-initiated interactions with positive outcome increased;
- the rate of other-initiated interactions increased.

CHANGE IN ACADEMIC ACHIEVEMENT Len's Exam Results

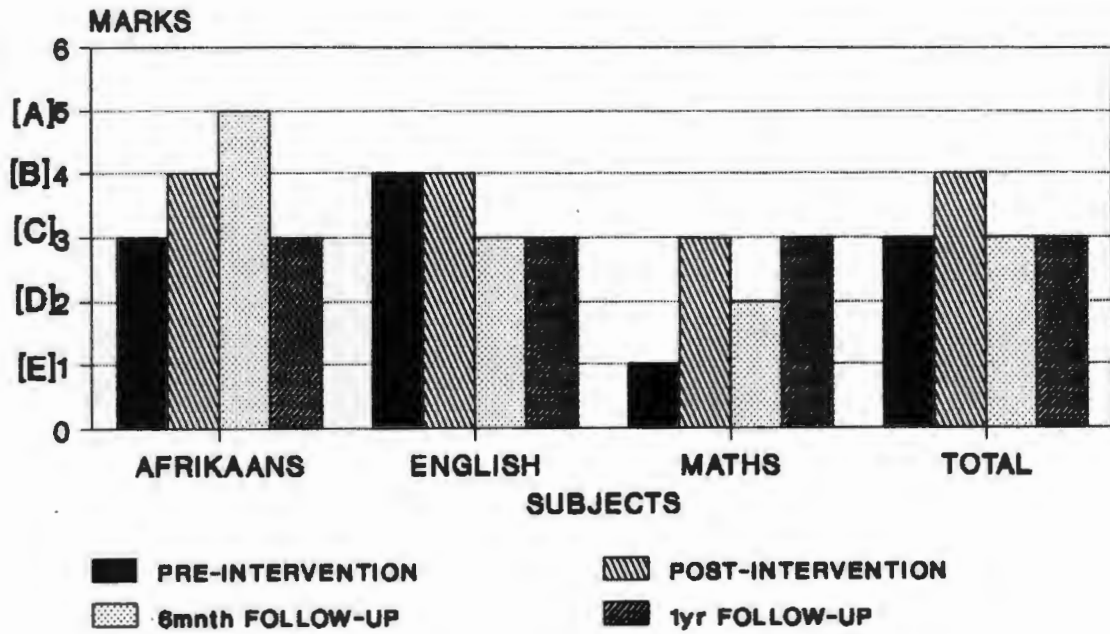


Fig III

CHANGES IN BEHAVIOUR Len's Results on Video Clip Analysis

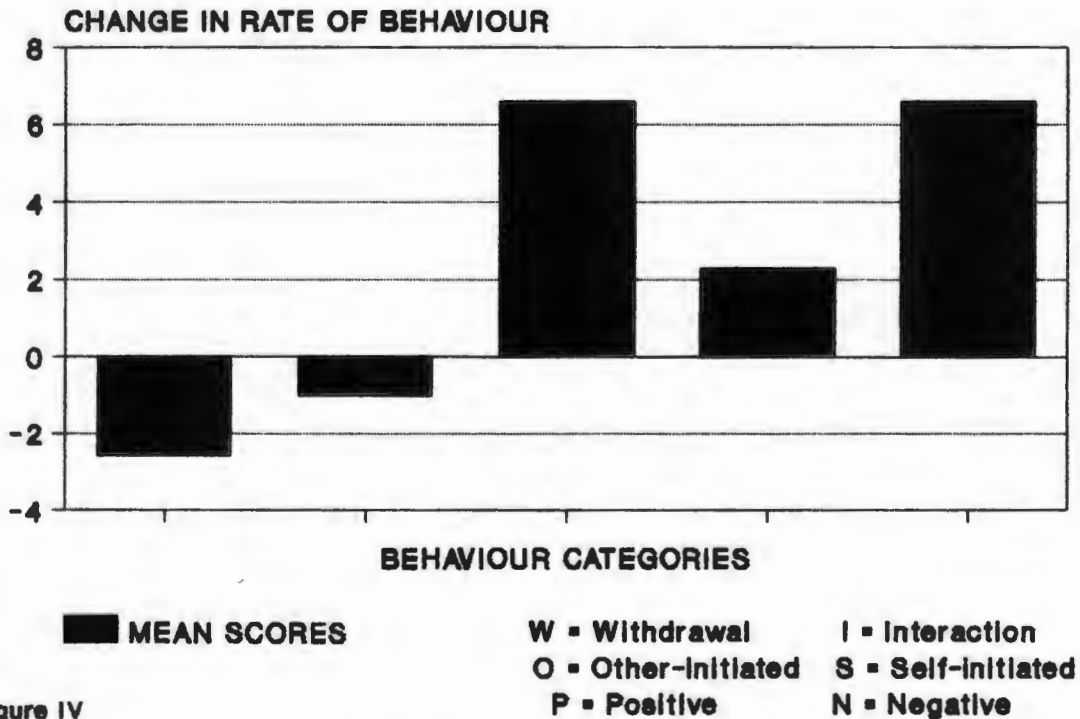


Figure IV

Although the figures quoted in the table appear to show fairly close inter-rater correlation, there was often considerable disagreement on how to score individual interactions.

Table 6 CHANGES IN LEN'S INTERACTIVE BEHAVIOUR

	TOTAL I	W	O I N	O I P	S I N	S I P
RATER 1	15	-2	-1	5	3	8
RATER 2	14	-3	-1	8	2	7
RATER 3	13	-3	-1	7	2	5
MEAN	14	-2.6	-1	6.6	2	6.6

NOTE: Scores are expressed as a difference [penultimate score minus initial score];
 A +ve number = increase in behaviour; a -ve number = decrease in behaviour;
 Std. deviation of Initial rate of interaction = 1.2;
 Std. deviation of Penultimate rate of interaction = 2.1.
 Pearsons Product Moment Correlation Coefficient = .96 to .99
 W:withdrawal; I:interaction; O:other-initiated; S:self-initiated; N:negative; P:positive.

Qualitative comments made by raters were as follows:

- (i) during the initial interaction the child was "disengaged and passive", "very withdrawn" and "an outside observer". Raters commented that the child seemed to want to join the group but couldn't, and that his actions were often only fulfilling his own individual needs;
- (ii) during the final interaction the child appeared "much more involved", and "more goal-oriented, more attentive, more assertive, more eye contact, more responsive".

4.5 CLINICAL ASSESSMENT OF GROUP PROCESS

Due to the length constraints of this thesis, analysis of the group process can only be very briefly outlined (see Appendix VII). Obviously this cannot do justice to the complexity or richness of the group process which was fully documented at the time, and which provided a basis for critical assessment of (i) the extent to which the group achieved its aims; and (ii) Len's engagement in the group. A very condensed summary of this analysis is presented here.

GROUP: the children were initially very anxious and acted out sibling rivalry issues, with Sessions 2 to 4 involving primarily 'testing out'. The facilitators tried to accept and contain the children, resist the desire to control them, and find a balance between task and maintainence. Although group cohesion was low and

the children were only able to 'work' together for brief periods, the group was able to learn some targeted social skills, achieve some exploration of interpersonal relationships, and briefly explore some negative feelings. The facilitators found the testing out in Session 5 very difficult to endure but affirmation of the children seemed to assist growth out of this phase and they made initial attempts to forge positive lasting relationships. Trust and group cohesion improved from Session 6, and there were strong expressions of wanting to belong to the group. A good working phase was achieved and task requirements were attended to (social skills training). However, towards the end of this session facilitators began to talk about termination and the group regressed (and needed containment and affirmation). In the final 2 sessions, brief working periods alternated with dependant or angry behaviour and ambivalent feelings about termination. These anxieties were acknowledged by facilitators but not entirely dealt with. However, some changes were evident in these sessions; the children showed attempts to identify with one another, willingness to accommodate to others needs, evidence that they had forged bonds with other children (and facilitators), a developing ability for positive self-evaluation, and an increase in some of the targeted social skills such as sharing and problem solving.

LEN: Initially his behaviour was quietly compliant and he interacted only with facilitators. He was alert to the interactions in the group but tended to just watch others; he appeared to have difficulty engaging verbally, making his needs known, and entering into play. In Session 2 he tried to identify with a powerful disruptive subgroup who's members were getting all the attention (albeit negative). He was absent in Session 4, but in Sessions 3 and 5 he began testing out. Both his assertiveness and his interaction with peers increased and he attempted to initiate more lasting contact with another child by swapping telephone numbers. In the final two sessions he began to identify with, and model from, a popular child who was instrumental in promoting group cohesion. He made more attempts to enter into interactions with other children by sharing, copying, or helping.

CHAPTER 5: DISCUSSION

5.1 RESULTS OF THE OUTCOME EVALUATION

In general, statistical measures indicated mildly positive results of variable significance. Qualitative results suggested that the intervention effected a general improvement in the self-concept and general adjustment of all the children, and improvement in the peer relationships of the target child. Teachers and parents expressed positive attitudes to the intervention, and clinically trained research assistants noted distinct positive changes in the behaviour of the target child. These results, and some of the problems involved in the intervention and study, are discussed in more detail below.

Self-concept

The P-H results indicate that the intervention effected a mildly statistically significant improvement in the children's self concept scores post-intervention. The greatest improvements were measured on cluster scores of anxiety, behaviour, popularity and happiness.

However, many variables confound the interpretation of these results:

- (i) the large standard deviation of scores (the intervention was more successful for some children than for others) may have limited measures of statistical significance;
- (ii) pre-intervention self-concept scores ranged from extremely high to extremely low. Researchers note that "while we cannot assume that all high scores (particularly the very high) reflect truly positive self-attitudes, we probably can assume that the low scores reflect truly negative self-attitudes" (Piers & Harris, 1969:14). Children scoring particularly highly may have been 'faking good' - a defensive strategy (Patterson, Kupersmidt, & Griesler, 1990) which Boivin & Begin (1989) found to be characteristic of unpopular children (in Hartup & Moore, 1990). This phenomenon clouded the results, making it difficult to assess the actual change in the children's scores;
- (iii) results displayed a 'ceiling effect' (children with initially high scores showed little improvement) and a tendency for 'regression towards the mean' (low scoring children achieved scores which were closer to average on post-test). This exacerbated problems with interpretation of the statistical measures;
- (iv) scores indicated a large reduction in self-reports of anxiety post-intervention. This phenomenon has been reported by other researchers (Pellegrini, 1985). Although the P-H questions generally referred to situations outside the testing situation (*e.g.* "I get nervous when the teacher calls on me"), the child's response to these questions may have been contaminated by

anxiety about the upcoming group and/or about testing itself (unfamiliar tester and task). This would have influenced pre-intervention scores in particular, resulting in falsely lowered pre-intervention scores and misleadingly large changes post-intervention;

- (v) higher scores are often found on retest, possibly as a result of test familiarity (Piers & Harris, 1969). Thus, researchers warn that a control group is essential when conducting research with the P-H. As no control was used in this study, results must be interpreted with caution.

Notwithstanding these confounding effects, both quantitative and qualitative results for Len record improvement in global self-concept and his assessment of his physical attributes, popularity and happiness in particular. This improvement is clinically significant as Len's score moved from being deficient (11th percentile) to within the normative range (49th percentile).

Because of the problems outlined above, it is not possible to conclude that the intervention had an unequivocally significantly positive effect on self-concept, even although changes in self-concept scores did reach statistical significance. The intervention seemed to achieve better results with some children than with others and this underscores the importance of good assessment for therapy. In particular it seems to have effected an improvement in a depressed child's self-esteem, satisfaction with his relationships, and his assessment of his happiness.

Popularity

Results on the Party List indicated a statistically non-significant improvement in Len's general acceptance and reduction in the level of rejection/neglect by his classmates, and a statistically significant improvement in the extent to which he was 'favoured' by certain classmates. This suggests an improvement in the intimacy of his relationships on 6 month follow-up. These results highlight the importance of differentiating the multiple qualitative aspects of peer relationships. Claes's (1992) study on aspects of adolescent friendship supports this; he claims that the most important features of friendships were level of attachment (communication and trust), and absence of conflict (rivalry, confrontations, and feelings of alienation) not **number** of friends or acquaintances. The Party List fails to do full justice to such complexity in not distinguishing rejected and neglected status (see Parker & Asher, 1985), duration of friendships, frequency of contact with friends, level of conflict in the relationships, and expectations towards friends. Furthermore, literature suggests that it is the child's **satisfaction** with his peer relationships that is of prime importance (Belle, 1989; Parker & Asher, 1987; Patterson *et al*, 1990; Rutter, 1985). Thus, it may have been useful to incorporate a direct assessment of this via interviews with the child. Semi-structured interview schedules, using the child as informant, have been found to be a reliable method of eliciting a child's perception of his/her relations with peers and friends for assessment of pre- and post-therapeutic interventions (Goodyer *et al*, 1991; Goodyer *et al*, 1989; Kernberg *et al*, 1992).

Methodological problems with the administration of the 'Party List' may have introduced some errors in interpretation, i.e:

- (i) the 'Party List' is of unknown reliability and validity. Although a similar method has been used by Feiring & Lewis (1989) there is no published data on the internal consistency or validity of this method. Its interpretation involves making various assumptions which may not be valid *e.g.* that a child will only invite those children he likes to his party and that he will list them in some kind of ranked order;
- (ii) an absent child would not have had the chance to complete a list (and may have been left out of the lists of peers because he was less visible). This would introduce errors, and needs to be considered a major limitation since 8 more lists were completed by Len's class pre-intervention compared with post-intervention;
- (iii) data is collected at a static point in time and a child's nominations on the day of data collection may have been influenced by situational variables (such as a recent conflict with a best friend);
- (iv) the children were given pre-prepared strips of paper on which to write. The administration instructions did not specify that a child could invite as many or as few peers to his/her party as he/she wished and some of the children seemed to feel compelled to fill the paper with names. Thus there was a preponderance of nominations comprising 15 or 30 names, and this may have resulted in children including unwanted peers or excluding wanted peers in order to fit the constraints of the paper.

The assumption that children's relationships can be classified and measured is problematic in itself, but a review of the methodological and conceptual debates on the issue is beyond the scope of this paper. However such issues, together with the abovementioned shortcomings, make it difficult to draw definite conclusions about improvements in the child's peer relationships from the 'Party List' alone. The usefulness of this measure was considered to be in the extent to which it confirmed changes found by other methods. Qualitative data from the teacher reports seemed to corroborate the 'Party List' findings of improved social relationships.

Behaviour and social adjustment

Teacher reports post-intervention indicated a general improvement in the children's functioning. Len's teacher noticed social, emotional, scholastic and behavioural improvements and was surprised by the academic progress he made in the 3 months following intervention. This indicates that the intervention had a general therapeutic effect on the children, and particularly on a depressed child.

These results are limited by the fact that the teacher reports were not designed to pick up specific changes in the children's peer relationships, and therefore no conclusive assessment of such changes can be made. Thus, it is still unclear exactly what aspects of the children's functioning have been influenced by the intervention. Some SST programmes recorded constructive changes in children's peer relationships

without firm evidence that new skills were incorporated into the child's behavioural repertoire (Ladd & Mize, 1982).

In addition, confounding factors introduced two possible sources of bias during these interviews. Firstly, teachers may have over- or under-represented problems because:

- (i) the interviews provided support for teachers who were having difficulty coping with the child in the classroom ("He makes me really exasperated - I just don't know how else to teach him, I can't get through to him, he just looks at me") and reassured the teacher that someone was intervening with the child;
- (ii) some teachers responded defensively to the interviews; *e.g.* one teacher initially declined to be interviewed, and another began the interview with "I never hit him or anything".

Secondly, the process of collecting information from the teachers seemed to have a therapeutic effect in itself and following the initial interview some teachers became more aware of the child, took special interest in the child, and made efforts to aid the child ("Mrs X filled me in on what was happening with him last year and I have been giving him tasks in the classroom").

These factors make it difficult to conclude that the general improvements in social, behavioural and emotional functioning reported by the teachers were: (i) accurately described, or (ii) due to the efforts of the intervention alone.

Social Interaction

Results from the video clip indicate improvements in the quality and quantity of Len's interaction between the initial and penultimate group sessions, and a reduction in withdrawal.

The results appeared encouraging, but may have been confounded by:

- (i) a 'halo effect' brought about by the fact that it was immediately obvious to raters which clip had been taken post-intervention as the quality of the child's interaction was so different;
- (ii) rating inconsistencies. Although the figures quoted in Table 6 appeared to show fairly close inter-rater correspondence, there was often considerable disagreement on how to score individual interactions. This intervention required that minimally trained observers make subjective judgments about behaviour and discrepant judgments seem to have been obscured by cumulative effects.

Interpretation of these results must consider certain limitations:

- (i) behaviour rates vary across settings and therefore the behaviour measured in the videoclip interaction cannot be directly compared to behaviour in the outside environment (behaviour change in the group may not generalize to behaviour outside of the group);
- (ii) the behaviour changes observed may be due to the confounding influence of group process and the stage of group development; *i.e.* influenced by the increased trust between members, familiarity with others and/or the setting, etc (and not due to actual behaviour change in individual members);
- (iii) observer effects may be confounding the results on the videoclip. Although the video equipment was relatively unobtrusive, the children did 'play' to the video camera at times. They would also have been more at ease with the camera in the penultimate session and this differential response may have confounded results;
- (iv) this study does not indicate that the learning of particular social skills resulted in improvement, nor does it isolate elements of the intervention which were helpful for any individual child.

Anstey (1983:50) holds that "Interaction is the basic process in group life". At very least, Len's interaction seems to have improved but perhaps all that can be reliably concluded from this observation is that Len engaged with the group process.

Academic Achievement

There appears to have been some improvement in Len's academic achievement following intervention (although this levelled off in the following year). This cannot, without serious reservation, be directly attributed to (intervention-induced) improvements in self-concept, social adjustment, or depressive symptomatology. However, a cogent indication of change following intervention was the comment by Len's teacher that his promotion to a higher standard was contrary to her expectations. It certainly appears that some changes have occurred in this child's life following intervention.

5.2 EVALUATION OF THE INTERVENTION

The intervention had two basic goals; *i.e.*:

- (i) to reinforce positive aspects of behaviour and help each child feel accepted in the group; and
- (ii) to teach certain social skills to the children.

Although the first goal was successfully attained much of the time, it proved difficult to fulfill the 'task' requirements of the second goal and some planned social skills activities were not accomplished.

Various problems limited the extent to which the group was able to achieve its goals. Firstly, the group was dispersed and only intermittently moved out of a 'testing-out' phase and into a 'working' phase. This lack of cohesion, so essential to group functioning (Toseland & Rivas, 1984), was partly a function of the stage of group development but may also have been affected by too much diversity in group members. The children in this group:

- (i) were of similar ages and all had poor peer relationships, but they had different ways of coping with their problems;
- (ii) came from different socioeconomic and race groups. The fact that the group was a mixed-race group in a racially segregated society may have negatively influenced group cohesion;
- (iii) were of mixed gender and this decreased group cohesion by encouraging a destructive subgroup formation which could not be adequately worked through in a brief time span.

These differences may not necessarily disrupt group cohesion, but a balance needs to be achieved between similarity and diversity; "groups should be homogenous in enough ways to ensure their stability, and heterogeneous in enough ways to ensure their vitality" (Anstey, 1983:46).

Secondly, the group was anxiety provoking and children acted out their anxiety in ways which were characteristic of their individual problems. The children all had (various) emotional problems and some demanded a great deal of attention in the group. Much competition and rivalry was played out in the group and facilitators often needed to focus on 'maintenance' functions in order to contain the group process. Facilitator inexperience meant that not all the children were equally well contained in the group (although this was considered to be, to some extent, an inevitable part of a group intervention). Consequently, 'task' goals were not always achieved.

This highlights an issue which is likely to be a common problem with any planned social skills intervention; *i.e.* any group which is brought together for any purpose interacts in a unique and dynamic manner. Group facilitation demands ongoing monitoring of the changing PROCESS of that group, and constant attention to both TASK¹ and MAINTENANCE² functions (Anstey, 1983; Toseland & Rivas, 1984).

¹ "Task-oriented acts are directed at getting on with the job, including initiating tasks, defining activities and procedures, asking for opinions and suggestions, offering facts, clarifying, interpreting, indicating alternatives, marshalling data, testing opinions, checking levels of agreement and offering decisions or conclusions" (Anstey, 1983:50).

² "Maintenance acts are concerned with attempts to facilitate the participation of others by the expression of feelings, mediating differences, reducing tensions, keeping communication channels open, compromising and maintaining standards" (Anstey, 1983:50).

Thus the group process cannot be planned beforehand, and does not readily conform to the demands of a structured programme. It is difficult simply to develop an effective 'programme', apply this to a group of 'patients', quantify the results, and then reproduce similarly effective results with different groups of 'patients'. One cannot propose a 'winning formula' which will always ensure future successes. Perhaps, as Frank (1979:311) suggests, "more of the determinants of the therapeutic success lie in the personal qualities of the patient and the therapist and in their interactions than in the therapeutic method".

Analysis of group process indicates the intervention engaged the children in different ways. Len seemed to benefit from some brief experiences of feeling accepted, and from exploration and expression of negative feelings towards authority figures. This raises questions about which aspect of the group has contributed to the changes noted (was it the learning of social skills, or engagement in the therapeutic process of the group?). Such questions do not belie the group's effectiveness, as engagement in group process is perhaps an overriding goal of intervention. There are several theories about groups, their development, use and dynamics (Anstey, 1983; Heap, 1978; Moss-Morris, 1990) but most theorists agree that the essence of group therapy is in the emotional experience resulting from being part of a group; an 'emotional relearning experience' (Moss-Morris, 1990).

Not surprisingly, the group proved to be a considerable learning experience for the facilitators. It afforded them the opportunity to learn not only about group process and group facilitation, but also about their own responses to groups, their styles of relating and reactions to expressions of anger, anxiety and dependency (these issues cannot be explored in this paper). The group was run in a Child Guidance Clinic which trains 1st year MA (Clin. Psych.) students and could prove a valuable didactic teaching tool.

5.3 ADVANTAGES OF TIME-LIMITED GROUP INTERVENTIONS

A time-limited group intervention, such as outlined here, offers various benefits; *i.e.*:

- (i) it is relatively cost effective in terms of manpower, time, and financial cost. It is therefore a more appropriate intervention for use in a country where the majority of the population has limited access to specialized resources;
- (ii) group interventions minimize some of the problems of long-term individual therapy with a child. Besides the problems of financial cost and the time and motivation required from both child and family, the risk of stigmatization of the child is greater if that child is taken into long-term individual psychotherapy. A group intervention, particularly if implemented in the child's natural environment, can take the form of a 'fun' or 'learning' experience rather than a 'treatment' for some problem;
- (iii) groups could be offered in schools, clinics, or children's homes perhaps by allied professionals (teachers, nurses) in consultation with a psychologist. This would have the advantage of enabling psychologists to provide services directly to the community, and particularly to those

- sectors that may be at greater risk (*e.g.* disadvantaged children in residential care facilities, or communities without ready access to appropriate services);
- (iv) it has some advantages over pharmacotherapy, considering the problems associated with the use of anti-depressant medication in children (Kazdin, 1990; Rutter & Hersov, 1985).

5.4 LIMITATIONS OF THE STUDY

Evaluated as a piece of empirical research, this study has many methodological shortcomings (many of which have already been raised). However, clinically it represents an actual therapeutic intervention as it would have occurred in a setting where all variables cannot be controlled. Intervention was designed to achieve therapeutic aims in the most appropriate and accessible way possible. Its limitations are, in part, due to a tension between clinical and research aims (see Barlow & Hersen, 1984). Some of these limitations are discussed below.

This study uses a sample of small size and therefore it has narrow generalizability. Since sample size is small, and the statistical power of the measures is unknown, the risk of concluding that there is no difference between measures is large. The subjects are drawn from a clinic referred population and therefore are only representative of an 'at risk' population. The experimenter functioned as co-therapist, as well as administrator and scorer for many of the evaluation measures, and this may have introduced a bias in the results.

Although the assumption that an experimenter can set up a matched control group of subjects for a therapeutic intervention is conceptually problematic in itself, this study made no attempt to compare the progress of the children to a 'no-treatment', 'alternative treatment' or 'placebo treatment' group. Puig-Antich *et al* (1984) documented a 60% improvement in depressed children treated with pharmacological placebo which suggested to them that "non-specific psychological management will be effective in a high proportion of cases" (Rutter & Hersov, 1985:706-707). This limits the conclusions that can be drawn from these results as it is not possible to conclude that this intervention was any more effective than no intervention, or than any alternative intervention.

This intervention explicitly aimed to change behaviour that would result in improvements of social adjustment over the long-term. Thus the 6 month (to 1 year) follow-up was an inadequate period in which to evaluate the full effects of the intervention. Tremblay *et al* (1991) conducted a 2-year treatment programme, which included social skills training, with disruptive boys and he found that some of the improvements were only evident on 3 year follow-up. In fact, he found there were signs of adverse treatment effects immediately following treatment (p.159). Conversely, Stevens (1974) studied the effects of didactic group therapy on the self-esteem of potential school dropouts and found some significant

increases in self-concept on post-test, but not on follow-up (Piers, 1976). Thus, a longer follow-up period might have offered divergent results.

Most interventions for isolated, rejected and friendless children have been based on a 'skill deficit' hypothesis. However, there is considerable disagreement as to what skills should be taught and how, and what skills are most appropriate during various developmental stages. This study has attempted to draw from a large body of empirical research when deciding which skills to teach to children in this age group. However, one needs to continually bear in mind that these hypotheses are not conclusive, and one must take care to ensure that one's behavioural expectations mesh appropriately with the larger peer culture in which the child is embedded. In addition, there are some conceptual problems with the skills deficit hypothesis. One can argue that there is no causal link between poor social skills and poor peer relationships and that the changes in peer relations following improvement in social skills are coincidental; *i.e.* due to the intervention affecting the child at other levels. This is supported by research which has taught social skills to children, measured improvements in peer relationships, but found no improvement in social skills (Ladd & Mize, 1982).

Literature documents a relatively high rate of spontaneous remission of childhood depression (Kazdin, 1990:138). Although the time required for recovery from dysthymia was relatively long (cumulative time = 81 months, median = 45 months in a sample of 100 children), the effect of spontaneous remission may have confounded the results.

This evaluation is essentially a case study and it thus has numerous limitations. Barlow and Hersen (1984, 141) note that:

"the case history method yields interesting (albeit uncontrolled) data, that it is a rich source for clinical speculation, and that ingenious technical developments derive from its application, (however) the multitude of uncontrolled factors present in each study do not permit sound cause and effect conclusions".

i.e. one cannot conclude that the changes noted were due to the intervention alone. During the follow-up period some of the children had changed schools or teachers and may have experienced diverse changes to their home circumstances which may have influenced the results to some extent. Although the case study method has limitations as an evaluative tool, it can be effectively used to: (i) generate hypotheses which can be later tested more rigorously; and (ii) provide clinical data which can be used as a departure point for subsequent controlled investigations.

5.5 FURTHER RESEARCH

A problem with the **group** application of a social skills training technique is that "targeting the same behaviours for any heterogeneous group of individuals implies that all the members of the group are identical, and that they have the same problems, and that the same treatment techniques will help any individual" (LeCroy, 1982:110). This is rather simplistic. Referrals and assessments for therapy ideally need to be carefully considered, and based upon empirical research that demonstrates the appropriateness of the therapeutic method. For example, Rose (1982) has suggested that an Interpersonal Cognitive Problem-Solving approach is best suited to impulsive and hyperactive or aggressive children, while Social Skills Training appears to be more beneficial for socially isolated and withdrawn children. Further research needs to clarify which diagnostic or personal factors ensure effectiveness with this particular approach, and refine or elaborate methods of intervention.

The focus of the intervention was broad-based and multifaceted, with several techniques being used simultaneously (*i.e.* positive reinforcement, modelling) and various aspects of functioning being targeted (*i.e.* self-esteem, problem solving, various social skills). This makes it difficult to isolate which elements of the intervention were most effective and which were least effective. A narrow focus does not necessarily ensure more valuable results as an intervention is more than a simple sum of its parts; *i.e.* certain combinations of treatments are more effective than the sum of those treatments on their own. Breaking a treatment package down into components which are too small is as inadequate for clinical purposes as evaluating a large, multi-component treatment package is inadequate for research purposes. The only answer to this problem seems to be to test the limits of any intervention technique through replication studies which both break down and expand treatment packages in varied settings.

"Observations conducted in multiple settings are required: (i) if generalization of treatment effects is to be demonstrated; (ii) if a representative portrayal of the target behaviour is to be obtained; and (iii) if important contextual variables that control responding and that may be used to generate effective interventions are to be identified" (Barlow & Hersen, 1984:112).

CHAPTER 6: CONCLUSIONS

In summary, outcome evaluation seemed to indicate that a time-limited group intervention (focusing on broad-based development of social competence and self-esteem) could effect improvements in self-concept and general social functioning, although the intervention was obviously more useful for some children than for others. Closer assessment of the response to this intervention of a depressed child (Len) indicated:

- that Len was able to engage with the group process and show an increase in interactive behaviour across group sessions;
- that there was a statistically significant improvement in the intimacy of Len's relationships, a non-significant improvement in his level of acceptance by classmates, and a non-significant reduction in the extent to which he was rejected or neglected by classmates;
- qualitative improvements in Len's social and emotional functioning and his behaviour;
- mixed changes in Len's scholastic achievement.

Qualitative data and clinical impressions reinforced the results and led to the conclusion that the intervention had a positive clinical effect on the general functioning of the target child (a depressed child with low self-esteem and poor peer relationships). This supports research findings which indicate that this method of intervention compares favourably with other methods.

Methodological problems (including the questionable validity of some of the measurement techniques employed) confounded the results and imposed some limitations on the validity of the conclusions, e.g:

- there is no evidence that this intervention was more effective than no intervention, placebo intervention, or alternative interventions;
- it is difficult to conclude that the changes found were due to the intervention alone;
- one cannot isolate which particular aspects of the intervention were most effective;
- the study does not indicate which types of children or which problems would be most amenable to this form of intervention;
- the small sample size limits the generalizability of the results.

Self-concept refers to a set of **relatively stable** self-attitudes which, by definition, are especially difficult to change. Similarly, literature bears testimony to the stability of children's relationships over time (Asher & Gottman, 1981; Coie & Dodge, 1983) and this means that a child's popularity is a very difficult thing to change. A child takes on a role in his social environment which resists transformation despite changes in the child himself and this leads researchers to argue that one needs to change the way peers see the child as well as the way he sees himself to effect any lasting change (Pellegrini *et al*, 1985). Thus little change was to be expected and it is perhaps encouraging that the intervention recorded the mildly significant results that it did. Small or subtle changes in self-concept are likely to have substantial clinical impact, which may

be particularly important as an early intervention for those children who may already be disadvantaged by the South African social and educational systems.

This type of intervention might be particularly useful as part of a multimodal treatment programme. Multimodal approaches assert that human beings need to be understood across seven modalities of functioning - behaviour, affect, sensation, imagery, cognition, interpersonal relationships, and neurophysiology/biochemistry. They propose that psychopathology arises from an interplay of problems in these various modalities and thus effective therapy requires that problems across all these modalities be addressed (Lazarus, 1992). "The multimodal orientation is predicated on the assumption that by treating only one or two significant problems or issues, relapse is likely" (Lazarus, 1992:53). Such approaches use cognitive and behavioural techniques, social skills training (SST), and systems approaches, along with basic therapeutic skills, and medication where necessary. Tremblay *et al* (1991:150) makes the point that "lasting changes may depend on multifaceted approaches" and there have been positive results from programmes using broad-based SST in combination with other therapeutic interventions (Friedman, Quick, Mayo & Palmer, 1982).

The reinforcement which will come from improved self-concept and social relationships is likely to encourage a positive cycle of adjustment. In view of the prevalence of peer relationship problems in at risk children and the long-term negative prognoses for these children, early detection of and intervention for these problems may prove to be an important preventative measure. Bierman (1987:238) claims that:

"minor interventions, such as the provision of social skills training or increased opportunities for positive peer interactions, may have prevented the child's development of serious social behavioural and peer relation problems (and) prevent future social adjustment difficulties".

Kornberg and Caplan (1980) reviewed 650 papers on biopsychosocial risk factors and preventative interventions, and concluded that broad-based social competence promotion programmes (SCP) were "one of the most significant developments in recent primary prevention research" (in Caplan *et al*, 1992). Several previous evaluative studies of social skills training have indicated that SST can generalize to broader changes and to behaviour in the natural environment (Pellegrini *et al*, 1985) and "may function in a preventative as well as ameliorative manner" (LeCroy, 1982:108-109). In a 2-year follow-up study conducted with disruptive boys during their early primary school years, Tremblay *et al* (1991) showed that a preventative treatment programme which included social skills training could have some usefulness in the longer term. Preventative interventions could possibly be undertaken in the community and perhaps even be administered by trained mental health practitioners or teachers. Rose (1982) proposes that the classroom is an ideal setting for such preventative efforts and a study by Cauley and Tyler (1989) indicated that teachers can be effective agents for change. One advantage of such preventative intervention programmes would be the opportunity it would afford at-risk children to model effective behaviours from

their more socially competent peers. However, Nezu *et al* (1989) warn that "skills acquired during training require continued reinforcement and refinement as students progress through the adolescent years" (Caplan *et al*, 1992:62).

One could argue that the root of social skills deficits lie in family or individual psychopathology and it would be more appropriate to address the root of the problem in insight-oriented therapy; perhaps SST effects only symptomatic improvement which will have limited durability and generalizability, and be open to symptom substitution. However, if the child and his symptoms are seen as part of a total system, changing one aspect of the dysfunctional system will cause a global shift in functioning. (It is important to question how effectively an intervention can change a child's behaviour if other aspects of his family system are not also changed. This intervention attempted, on a simple level, to effect some corresponding changes in the family through the letters which were sent home to parents, but was limited in that it in no way attempted to look beyond this to an understanding of the function and meaning of the child's symptoms). Thus the approach taken in this study is based upon cognitive-behavioural models which tend to overlap with one another and with alternative models. Kazdin (1990:143) suggests that "the idea of an integrated model... suggests that the processes that lead to depression might be interrupted at different places... (and that) many different treatment foci may be effective".

This intervention used brief and somewhat limited techniques to promote a modest shift in one aspect of the child's total system. Thus, it may not be the best way to achieve a 'cure' but it is proposed that this form of intervention has numerous benefits which make it a valuable treatment option; in particular, it is cost effective, has potential for community application, and may be less threatening to children.

These conclusions may be put into perspective by Stravynski & Greenberg's (1992:412) comment:

"it may be that regardless of the actual therapeutic techniques, any relationship that helps patients change notions about themselves and their world and encourages them to enact new and more powerful ones would prove to be helpful".

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APPENDIX I
THE PIERS-HARRIS CHILDREN'S SELF CONCEPT SCALE

THE PIERS - HARRIS
CHILDREN'S SELF CONCEPT SCALE

THE WAY I FEEL ABOUT MYSELF

NAME.....

AGE.....GIRL OR BOY.....

STANDARD.....SCHOOL.....

DATE.....

Here are a set of statements. Some of them are true of you and so you will circle the yes. Some are not true of you and so you will circle the no. Answer every question even if some are hard to decide, but do not circle both yes and no.

Remember, circle the yes if the statement is generally like you, or circle the no if the statement is generally not like you. 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.....yes no
2. I am a happy person.....yes no
3. It is hard for me to make friends.....yes no
4. I am often sad.....yes no
5. I am clever.....yes no
6. I am shy.....yes no
7. My looks bother me.....yes no
8. I get nervous when the teacher calls on me.....yes no
9. When I grow up, I will be an important person....yes no
10. I get worried when we have tests in school.....yes no
11. I am unpopular.....yes no
12. I am well behaved in school.....yes no
13. It is usually my fault when something goes wrong.yes no
14. I cause trouble to my family.....yes no
15. I am strong.....yes no

16. I have good ideas.....yes no
17. I am an important member of my family.....yes no
18. I usually want my own way.....yes no
19. I am good at making things with my hands.....yes no
20. I give up easily.....yes no
21. I am good at school work.....yes no
22. I do many bad things.....yes no
23. I can draw well.....yes no
24. I am good at music.....yes no
25. I behave badly at home.....yes no
26. I am slow in finishing my school work.....yes no
27. I am an important member of my class.....yes no
28. I am nervous.....yes no
29. I have pretty eyes.....yes no
30. I can give a good talk in front of the class.....yes no
31. In school I am a dreamer.....yes no
32. I fight with my brother(s) and sister(s).....yes no
33. My friends like my ideas.....yes no
34. I often get into trouble.....yes no

35. I am obedient at home.....yes no
36. I am lucky.....yes no
37. I worry a lot.....yes no
38. My parents expect too much of me.....yes no
39. I like being the way I am.....yes no
40. I feel left out of things.....yes no
41. I have nice hair.....yes no
42. I often put my hand up to answer questions.....yes no
43. I wish I were different.....yes no
44. I sleep well at night.....yes no
45. I hate school.....yes no
46. I am among the last to be chosen for games.....yes no
47. I am sick a lot.....yes no
48. I am often nasty to other people.....yes no
49. My classmates at school think I have good ideas.....yes no
50. I am unhappy.....yes no
51. I have many friends.....yes no
52. I am cheerful.....yes no
53. I am dumb about most things.....yes no
54. I am good looking.....yes no
55. I have lots of energy.....yes no

56. I get into a lot of fights.....yes no
57. I am popular with boys.....yes no
58. People pick on me.....yes no
59. My family is disappointed in me.....yes no
60. I have a pleasant face.....yes no
61. When I try to make something, everything
seems to go wrong.....yes no
62. I am picked on at home.....yes no
63. I am a leader in games and sports.....yes no
64. I am clumsy.....yes no
65. In games and sports, I watch instead of play.....yes no
66. I forget what I learn.....yes no
67. I am easy to get along with.....yes no
68. I lose my temper easily.....yes no
69. I am popular with girls.....yes no
70. I am a good reader.....yes no
71. I would rather work alone than with a group.....yes no
72. I like my brother (sister).....yes no
73. I have good figure.....yes no

74. I am often afraid.....yes no
75. I am always dropping or breaking things.....yes no
76. I can be trusted.....yes no
77. I am different from other people.....yes no
78. I think bad thoughts.....yes no
79. I cry easily.....yes no
80. I am a good person.....yes no

APPENDIX II

SUMMARY OF INTERVIEW WITH LEN'S TEACHER

PRE-INTERVENTION

(personal interview with Mrs X, Len's class teacher, on 11/9/90)

Mrs X was very defensive at first, telling me that she 'never hits the children or anything' (I spent a long while trying to put her at ease and indicate to her that I would be supportive of her). She then talked about Len's schoolwork, saying that she is exasperated with him; she doesn't know how else to teach him, she can't get through to him as he just looks at her blankly. She showed me his books and exam marks, and said that he is having a lot of problems - especially with maths. He is very concrete, can't do any abstract problems. He generally gets on much slower than the other children and can't concentrate for very long.

She also said: 'he is very withdrawn and moody and he cries a lot at school. I think there are problems with his father - he seems to be very attached to but terrified of his father, one day he thought he saw his father coming to pick him up at the school gate and he refused to leave the classroom. His father used to beat him up but this doesn't seem to happen anymore since his father left home.

(telephone interview with 'oorplasingklas' teacher Miss M on 15/9/90)

Miss M was extremely concerned about Len's schoolwork. 'His schoolwork is really poor, especially his maths. He finds it really difficult to abstract and can only perform really concrete arithmetic. He is slower than the other children in his class and seems to have a lot of difficulty concentrating. I think there is a problem at home with his father. I think his father used to beat him up but he seems very attached still to his father as he often talks about him and gets tears in his eyes. He seems to have no confidence in himself. He gives up without trying and can't be left to do things on his own. I have tried to discipline him more but he just cries - I don't know what else to do, he is unlikely to make Std 2.

POST-INTERVENTION

(Personal interview with Mrs X on 23/11/90)

Mrs X gave me Len's recent school results. She was excited about the fact that he had passed - contrary to all expectations. She said that he has "really changed". When I asked what she felt had changed she said 'well, its primarily his mannerisms that have changed. He doesn't sulk anymore. He seems more eager to

learn and he seems to be more free, in a way. He seems to be opening up a bit more and he fits in better with the other children'. On probing further into these changes, she gave the example that he used to sulk if he couldn't get something, but now 'he looks happier - more contented'. She also noted that Len seemed to have developed a friendship with another child in the class and was spending much less time on his own (she also mentioned that this other child was usually a bit of a loner so they both seemed happier and would sit together in the playground).

(telephonic interview with Mrs M on 26/11/90)

Mrs M said that 'he is learning better, and concentrating better. He actually passed his exams at the end of the year and we have decided to promote him to the next standard, which I really didn't expect. I can really say that he is improved - but I can't say exactly how. He just looks much happier ... goes on, plays with the other kids at soccer and that... not so withdrawn. I must say though that he.. well, he has never been a rude child, but he is more naughty in class these days... he used to be very shy and quiet.

APPENDIX III

OUTLINE OF TRAINING PROGRAMME FOR VIDEO CLIP RATERS

You will watch two (randomly sequenced) 16 minute 'video clips' of children engaged in a set group task at different times during an 8 session group intervention. Each clip has been divided up into 2 minute 'observation' segments, separated by 30 second 'scoring' intervals.

During the observation segment you must watch the target child and rate his behaviour according to the following scheme:

'Absence' vs 'Presence' of interaction, where:

- (W) indicates absence of interaction (*i.e.* withdrawal) and suggests a desire to avoid interaction *i.e.* child does not engage in shared activities either in co-operation or in competition with another child but engages in solitary, unoccupied, or onlooker activity. W is scored only when the child is involved in no interaction at all during the 2 minute time period; and
- (I) indicates presence of interaction and suggests a desire for verbal or physical contact with another. This includes making eye contact, and non-verbal 'entry' signals (such as leaning forward into a group);

'Other-initiated' vs 'Self-initiated' interaction, where:

- (O) indicates other-initiated interactions *i.e.* those which are instituted by the other party, or on the suggestion or instruction of a third party (*e.g.* a co-facilitator suggests "Sam needs to use the glue, why don't you pass it to him?");
- (S) indicates self-initiated interactions *i.e.* those which are entered into spontaneously;

'Negative' or 'Positive' outcome of interaction, where:

- (N) indicates negative outcome characterized by: an increase in conflict, competition, division amongst participants; and/or an outcome which is experienced as aversive by one or both of the participants in the interaction; and/or one in which the participants needs have not been met;
- (P) indicates positive outcome characterized by: some mutual satisfaction; and/or a reduction of conflict, or competition; and/or maintenance of interaction, or co-operation;

During the scoring interval you may rest, catch up or check over your scoring, or make any comments about the quality of the child's interaction (use rating schedule provided).

If you feel that you have lost concentration or missed an important interaction during any segment of the video clip, please ask for that segment to be replayed immediately.

In the first clip the target child will initially appear at the bottom right hand side of the screen, dressed in a mauve and white jacket.

In the second clip the target child will initially appear at the bottom left hand side of the screen, dressed in a navy blue jacket.

He will be pointed out to you as the video begins.

Some examples of scoring situations are presented below so that you can practice using the scoring categories.

Example 1:

"Target child spontaneously grabs a pen out of the hand of a peer causing the peer to hit back".

Score: S I N

a self-initiated (S) interaction (I) with negative outcome (N).

Example 2:

"Target child is sitting quietly drawing. A peer leans over and grabs the crayon he is about to use. He watches impassively".

Score: no active interaction from target child

Example 3:

"Target child watches peer using glue. He puts his hand out and whispers 'Please', indicating that he wishes to use the glue. Peer does not notice him and passes the glue to another child".

Score: S I N

a self-initiated (S) interaction (I) with negative outcome (N).

Example 4:

"Peer notices that target child is struggling to tear a piece of cardboard and so hands target child scissors".

Score: no score as target child is not active in interaction.

Example 5:

"Peer notices that target child is struggling to tear a piece of cardboard and so hands target child scissors. Target child smiles and says thank-you".

Score: O I P

an other-initiated (O) interaction (I) with positive outcome (P).

Example 6:

"Target child makes eye contact with peer. Peer notices and returns eye contact".

Score: S I P

self-initiated (S) interaction (I) with positive outcome (P).

Example 7:

"Target child is sitting watching children. Facilitator asks target child 'What do you need next?'. Target child replies 'scissors' whereupon peer passes scissors to target child".

Score: O I P

other-initiated (O) interaction (I) with positive outcome (P).

EXAMPLE OF RATING SCHEDULE FOR VIDEO CLIP ANALYSIS

W: withdrawal O: other initiated N: negative outcome
 no interaction
 I: interaction S: self initiated P: positive outcome

VIDEO CLIP RATING SCHEDULE

SEGMENT	CLIP ONE	CLIP TWO
1		
2		
3		
4		
5		
6		
7		
8		

APPENDIX IV

SUMMARY OF LEN'S CASE HISTORY AND MENTAL STATE EXAMINATION

Len is a 9 year old std 1 boy who was referred by his mother because of poor school performance. He presented with a 3 year history of general scholastic problems (described as "forgetfulness") and crying, irritability, tantrums, and a 6 month history of physical and verbal aggression.

He lives with his 39 year old mother and 14 year old sister in a small rented house. His parents divorced 3 yrs before (in 1986) following the arrest of his alcoholic, unemployed father. Their 13 year relationship was conflictual and violent, and there was evidence that Len was physically abused by his father. Mother now has a 27 year old boyfriend.

The family relationships are characterized by withdrawal and disengagement. There is a history of physical violence in the home, with possible ongoing physical abuse. Len has little contact with his father, is ambivalent towards him, and afraid of him (once hiding in the classroom because he thought he saw his father at the school gates). Mother is a factory worker who works long hours and weekend shifts; she is both physically and emotionally unavailable. Discipline and nurturance are inconsistent and Len spends most of his time alone.

Len's birth and developmental history are normal. He displays some neurotic symptomatology in that he grinds his teeth at night. He is described as a sensitive, quiet, shy child who expresses emotion in physical acting out. His peer relationships are poor; he is bullied and teased (*e.g.* his peers hang his satchel over the balcony so that he cannot retrieve it), and his friends apparently 'steal' (toys, food, books, clothing) from him.

Len speaks Afrikaans at home, yet he started Sub A in an English medium class in 1986 (at 6 yrs). During this year he moved schools and home twice due to family violence, his parents divorced, his father was jailed, he was involved in a minor car accident and he subsequently failed Sub A. He repeated Sub A in the Afrikaans class and joined an "oorplasingsklas" (a bridging class) from Sub B onwards. He is presently in Std 1 and is performing at a below average level. His maths is especially poor.

Len presents as a slightly-built, passive and avolitional boy. He sits almost motionless during the interview and does not engage with play materials. His speech is quiet and indistinct, and comprises primarily single words or phrases. He makes little spontaneous contact and his affect presents as restricted and sad. Results of a cognitive assessment (Senior South African Intelligence Scale in Afrikaans) suggested that Len functions towards the upper end of the average I.Q. range. There was no significant

Verbal - Non Verbal discrepancy or subtest scatter. His performance indicated impaired concentration, increased distractibility, lowered frustration tolerance. On the Draw-A-Person he scored a 'Mental Age' equivalent to 11 yrs 9 mnths (superior I.Q. range). Projective testing (Bene-Anthony Family Relations Test, Draw-A-Person, Kinetic Family Drawing, Rorschach) revealed:

- a possibly enmeshed relationship with Mother; he has extreme dependency needs and feels deprived of her attention;
- ambivalence towards Father;
- feelings of insecurity and inadequacy;
- depressive tendencies; asponeneity and lowered emotional responsiveness (possibly as a result of depression);
- difficulty acknowledging negative feelings and a tendency to act out his aggressive impulses;

On the basis of this history and presentation Len was diagnosed as suffering from Dysthymia - early onset, primary type (DSM-III-R, 1987).

APPENDIX V

TRANSCRIPTS OF SEGMENTS OF THE GROUP SESSIONS

SEGMENT 1: FUNNY FACES VIDEO (session 4):

(There were large cardboard boxes in the room which children tended to sit in when they were anxious and in need of containment)

We were attempting to plan and act out a 'movie' but this was proving difficult to achieve as children were still unable to work as a group. Facilitator 1 suggested we make a 'funny faces' movie where we all pull faces at the camera (*i.e.* scaling down goals and expectations to make these attainable for the children). The session progressed thus:

"The children were very enthusiastic about this. We all lined up and made funny faces in front of the video with much delight. The facilitators brought the video equipment into the room, set limits on the use of the equipment by saying that only facilitators could touch the equipment, and suggested we all sit down to watch the result of our efforts. G refused to sit and continued playing on his own with the boxes. There was some jostling about where to sit by the other children. A said 'I'm gonna look stupid'. G said "I'm gonna look gross". All the children began to comment on how terrible they were going to look. A climbed into a box. Facilitator 1 said "I think we are going to see some very funny faces on that video". Facilitator 2 said "Boy ! some of you were really making interesting faces" and she mimicked a couple of the children's faces. A got out of the box but still hung on to it. Facilitator 2 turned on the video and we watched it with much hilarity. Facilitators kept pointing out funny things about each child's faces, trying to 'stroke' the children as much as possible. The video clip finished and Facilitator 2 commented that we had really made a success of that movie because everyone had joined in together. A and C shouted that they wanted to see the movie again, and then that they wanted to make another one. Facilitator 1 pointed out that time was running out and suggested that the children think about characters and a story for next weeks movie. A and C said they wanted to be clowns, and G said he wanted to be a joker. G asked F (a withdrawn and rejected child) his name and playfully bashed him over the head with a pillow when F responded".

There were some more spontaneous interactions between the children, including some competition during which F began to assert himself for the first time. There was also some successful negotiation of sharing out of boxes. The session ended shortly after this.

SEGMENT 2: SNAKE GAME (session 4):

This interaction occurred towards the end of a session and involved a very withdrawn and rejected child (F) and an insecure, bullying child (G).

"F picked up the snake and said "remember, we still have to do Willie Worm". E and G tried to grab the snake from F. After some jostling G won possession of the snake. Facilitator 1 grabbed the tail of the snake and wrapped it around G, pretending to eat G up (tickling him at the same time). G laughed. F was hanging around, watching this interaction but unsure of how to join the game. Facilitator 1 wrapped the snake around F, pretending to eat him up, and then left the snake with F. F began to chase G with the snake and they began to play with one another, chasing one another around the room with the snake.

Facilitators called the children together to finish off. Facilitators usually ended off the session by giving the children letters to remind them off the forthcoming group, but this session they suggested to the children that they write letters to one another. After some negotiations and arguments about who would write to whom, G declared that he would write to F, and E shouted that he wanted F to write to him.

SEGMENT 3: STARS FOR SPECIAL PEOPLE (session 7)

Children are planning a termination party, but one child (D) is reluctant to participate. He is running about the room.

"D leaves the board and runs to the table. Amongst the facilitators equipment he finds the sticky stars and asks if he can take them home. Facilitator 2 says that the stars are only for special people and each child can have a star when they tell us why they are special. A and C say that they are not special. G disappears to the corner to draw with crayons. Facilitator 2 says "I think you are very special", and Facilitators go round to each child in the group asking them to tell one thing that is special about themselves, and praising them for this quality. e.g:

D says "'cos I come every time to group";

E says "yes, I also don't miss the group ever";

A says "because I am going to bring all the nice stuff to the party";

F can't think of anything so Facilitator 1 says "I am sure that you will think of something as you always have such good ideas, we will give you some time to think" and eventually F says "because I am the eldest boy in my family";

C whispers her idea to Facilitator 2 as she is too shy to say it aloud to the group. Facilitator 2 affirms her for her quality and invites her to tell it to the group. She tells facilitator 2 to tell it aloud, so facilitator says "C says she is special 'cos people like her";

B can't think of anything and looks embarrassed. A suggests that he is special because he is always quiet and he never interrupts;

Each child gets a star stuck to his/her forehead. D wants another star so Facilitator 2 suggests we go around again and this time Facilitators tell the children one special thing about each. Facilitators give children affirmative feedback (focusing on reframing problems, or pointing out the positive aspect of difficult behaviour, or reinforcing hidden qualities); e.g:

D is very loyal to his friends;

E is always thinking of others;

F has lots of good ideas;

A knows what she wants and says so, and when she tells people what she wants in a nice way she has good ideas;

C can be independent and do things on her own very well;

B is good at using games to get on with people and helping them to have fun, and can also use talking to get on with people when he wants to;

G comes to claim his stars saying "I am special too 'cos I was born on the 7th day". Facilitators tell him that he is also very good at leading and organizing especially when he listens to others. It is difficult for him to acknowledge praise and he insists that he is only special because of his birthday. He is given 2 stars.

APPENDIX VI
EXAMPLE OF LETTERS SENT TO PARENTS



Child Guidance Clinic

University of Cape Town · Chapel Road
Rosebank 7700, Cape, South Africa
Telephone: (021) 685-5692

Dear Mr and Mrs

C shows she is a capable child who can work independently.

She is starting to gain confidence in this ability and is becoming more and more able to be a co-operative force in the group.

Greetings
Jenny and Natalie.



Child Guidance Clinic

University of Cape Town · Chapel Road
Rosebank 7700, Cape, South Africa
Telephone: (021) 685-5692

Dear Mr and Mrs

M is becoming more responsive to other members of the group and is starting to initiate contact himself.

He seems ^{to} quietly enjoy being in the group and responds well if he is sensitively drawn into activities.

Greetings
Natalie and Jenny.



Child Guidance Clinic

University of Cape Town · Chapel Road
Rosebank 7700, Cape, South Africa
Telephone: (021) 685-5692

CONFIDENTIAL REPORT

8 November 1990

Dear Mr and Mrs C

Re: N 's progress in Children's Group

N. presents as a confident, boisterous child with excellent ability to express himself verbally. However, beneath this there seems to be a measure of insecurity. His high level of activity seems to be a way of covering up his uncertainty about whether he will be liked or not. N has some good, sound problem solving abilities but cannot always use these because he has difficulty sharing attention. We became aware that N. also had difficulty accepting realistic praise, and this may indicate that he has a low self-esteem.

We noticed that when the children set up rules for behaviour in the group, N. became quieter and more contained. We enforced these rules consistently and it appeared that setting limits in this way helped him to control his own behaviour better. He seemed to feel more secure in the group and he was able to think more of other children (learning to give and take) and consider their needs. During the group he became more aware of some of his strengths and became more able to accept and use praise.

There are a number a ways in which N. can be helped to get along better with other children;


- (i) setting consistent limits on his difficult behaviour would help him to feel more contained and possibly help him to control his own behaviour better. We found that the most effective discipline methods were time-out, and restriction of privileges, and we found that Naqqaash responded well to these;

(ii) he needs to be given a lot of praise which is specific and practical, which points out exactly what behaviour is approved of, and focuses on particular things that N: does well;

(iii) he needs to be encouraged to spend as much time as possible with children of his own age so that he can continue to learn to "give and take";

Best wishes for the future.

Regards



Natalie Leon and Jenny Twigg
Intern Clinical Psychologists

APPENDIX VII SUMMARY OF GROUP PROCESS

SESSION 1:

Len - Slow to join group, attempts to identify with facilitators and is very compliant. Very quiet and withdrawn, and just sat watching everyone else during group task. Seemed unsure of how to enter group. Indicated his desire to enter group by rocking his body but not able to verbalize (unable to even ask for a crayon). He began taking a more confident position in group after the late entrance of one more child who then became the outsider (anger was expressed towards this child who entered the group half-way through). Still unable to join in with group he withdrew along with latecomer, forming a subgroup with the latecomer.

Group - Theme: competition, sibling rivalry. Characterized by extremely high levels of anxiety. Members obviously defensive, and unable to acknowledge negative feelings. Disruptive subgrouping between 2 members who acted out extreme anxiety, and split between boys and girls. Cohesion only achieved briefly towards end when discussing a password for the group. Facilitators responded by trying to control.

SESSION 2

Len - Very quiet, and withdrawn but tried to engage with single peers by standing close to them. Others tended not to notice him. Made no verbal overtures or contributions. Towards end he began to ally himself with the powerful disruptive sub-group and gained some confidence via being accepted into this subgroup.

Group - Theme: Testing out, competition. There were beginnings of some trust and attempts to relate. But facilitators anxiety caused movement to task and these attempts were not praised sufficiently. Thereafter, there was plenty testing out and best-beloved behaviour. Entire group (including sub-groups) became less cohesive. Facilitators found it difficult to acknowledge bad feelings and responded to testing out by taking more control; this resulted in inadequate problem-solving as facilitators tended to impose decisions on the group when threatened with loss of control. Facilitators tended to forget to affirm the disruptive members. In general, there was some growth in the testing out and exploring of interpersonal relationships in the group.

SESSION 3

Len - Began testing out by quietly refusing to participate at times. Began to interact more with peers and was less compliant towards facilitators. Showed some assertive behaviour.

Group - Theme: Trust. Characterized by expression of negative feelings which was extremely frightening for the group and difficult to contain. There was a general increase in spontaneous dyadic interactions between peers and decreased interaction with facilitators, and greater independence and problem-solving. However, the girls were split off in separate sub-group, while a power struggle between two members of the dominant sub-group caused some dispersion of this sub-group. Cohesion was low. Children had very little confidence in themselves and this, as well as the power struggles, hampered attainment of task goals. Children ambivalent about ending. In the main the session was successful in demonstrating acceptance and setting norms, both of which are important for building trust. Facilitators achieved more expression and acknowledgment of feeling, and better use of positive reinforcement. The children responded well to facilitators better acceptance of themselves, their ambivalence, and negative feelings. In general, better attention to maintenance requirements but poorer achievement of task requirements.

SESSION 4

Len - Absent

Group - Theme: sibling rivalry, brief working phase. Sub-groups began to disintegrate. Although it was difficult to share and work as a group (primarily due to low self-esteem and lack of confidence), the children were able to work together for a short time on the funny faces video. This improved their self-confidence and allowed some effective problem solving. Facilitators focused on containing and affirming children as much as possible.

SESSION 5

Len - Initially attention seeking and disruptive, making lots of noise. Was largely left out of movie making due to unassertiveness. Swapped phone nos with another child at end of group.

Group - Theme: testing out, sibling rivalry, ambivalence about dependence/trust. Characterized by expression of anger, disappointment and frustration at individual needs not being met (exacerbated by separation issues). Group dispersed and fragmented. Children responded by taking more control for themselves and uniting against facilitators. Although task requirements were hampered by low self-esteem and fear of failure, some effective problem-solving was achieved. There was some swapping of phone nos.

and suggestions that they visit one another. Facilitators found this session very difficult and felt totally out of control. They used lots of affirmation.

SESSION 6

Len - Identifying more strongly with one other child who tends to act as peacemaker. Some attempts to copy/model this child's behaviour.

Group - Themes: belonging, co-operation (working phase). Children managed to play some games which required group participation and co-operation. Task requirements were achieved (social skills training focused on co-operation, problem-solving, listening). There was strong expression of wanting to belong to the group. After being reminded of the up-coming termination children became babyish, dependant and demanding. Ambivalence about group expressed. Facilitators used lots of affirmation and physical holding (hugging) of the children.

SESSION 7

Len - Very quiet, co-operative and considerate of others. Trying very hard to look out for others (made very nice hat and unobtrusively demonstrated for and aided a child who felt unable to make a hat). Showed initiative and determination in achieving goal.

Group - Theme: termination issues. There was some working together but this was disrupted at times by individuals anxiety about termination. Expression of anger at facilitators for termination, reluctance to terminate. Behaviour was babyish. After concrete positive feedback from facilitators they settled down to work well on a co-operative group task (during which children were more able to ask for help, attempted to identify with other members, and shared more readily even to the extent of neglecting own needs to satisfy the needs of another). On leaving children asked to take things home, and 2 children made arrangements to meet after termination. Facilitators were affirming but firm with the children (less controlling and more containing).

SESSION 8

(Food seemed to representing love and attention for the children and they all displayed different relationships with food; e.g: kept control of the food; expressed anxiety that we would run out of food or that food would not be enough; expressed guilt about indulging in food; hoarded food; withdrew from food;

Len withdrew and got by with very little - sitting eating only one biscuit from a spread of cakes, sweets, chips and biscuits. He had to be invited to have more. When the food was wasted he got very upset).

Len - Initially withdrawn but later attempted to join with another child by sharing pillows. Was quick to team up with another child in a paired activity, and chose to write a goodbye letter to the most popular child in the group.

Group - Theme: ambivalence about termination. Children were demanding. They expressed anxiety about whether there would be enough food to go round and whether they could eat as much as they liked; they were fairly preoccupied with themselves and their own anxieties about the 'food'. Only after considerable reassurance were they able to offer food to one another, consider others needs, pour for others, and even praise another child. Although in session 7 children found it difficult or impossible to think of positive things to say about themselves, in this session there was some indication that certain children had incorporated a sense of achievement ("I was in it - one of the best"). There was also more sense of group cohesion ("I need ... we need some more milk"). There was an increase in some behaviours we had reinforced, *e.g.* assertiveness from F. However, as the session neared its end the children became more concerned about termination and more dispersed. Ambivalence was expressed directly, as were feelings of sadness and anger at facilitators. At the end the children took great care in writing letters to one another and Swapped addresses. Facilitators struggled to find the balance between task and maintenance and did not adequately deal with the anxieties about termination (perhaps because of facilitators own anxieties about termination and needs to have achieved certain things).