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Group Interventions and Exercises for Enhancing Children's Communication, Cooperation, and Confidence

Introduction

ABOUT THIS BOOK

This book stems from years of research and clinical experience working with children to improve their social relationships. In cooperation with Dr. Nancy Guerra and colleagues at the University of Illinois at Chicago, the author set about developing a social skills group therapy intervention to help children make and keep positive friendships. The primary goal of this endeavor was to develop a program that would be widely applicable to a variety of peer problems, rather than focusing on specific negative behaviors such as aggression. Communication and cooperation skills are essential within any social relationship. When children are able to communicate and cooperate well with others, their confidence rises. In turn, children who are more confident are better able to cope with social adversity, such as teasing and rejection. Reflecting the emphasis on these three areas, the social skills group therapy program outlined in this book is entitled the "3-C Program: Enhancing Children's Communication, Cooperation, and Confidence."

In developing the 3-C Program, the author drew on, among others, the YES I CAN social responsibility training program (Guerra et al., 1993), coaching programs (e.g., McFall, 1976; Oden & Asher, 1977), and anger coping training programs (e.g., Lochman et al., 1993). The 3-C Program social skills group intervention primarily reflects social learning and cognitive-behavioral theoretical perspectives and incorporates techniques and strategies as well as methods of teaching that have been deemed effective for improving children's peer relationships and behavior (see Asher, Parker, & Walker, 1996, and McFadyen-Ketchum & Dodge, 1998, for reviews).

PROGRAM OVERVIEW

Children's social relationships have a tremendous impact on their academic, behavioral, and emotional functioning. When children lack friends or are actively excluded or rejected by their peers, they are at-risk for a wide variety of problems, including school failure, alcohol and drug abuse, serious aggression and criminality, depression, and poor social relationships into adulthood. There are many different reasons why children may experience problems in their social relationships with peers. Children with immature social skills and inappropriate social behaviors are particularly likely to experience problems interacting with other children. As children experience social failure, many become increasingly negative about themselves and anxious in social situations. They may withdraw, becoming more socially isolated, or they may act out their anger and frustration on others. Over time, children with peer problems tend to come together, compounding negative behaviors and attitudes. In effect, a vicious cycle develops where poor social skills, social anxiety, and negative attitudes reinforce each other over time, propelling a child further down the path toward serious academic and/or behavioral problems. (For reviews of research on peer relationships

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and their impact on children, please see Asher & Coie, 1990; Bukowski, Newcomb, & Hartup, 1996; and Parker et al., 1995.)

The 3-C Program is a group therapy intervention designed to build children's social skills and social relationships with peers. The overarching goals of the 3-C Program are (a) to build basic behavioral and cognitive social skills, (b) to reinforce prosocial attitudes and character traits, and (c) to build adaptive coping strategies for social problems. As children's social skills improve and they gain practice and reinforcement for positive social behavior, their self-esteem and self-confidence increase. Greater confidence enables children to try new social behaviors with peers outside of group. In this way, the skills learned through the 3-C Program can be generalized to the relationships in the regular peer group.

A number of basic social skills are taught and practiced through the 3-C Program, including communication (verbal and nonverbal), cooperation, impulse control (Stop & Think), perspective taking, conflict management, and initiation of play/conversation. Children are encouraged to set appropriate goals and assess the consequences of their actions. Prosocial attitudes and character traits, such as respect, responsibility, perseverance, empathy, and self-control, are emphasized throughout the group sessions. Negative assumptions about themselves and others are directly combated. The group sessions address specific social problems, such as being teased and rejected by others and peer pressure. The group leaders work with the children to develop more appropriate methods by which to cope with these stressful social experiences.

The 3-C Program emphasizes not only social behavior, but also cognitive and emotional components of relationships. Each of these components is an integral part of social interactions that can either enhance or disrupt the quality of a relationship. The 3-C Program strives to increase children's awareness of how their thoughts and feelings can interfere with their social behavior and, thereby, improve their control over their behavior. By weaving together social skills from a more holistic perspective, including behavior, cognition, and emotion, the overall effectiveness of the intervention can be enhanced.

INTENDED PROVIDERS

The 3-C Program is designed to be used by mental health professionals, including psychologists, school counselors, and social workers. Any professional who treats children for social, emotional, and behavioral problems can use this program to help children develop better social skills and coping strategies. It is essential that the mental health professional have adequate training and experience working with children through group therapy. However, this book is written in a very detailed and descriptive fashion so that mental health professionals will have little difficulty implementing this new intervention. In addition, with proper training, less experienced undergraduate and graduate students or employees can successfully lead 3-C groups under the supervision and guidance of a trained mental health professional.

APPROPRIATE SETTINGS

The concepts and skills taught within the 3-C Program are universally applicable to all social relationships. Neighborhood friendships, sibling relationships, and peer relationships within the school, camp, or residential program can all be improved by building children's communication and cooperation skills and self-confidence. The 3-C Program is designed so that groups can be easily implemented within a wide variety of settings, including, but not limited to an independent practice, elementary or middle schools, community mental health centers, hospital and residential programs, Boys and Girls Clubs, and Y programs. The 3-C Program is flexible so that it can be used within a clinical setting or in a programmatic manner across multiple settings. It is essential that the group leaders be appropriately trained mental health professionals with experience implementing groups with children. If this is not the case, appropriate training and supervision is critical.

BENEFITS OF A GROUP INTERVENTION

Peer relationship problems are social in nature. It is the quality of the interactions between the child and his or her peers that is problematic. Understandably, group interventions are often the treatment of choice. In a group, children are able to learn and practice social skills in vivo with other same-aged children. Peer interactions in a group environment occur in real time so that group leaders can directly intervene with problem situations and reinforce positive changes as they occur. At the same time, a group setting is more structured and safe than real-life peer settings, so that fear of rejection and teasing is decreased and willingness to try new social behaviors is increased. Also, children receive immediate, constructive feedback from peers.

The professional may wish to augment group therapy with individual therapy. Individual sessions with children who also attend group can be particularly helpful for (a) reinforcing progress made in group and (b) privately increasing children's awareness of their social difficulties getting along with peers. More generally, it is important to note that though the 3-C Program is designed as a group therapy intervention, many of the activities and workbook exercises are easily transferable to an individual therapy setting.

CHILDREN WHO WOULD BEST BENEFIT

All children can benefit from enhancing their communication and cooperation skills and building their social confidence in working with others. Children want positive friendships and they all must face social adversity, such as teasing and rejection, at some point. Although the skills taught within the groups are widely applicable, the 3-C Program is designed to particularly address the needs of elementary-aged children with three specific sets of peer difficulties: (a) children with immature social skills relative to other children of the same age; (b) children with few, if any, close friends and/or who experience rejection and teasing by their peers; and (c) children who are socially anxious and awkward with their peers. Children with impulse control problems, such as Attention-Deficit/Hyperactivity Disorder, are appropriate for the groups. These children often have significant difficulties with their peers, such that they may be included in one or all of the above categories.

The group sessions teach a broad array of social and communication skills, including anger-control and conflict management skills. By building basic skills and improving social relationships, the 3-C Program aims to prevent the development of serious aggression or violence and to build nonaggressive children's ability to cope with social adversity. Children with moderate levels of aggression can be included in the groups. However, research shows that group therapy may worsen aggressive behavior if aggressive children are placed together and mutual reinforcement for aggressive behavior and attitudes occurs. It is important that groups include only one aggressive child, so that the other children model less-aggressive responses and the aggressive child is not provided with a peer who reinforces his or her aggressive behavior and attitudes. Children who are already excessively aggressive would best be served by participating in an intensive anger-control/conflict management group therapy and/or individual therapy before entering the 3-C Program.

IDENTIFYING CHILDREN FOR THE 3-C GROUPS

The following methods can be used to identify children with the preceding characteristics. Use of more than one method will increase the accuracy of identifying children in need of group social skills intervention.

- *Teacher Referrals* (see Teacher Report Measures, pp.11-13). Classroom teacher referrals are particularly useful for identifying children in a school setting who have immature social skills relative

to same-age peers. When asked to identify children with peer problems, teachers tend to nominate unpopular children who disrupt and bully others in a more overt and detectable fashion. However, a significant amount of rejection and teasing occurs outside of adults' awareness. As a result, teachers identify only about half of the children who experience significant isolation or teasing by peers. For this reason, it is recommended that classroom teacher referrals be combined with referrals from other adults, such as parents, school counselors, and/or nonacademic teachers (e.g., PE, Music, and Art). Combining referrals from adults who see children in different settings with different social demands will increase the likelihood of identifying children with more covert social difficulties.

- *Agency Referrals* (see Agency Referrals, pp. 15-17). Similar to teachers, personnel within a variety of agencies, including residential treatment centers, hospitals, and outpatient mental health centers, can provide referrals for group therapy. It is important that the nominating person be sufficiently familiar with the children and have access to observing their social behavior with peers. Again, combining referrals from more than one person would maximize the ability to identify children in need of group services.

- *Parent or Other Adult Referrals* (see Parent and Other Adult Measures, pp. 19-21). Within private practice and outside of the school setting, referrals from parents and other adults are essential for identifying children for group services. Often social difficulties are not the primary reason that parents seek professional services for their child. However, relationship problems are central to many psychiatric diagnoses, either as a key symptom or as a consequence of other symptoms. The stress caused by peer problems may worsen children's psychiatric symptoms and negatively impact their adjustment. It is the job of the professional to determine the degree to which social problems contribute to and are the consequence of other psychological or behavioral difficulties, such as depression, anxiety, acting-out, autism, and academic failure. Attention to the quality of children's social relationships during the assessment phase of treatment will promote an awareness of the importance of social functioning for the child's adjustment and will help identify those who would benefit from a social skills group.

- *Peer Nominations* (also known as Sociometrics or Sociograms). Peer nominations provide the most accurate information about which children are rejected, isolated, and/or victimized within the peer group at school. Peer nomination techniques have been widely used for over 50 years to identify children with peer problems at school. Sociometrics entails asking children to nominate peers in their grade who match a given description. This procedure is too detailed to fully describe here. For further information, please consult the journal article by Coie, Dodge, and Coppotelli (1982).

- *Child Self-Report* (see Child Self-Report Measures, pp. 23-26). There are a number of available self-report questionnaires for children as young as 7. Some children do not yet experience an extreme level of peer problems, but they lack self-confidence in working with others, are socially anxious in groups or with new children, and/or are unhappy with the quality of their friendships. Associated social withdrawal and awkwardness can then set into motion a vicious cycle leading toward social isolation and rejection. Children often keep their feelings to themselves such that teachers and peers are less able to identify socially anxious and insecure children. The most accurate way to identify children with these types of social difficulties is to use self-report. The Child Self-Report Measures explains several questionnaires that Dr. DeRosier and other researchers have used to help identify children with social anxiety or perceived social problems.

CONFIDENTIALITY OF IDENTIFICATION

Regardless of what identification method is utilized, confidentiality must be maintained. It is the responsibility of the mental health professional to keep all personal information private and to establish procedures by which to secure all information. School personnel and other adults and children should not be

privy to information obtained through the identification methods and group therapy unless a signed release of information form has been obtained from the parents.

PARENTAL CONSENT AND INVOLVEMENT

Consent procedures vary across settings. Standard procedures for obtaining parental consent within a given setting should be implemented. These procedures will be most crucial in a school setting rather than a private practice where parents generally initiate treatment for their child. Consent for the identification procedures as well as for involvement in the group therapy should be obtained.

Parent involvement in any child intervention enhances efficacy for a number of reasons. First, parents who are educated regarding the skills and goals of their child's treatment can support and reinforce positive changes within the home environment. Second, parental involvement may enhance communication between home and school/treatment center and promote joint efforts. Third, parents who are involved in their child's treatment may value and support intervention efforts to a greater extent, modeling positive attitudes toward psychological treatment.

Any method by which to increase parental involvement in therapy should be implemented. For the 3-C groups, it is recommended that group leaders share the Child Workbook and periodic progress reports with the parents, meet with parents periodically to discuss progress, and send home information sheets with descriptions of the vocabulary and activities that are used. Parents can be a tremendous source of reinforcement and support, and can help children generalize the skills they learn to their friendships outside of group.

GROUP SESSIONS

Ten group therapy sessions are included in the 3-C Program to systematically teach and build specific social skills. Each session is designed to be implemented during a 1-hour session. If less time is available, certain topics or activities can be skipped. A scissors symbol (✂) is inserted in the text of each session to indicate preferred topics or activities to cut if time runs short. Similarly, a watch symbol (☉) indicates methods by which to cut the time requirements for certain activities. If at all possible, however, the preferred strategy would be to increase the number of sessions so that all topics and activities can be included.

As with academic skills, a step-wise approach is used to teach social skills, in which each session reviews and builds on past sessions. Each session contains detailed scripts and instructions for activities designed to achieve several specific goals. Recommended verbatim material is presented as **bolded text**. Suggestions for alternate procedures for younger children and/or for use specifically within a school setting are presented as *italicized text*. Reproducible activity sheets for each session are included in the 3-C Program Workbook. The Resources on pages 11 to 30 include a variety of methods that should be used to promote the use and effectiveness of the group therapy, including methods for identifying social relationship problems, behavior management techniques (pp. 27-28), and reproducible attendance and progress note sheets (pp. 29-30).

RECOMMENDED GROUP STRUCTURE

The following guidelines are recommended in order to structure groups in the most effective and functional manner.

Leaders: Proper training and experience working clinically with children is essential to the successful implementation of the 3-C Program. Two coleaders are recommended in order to ensure

proper behavior management, particularly in groups where impulse control problems are prominent.

Group Size: Each group should include between six and eight children in order to best implement activities and to provide ample social opportunity to practice skills.

Time: Each session is designed to be completed within a 55- to 60-minute timeframe. If less time is available, the professional can either carry over uncompleted sections to subsequent weeks and add additional sessions or delete sections as deemed appropriate. Completing workbook activities aloud and as a group, rather than writing responses individually, can also cut down on needed time during sessions.

Gender: Same-gender groups are typically recommended, though mixed-gender groups can be used if there are at least two of each gender within the group. It appears that boys benefit more from mixed-gender groups than do girls.

Age: Approximately same-age children are recommended (i.e., within 2 years). The program is best suited for children ages 6 to 12. Age-appropriate alternatives are included in order to better tailor group activities to the children's particular developmental level.

Reading Level: Relatively little reading and writing is required during the sessions. If the reading level of children is below third grade or children have reading or written language learning disabilities, it is recommended that the group leaders modify workbook and group activities, as appropriate, in order to minimize the reading and writing requirements. Reading questions aloud and obtaining verbal responses are helpful in this regard. Spelling and punctuation errors should be ignored.

Familiarity: Reputational biases can be difficult to overcome and can interfere with group cohesion. Friends or enemies in a group can serve to divide the group into separate camps. Placing children who do not know each other or who are less familiar with one another is recommended whenever possible. When not possible, the group leaders should pay special attention to emerging subcamps and intervene to ensure group cohesion.

Similarity: High homogeneity in the social problems of group members poses the threat of reinforcing problematic social behaviors, especially aggression. High heterogeneity poses the threat of low group cohesion. A moderate level of heterogeneity is recommended with no more than one highly aggressive child per group. Moderate heterogeneity will also minimize the likelihood of stigmatization by making it less easy for others to identify why children were selected for the group.

ROOM SET-UP

In general, the group room should be quiet and separate from other children in order to provide privacy and decrease interruption. A chalk- or white board will be needed for each session. Desks or chairs should be placed in a semi-circle to increase interaction among children. A tape recorder and cassette will be needed if the group leaders wish to tape sessions. Taping is often useful for supervision and review during training in the 3-C Program. Before taping occurs, explain the purposes of taping and how privacy will be maintained. Address any concerns, but do not record the sessions without permission from parents and full cooperation and assent by all children.

GENERAL SUPPLIES

The following supplies will be needed for each session:

- Attendance and progress note (see Attendance and Progress Note, pp. 29-30)
- Pencils and sharpener
- Crayons or colored pencils to be used for coloring activities
- Ticket board with tickets (see Ticket Board Construction, p. 31)
- Posterboard with group rules displayed (see 3-C Program Rules, p. 33)
- 3-C Program Title Handout (see 3-C Program Title Handout, p. 35)
- Stickers to be used to reward children for being responsible in bringing their workbook to group each session. Stickers should be interesting and motivating for children. Bright colors and interesting content (e.g., popular cartoon characters or sports figures) will work best.
- Small prizes (e.g., decorated pencils, pencil grips, post-its, glue sticks, notepads, special folders, pens, cool erasers, rulers, rings, buttons, or any inexpensive but interesting item) to be used for the short-term behavior management contract. Low cost items are sufficiently motivating ($.25-$.50 for small prizes, $2-$3 for medium prizes, and $3-$5 for large prizes). The leader can either hand out these items to the children or allow them to choose from a selection.

PROGRAM EVALUATION

One method of assessing the effectiveness of the 3-C Program is the evaluation of prepost data. In other words, information about children's peer relationships or other adjustment areas (such as self-esteem or academic performance) should be collected using the same methodology before and after the administration of the group therapy. Then, changes in the quality of children's peer relationships as a function of participation in the groups can be examined. However, it is advisable to obtain prepost data on all children within a setting. Changes in these areas are seen typically as children develop over time. Comparing the degree to which peer relationships or other adjustment areas change for children who did versus did not participate in the groups would be most informative.

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Resources

Resources

Teacher Report Measures

TEACHER QUESTIONNAIRE

The Teacher Report Form (TRF; Achenbach & Rescorla, 2001) is a widely used and statistically sound screening tool for a variety of internalizing and externalizing problems, including social problems. On this questionnaire, teachers report the frequency with which over 100 symptoms have been present for a child over the past 6 months. T-scores for several scales are generated: Withdrawn, Somatic Complaints, Anxious/Depressed, Social Problems, Thought Problems, Attention Problems, Delinquent Behavior, and Aggressive Behavior. T-scores above 70 indicate a significantly higher level of problem behavior than would be expected of a child of the same gender and age (i.e., greater than 98th percentile). Because this questionnaire is very lengthy and needs to be completed for each child of interest, for the purposes of identification for group, it may be helpful to include only the items pertaining to social problems.

TEACHER REFERRALS

Teacher referrals are an efficient method for identifying children in the school setting who would benefit from participation in group therapy. It is important to be as specific as possible in describing the targeted set of social problems. The next page includes a sample form for obtaining teacher referrals for social problems. Each item identifies a specific problem area:

A. Unpopular/Rejected
B. Shy/Isolated
C. Aggressive
D. Teased/Victimized
E. Bossy
F. Immature

Other descriptions can be substituted as needed. Teachers should be informed that they can nominate the same child for multiple problem areas. This form may be copied and used, but if any research or other document is published from data gathered through use of the Social Interaction Survey (SIS) Teacher Referral Form, this manual must be referenced.

SOCIAL INTERACTION SURVEY
(Teacher Referral Form)

Instructions: For each of the following items, write the names of ALL the students in your class who fit that description. If a student can be nominated for more than one category, please write his or her name under each category.

A. Some students are very disliked or rejected by lots of other students in their grade. Often, other students don't like to play with them, eat lunch with them, or even be on the same team with them. Other students may try to avoid them or leave them out of their group during work or play.

1. _____

2. _____

3. _____

4. _____

B. Some students play or work alone a lot. They may be quiet, shy, and timid about joining other children. They may be anxious and insecure in social situations, self-conscious, or easily embarrassed. Most other students in their grade may not even notice or pay much attention to these students.

1. _____

2. _____

3. _____

4. _____

C. Some students often start fights or arguments with other students. They may hit, kick, pinch, or otherwise physically hurt others. They also may say mean or nasty things to hurt other students' feelings. They may tease children directly or by joking about a child with other children.

1. _____

2. _____

3. _____

4. _____

D. Some students get picked on, teased, called names, or beat up by other students a lot. Other students often make fun of them or say mean or nasty things about them.

     1. _____

     2. _____

     3. _____

     4. _____

E. Some students try to tell other students how things should be done. They want to be in charge, set rules, and give orders. These students may get impatient when other students do not do things the way these students think they should.

     1. _____

     2. _____

     3. _____

     4. _____

F. Some students act silly or immature compared to other students their age. Their social and emotional maturity level is lower than that of other kids. They may do things that are strange or inappropriate. They may be awkward or unskilled in talking or working with other students.

     1. _____

     2. _____

     3. _____

     4. _____

Agency Referrals

Agency personnel may be solicited for referral of children within the agency to group therapy. The person giving the referral must have adequate knowledge of the quality of the child's social relationships. Direct observation of the child's interactions with peers across several occasions is essential in making these referrals. When seeking referrals, it is important to be as specific as possible in describing the targeted set of social problems. The next page includes a sample form for obtaining agency referrals for social problems. Each item identifies a specific problem area:

A. Unpopular/Rejected
B. Shy/Isolated
C. Aggressive
D. Teased/Victimized
E. Bossy
F. Immature

Other descriptions can be substituted as needed. The person completing the form should be informed that the same child can be nominated for multiple problem areas. This form can be copied and used, but if any research or other document is published from data gathered through use of the SIS Agency Referral Form, this manual must be referenced.

SOCIAL INTERACTION SURVEY
(Agency Referral Form)

Instructions: For each of the following items, write the names of ALL the children in your agency program who fit that description. If a child can be nominated for more than one category, please write his or her name under each category.

A. Some children are very disliked or rejected by lots of other children. Often, other children don't like to play with them, eat lunch with them, or even be on the same team with them. Other children may try to avoid them or leave them out of their group during work or play.

1. _____

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B. Some children play or work alone a lot. They may be quiet, shy, and timid about joining other children. They may be anxious and insecure in social situations, self-conscious, or easily embarrassed. Most other children may not even notice or pay much attention to these children.

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C. Some children often start fights or arguments with other children. They may hit, kick, pinch, or otherwise physically hurt others. They also may say mean or nasty things to hurt other children's feelings. They may tease children directly or by joking about a child with other children.

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4. _____

E. Some children try to tell other children how things should be done. They want to be in charge, set rules, and give orders. These children may get impatient when other children do not do things the way these children think they should.

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2. _____

3. _____

4. _____