Thoughts, Feelings and Behaviour:

*Cognitive Behavioural Psychology and Group Work with Adolescents*

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Cognitive Behavioural Therapy derived from the work of Beck and Emery has proved useful in the medical context. It has been adapted for use in schools to evaluate whether or not such an approach would lead to beneficial changes for groups of adolescents. This article reports a study in which three groups of pupils have been through a six session programme and gains have been found in perceived levels of self control and classroom behaviour. Anecdotal evidence suggests improvements in peer relationships and self concept, though these were not found to differ significantly in pre and post group self-report ratings. Anecdotal evidence suggests that the gains made are long lasting and extend to all areas of the child’s life.

Introduction
Schools have a number of pupils who present a range of low frequency behavioural difficulties that interfere with learning outcomes or cause disruption to the running of the school. The behaviour often arises at times when the pupil is not being directly supervised, making behaviourist approaches more difficult. The low frequency tends to make it difficult to obtain accurate information about antecedents and it is often too low to establish consistent responses that could lead to contingency-based learning. Yet the frequency of the behaviour is high enough for the pupil to gradually move through the pastoral system of the school towards exclusion, or for teachers to want to seek an alternative approach to supporting the pupils in developing greater self-control. For some of these pupils, it is their emotional reactions to events in the social world of the school that lead to what would be considered an over-reaction for most pupils. This generally leads to unacceptable overt behaviour that gets the pupil into trouble and in this respect is dysfunctional. The children had been over-anxious; aggressive; often had difficult family backgrounds; may have started fights or have been bullied; their behaviour may have led to classroom disruption or disruption to breaks or lunchtimes.

The types of disruptive behaviour found in schools has been classified by Cameron (1998) into 5 major areas:

1. aggressive behaviour (hitting, pulling hair, kicking, pushing, using abusive language)
2. physically disruptive behaviour (smashing or damaging or defacing objects, throwing objects, physically annoying other pupils)
3. socially disruptive behaviour (screaming, running away, exhibiting temper tantrums)
4. authority challenging behaviour (e.g. refusing to carry out requests, exhibiting defiant verbal and non-verbal behaviour, using pejorative language)
5. self disruptive behaviour (e.g. day dreaming, reading comics under the desk etc)

The first 4 of these could be described as acting-out behaviours or externalising behaviours and have been found to be negatively predictive of self-esteem and strongly associated with peer rejection (Sletta et al, 1996). It has been argued that this is because the subjective emotional experience of loneliness strongly affects both self-esteem and self-perception of social competence (Sletta et al, 1996). This suggests that a linkage exists between emotional experience with thoughts about self and subsequently exhibited behaviour.

Such poor emotional experience or emotional difficulties amongst children may be higher than anticipated. For instance, the incidence of children with anxiety disorders has been estimated as being as high as 5.7% of all 9 to 13 year olds (Castellanos, 1999). If Sletta is right, then there are a lot of pupils who would be predicted to be at risk of presenting with some form of emotionally based behavioural difficulty.
Over the last couple of years, schools have referred a number of pupils to the County Psychological Service who have difficulty controlling their emotional responses. I have been able to use techniques from cognitive behavioural therapy (CBT) to work with them. As I would not consider myself a therapist or a counsellor, I would not say that I am engaged in therapy as such, but in an approach based upon cognitive behavioural psychology. Teachers have reported that such an approach has led to improvements in the behaviour of individual pupils that has been recognised and valued by the schools concerned. For the individual pupils it has resulted in difficulties subsiding and them being moved down the Stages of the CoP or off the Special Needs register altogether. The value of such an approach is evident by the referral of other children by the same schools asking me to ‘do the same thing as you did with X’.

Given that cognitive behavioural psychology seemed to offer some benefit with a handful of individuals seen over the last two years, I wondered whether it could be used with pupils ‘at risk’ of developing more severe emotional or behavioural difficulties. Could I work with schools in a preventative way to reduce school disruption and future referrals of pupils with behavioural difficulties? To do this successfully I would need to see more pupils and, given limited psychologist time, a pragmatic solution was needed – the pupils would have to be seen in groups!

What is CBT?
Cognitive behavioural therapy grew out of Beck’s attempts to validate certain psychoanalytical concepts of depression in 1956. He was also interested in how the precise psychological configuration characteristic of depression could be pinpointed in order to produce a brief form of psychotherapy.

Psychoanalytic theory had suggested that depressed patients need to suffer, but experiments revealed that this was not the case and, in fact depressed people were more likely than non-depressed people to avoid situations that involved rejection or disapproval. What Beck noticed was that depressed patients seemed to cognitively construct themselves as more negative in their life experiences. The development of CBT was based around the development of techniques to attempt to correct cognitive distortions through the application of logic and search for evidence. It differs from conventional psychotherapy in having an emphasis on “collaborative empiricism” (Beck, 1979). There is a deliberate interaction with the client that requires the client’s active participation and collaboration to test out hypotheses in the real world in the ‘here and now’ paying little attention to childhood recollections. The focus is on considering the client’s thinking and feeling during the session and between sessions. This means that almost “every experience or interaction presented a potential opportunity… …to test out negative predictions and interpretations”. This sets out the importance of homework or “extended self therapy” to extend what happens in each of the sessions (Bush, 1996).

Behaviourism contributed the ideas of specifying discrete goals, deciding how the goals could be achieved and setting out how to measure progress towards goals such that this could be used as feedback. CBT differs from behavioural therapy in that it has a greater emphasis on internal (mental) experiences and this requires an empirical investigation of automatic thoughts, inferences and conclusions by formulating hypotheses that the client can test in a systematic way. Bush (1996) suggests that CBT works because it sticks to the point and is structured and focussed.
Emery (1985) describes CBT as being brief and time-limited when compared to psychoanalytic therapies. It typically lasting from 5 to 20 sessions and this means that the pace of therapy is relatively brisk, it is task-orientated and focuses on problem-solving. There needs to be an agenda for each session to provide a framework for time management. Beck (1979) adds that it should be active and directive and “based on an underlying theoretical rationale that an individual’s affect and behaviour are largely determined by the way that he structures the world.”

**Theory**

CBT is based on an understanding of how we process information from the environment in order to lead to actions. It goes beyond the simple stimulus-response theory of behaviourism to include elements of internal factors, most importantly ongoing thoughts and visual images and the emotions evoked by such cognitions.

The way in which a person appraises their situation is evident in their thoughts, visual images and the way in which they construct their world. Cognitions involve a synthesis of external data with internal data to link perception and experience together into a “stream of consciousness” or “phenomenal field” (Beck, 1985) reflecting a person’s construction of himself and the world. This in turn leads to a particular affective state and associated behavioural pattern.

![Figure 1: Cognition precedes emotion](image)

Cognitions → Emotional Affect → Behaviour

This understanding of the role of cognitions as underpinning emotion was originally expressed by Schachter and Singer (1962) following experimental manipulation of arousal and environmental factors to investigate how participants attributed emotions. Schachter’s two factor theory has been developed into a four factor theory by Parkinson (1994). The underlying processes remain the same:

Cognitions are based on attitudes or assumptions developed from previous experiences and help us respond to new situations. We draw upon previous experiences of similar situations to predict what to expect and provide data on how to cope. This requires the selection and application of appropriate ‘formulas’ and activation of cognitive structures or schemas to orientate the individual, select relevant details from the environment and allow recall of relevant data.

Cognitive schemas are organised into assemblies or constellations of the structural components of a cognitive set.
The term ‘cognitive set’ refers to the expression of the controlling cognitive constellation to provide a composite picture of the situation. Activation of the schema or constellation of schemas directly influences perception, interpretation, association and memories. They are used to label, classify, interpret, evaluate and assign meanings to objects and events. A cognitive set allows the interpretation of the greatest amount of relevant information in the shortest possible time.

Under normal conditions the activation of a cognitive set leads to adaptation and problem solving. However, some of the difficulties that people face, result from an inappropriate activation of some cognitive sets. The activation of the cognitive set is started by some physical stimulation that leads to an automatic thought. This then leads to activation of other systems:
Beck (1985) illustrates this in a discussion about anxiety. The tendency to exaggerate certain situations, to the point of treating them to be a matter of life and death, over-mobilises reactions to threatening situations and over-rides normal functioning. The person brings on the very thing that they fear the most with every system in the body affected:

- the physiological system – increased heart rate,
- the cognitive system - ‘I’ll probably disgrace myself’,
- the motivational system - I wish to be as far away from the situation as possible,
- the affective or emotional system – feeling afraid,
- the behavioural system - in swaying or inhibiting thinking.

This leads to a vicious circle:
Anxiety uses up attentional capacity in scanning for threatening stimuli and this results in a lowering of resources that can be allocated to short term memory or focussing on an aspect of a specific task. The pre-occupation with danger involves “perseverative involuntary intrusion of automatic thoughts (in verbal and visual form) whose content involves possible physical or mental harm” (Beck, 1985). The automatic thoughts repeat rapidly and seem entirely plausible at the time. Emery (1985) argues that anxiety results from exaggerated automatic thinking. Often the thought is so fleeting that there is only awareness of the anxiety that is generated.

Inappropriate and dysfunctional emotions and behaviour result from cognitive distortions and the principle of CBT is to produce alterations in the content of cognitive structures produce changes in affective state and behavioural pattern by helping the person become aware of their cognitive distortions. Beck argues that correction of dysfunctional constructs will lead to clinical improvement.

**CBT Tools and techniques**

CBT is structured and directive with the structure promoting learning and providing emotional security. It helps people to make sense of their emotions by seeing them as falling into the four emotional categories of anxiety, anger, depression or pleasure, (“scared, mad, sad and glad”, Emery; 1985).

In common with many humanistic therapies the therapist is required to display warmth, accurate empathy and genuineness. Interventions are based on basic trust between the client and therapist and a well developed rapport.

Beck and Emery outline a long list of strategies used to induce the client to:

- recognise the correlation between cognition, affect and behaviour
- become aware of what their thoughts are and to identify cognitive distortions and distorted automatic thoughts
- examine cognitive distortions through reality testing and teaching how to respond to distorted thoughts with logic, reasoning and empirical testing
• substitute more balanced thoughts to replace distorted cognitions to modify long-held
dysfunctional assumptions and underlying major concerns
• make plans to develop new thought patterns

Strategies employed in CBT

Dealing with the affective component;
• accepting the feelings
• reducing anxiety about feelings
• reducing shame about the feelings
• normalising the feelings
• active acceptance – choosing to accept the
feeling rather than just acknowledging the
feeling e.g. “Hello anxiety”
• identifying emotions

Confronting schemas
• schematic restructuring – replace dysfunctional
schemas with schemas that are functional
• diaries to organise and store observations
• diaries to test out predictions about what might
happen so that this can be tested out in practice
• diaries to allow comparison of old and new
schemas (schema diaries)
• schematic modification - allow the schema to
be used in some situations but not all situations
and to evaluate the outcome and usefulness of
the schema
• schematic reinterpretation – maintain the
schema but find situations when it is applicable
• relaxation training and behavioural distraction
training
• in vivo exposure
• graded task assignment – to allow the client to
experience changes in an incremental way

Behavioural techniques
• actively monitoring and scheduling to permit
retrospective identification and planning of
changes
• scheduling mastery and pleasure activities to
enhance personal efficacy
• behavioural rehearsal, modelling, assertiveness
training and role play
• reverse role play allows the therapist to model
appropriate behaviour

Role play
• skill development
• overcoming inhibition
• experience dysfunctional cognition associated
with emotionally charged situations in a safe
way
• collaborative empiricism – working with the
client to test the validity of beliefs,
interpretations and expectations by:
• eliciting raw data
• authenticating introspective data – encouraging
the client to identify, observe and evaluate his
thought in an objective manner
• investigating underlying assumptions – asking
for evidence for and against each assumption
and considering alternative explanations.
• Setting up experiments using a problem solving
approach
• conceptualisation
• choose a strategy and technique or strategy
• implement strategy
• assess effectiveness
• Homework assignments

Cognitive strategies and techniques
• monitoring negative and automatic thoughts
(cognitions) E.g. counting automatic thoughts
helps by giving control over the thoughts,
allowing the client to distance himself from the
thoughts, to recognise the automatic quality
rather than accepting them as an accurate
reflection of external reality
• substituting more reality-orientated
interpretations for the biased cognitions
• learning to identify and alter dysfunctional
beliefs which predispose to distorted
experiences.
• Using role plays, guided discovery, fantasy
induction to test and assess beliefs
• search for idiosyncratic meaning
• labelling of inaccurate distortions or inferences
• conceptualisation
• choose a strategy and technique or strategy
• implement strategy
• assess effectiveness
• Homework assignments
examining the explanations for other people’s behaviour
• scaling – counteracting dichotomous thinking by translating it into dimensional terms
• retribution – reassigning the responsibility for actions and outcomes
• deliberate exaggeration - to take an idea to its extreme to reveal a dysfunctional conclusion
• ‘catastrophising’ – an over-emphasis on the worst possible consequences of an occurrence.
• Decatastrophising - helping the client to counter the tendency to think exclusively in terms of the worst possible outcome

Reliving childhood experiences is a strategy that is not crucial to CBT but may reveal the origins of maladaptive patterns. It could be that the adults current reasoning is based on parents unreasoning reactions. It allows reality testing of the validity of childhood-originated schemas and allows the emergence of “hot schemas” – dominant cognitive structures, making them more accessible to change. In each case, it is the way the person thinks now that is important and this includes how the person constructs things that have happened in the past.

Paradoxical interventions do not fit the CBT framework and are not used.

Group work versus individual work
Group treatment offers a major pragmatic advantage with more people can be treated in the same given time. The group provides an experience in which the group leader is able to model self-observation and self-correction and to encourage others to do the same using vicarious reinforcement of group members, e.g. “I was pleased to hear that you …”

However this advantage comes with possible costs:
• people can compare themselves unfavourably to other group members
• the intensive needs of individuals may not be met within the group setting
• some people are destructive to the group processes

Sherman (1999a) reports a study that compared the effectiveness of group work to individual work with schizophrenic patients. This showed that group therapy required fewer sessions ( 7 compared to 20 for individuals) and the group reported other benefits such as being happier to attend and being able to exchange ideas about coping strategies.

Individual therapy has a number of advantages over group therapy. It enables a more specific approach that is focussed on the individual and can be more directive to the individuals circumstances. In individual therapy homework is the first and last item of the session, the next 15 minutes are taken up with setting the agenda – Is there anything you want to talk about? Is there anything that you are reluctant to talk about? Homework activities can be designed collaboratively, Emery suggests that the therapist can ask the client if they think that activity is appropriate and will work. In group work, homework is shared and more likely to be directed by the group leader. Individual therapy has been shown to be more effective for people suffering from panic than group therapy (Neron et al, 1995)

Emery argues that rapport is enhanced and accurate therapy is conveyed through the reporting back of the client’s thoughts and images. The collaborative element is more easily maintained throughout a session with an individual, with the therapist being prepared to admit mistakes or to saying something inappropriate. In doing so, the therapist models a coping model of self-
observation and self-correction. This is more difficult in a group, where there is a tension between providing accurate feedback to an individual and yet not providing undue attention to one person at the exclusion of the remainder of the group. In practice this can be managed through the EP picking up on a point raised by one person and then feeding it back to the group and inviting further comment from other members. This makes it possible to point out contradictions in view points (either from the same person, or from different people).

What evidence is there that CBT is successful?

Many studies have been conducted to evaluate the efficacy of CBT in adults. Andrews (1996) claims that this is better than counselling (though he does not distinguish what type), and long-term psychodynamic psychotherapy, both of which have not produced effects greater than the placebo effect. CBT has been used to reduce unwanted intrusive thoughts in patients with obsessive-compulsive disorder (Shafran, 1999), and to reduce anxiety, depression and panic attacks (Westling and Öst, 1999). Using CBT with schizophrenic patients to encourage them to talk about the source of their hallucinations has been shown to reduce symptoms by 50%, to improve insight into the psychosis and helped to develop coping strategies (Sherman, 1999a, 1999b). Adults with learning difficulties have been shown to improve in self-report of anxiety (Lindsay 1999), depression (Lindsay, 1999), self-esteem (King et al, 1999), and anger management (King et al, 1999; Lindsay, 1999). CBT has produced a lowering of self-report ratings of attitudes consistent with sex offending (Lindsay, 1999). General improvements in emotional and behavioural adjustment have been noted in evidence provided by carers of adults with mild intellectual disability (King et al, 1999).

Andrews (1996) has reviewed a number of other studies that compared the effects of cognitive behavioural therapy with placebo treatments. Noticeable effects have been shown with generalised anxiety disorder, obsessive-compulsive disorder, reducing alcohol dependence and, in treating schizophrenia cognitive behavioural therapy outperformed drug treatment. CBT is at least as successful as pharmacological treatments for depression with a lower dropout from treatment (Antonuccio et al, 1995).

With adults it seems that CBT is suitable for treating a wide range of mental disorders. The treatment of children differs to that of adults in one fundamental way – adults seek help themselves, children are usually referred by adults (teachers, parents or others). In clinical settings there is no correlation between the amount of coerciveness used and the dropping out rate (Kazzlin, 1996). The evidence concerning the success of CBT with children is more limited but randomised trials have been shown it to be effective in the early childhood treatment of anxiety disorders (Castellanos, 1999). Similar results were noted for children and adolescents with depressive disorders (Harrington et al, 1998).

Optimistically, Bush (1996) lists a range of 15 conditions that cognitive behavioural therapy can help with. Among the list are a number of conditions applicable to this study: school difficulties and trouble keeping feelings such as anger, sadness, fear, guilt, shame, eagerness, excitement etc within bounds.
One of the benefits of CBT is that it is a brief therapy. This table shows the amount of time different clinicians have run therapy session for:

<table>
<thead>
<tr>
<th>Author</th>
<th>Target group</th>
<th>Individual</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bush (1996)</td>
<td>Adults</td>
<td></td>
<td>Few weeks</td>
</tr>
<tr>
<td>Harrington (1998)</td>
<td>Children and adolescents with depression</td>
<td>8 to 12 weeks</td>
<td></td>
</tr>
<tr>
<td>Neron et al (1995)</td>
<td>Adults with panic attacks</td>
<td>12 weeks x 1 hour</td>
<td></td>
</tr>
<tr>
<td>Sherman (1999a)</td>
<td>Schizophrenic adults</td>
<td>20</td>
<td>7 sessions</td>
</tr>
<tr>
<td>Westling and Öst (1999)</td>
<td>Adults with anxiety, depression and panic attacks</td>
<td>4 sessions of 1 hour each</td>
<td></td>
</tr>
</tbody>
</table>

It has been shown that 60-70% of symptom improvement occurs in the first 4 weeks (DeRubeis and Tang, 1999). Though it should be noted that in many clinical uses of CBT the sessions are more intensive at the beginning of the treatments so that most of the cognitive techniques are applied during that time. By contrast, there have been reports that short-term attendance of less than 8 sessions did not lead to improvement in children aged between 9 and 16 years (Angold, 2000).

The effects of CBT have been shown to be long-term with outcomes maintained over 6 months (Westling and Öst, 1999) and up to 2 years after treatment. (Westbrook and Hill, 1998). This suggests that if a change can be produced in the construct system of participating pupils then it is likely to be maintained over a formative part of the pupil’s school life.

**Project aims and predictions**

This project sets out to evaluate the effectiveness of a cognitive behavioural approach with groups of adolescents. From the perspective of measuring cost-effectiveness in terms of pupil improvement per unit of EP time; the project would be considered to be successful if more than 1 pupil showed improvement per 6 hours direct casework time, (the time spent with previous individual referrals to use the same approach).

It is predicted that CBT will lead to the following improvements:
**Methodology**

**Overview**
3 groups of 6 to 9 pupils were formed in 2 schools. Each group was supported by a teacher from the school and met for 6 one-hourly sessions to run through materials devised from a CBT framework. Pre-group and post-group measures were made to establish changes in self-perceptions and in the perceptions of subject teachers.

**Participants**
Two schools were selected to take part in this study on the basis of previous casework. Referrals that had been received from these schools in previous years had included pupils experiencing behavioural difficulties that were not severe enough to warrant a Statement of SEN but which were causing concern to teachers. The application of Cognitive Behavioural principles had led to an improvement for such pupils.

**School 1**
The first school was a Middle School with a supportive ethos and seemed willing to engage in approaches that did not rely on individual casework. More importantly, the caseload for the school was low enough to be able to allocate time from within the Service Level Agreement for the work without jeopardising Code of Practice assessments of children with severe difficulties. This school also had an age spanning both Primary and Secondary children and was a school big enough in size as to be able to find a sufficient number of ‘target’ children.

The first teacher was chosen to participate in supporting the group on the basis of her previously wanting to try a class approach to support an individual using Circle Time. Personality traits were also considered in terms of not being over-controlling in her approach to behavioural
management, having a respect for pupils and having their respect, and believing that even difficult pupils could be helped.

The second teacher self-selected after hearing about the start of the first group. Both teachers were Heads of Year and involved with dealing with complaints about pupil behaviour from subject teachers.

School 2
The second school was a High school with a newly appointed SENCO with senior management responsibility for behaviour. The school had been told about the project in September on a tentative basis as a possible school to be involved. Interest did not seem high when mentioned and from a pragmatic perspective I did not raise the project again – since I had sufficient pupils involved and the SENCO was still settling in. In December, the SENCO contacted me to ask about the possibility of the school being involved. This makes the school a self-selected participant.

Pupils
Pupils were selected by teachers following a discussion of a broad outline as to which pupils could be included and which should not:

- The types of pupils that this project is aimed at are those who might be disruptive in class either overtly (teasing others, arguing, causing fights) or covertly (day-dreaming, reading comics under the desk). They might be perceived of as bullies or victims, as anxious or insecure, as having low self-esteem or poor social skills. They might be withdrawn or acting out. The groups should consist of a mixture of pupil types.
- Pupils not suitable for this project are those who are on the verge of being excluded or referred to me because they might need to be assessed for a Statement of SEN for emotional and behavioural difficulties. Equally pupils who are in an acute crisis should be avoided (e.g. those with a recent death in the family, parents divorcing, undergoing a change of foster home).

It was anticipated that pupils would be invited to take part in the project and would volunteer. However, many of those chosen for the first group indicated that they were ‘told to join’ the group. During the first session they were given the option to leave. All of the pupils in the second and third groups indicated that they wanted to participate.

A standard letter was sent to the parents of each child to seek permission for them to be included in the project (see Appendix). This also enabled files to be opened for each pupil in line with County Psychological Service procedures. Files were closed on completion of the project.
### Group composition

<table>
<thead>
<tr>
<th>Gp</th>
<th>Pupil</th>
<th>Gender</th>
<th>Yr</th>
<th>Reason for being selected by teachers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>Male</td>
<td>8</td>
<td>Aspergic</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Male</td>
<td>6</td>
<td>Aggressive with peers, difficult home background with alcoholic mother</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Male</td>
<td>5</td>
<td>ADHD</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Male</td>
<td>6</td>
<td>Lying to teachers and parents</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>Male</td>
<td>5</td>
<td>Withdrawn</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Male</td>
<td>5</td>
<td>Acting out</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Male</td>
<td>7</td>
<td>Attention Seeking.</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Male</td>
<td>7</td>
<td>Acting out and antisocial behaviours</td>
</tr>
<tr>
<td>2</td>
<td>9</td>
<td>Female</td>
<td>7</td>
<td>Attention Seeking. Acting out. Fostered.</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Female</td>
<td>7</td>
<td>Withdrawn</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Female</td>
<td>5</td>
<td>Withdrawn but a nuisance in most classes</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>Male</td>
<td>8</td>
<td>Bully/victim.</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>Male</td>
<td>6</td>
<td>Behavioural problem in most lessons</td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>Male</td>
<td>6</td>
<td>IBP in place during Yr 5.</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>Male</td>
<td>5</td>
<td>Withdrawn</td>
</tr>
<tr>
<td></td>
<td>16</td>
<td>Male</td>
<td>6</td>
<td>Acting out. Difficulties with peers.</td>
</tr>
<tr>
<td></td>
<td>17</td>
<td>Male</td>
<td>6</td>
<td>Difficulty with relationships. Step-brother taken into care.</td>
</tr>
<tr>
<td>3</td>
<td>18</td>
<td>Female</td>
<td>8</td>
<td>Withdrawn Difficulties with peers</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>Male</td>
<td>8</td>
<td>ADHD</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>Male</td>
<td>8</td>
<td>Difficulties with peers</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>Male</td>
<td>8</td>
<td>Withdrawn</td>
</tr>
<tr>
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<td>8</td>
<td>Withdrawn</td>
</tr>
<tr>
<td></td>
<td>23</td>
<td>Male</td>
<td>8</td>
<td>Acting out.</td>
</tr>
</tbody>
</table>

### Session times

The timing of the group sessions was made to coincide with when the teachers involved were not committed to class teaching. Group 1 met during the last lesson on a Thursday afternoon during the latter part of November and throughout December. This was a time which the teacher recognised would be difficult because the pupils were reported to experience greatest difficulties in class. Group 2 met during the first lesson on a Thursday morning through the last 3 weeks in January and continuing through February (with a break halfway through for half term). Group 3 met during the last lesson on a Wednesday afternoon starting at the end of February and continuing through March.

### Data collection

Pupils in Group 1 discussed hopes and fears about being in the group as part of the first session. This reduced the time for other activities, so pupils in the other groups met individually with the psychologist to discuss their hopes and worries about being in the group prior to session 1.

All pupils completed a questionnaire prior to the first session and again during the last session to provide pre-group and post-group data. The questionnaire consisted of:

- **Self Concept Scale for Children (SC), (Lipsett, 1958)** This scale consists of 22 statements that the child is asked to rate from 1 to 5 according to how often they apply. It also negatively correlates with the Manifest Anxiety Scale. A score between 22 and 110 is produced, the higher the rating the higher the self-concept and the lower the amount of self
disparagement (and lower anxiety). This scale was chosen because it is easy to complete and takes less time than other measures of self-esteem or self-concept (Culture Free Self-Esteem Inventory; Battle, 1991; and the Personal Attribute Inventory for Children, Parish; 1978).

- Index of Peer Relations (IPR), (Hudson, et al 1982). This consists of 25 items rated on a scale of 1 to 5 to indicate the magnitude of problems when relating to peers. A score between 0 and 100 is produced with lower scores indicating better relationships with peers.

- Children’s Perceived Self-Control Scale (CPSC), (Humphrey, 1982). This is an 11 item scale in which the children decide whether or not the statement applies to them. The scale was chosen because it is quick to administer and was devised from a cognitive behavioural perspective including items on problem recognition, commitment, protracted self regulation and habit re-organisation. A score between 0 and 11 is produced with higher scores being indicative of greater self control. Having a small range of scores makes this the least sensitive of the 3 scales chosen.

The post-group questionnaire also contained open ended questions to allow the pupils to comment on changes that they had noticed.

Pre-group and post-group teacher ratings of classroom behaviour across the curriculum were made using the Observation Checklist Secondary (11-16), (Faupel et al, 1998). This consists of 20 statements that teachers are asked to rate from 1 to 4. This produces a score from each teacher that is between 20 and 80. Lower scores indicate better classroom behaviour.

Observations from each session were recorded a day after the session, recalling what had appeared to happen in each session. This was aided for Group 1 through being able to discuss the session with the participating teacher. This was not possible for the other two groups, though opportunistic discussions led to some observations being shared.

**Course structure**

It was decided to run the course over six sessions, mainly based on the amount of time that could be afforded to the project with the school, but also based on the view that most therapeutic work is done during the first 4 sessions (DeRubeis and Tang, 1999). Between each session there was a homework activity designed to encourage the children to generalise what had been covered during the session and to collect personal material to bring into the next session.

<table>
<thead>
<tr>
<th>Session</th>
<th>Content</th>
<th>Homework</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Formation of group identity. Naming emotions</td>
<td>Diary 1 Collecting Emotions</td>
</tr>
<tr>
<td>2</td>
<td>Rating feelings. Alternative thoughts.</td>
<td>Diary 2 Alternative thoughts</td>
</tr>
<tr>
<td>3</td>
<td>Automatic thoughts. Hot thoughts. Seeking out supportive evidence</td>
<td>Diary 3 Seeking out evidence</td>
</tr>
<tr>
<td>4</td>
<td>Experiments and action plans</td>
<td>Checking out thinking</td>
</tr>
<tr>
<td>5</td>
<td>Anger</td>
<td>Anger spoilers (optional)</td>
</tr>
<tr>
<td>6</td>
<td>Anxiety and relaxation. Close activities.</td>
<td>Nil. Course summary</td>
</tr>
</tbody>
</table>
Each session was run in a classroom with the pupils sitting in a circle with the two adults and had a similar structure (see Session Manual for more detail):

- welcome
- ground rules (or reminder of the ground rules)
- warm-up activity chosen to match the theme for the session
- review of homework activities
- teaching points
- setting homework task
- feedback and self-validations

Although activities were formulated before hand, flexibility was built into the course structure with the relationship between participants being seen as more important than the course programme. This meant that issues brought in by the children could be used instead of materials developed specifically for the course e.g.

Two children come in and start squabbling over a chair. This presents an opportunity to explore further with the group. E.g. Steven, tell me what you think was happening there. Robert, you tell us what you thought was happening. How do you think X might feel? Adding reference to my own feelings e.g. I feel upset/let down etc by what you were doing.

The emphasis was on owning behaviours and noting how we feel in each situation. This allowed alternatives to be explored and opens up opportunities for behaving differently. This was found to be particularly effective with the first group and encouraged self reflection as well as peer support e.g. by asking, I wonder what other people in the group think… what else might X have thought was happening? How might they have felt? If you had felt like this, what would you have done?
Results and Discussion

Attrition
Out of 23 pupils starting the programme, 6 pupils (26% of intake) did not complete the course:

- P7 – Found it very difficult to be involved in the group and disrupted the working of the group. He has been followed up individually and is expected to move from Stage 3 of the CoP to Stage 2 when he is next reviewed.
- P8 – Permanently excluded from school between the 1st and 2nd Session. Now has a Statement for EBD and has subsequently been diagnosed as having Tourettes syndrome.
- P12 – Did not participate and spent most of the first two sessions trying to avoid the group work and he was asked if he wanted to continue, he chose to go back to lessons.
- P14 – Opted out of the group after the third session because he was concerned about missing English lessons and wanted to achieve good grades in his SATs.
- P15 – Found the level of content too difficult and the teacher decided that he would be better returned to lessons.
- P23 – So disruptive that the rest of the group decided that he should not attend any more.

This level of attrition is comparable to other treatments such as Insight Therapy (Antonuccio et al, 1995). It is favourable to the 60% of patients who are taking medication that drop-out from the course of treatment (Antonuccio et al, 1995). Perhaps an individual approach would have been more appropriate for P8, P12, P15 and P23 allowing the advantages outlined by Emery. This seems to have been beneficial to P7.

Evidence of beneficial change
The pupil self-rating sheets and the teacher classroom behaviour rating sheets were used to compare pre-group and post-group behaviours:

<table>
<thead>
<tr>
<th>Pupil</th>
<th>Self Concept/Manifest anxiety</th>
<th>Index of Peer Relations</th>
<th>Perceived self-control</th>
<th>Teacher Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>1</td>
<td>69</td>
<td>74</td>
<td>78</td>
<td>69</td>
</tr>
<tr>
<td>2</td>
<td>68</td>
<td>82</td>
<td>33</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>78.5</td>
<td>50</td>
<td>42</td>
<td>37</td>
</tr>
<tr>
<td>4</td>
<td>Not included</td>
<td>No data</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>5</td>
<td>69</td>
<td>64</td>
<td>42</td>
<td>53</td>
</tr>
<tr>
<td>6</td>
<td>74</td>
<td>65</td>
<td>43</td>
<td>54.5</td>
</tr>
<tr>
<td>9</td>
<td>68</td>
<td>102</td>
<td>36</td>
<td>26.5</td>
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<tr>
<td>10</td>
<td>88</td>
<td>87</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td>11</td>
<td>39</td>
<td>69</td>
<td>54</td>
<td>47</td>
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<tr>
<td>13</td>
<td>92</td>
<td>81</td>
<td>15</td>
<td>30</td>
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<tr>
<td>16</td>
<td>78</td>
<td>79</td>
<td>39</td>
<td>39</td>
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<tr>
<td>17</td>
<td>71</td>
<td>93</td>
<td>32</td>
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<td>18</td>
<td>76</td>
<td>76</td>
<td>21</td>
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<td>19</td>
<td>70</td>
<td>63</td>
<td>46</td>
<td>30</td>
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<tr>
<td>20</td>
<td>67</td>
<td>61</td>
<td>50</td>
<td>59</td>
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<tr>
<td>21</td>
<td>74</td>
<td>84</td>
<td>42</td>
<td>85</td>
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<td>22</td>
<td>78</td>
<td>81</td>
<td>59</td>
<td>58</td>
</tr>
<tr>
<td>Means</td>
<td>72.47</td>
<td>75.69</td>
<td>40.53</td>
<td>39.24</td>
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<tr>
<td>σ</td>
<td>11.43</td>
<td>13.25</td>
<td>15.72</td>
<td>22.02</td>
</tr>
</tbody>
</table>
The data appears to show that there has been a positive change for most pupils. The table below shows this change for each child:

Pattern of improvement (3 means improved, = means no change)

<table>
<thead>
<tr>
<th>Pupil</th>
<th>Year Group</th>
<th>Gender</th>
<th>Self Concept/ Manifest anxiety</th>
<th>Index of Peer Relations</th>
<th>Perceived self-control</th>
<th>Teacher Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8</td>
<td>M</td>
<td>3</td>
<td>3</td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>M</td>
<td>3</td>
<td>3</td>
<td>3</td>
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<tr>
<td>3</td>
<td>5</td>
<td>M</td>
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<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>6</td>
<td>M</td>
<td>No data</td>
<td>3</td>
<td>3</td>
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<tr>
<td>5</td>
<td>5</td>
<td>M</td>
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<tr>
<td>6</td>
<td>5</td>
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<td>3</td>
<td>=</td>
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<tr>
<td>7</td>
<td>7</td>
<td>F</td>
<td>3</td>
<td>3</td>
<td>=</td>
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<tr>
<td>10</td>
<td>7</td>
<td>F</td>
<td>3</td>
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<tr>
<td>11</td>
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<td>F</td>
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<tr>
<td>13</td>
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<td>M</td>
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<td>3</td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>6</td>
<td>M</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>17</td>
<td>6</td>
<td>M</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>18</td>
<td>8</td>
<td>F</td>
<td>=</td>
<td>3</td>
<td>No data</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>8</td>
<td>M</td>
<td>3</td>
<td>=</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>20</td>
<td>8</td>
<td>M</td>
<td>3</td>
<td>3</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>21</td>
<td>8</td>
<td>M</td>
<td>3</td>
<td>=</td>
<td>No data</td>
<td>No data</td>
</tr>
<tr>
<td>22</td>
<td>8</td>
<td>M</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>No data</td>
</tr>
<tr>
<td>% of pupils improve</td>
<td>50%</td>
<td>58.82%</td>
<td>58.82%</td>
<td>75% (for data available)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This is categorical data, not integer data and this means that a non-parametric statistical analysis is required. SPSS was used and the Wilcoxon Signed Ranks test selected. This produced the following levels of significance for each pre-group-post-group comparison:

- Self-Concept \( .570 \) Not significant
- Index of Peer relations \( .660 \) Not significant
- Perceived self-control \( .040 \) Significant
- Teacher Rating \( .028 \) Significant

This shows that while there are differences for individual pupils; the effect of working with a group does not lead to overall significant differences in development of self-concept or how all of the pupils perceive their relationships with their peers. This suggests that simply meeting with an EP to talk or work through a programme does not lead to improvements in self-esteem and does not improve social skills. The latter point is relevant since the children in the groups were able to demonstrate adequate social skills in the group setting.

Although there are small differences for some pupils that could be accounted for by random variations, a few pupils have reported large differences in self perception of self-concept and
peer relations. This was also evident in responses to open-ended questions in the post-group questionnaire:

- ‘I’ve not beat up as many people’
- ‘it will help me to get along with other people and get a better education’
- ‘friends, teachers and parents like me more’.
- ‘I liked more people in my class – but they tell me to XXXX or else’.
- ‘I will get a better job because I can get on with people’.
- ‘now when I get angry with other people … . . . I don’t hit them . . . .or I don’t hit them as hard’.
- ‘I’d like to say something to the group… my homework has improved …’
- ‘I have been trying to get on better with my sister’
- ‘This has helped me with my handwriting because I don’t get as angry with it’

The effects on perceived self-control appear to be real significant effects across the sample and seems to be resulting in improved classroom behaviour. Pupil’s reported that:

- ‘It’s helped me learn not to shout out’
- ‘others see me as more behaved’
- ‘it’s helped me behave better’
- ‘I want to be good in all lessons’
- ‘I am able to talk about my feelings’
- ‘I felt that I could tell everybody about my problem’.
- ‘we have got our diaries and I think it will go well’
- ‘The diary was best because it was good listening to other people’

These comments show that the children identified benefits to themselves about having been involved in the project. There is an indication that they were more aware of their emotions and their reactions to them and to what they saw as the cause of the emotion.

Other comments from pupils included:

- ‘the course was very good’
- ‘I enjoyed being in the group because I was able to share my feelings with others’
- ‘I was able to bare my soul’

**Duration of CBT**

Improvement has been shown for most children in at least one area and this is contrary to that expected from Angold (2000). This suggests that a 6 session course is appropriate and sufficient to produce change. Pupils who dropped out of the group sessions were not followed up as Angold had found that CBT produced a detrimental effect for pupils who only attended 1 or 2 sessions. Perhaps a similar effect could be achieved with fewer sessions, though subjectively, 6 sessions feels about right in terms of how the groups developed and worked together. One of the aims of the sessions was to enable the pupils to provide support for each other, outside of the group and beyond the termination of the group sessions. This would not have been evident in Angold’s study since the children followed up were seen as outpatients at mental health centres, drug treatment programmes, a crisis centre, an in-home treatment programme and at a community health centre. It is unlikely that the group support continued beyond the sessions and many of the children received individual CBT.
Development of group members
For some pupils the experience of being in a group and being asked to think about the thoughts underlying feelings and actions led to an immediate change. One of the pupils diagnosed as having ADHD showed quite a change in his attempts to control his impulsivity. At the start of the first session, he blurted out answers without thinking about them e.g. suggesting a ground rule of ‘no farting’ – this was reflected back and shaped into a ground rule of ‘no rude things’. Towards the end of the session he was thinking more about what he said, e.g. on seeing stars to indicate an expletive response, he offered, ‘Oh I’ve thought of a word – but I’m not saying it because it is rude.’

One pupil went from not wanting to participate in the first session and saying that he wanted to go back to lessons to participating well in activities during Session 5 e.g. waddled across the floor to show how his legs could barely sustain his weight as they turned to jelly. The overall pattern seemed to have been one of moving from initial resistance at being in the group to wanting to have more contact with the group.

Another pupil started the first session by only making comments that were ‘put-downs’ to other pupils and sitting on the extreme edge of the group with her chair behind the others. By the last session she was sitting closer to other pupils and making supportive comments.

Development of the group as a supportive mechanism
I had hoped that the group members would find support from each other, partly through sharing common experiences and partly through meeting up outside of the sessions. This aim could have been met through any group activity that provided novel experiences (e.g. circle time, social skills training etc). One of the worries of the school was that the group would develop such a strong identity that they would form a ‘gang’ of like-minded pupils that would help each other get into even more trouble.

The first session was to establish a group identity through a group name and shared ground rules. This aim seems to have been met and was reinforced through successive sessions by using logos on ground rule sheets and OHTs. Group support started to develop quickly. E.g. in the first group rewards were used for participation, the group members had got together and found out about each other’s rewards from Session 1. They established that one pupil had not been rewarded and supported him by suggesting that he went to see the teacher about it.

The teacher helped to maintain group identity by making use of the heading used for ‘ground rules’ and ‘emotions’ on the reminder letters to each person. Group members also spent time talking to the teacher on the playground. Further reinforcement of the group identity arose from the teacher giving up more time to meet the group at lunchtime to consolidate key points from session 2.

As the sessions continued, group members started to enforce the rules with each other and pointed out infringements. Initially they looked to the adults to arbitrate and decide on sanctions, but gradually they became more independent and took steps to regulate each other’s behaviour.

Spill-over effects
There has been a positive and beneficial use of strategies and materials beyond the target group. Some of the materials are being used by pastoral staff with other pupils that have not been part of the group sessions. For example, the Anger Spoilers sheet is being used with pupils displaying poor anger management in the playground in both schools involved in the project.
Diaries have been used by Heads of Year in the second school. The teacher involved in the project in the second school has set up her own group using some of the strategies learnt although using a different set of activities.

The course manual has also been borrowed by other EPs within the Service to select activities from for use within their schools.

**Follow-up**

Parents were invited to contact me if they wanted to discuss the group work or any effects that they noticed. The following contacts were made:

- 1 parent indicated that difficulties with her daughter were continuing and getting worse at home. She was advised to contact her GP for referral to the Child and Adolescent Mental Health Service for support at home.
- 1 parent indicated improvement with her daughter and that ‘things are a lot quieter at home now’.
- A social worker indicated that she had found it difficult to get one pupil to engage in discussion in sessions that took a psycho-dynamic approach and was pleased to hear that she had been very open during the group sessions in school. The pupil had also reached the point of being able to make a decision about the terms under which she would continue to make contact with her mother. The social worker attributed this to her involvement in the group sessions.

A two month follow-up was offered to the teachers at School 1 to discuss how the children had been since the group work. The following comments were made by the teachers:

- One pupil was reported to have been noticeably better in all lessons and to have maintained this.
- There was a problem in the way one pupil responded to the teacher who had been involved. He had remained too familiar in contexts out of the group.
- Both teachers commented that the ‘connection made with the pupils’ was valuable.
- Both teachers felt that the experience had been helpful in developing their roles as Heads of Year. They thought it might be helpful to other teachers when dealing with discipline in the school.
- Both teachers commented that the group work had been very talk orientated and felt that if they were to do something similar they would include more role play and make each session more active.
- An English teacher had commented to one of the Heads of Year that for one pupil; “[he] used to shout out a lot in lessons. Now he goes to, but stops himself and puts his hand over his mouth”.

A six month follow-up was offered to pupils as a chance to meet up again informally and discuss how things were going. Four pupils turned up and made the following comments:

- “I’m alright in lessons now”
- “Things are going well, I’m better behaved and better at home.” “If you do the course again, can I come again. I enjoyed all of it.”
- “things are going well, I would like to come again if possible”
- “I’ve been having some difficulties over the last two weeks. I found out that my sister is really my half sister. I decided not to see my mum anymore.” “My favourite part was the Old Family Coach”
- One pupil could not make the meeting but sent a note – “I’m behaving a lot better now, since you, Mrs D and the guys helped me.”
- One pupil was reported to be having some difficulty at home and was worried because his mum was in trouble with the police.

While the follow-up comments are generally positive and indicate lasting effects for some of the pupils, there are continued difficulties expressed for some pupils. Where progress has been evident it seems to have extended beyond the initial group setting producing wide-ranging effects in the children’s lives.

The school seems to have benefited and the teachers indicated that they had developed worthwhile skills. It was hoped that the school would want to run subsequent groups with teachers in the school taking a lead in developing more specific projects with the Educational Psychology Service providing consultative support. However, the difficulty of how to deploy staff time given the range of demands on teachers meant it was unlikely that the two teachers would run their own course. There was some discussion about the possibility of other groups being run by external agencies in the future and this was welcomed by the teachers.

**Overall conclusion**

The use of cognitive behavioural psychology as a basis for small group work in schools to help raise children’s levels of self-control and improve classroom behaviour seems to produce a significant effect when measured on self-rating scales and teacher ratings of classroom behaviour. This is consistent with previous research outside of educational settings (e.g. Lindsay, 1999; King et al, 1999; Andrews, 1996; Castellanos, 1999; Harrington et al, 1998).

There appears to be development of self-concept and improved peer relationships in some children, although a significant effect has not been noted across the groups run. Individual comments from pupils, their teachers and from carers indicates that positive effects are real and not simply random noise produced by completing the questionnaire a successive time.

Long term gain consistent with previous studies (e.g. Westling and Ost, 1999) seem to be evident from the anecdotal evidence received, however, no attempt has been made to measure this effect using the self-report questionnaires or teacher ratings. This is a weakness of the present study and could be addressed through future group work studies e.g. giving a questionnaire at 3 time points – before, immediately after and after 6 months.

For some pupils, there appears to be a need for an individual approach rather than a group approach and this seems to be more so with pupils who are acting out and who are attention seeking. Their behaviour disrupts the group dynamics yet when seen individually progress seems to be possible. This is based on a very small sample size of 1 pupil and further investigation is needed.

Not all of the effects are ipsative and there is evidence of beneficial effects to the adults involved in the study and to the school. Spill over effects have been noted anecdotally at different levels.

Resourcing tensions remain for schools that may prevent future group work without direct support from outside agencies such as the CPS. However such a role for EPs makes sense as a preventative strategy. With increased self-control and improved classroom behaviour, there is less need to resort to SEN Statements to provide costly support for emotional or behavioural
difficulties. Group work allows more pupils to be seen when EP time is limited. Though any future groups should involve a school representative, partly to maintain ownership of the problems but also because this allows wider effects to be produced.
Evaluation
This project was covering new territory for me in that I had not run this type of group before. There was a feeling of standing on the edge of a precipice looking down and wondering whether or not the gap could be crossed. In reading about group dynamics I encountered a variety of approaches, but most had an emphasis on allowing the group to go off at tangents and not being too controlling. While I wanted the group to explore their thoughts and feelings and consider how these led to behaviours, I knew that there was a time imperative. This produced a tension between wanting to get through the materials and wanting to involve the pupils in self-exploration.

One of my worries had been that it would be difficult to create an atmosphere in which the pupils felt secure enough to discuss their feelings. Consequently, I had lots of short activities planned for each session and had hoped to review the participation of group members with the group at the end of the session. In practice, the pupils were very open and had lots to say. The problem became one of moving them on and completing the core parts of each session.

I had imagined that the teachers would be able to maintain a role as a group leader and was surprised by how the group dynamics affected the teachers. There were some instances of them being defensive and over-reactive to comments made by the pupils when they were exploring their perceptions of how some teachers reacted to them. When I first encountered this it took me by surprise, since the same comments made by the children of other adults had not led to the same response. I chose to interject by explaining that we all perceive things differently and this leads to us thinking differently about the same events (i.e. to put the episode into a cognitive behavioural framework). This seemed to diffuse the tension and helped the group move on. It also provided a real difference of opinion within the group that could be explored as a model for the children.

During my initial drive to the first session I was reflecting on my teaching experiences and the role that I had had in managing classes. This led to some doubts about me not being able to relax control of some elements sufficiently well enough to allow the group to take responsibility for the members behaviour. In practice, reflecting behaviours back to the group with reference to self e.g. “when you called X names that made me feel …, I wonder how X felt?” “What does the group think?” Etc. The first group acted as a learning ground to develop this skill and the approach worked well resulting in the group and individuals within it taking the responsibility for behaviour.

Providing an ethos of acceptance was not always easy, particularly with the children with ADHD. One spent most of the first session sitting in the centre of the group sitting on the floor, moving on and off his chair. The other spent time sitting forward with his head almost touching the floor and the rest of the time tilting so far back on his chair that it almost tipped. In both cases the behaviours were ignored and both children participated well.

In contrast there were some behaviours that were extremely helpful. E.g. having an Aspergic child who volunteered lots of useful suggestions for helping with group organisation. He formulated rules and accepted rules easily and stuck to them rigidly! In later sessions he ensured that others did so too (me included!).

Not all comments were positive. During the initial sessions, P6 kept asking when we were going to do some ‘real work’, by which he meant writing. In later sessions, which included self-rating questionnaires he seemed much happier. Some pupils commented, ‘this is boring’ and
this seemed to coincide with periods that required them to listen to other pupils giving their point of view.

The missing of particular lessons to be involved in the group work produced a range of responses from, ‘great – I’m missing Science’ to ‘Do I have to come? I want to go to DT’. This required some management by teachers to ensure that learning opportunities were not missed e.g. arranging for a pupil to build his model car during the lunch hour.

The teacher involved in the second school was experiencing personal difficulties, partly to do with her joining the school and being given a newly created job that attempted to link SEN with responsibility for behaviour and partly because of home circumstances. This led to difficulty in collecting all of the school based data and I felt it inappropriate to pursue the matter. This did result in a reduced data set, but sufficient evidence was collected to allow a statistical treatment.

**Opportunities and tensions:**
A project like this one is unusual in many schools and has implications, as it will inevitably disrupt the smooth running of the school.

- There was a resource issue for the school centred on the tension between allowing teachers to take part and using them for class cover. The first teacher had experienced difficulty ensuring that the SMT released her for the sessions and we discussed how I might have made this easier – perhaps if I had discussed the project with the Head teacher directly rather than expecting pastoral staff to do this? In contrast, during Session 1, 3 members of staff were off ill, the teacher was put down to cover for one session but she was able to persuade colleagues to cover for her. The school valued pastoral work despite the new threats it presented to school systems. The teacher had been quite forceful with the Headteacher to ensure that she could work with the group and have that time counted as ‘cover’ so that she did not have to give up too much none-contact time. By the time the second group ran, this issue had been resolved with time allocated to the second teacher.

- The teacher experienced the tension between taking part in the sessions and going on a course or dealing with other unexpected events. Another colleague was prepared to take part in one session, while the teacher involved went on a course. The group needs stability to be able to work and changing members of the group leads to the pupils feeling insecure. This could have been dealt with at the planning stage.

- Teacher role and group leader role are not exactly the same and require different responses to the children. Difficulties had been encountered for the teacher in working with the children who had started to confuse her role in the group with her role as a class teacher. She had resolved it by reminding them that she was treating them differently as a teacher.

- There is a tension between which children want to be part of the group and which children the school would like to be part of the group. Is this for difficult children or could it be for anyone? Discussion with the teacher after a session focussed on applying the framework to teachers in the school and the difficulties that some colleagues had in responding to children that were challenging in a positive or non-aggressive way.

- There were differing attitudes of teachers to the project. The two extremes were represented with some staff saying, ‘what’s the point of doing this – you’ll never do anything with those kids’. One member of staff had told some of the pupils that the
group was for ‘pupils who had behavioural difficulties’ At the other extreme the English teacher wants to continue the group after the six weeks are up allowing pupils to continue with role play and drama. Other teachers were generally interested to hear ‘how things are going’ between the sessions.

- Individual tensions surround the development of new skills or sticking with the ones that work well. Naturally, we all feel unsure when starting something new. The teacher in this project was no exception, even by Session 5 she was still concerned about her level of control with the group, feeling a little uncomfortable when the children acted out or moved off at a tangent. Yet I felt that her level of control was just right – setting boundaries in a clear, yet subtle way and leaving enough room for the children to explore and to regulate each other. By the end of Session 6, she appeared to be a lot more confident when we met with the teacher due to start with the next group.

Where now?
The study has shown that CBT can be beneficial to children and this has established a basis for future work both with individuals and with groups. I have learnt a lot by carrying out this project and have started to develop new skills – I probably would not have engaged in this type of work if I had not chosen to do it as a doctoral research project.

Group work is very different from individual casework and this makes it an interesting thing to do. But, carrying out the project requires a tremendous commitment of time on a regular basis. It also leads to teachers making use of the time around the group work to seek advice and discuss pupils. This makes the project tiring to maintain and trying to do 2 groups at 2 different schools 15 miles apart was particularly difficult. The advantages of working with one school at a time on a project like this make the commitment worthwhile – particularly through increased rapport with teachers and a working with a wider range of teachers than are normally encountered in direct casework. This makes group work an attractive thing to offer.

It remains to be seen whether this is truly preventative. Only one child of those seen has remained on my caseload. It could be that the children chosen for the group work would never have been referred if the project had not been available.

Perhaps instead of working with one school, it might be possible to offer the group approach to a cluster of schools who had already referred children with behavioural difficulties. This raises questions of how the group sessions would be managed:

- Who else would run the session? Could inter-agency working be used e.g. an EP and a behaviour support teacher? If so, who would take the lead?
- How would it be paid for? Could SLA time be taken proportionally from the different schools referring to the group?
- Where would the sessions be held? How would the children get there?
- How would ownership of the school based problem be maintained?
Bibliography


Sources for developing activities


Appendix

Suggested letter to parents

Dear ……
Your son/daughter has been invited to join a workshop for a mixture of pupils. The workshop will last 6 sessions during school time. It is being run by Mrs …. (Head of Year) and Mr Squires (Educational Psychologist).

The aim of the group is to encourage young people to develop their social skills and work co-operatively together in a number of structured activities. The particular approach taken will be one that invites the children to think about how the way they feel affects the way they respond to others.

In order for Mr Squires to work with your child it is necessary that parental permission is received and a file temporarily opened by the County Psychological Service. The file will be closed on completion of the workshop.

If you have any questions you can contact the school and speak to ….. or Mr Squires on 01785 356 915.