Curriculum Guides for Group Therapy

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Introduction

This paper provides strategies that classroom teachers can implement with youngsters who have emotional and behavioral disorders (EBD). All of the selected group therapies and interventions provide information on activities and assessment criteria to help the instructor implement these procedures designed to strengthen the social, cognitive, behavioral and emotional needs for EBD students.

Strategy

Art Therapy for Autistic Spectrum Children

Goal

Use of icons, symbols, and social stories help the children to remember what they were taught. When children and therapists collaborate to custom make these symbols, icons, and stories for each child's unique challenges and goals, the children take ownership of them and integrate them into their internal experience (Epp, 2008).

Objective

Art therapy is appropriate for children on the autism spectrum because they are often visual, concrete thinkers. As a component to social skills training, it may increase the willingness of children to participate because art is an activity that they find acceptable and finds a way to solve problems visually. It forces children with autism to be less literal and concrete in self-expression, and it offers a nonthreatening way to deal with rejection. It replaces the need for tantrums or acting-out behaviors because it offers a more acceptable means of discharging aggression (Epp, 2008).

Activities
The SuperKids therapeutic model uses group therapy of approximately six children of similar age and social communication ability; the leadership team has at least one highly trained therapist (Epp, 2008). Cognitive behavioral strategies are integral to the group therapy session. For example, a therapist would ask a student, "When you're frustrated or happy, what do you say to yourself? What's your self-talk?" Furthermore, artwork solicited by the therapist shows a deeper level of meaning than words can deliver because these students have communication disorders (Epp, 2008).

The group’s function is to discover ways to change self-talk, to improve feelings or make better choices with difficult feelings. The social skillsaddressed include compromise, graciously winning or losing a game, conversation skills, eye contact, voice modulation, friendship skills, understanding nonverbal cues, awareness of the environment, learning to identify and express feelings, awareness of others' feelings, and modulating intense emotions (Epp, 2008).

Therapists who carefully watch how children approach or do not approach each other, intervening in a helpful, nonthreatening, concrete manner so that the children learn how to structure their own play time in a social context teaches social skills. Weekly clinical supervision is conducted to assess which skills intervention is needed. As each group progresses, the therapists make decisions on how to best use the group therapeutic experience for their particular students. A typical hour-long group therapy session for ages 6 through 12 is as follows (Epp, 2008).

• Children come into the room and are greeted by the therapists with a snack and drinks.
• Conversation skills practiced in an unstructured manner (10 minutes), with leading questions such as "What's the best thing (or worst thing) that happened today?" and "Does anyone have any news to share with the group?"
• Structured activity (30 minutes), with instructions such as "Fold the paper in half and on one side draw a picture or write something about yourself that you love and would never change, and on the other side draw or write something about yourself that you wish you could change."

Other instructional activity might include “Draw a picture of what animal you would be if you were an animal." The next activity has the children create a zoo or jungle over the subsequent weeks in which all animals can live together. The students explore sharing space and materials as well as dealing with issues like sensory overload and frustration (Epp, 2008).

• Unstructured free time (20 minutes) in which the students can choose an activity, such as play a game or create art, with the one rule that they cannot do it alone. Group leaders stand back and coach the children in skills such as communicating, brainstorming, initiating play, joining into existing play, and compromising about rules (Epp, 2008).

Assessment

An evaluation of the effectiveness of the SuperKids program found evidence based on questionnaires filled out by teachers and parents shows that both at home and at school the frequency of assertive social skills increased, whereas internalizing behaviors, hyperactivity, and problem behaviors decreased. This is important for children who are developmentally delayed in social skills because they are at a higher risk of social maladjustment and resulting in emotional stress. The SuperKids curriculum incorporates group therapy and art therapy to translate abstract social emotional concepts into a curriculum that reaches children who function more easily in a visual/kinesthetic orientation than in the social/intuitive environment (Epp, 2008).
**Strategy**

*The Use of Group Therapy as a Means of Facilitating Cognitive Behavioral Instruction for Adolescents with Disruptive Behavior*

**Goal**

Cognitive behavioral therapy is concerned with reducing maladaptive behaviors through the identification and modification of apparent distorted patterns of thinking. Practitioners of cognitive behavioral therapy work collaboratively with their clients focusing on the areas of behavior, cognition and affect to facilitate changes in behavior (Larmar, 2006).

**Objective**

Interventions involving cognitive behavioral therapy build on existing known principles of behavioral therapy. The therapist examines external behaviours, recognizing the significance of client cognition in the process of behavior change and encourages the client to analyze maladaptive thought processes and to assist the client in identifying faulty patterns of thinking. The client is further encouraged to replace such thought patterns with rationally centered cognitions (Larmar, 2006).

Group therapy is a successful intervention treatment for child and adolescent populations. The inherent propensity of children and adolescents towards socializing offers group therapy a salient model of intervention for working with the adolescent population. Youngsters can benefit developmentally from relationships formed with peer groups within the context of group therapy. Children and adolescents can engage in an experience of belonging that can facilitate them examining the nature of their interpersonal problems (Larmar, 2006).

**Activities**
The curriculum comprised the tenets of cognitive behavioral therapy, adapted from Kaplan and Carter’s (1995) process of cognitive behavior modification. It facilitated participant on covert behaviors. The instruction delivered over a nine-week period; teaching techniques stressed group interaction, including a series of physical games and challenges linked to principles of cognitive behavioral instruction. The duration of each meeting was approximately 1 ½ hours; students who participated in the group were freed from regular school activities during the period allocated for the intervention meetings (Larmar, 2006).

A series of group discussions focused on key principles of cognitive behavioral instruction. Each discussion was conducted either on the floor or around a large table with participants forming a circle to encourage individual focus and group inclusivity. The organization of each discussion was considered with a view to eliciting meaningful engagement and interaction for all participants (Larmar, 2006).

- The use of age-appropriate, personal examples to illustrate concepts of cognitive behavioral instruction was effective in assisting participants to comprehend concepts explored.
- The use of a whiteboard during the discussion of writing tasks was effective in helping the group focus on the activity and facilitated the sharing of individual responses this strategy, further, provided visual cues that assisted in encouraging participant focus (Larmar, 2006).

A sequence of management strategies were implemented in the intervention to promote individual and group cooperation and were successful in eliciting participant prosocial behaviors and the maintenance of group order and homogeneity. The management strategies were either preventative or reactive in the event that undesirable behaviors surfaced during the course of the intervention (Larmar, 2006).
• The practitioner’s democratic approach to the facilitation of each session was effective in eliciting individual and group cooperation. The practitioner’s observation of participant’s conciliatory responses to his instruction indicated that student participants felt comfortable with the adopted style of management of the group (Larmar, 2006).

• The formulation and incorporation of group goals such as listening to the contributions of others, respecting the rights of others and communicating positively to all participants of the group. To provide a framework for communicating behavioral expectations for each session was effective in encouraging prosocial behaviors. It provided students with continual reminders that assisted in reinforcing positive behaviors deemed necessary for the facilitation of group cooperation (Ibid).

• The initial focus on group goals and behavioral expectations at the commencement of each session was effective in focusing the group and reminding participants of the group’s expectations regarding behavior and participation (Ibid).

• Seating participants at risk of group exclusion (due to inappropriate behavior) in close proximity to the practitioner assisted them in maintaining focus and choosing prosocial behaviors. The development of a contingency plan for extreme inappropriate behaviors was effective in preserving the sense of order and encouraging full participant cooperation (Ibid).

• Having each session prior to the participants’ main lunch break was preferable to running the session following lunch. The participants appeared generally more focused during morning sessions in contrast to afternoon sessions where certain students were more disruptive (Ibid).
• The incorporation of activities that required participants to work in smaller groups was effective in facilitating peer support for individuals who were struggling to complete activities on their own; the participants identified as ‘supporters’ appeared enthusiastic in this role (Ibid).

• The use of ‘noninvasive’ management strategies that provided cues for the redirection of minor disruptions were effective in maintaining group order and eliciting positive behavioral choices. These strategies also served to minimize the potential for negative attention focused on the disruptive individual (Ibid).

• Communicating expectations prior to the start of a new activity facilitated participant focus and comprehension of behavioral and task guidelines; this strategy served to minimize disruptive behaviours during each activity (Ibid).

Assessment

Through a textual analysis of the students’ comments, the experience of working as a group facilitated a positive learning experience through a cognitive behavioral therapy framework. It was found that the practitioner’s democratic approach to the management of each session, and the incorporation of the physical activities and discussion were brought together in a nonthreatening, naturalistic setting to bring about positive, cohesive responses (Larmar, 2006).

Strategy

A School-Based Intervention for Social Anxiety Disorder in Adolescents

Goal

Social anxiety disorder is highly prevalent in adolescents, with estimates ranging from 4 to 9%. Various reasons account for the maintenance of social anxiety. The cognitive conceptualization suggests that negative beliefs about one’s competence play a key role in perpetuating social anxiety. Social situations elicit negative expectations regarding evaluation
and rejection, which in turn produce physiological and behavioral symptoms of anxiety. Skills for Academic and Social Success (SASS) program for high school students developed to help them cope with social anxiety disorders (Fisher, et.al, 2004).

**Objective**

The primary feature of social anxiety disorder is an intense fear of embarrassment in social or performance situations. Commonly feared situations include initiating conversations, answering or asking questions in class, attending social events, being assertive, and performing in front of others. Discomfort in such environments often leads to avoidance of a wide range of social interactions. This avoidance can have long-term consequences since socializing and friendships are key developmental tasks during adolescence. In addition to social disruptions, socially anxious adolescents are at risk for poor academic performance and substance use. Social anxiety disorder is often chronic, with impairments such as risk for suicide, substance abuse, and academic underachievement continuing into adulthood (Fisher, et.al, 2004).

Considerations guiding SASS implementation: (1) Sessions could last no longer than a typical class period, approximately 42 minutes and could not interrupt academic courses. (2) The school environment as a setting for exposures in order to encourage generalization; therefore, teachers identified students’ specific difficulties and assist in classroom exposures. (3) Parents learned techniques to decrease their children’s avoidance and enhance skills generalization (Fisher, et.al, 2004).

**Activities**

The SASS intervention consists of 12 weekly group school sessions (approximately 40 minutes each), two group booster sessions to address relapse and assess remaining obstacles, and two brief individual meetings (15 minutes). Additionally, four weekend social events (90


minutes) that include prosocial peers, called “peer assistants” provide real-world exposures and skills generalization. Parents attend two group meetings (45 minutes) during which they receive psychoeducation regarding social anxiety and learn techniques to address their child’s anxiety (Fisher, et.al, 2004).

Teachers participate in two psychoeducational meetings (30 minutes) and conduct classroom exposures supervised by group leaders. The program designed to be flexible to accommodate school calendars and typically spans about 3 months; each treatment group conducted by a psychologist and includes six students. The group sessions cover five core components: (1) psychoeducation, (2) realistic thinking, (3) social skills training, (4) exposure, and (5) relapse prevention (Fisher, et.al, 2004).

Psychoeducation is the first group session. Group leaders provide a description of the cognitive, somatic, and behavioral symptoms of social anxiety. Students are encouraged to identify their own anxiety symptoms, and to examine how social anxiety is manifests itself through the interaction of negative thoughts, physical sensations, and avoidance (Ibid).

The second group session focuses on realistic thinking, primarily adapted from Ronald Rapee’s book *Overcoming Shyness and Social Phobia*. Group leaders highlight the relationship between thoughts, feelings, and behavior. They explain that youngsters with social anxiety tend to overestimate the likelihood of negative outcomes and exaggerate the consequences. Students identify such negative expectations and to use specific questions to evaluate them more realistically (e.g., Am I exaggerating? How many times has this happened in the past? How do I feel when I see others in similar situations?) (Fisher, et.al, 2004).

The four social skills sessions include (1) Initiating Conversations, (2) Maintaining
Conversations and Establishing Friendships, (3) Listening and Remembering, and (4) Assertiveness. For each skill, group leaders introduce the concept and rationale, and then facilitate group discussions. The co-leaders demonstrate the skill in brief role-plays, choosing situations relevant to adolescent experiences (e.g., paired with another student to work on a project, or meeting new people through friends) (Fisher, et.al, 2004).

Each student participates in at least two role-plays. Both group leaders and members provide feedback, praise positive aspects of role-play performance, and provide suggestions for improvement, such as speaking more clearly or increasing eye contact. If appropriate, students repeat the role-play in order to integrate suggestions and practice learned skills outside of the sessions (Ibid).

Group leaders emphasize the role of avoidance in maintaining anxiety and the expectation that anxiety will diminish with increased exposure. Each student develops a “Fear Hierarchy”, or ladder, that rank orders ten typically avoided situations, beginning with the least-feared (Fisher, et.al, 2004).

They assist students to identify specific contexts that make a situation more or less comfortable, such as speaking with males versus females, or friends versus family members. A typical situation at the bottom of the hierarchy might be talking on the telephone with a friend, while answering the telephone when the caller is unknown might be closer to the top. At each exposure session, group leaders select hierarchy items that gradually address each student’s fear. When appropriate, exposures include school personnel or peer assistants, such as going to the office to ask the school secretary questions or scheduling a meeting with a teacher to join a club. Students provide permission before other individuals enlisted to help with exposures. If a student is reluctant, negative thoughts about the student’s expectations were further discussed (Ibid).
Students provide “Subjective Units of Distress” (SUDS) ratings from 1 to 100 (1 = completely calm, 100 = absolutely terrified), which are expected to decrease by at least 50% by the end of the exposure. After the in-session exposure, the student discusses his experience, then the group provides feedback (Fisher, et.al, 2004).

In the final session, group leaders introduce the possibility of relapse and prepare students for potential setbacks. The warning signs of emerging symptoms and strategies for reversing are discussed (Ibid).

There are four social events are considered an essential component of the program. Activities may consist of bowling, laser tag, going to the mall, playing billiards, miniature golf, or a picnic. They are aided by “outgoing” peer assistants from the students’ high schools. The activities provide group members the opportunity to practice social skills and allow for exposure to several commonly avoided situations (e.g., attending a social event without friends or with unfamiliar peers, initiating conversations, performing in front of others, etc). These activities also offer a unique opportunity for group leaders to observe students’ functioning in realistic social situations (Fisher, et.al, 2004).

Many parents have a limited understanding of the symptoms and impairment associated with social anxiety. They may interpret socially anxious behavior as part of their child’s personality, something their child will “grow out of,” or “unfriendly behavior.” In addition, parents are often frustrated and overwhelmed by their children’s avoidance behaviors (e.g., refusing to order food in restaurants), and fail to understand the extent of their suffering. Group meetings held to teach parents about social anxiety and the SASS program, and to provide them with support and suggestions from group leaders and other parents (Fisher, et.al, 2004).
In parent meetings, they receive information about the symptoms and maintenance of social anxiety and common parental reactions to children’s anxiety. Parents are encouraged to discontinue providing excessive reassurance, being directive and allowing avoidance of social interactions. Instead, parents are encouraged to model independence and positive coping, to provide reinforcement for nonanxious behavior, to prevent avoidance and to communicate empathy (Fisher, et.al, 2004).

Teacher education and collaboration are essential to SASS intervention in the school setting and taught to identify areas of social difficulty for students. For instance, if a student fears answering questions in class, the teacher may initially provide the student with the answer to a question prior to class, followed by providing the student with the question but not the answer, until eventually the student practices answering questions more spontaneously. Eventually teachers provide feedback about students’ progress, and additional classroom exposures are discussed (Fisher, et.al, 2004).

**Assessment**

The SASS program has received positive responses parents and teachers describe the improvements in students who have participated. A majority of program participants are eager to return to the program to serve as peer assistants. Significantly, casual observers unaware of the students’ backgrounds have not been able to distinguish between peer assistants who were former SASS treatment participants and those nominated by teachers.

**Strategy**

*Multi-Family Group Therapy for Sexually Abusive Youth*

**Goal**

Multi-Family Group Therapy (MFGT) is a clinician-facilitated treatment group comprised of several youth, their parents, and adjunct caregivers. It becomes a microcosm of
society where multigenerational families can interact with and influence one another. The MFGT process parallels family systems theory, where change in individual members influences the entire group and more global group change is infectious to individuals. Youth-oriented goals for this intensive treatment process include improving community safety, improving supervision of high-risk youth, assessing and reducing risk of recidivism, profiling offense patterns, and teaching offenders to improve self-control and decision-making skills (Nahum & Brewer, 2004).

Objective

The emotional intensity generated by this group format aids in bringing feelings, motivations, and perspectives to the surface, thereby allowing opportunities to confront denial and more quickly push families in the direction of curative emotional experiences. Families have greater difficulty hiding counter-treatment attitudes, distortions, and secrecy amongst a roomful of their peers. The group aids in providing a more accurate representation of the family and youth participants (Nahum & Brewer, 2004).

Activities

For all treatment bound youth, effective family and/or caregiver participation is both necessary and critical to the execution of treatment plan objectives. The emotionally balanced, informed, and committed parent can provide important leadership within the treatment team and persuade non-compliant youth to break through denial and make strides in accountability and responsibility. Positive family participation can also model empathic regard for others and perseverance in the face of adversity (Nahum & Brewer, 2004).

Typical family treatment goals include gaining a clearer understanding of not only what happened during the offense (disclosure), but how and why it happened (motivation and planning), and working to prevent continued abusive behavior (relapse prevention). This
program is most productive with an audience of 10-15 families. A comfortable, spacious, and well-lit room helps to set the tone for a successful group setting.

Increasingly, 8- through 11-year-olds admitted into outpatient sexual offense-specific treatment programs, and as their age may be similar to that of peer victims, not advised that they join a large heterogeneous multi-family group. Surprisingly, it was not problematic mixing sexually abusive male and female teens. Adult or late teenaged siblings of offending youth may participate in the group, if they have their own perpetrator profile. Sibling therapy is valid and necessary in the course of each family’s treatment, outside of the MFGT model (Nahum & Brewer, 2004).

Recommended curriculum and exercises include *Introduction to sexual offense-specific (SOS) treatment* describes how treatment modality differs from traditional psychotherapy and why it requires such intensive family participation. Next, present national recidivism rates with and without treatment. Outline the treatment process including anticipated length of treatment, treatment goals, program philosophy, and treatment language. Discuss why full sexual history disclosure and polygraph are central to the treatment process (Nahum & Brewer, 2004).

Parents instructed on how to responsibly supervise youth at home, school, and other community settings and how to safety plan effectively. Parents are encouraged to adopt a perspective of “healthy suspicion” in the day-to-day scrutiny of their child. The components of a thoroughly written safety plan reviewed. Families are introduced to the model of *Containment Treatment* that popularizes the notion that one best manages high risk youth, especially sexually abusive ones, by surrounding them by a closely knit, highly communicative, an interdependent group of responsible adult supervisors (Nahum & Brewer, 2004).
Use *Tool Cards* a set of 40 visual flash cards that help youth, especially those presenting with ADHD, learning disabilities, cognitive deficits, or lower intelligence, to learn and internalize treatment concepts central to success in sexual offense-specific treatment. Each card contains a treatment concept and accompanying picture to portray that concept. *Tool Cards* represent concepts such as *Stop and Think, Think About the Consequences, Share Your Secrets, Share the Power*, and *Ask My Body How It Feels* (Nahum & Brewer, 2004).

Group participants are generally unaware of the extent to which victims affected by sexual abuse, both in the short-term and longitudinally. This module is a revelation for parents and youth who might minimize the effects of a young person’s abusive behaviors. Primary victims are differentiated from secondary victims (parents and non-abused siblings). This discussion becomes emotional, as parents are finally able to demonstrate to offending youth how they were affected by the sexual offense (Nahum & Brewer, 2004).

The term “victim clarification process” refers to a series of carefully planned and orchestrated therapeutic meetings between offenders, survivor (victim), supporting therapists, and sometimes parents of the survivor, during which the perpetrator takes full responsibility for their abusive behaviors and answers any of the survivor’s questions. The clarification process should primarily benefit the survivor, though the perpetrator should experientially evidence improved empathy skills, understanding the harm and impact they have done, with healthy levels of guilt and remorse that serve as motivators to prevent relapse. Give a general description of this process, criteria for beginning the clarification process, and criteria for family reunification (i.e., the offender’s return to home). Encourage participants to identify victims by first name and not refer to them as “John’s victim” (Nahum & Brewer, 2004).
Each family has a large sheet of paper and an assortment of colored markers. Following a brief demonstration of family genogram construction, they are asked to take 20 minutes to complete a three-generation genogram highlighting: victims of abuse, perpetrators of abuse, emotional cut-offs, individuals who have engaged in criminal behavior, individuals with mental health issues, individuals with substance abuse issues, and individuals they view as functioning well (Nahum & Brewer, 2004).

Each family has the opportunity to present their extended family to the group with the goal of identifying “patterns” of behavior or historical links to their child’s abusive behavior. This exercise accelerates the process of being acquainted and is a test of family honesty and willingness to be vulnerable amongst peers. At best, the exercise forces families to unveil secrets, view the big picture of family dysfunction, and remove barriers with other group members (Nahum & Brewer, 2004).

Assessment

Go around the circle of participants and have each group member state one important piece of learning they have absorbed over the course of MFGT. Have a group member write these points on a large sheet of paper archived for reflection in later group meetings. Facilitate a discussion of these items, allowing participants to teach the information to one another (Nahum & Brewer, 2004).

Separate the youth and adults into different corners of the room and have them generate a master list of possible youth and parent lapses over the course of treatment. The adult list typically includes not providing adequate supervision, modeling hostile or abusive interactions to children, keeping family secrets, denying the severity of family problems, and rescuing youth from accountability for their behaviors. Youth lapses include viewing pornography, faking
cooperation, not putting effort into treatment assignments, fantasizing about victims, using drugs or alcohol, sexually objectifying others, and lying about time spent with antisocial peers. Once the lists are developed, encourage group members to present their findings and facilitate a discussion of these items, highlighting the difference between youth and adult perceptions of risk (Nahum & Brewer, 2004).

**Before and after paintings**

In this exercise, individual families collaborate on two separate paintings symbolizing the family’s experience before and after involvement in treatment. Leaving instructions as unstructured as possible is advised as it pushes family members to converse and settle upon their particular interpretation of the task. This exercise is useful in that paintings succeed in expressing emotions that participants struggle to verbalize (Nahum & Brewer, 2004).

**Strategy**

_A group intervention for anger in people with physical and multiple disabilities_

**Goal**

The effectiveness of _The Anger Management Training Package_ for individuals with a range of levels of intellectual disability and/or complex communication needs.

**Objective**

To ascertain the effectiveness of anger management programs that are accessible to individuals with disabilities, and specifically, those with limited cognitive skills and complex communication needs.

**Activities**

The intervention delivered was _The Anger Management Training Package_ designed for individuals with a range of levels of intellectual disability and/or complex communication needs.
The theoretical framework draws on cognitive-behavioral conceptualization of anger. Physiological components of anger are addressed through training in the use of relaxation techniques (e.g., progressive muscle relaxation, visualization, deep breathing), but using modified procedures for people whose physical abilities, verbal abilities and capacity for understanding complex concepts are compromised (Hagiliassis, et.al, 2005).

The cognitive components of anger are through cognitive restructuring. A prominent feature of the package is an emphasis on pictographic symbols, a visual learning aid for clients with cognitive limitations, as well as an augmentative communication medium for clients with complex communication needs. The importance of pictographs as an adjunct to learning found that information presented to individuals with intellectual disabilities in the form of instruction without any accompanying visual aids are forgotten; similarly, active learning techniques, role-play and repetition to facilitate skills acquisition (Hagiliassis, et.al, 2005).

The program comprises of 12 weekly sessions of 2 hours duration, including a 15-minute break. Each session is fully scripted and follows a standard format, beginning with a review of skills learned during the previous session, followed by an introduction and explanation of the major session topic and then addressing the key learning aims for that session (Hagiliassis, et.al, 2005).

Assessment

Individuals who participated in an intervention group showed improvements in self-reported levels of anger between pre- and post-intervention, with treatment effects maintained at 4-month follow-up. In contrast, anger levels of individuals from the comparison groups remained relatively stable over the same period. The therapeutic approach was successful in reducing levels of anger in individuals with a range of levels of intellectual disability and complex
communication needs. Effectively, the finding extends the range of evidence-based resources available to practitioners for delivering interventions for individuals with anger control issues and disabilities (Hagiliassis, et.al, 2005).

Conclusion

Teachers need to be aware of techniques that provide EBD students with self-effacing skills. This is necessary so that youngsters may respond in socially acceptable and effective ways. To accomplish this they must incorporate paradigms that approximate or parallel actual problems faced by students in school and other social settings. The opportunity to practice skills in non-threatening environments increases the probability that skills will be maintained and generalized; therefore, teaching students problem-solving skills enables them to address such emotional and behavioral issues such as anger and empathy resulting from situations that cannot be predicted. It accomplishes the objective of providing students with the ability to self-manage their behavior.

There is a growing need for treatment for individuals who suffer from social anxiety and developmental disorders, presenting a parallel need for outcome-based research to analyze the effectiveness of these interventions. For example, The SuperKids program incorporates group therapy and art therapy to translate abstract social emotional concepts into a curriculum that reaches children who function more easily in a visual/kinesthetic orientation than in the social/intuitive environment. Findings support the efficacy of group therapy, such as MFGT, as a means of facilitating cognitive behavioral instruction for addressing maladaptive behaviors in children.
References


