Implementing positive clinical change: Cognitive behavioural group therapy for loners.

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IMPLEMENTING POSITIVE CLINICAL CHANGE: COGNITIVE BEHAVIOURAL GROUP THERAPY FOR LONERS

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ABSTRACT

Introspection and self-reflection has been used throughout this study in order to examine my effectiveness as a psychotherapist. I have explored the dynamics of engaging more effectively with pre-adolescent loners in group therapy by assessing the personal determinants and therapeutic conditions necessary to create positive social behavioural change. Did I make a difference? If not, why not?

My specific method, reality therapy, is a highly confrontational cognitive-behavioural therapeutic approach. Its difference to mainstream cognitive behaviour therapy is that, as well as treating the *symptoms* of a problem, reality therapy deals directly with the *cause* - unmet needs. As a reflexive practitioner, I have used action research to assist in the implementation of clinical change and allow me to amalgamate research with practice and vice versa. The action-evaluation-understanding design, combined with a reality therapy pedagogical tool, will take you through a personal journey of hope and despair: the advantages, conflicts and tensions of my role as a practitioner-researcher and the experiential learning along the way which improved my practice as a therapist. Significantly, the differences between the successful and unsuccessful outcomes of the three group programmes undertaken will be dissected and learned from.

I am confident that these needs-based interventions for children can be equally as effective with an adolescent or adult loner population. They are multi-functional and can also be used for one-to-one interaction. All are adaptable for wider use such as youth / adult offender programmes, substance misuse rehabilitation and the specific treatment of anticipatory anxiety and post-event processing in social phobia therapy. Undoubtedly, there is new learning to take into the workplace from my successes. However, there is even more new learning to be assimilated from my many mistakes.

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

....

Cassandra Perry
September, 2008

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged giving explicit references. A reference list and bibliography is appended.

Cassandra Perry
September, 2008

STATEMENT 2

I hereby give my consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

Cassandra Perry
September, 2008

IMPLEMENTING POSITIVE CLINICAL CHANGE: COGNITIVE BEHAVIOURAL GROUP THERAPY FOR LONERS

Table of Contents

APPENDICES

TABLES

FIGURES

PREFACE

Human beings are born dependent. In order for a baby to survive and thrive, it needs the constant support of other humans. Yet, as we grow, we do not gradually become independent of others; rather, we become interdependent. In the course of our lives we form many give-and-take relationships, building a healthy interdependence with family, community and culture. Humans are so adept at this because we are biologically designed to live, play, grow and work in groups. We are, at our cores, social creatures. Affiliation is the strength that allows us to join with others to create something stronger, more adaptive and more creative than any individual: the group (Coleman, 1974).

A family is a child's first and most important group, held together by strong emotional bonds. Yet infants are indirectly connected to other groups; they are born as a part of a larger culture and community. As they grow, children will encounter and take part in many groups outside the immediate family where they will have thousands of brief emotional, social and cognitive encounters that help define their development. The capacity to join in, contribute to and benefit from these various groups is essential to healthy development (Winnicott, 1965). Humans must learn how to interact successfully within a group. They must learn to communicate, listen, negotiate, compromise and share with many diverse people in many situations. These social skills are not always easy to master (Youngblade, Berlin and Belsky, 1999).

From the primary relationships with adults - parents and caregivers - the child learns basic rules of social interaction (Bowlby, 1969, 1973a). Group relationships, however, are more complex and dynamic than one-to-one relationships because the first social rules a child learns are influenced by the child's dependence on the adult and the adult's inherent size, strength and power. None of these factors are present when a young child first starts to interact with other young people. In fact, young children are often more adept at affiliating with adults than with peers (Spiegel, 1989; Larson, 1997). However, as children play together, they begin to learn and formulate their own social rules. Children with siblings have a head start in this process, as do children who have been involved in day care or play groups before beginning school (Perry, 1996). Children learn to join in with other children gradually. Firstly, they observe what other children are doing. They often play in parallel, working side by side with others. Children then begin to explore one-to-one interactions. They play together, pooling their strengths to

build a tower of blocks, for instance, or share imaginary characters and stories. Finally, children negotiate the transition to more complex, multi-peer groups (Marcoen and Goossens, 1993; Seligman, 1995). Learning and mastering the rules of groups are very important yet difficult processes for many children. 'Best friends' emerge. Temporary alliances form and may exclude one child and then later incorporate him or her. Being 'in' or 'out' can shift from hour to hour and day to day. Some children manage this process well. Others do not. These tend to be children with immature attachment or self-regulation skills (Peplau and Perlman, 1982). A child's acceptance into a group depends heavily on his or her own capacity to regulate anxiety, impulsive behaviour and frustration. Without these prerequisite strengths, a child will have difficulty forming and regulating the relationships with others that are necessary to develop affiliation skills (Perry, 1996). Group members are likely to reject a child who is impulsive or disengaged. Unfortunately, this creates a negative cycle as having fewer opportunities to socialise leads to slower social learning. These children become more isolated from their peers. They perform poorly in group interactions and avoid opportunities to be with others (Peplau and Perlman, 1982). Over time, the excluded child can take this pain and turn it inward, becoming sad or self-loathing. Or the pain can be directed outward, leading to aggression or even violence. Later, without intervention, these individuals are more likely to seek out marginalized individuals and affiliate with them. Unfortunately, the 'glue' which holds these groups together can be self-destructive or hateful beliefs (Rotenburg and Hymel, 1999).

Mental health problems affect us all to a greater or lesser extent. As we go through life it is inevitable that we will suffer stressful experiences that impact on our mental and emotional well-being and may cause us to behave in ways injurious to ourselves or others. However, while recognising this fundamental aspect of what it means to be human, we need to recognise the importance of support in enabling socially isolated individuals to cope with adverse circumstances through looking at their needs (Sullivan, 1953; Mental Health Foundation, 2002). By examining how reality therapy affects the social behaviour of three groups of pre-adolescent loners, I have considered a method which is practical, short-term and easy to implement. My study has aimed to show that reality therapy is a useful method for future provision of counselling in the British education system with children who are excluded and isolated and has used close analysis introspectively to see if I could have made reality therapy even more effective.

ACKNOWLEDGMENTS

'That which does not kill you makes you stronger'. I would like to thank my favourite philosopher Nietsche for his encouragement which kept me going whilst all my friends were sipping ale at the waterfront Smuggler's Inn on long hot summer evenings. Many times I felt like a dog with a bone with this research but it was also my inspiration and my passion. I am grateful to supervisors Dr Jaynie Rance and Dr Deborah Fitzsimmons for their constant faith in me and my deep appreciation also goes to Dr Jill Rodd from Cornwall County Council for her support with ethical and validation issues. Thank you to all school staff, parents / carers and group participants, without whom this would not have been possible. Daniel Craven, Sarah Peters and Steve Stone were my invaluable technology experts. Their patience was tested on several occasions when my computer 'gobbled up' huge chunks of work. The Pannier family and Lin Hargreaves were also brilliant, giving me keys to their homes or a comfy bed and a big welcome on my visits to Wales and Gloucestershire, where I was able to attend supervision and write up my findings in solitude. Lastly, a huge 'thank you' to my husband Ian for all the sacrifices he made and his patience in enduring frequent bursts of unplanned creativity in the reflective hours between midnight and dawn.

This research study is dedicated to my son Stuart who inextricably changed the direction of my life forever.

ABBREVIATIONS

CSA	Children's Services Authority
DfES	Department for Education and Science
EBD	Emotional Behavioural Difficulties
HEA	Health Education Authority
MHF	Mental Health Foundation
NECF	National Evaluation of the Children's Fund
PSD	Personal and Social Development
SATs	Standard Assessment Tests
SEBD	Social, Emotional and Behavioural Difficulties
SIS	Social Inclusion Survey
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION

One must feel chaos within, to give birth to a dancing star
- Friedrich Nietzsche 1844-1900

Contents

1:1 STATEMENT OF PURPOSE

My home was always full of laughter. Then on 9th February, 1994 the laughter suddenly stopped. My ten year-old son Stuart ran into the night, never to return. On reflection, he was always the loner, always the one who never quite fitted in, always the one who had his own agenda. This event broke my heart and it is still broken. I spent years grieving for him, questioning what had happened, continuously blaming myself. Being so entrenched in sorrow, self-loathing and regret I could easily have slipped down a number of destructive pathways. Somehow, miraculously, that did not happen. I switched careers instead, substituting my life as a primary school teacher to retrain as a child therapist, inspired by writers such as Frankl (1984) who spoke of hope and purpose within the blackness of our own personal dimension. After qualification, Social Services gave me my first post as a therapist working with children of all ages who had been emotionally, physically or sexually abused. It was imperative now that I set aside my own personal demons. Supervision and an enormous determination to gain strength from adversity helped me to do this. I became immersed in my new professional life.

Years on, intrusive thoughts still occasionally haunted me. The difference now, however, was that I was usually able to contextualise them within my own practice as a therapist. I was able to ask myself questions such as "How can I be more authentic as a therapist and reach out to vulnerable children?" or "How can I improve my working environment in order to make a difference to those who might be classed as loners?" I also started to re-examine the types of therapy I was using and began searching for a new method of counselling to try with disaffected, disengaged and disillusioned children because nothing, so far, had made any significant impact with these young people and it was noticeable that some had already 'thrown in the towel'. The widely adopted British school system of using rewards and punishments did not work. The humanistic approach was often 'too gentle'. The psychodynamic approach was usually 'too long-winded'.

Fortuitously, a chance meeting with a colleague who was working in the Rehabilitation Centre at a prison in Wales changed the focus of the search as he enthused about a cognitive-behavioural intervention from the United States called reality therapy which was changing the awareness of the prisoners in a way never before experienced. The most noticeable observation was how quickly the effects of the intervention was

changing insights in men who had led hardened lives of crime and knew no other way. Perceived changes by staff in prisoner attitudes appeared to be most noticeable with men who were classed as 'loners' - people who had been abandoned in childhood or abandoned because of their behaviour, or both. And so formed the first initial spark of an idea. Could this therapy also work with socially isolated children in school settings as a preventative measure to combat possible escalating social behavioural problems?

In those early days, I formed close links with the prison who allowed informal interviews to be undertaken with consenting in-mates who felt their lives had been dramatically 'turned around' by the therapy; the "internal wonder-drug" as one man described. From there, training in reality therapy to Certification had to be the next necessity. And so the idea kept growing. Reality therapy *did* work in the professional arena - not always but usually. So how could I establish the criteria necessary to address the times when it did not work? It was, at that point, that a clear decision was made to undertake this study to establish its strengths and weaknesses - but not with secondary school pupils. I needed to focus on younger 'loners' at the end of the primary stage to 'catch them before it was too late'.

1:2 THE TIP OF THE ICEBERG

Almost ten years on, a story in the local newspaper, not even making headline news, was that an eleven year-old boy had been found hanging in his bedroom. He had left a note which said that he was afraid of bullies at his school who had tormented him because he had no friends. Exactly one week later, on 15th June, 2006, a girl was pictured in the same newspaper. She had been found in a ditch, brutally beaten, after having run away from home. Her father described her as a quiet girl with social and emotional problems, who liked to withdraw into a world of fantasy, a girl with no real friends, a 'loner'. This type of news made me feel uncomfortable. It raised questions again about my own family network and inner world. However, dramatic examples of socially isolated children raise the bigger question of whether we are dealing with a small group of dropouts from society or with the tip of an iceberg.

1:3 THE LONER: A SIGN OF THE TIMES

The different manifestations of social isolation amongst young people become more poignant when the major importance our society attaches to personal relationships and having a rich social life is considered (Kauffman, 1997). Hortulanus, Machielse and Meeuwesen (2006) conducted an empirical study into reality television, which showed how twenty young people in their teens and early twenties lived with one another for several weeks and how relationships between them developed. Instead of intense social interaction between participants, as expected, the findings of their research showed that all the young people remained fairly aloof and detached, preferring to be identified with characters from soap operas which 'came into their homes' every day and seemed to form a surrogate relationship with them, often in place of families and friends (Hortulanus *et al.*, 2006). It was also found that young people, in general, were intentionally made part of the emotional highs and lows in the lives of the soap characters by the script-writers. This was overwhelmingly achieved within the study; all twenty of the research subjects admitting to being completely immersed in the storylines, even when quite far-fetched (Hortulanus *et al.*, 2006).

Ten years earlier, Castells (1996) had previously identified the importance social relationships had acquired in the booming market of dating and matchmaking services and the increasing space that personal advertisements were taking in newspapers and dating websites. Children as young as eight were both placing and responding to advertisements in magazines targeted at young people (Castells, 1996). Another remarkable 'sign of the times' was identified by Flap and Völker (2004) who were commissioned by the Salvation Army to ascertain the success of their general appeals and non-commercial advertising on television. Flap and Völker's research (2004) highlighted that civic awareness for lonely fellow human beings of all ages was significantly raised by media appeals.

1:4 THE LONER: DEFINITION

Human aloneness has various meanings according to recent research (Larson and Richards, 1991; Goossens and Marcoen, 1999; Youngblade *et al.*, 1999; Galanaki, 2004). Goossens and Marcoen (1999) described the state of having no one around or,

more precisely, the state of communicative rather than physical isolation as objective aloneness. On the other hand, the researchers identified the experience of sadness in the absence of intimacy or belonging, accompanied by a longing for human contact, as painful aloneness or loneliness (Goossens and Marcoen, 1999). Their small-scale case study research with teenagers concluded that loneliness might or might not emerge from aloneness. Furthermore, a child might experience loneliness even if not literally alone; loneliness was a subjective condition experienced even if others were present, important or not. Replicating this study, Galanaki (2004) further identified a third type of aloneness, frequently denoted by the word 'solitude.' She described solitude as a state of voluntary aloneness, in which personality development and creative activity might take place (Galanaki, 2004). Teenage case participants in this qualitative study often described solitude as their most creative and productive state. Therefore, Galanaki (2004) concluded that the objective state of being alone might result in feelings of loneliness or in an active and constructive use of time alone, which was the essence of solitude (Galanaki, 2004). Other researchers had previously found that the conscious choice and desire for aloneness were critical aspects of solitude with adult participants (Moustakas, 1961; Peplau and Perlman, 1982; Marcoen and Goossens, 1993; Buchholz, 1997; Larson, 1999). Also, solitude was not a non-social state; it acquired its meaning within the social context (Storr, 1988). Furthermore, solitude could be experienced even in the presence of others (Burger, 1995).

Freud (1955) and Winnicott (1965) defined an individual's capacity to be alone as a necessary condition for the experience of solitude. In psychological terms, Winnicott (1965) described children as needing to absorb a familial environment, which would imply that there was always someone present; therefore, a child would gradually be able to be actually alone. Moreover, according to Larson (1999), the capacity to be alone, a major sign of emotional maturity, would enable the child to simply exist without having to react to external stimuli or act with a purpose. Only in this way could the child discover his or her own personal life - that is, his or her true self (Winnicott, 1965; Larson, 1999). On the other hand, Peplau and Perlman (1982) felt that loneliness was an inherent aspect of society and not something which lay within the individual. They listed three social developments which might lead to loneliness: the disintegration of primary group relationships, the increase of family mobility and a general increase in social mobility. Others, again from sociological perspectives, saw the changed social

environment as causative of increasing loneliness. Riesman (1961), for example, posited that individuals in modern Western society had constantly to adjust their behaviour to their interpersonal environment. This cut them off from their inner self, their feelings and their aspirations, and together they formed a group who could be defined as 'loners' (Riesman, 1961).

1:5 THE LONER: CAUSES

Many researchers have postulated that in modern times it has become much more difficult to make and maintain social contacts in childhood, increasing the risk of loneliness (Buchholz, 1997;Youngblade *et al.*, 1999; Heller and Rook, 2001; Galanaki, 2004; Flap and Völker, 2004; Hortulanus *et al.*, 2006). These researchers have recognised that for many people, neighbourhoods have acquired a different meaning than they used to have through greater geographic mobility. Heller and Rook (2001) described how it might be assumed that loneliness was a typical phenomenon of the big cities but now, due to a heterogeneity of lifestyles and etiquettes, young people in urban neighbourhoods also had less contact with one another than used to be the case. From a sociological standpoint, Hortulanus *et al.* (2006) agreed that populations of many small towns had dropped significantly and many local facilities had disappeared. More and more pre-adolescents needed to leave their villages in order to participate in all kinds of societal activities or to use facilities. Both sets of researchers concluded that it was the less mobile groups in particular, such as dependents of single parents, who might well experience the negative consequences of the concentration of such activities and facilities. Such outcomes would make them more dependent on personal networks and hence more vulnerable to loneliness (Heller and Rook, 2001; Hortulanus *et al.*, 2006).

Flap and Völker (2004) identified several 'at risk' groups of potential loners. They found that as well as children in isolated environments where no potential friends are available, there were also children with serious physical, intellectual or emotional disabilities which caused them to be shunned by others. Additionally, there were also children who had little need or desire for friends at this particular point in their development - who were, at least for the time being, more interested in painting or reading or music than in interacting with other children (Flap and Völker, 2004).

Buchholz (1997) classified children who found it hard to make or keep friends as maybe lacking the necessary social skills. On the other hand, Hortulanus *et al.* (2006) believed that other children might lose friends because of a move from one neighbourhood to another. Additionally, Youngblade *et al.* (1999) spotted a third area of potential concern, noting that there were also young people whose friendships falter or end because they had grown apart psychologically. All researchers agreed that these three categories were not mutually exclusive (Buchholz, 1997; Youngblade *et al.*, 1999; Flap and Völter, 2004; Hortulanus *et al.*, 2006). For example, Buchholz (1997) described an example of a child who moved with her family to a new part of the country but was lacking in the necessary social skills to make friends in the new setting.

Thus, it would seem that various factors contribute to the loneliness of a pre-adolescent. Moreover, there would appear to be many developmental processes that introduce disruptive changes. Galanaki (2004) felt that such changes might create powerful new desires or expectations for social relations that could not be readily satisfied. She postulated that they might also precipitate loneliness by disrupting existing relationships, affecting social and personal adjustment. Hortulanus *et al.* (2006) agreed that loneliness might be fostered by features of a socio-cultural situation such as excessive stigmatisation and negative labelling within school, a competitive ethos, ill-defined or meaningless social roles or social processes leading to powerlessness and value confusions.

Of therapeutic significance, unmet needs contained within a wide range of personal characteristics such as shyness, low self-esteem, inadequate social skills and low social desirability were widely thought by many researchers to contribute to the state of pre-adolescent loneliness (Sullivan, 1953; Moustakas, 1961; Riesman, 1961; Weiss, 1973; Peplau and Perlman, 1982; Storr, 1988; Burger, 1995; Buchholz, 1997; Goossens and Marcoen, 1999; Larson, 1999; Youngblade *et al.*, 1999; Heller and Rook, 2001; Flap and Völter, 2004; Galanaki, 2004; Hortulanus *et al.*, 2006). For example, Sullivan (1953) used a biologically oriented language of human needs to explain that intimate relations provided, among other things, an opportunity for consensual validation of personal worth. Loneliness, in this context, was viewed as a response to the "inadequate discharge of the need for human intimacy" (Sullivan, 1953: p. 290).

1:6 THE LONER: CONSEQUENCES

If it is becoming increasingly difficult to meet our instinctual needs for social contact in modern times, as suggested by Bauman (2001), then it might be assumed that Hortulanus and colleagues (2006) were correct in their prediction that the risk of loneliness in society is generally on the increase. Backing up this warning, the BT Auto Update Friendship Survey (YouGov, 2006) discovered from its random-sample interviews with 2,001 phone users that today, in 21st century Britain, the under-30s were most likely to have friendships with a 'shelf life' of five years or less. The reasons given amongst interviewees aged ten to twelve were moving house and swapping friends. 52% of this age group reported changing their closest circle every two years or less. Drifting apart was cited by 63% as the main reason why friendships faded whilst only 9% said their family made up the largest proportion of their close friends. The researchers concluded that keeping friendships alive, if they existed at all, was difficult for the majority of young respondents and that friends were easily dropped and forgotten if they failed to meet ever-changing needs (YouGov, 2006).

Badr, Acitelli and collegues (2001) argued that individual pre-adolescents were unquestionably more self-dependent and less able to fall back on traditional social connections like church, neighbourhood, family or even school since these had lost a great deal of meaning. Heller and Rook (2001) agreed that not all social affiliations had disappeared, but that an individualistic lifestyle had changed the character of society. The effects could be noticed in personal life, in the dealings between people and in the general social environment (Heller and Rook, 2001). Galanaki (2004) expanded on these observations by noting that whereas young people used to have a limited number of relatively stable attachments such as a two-parent family, non-working mother, neighbourhood or youth club, nowadays there were many relatively fleeting bonds. The fairly small communities in which pre-adolescents used to live had made way for a multiplicity of social bonds within which children had to function. Within each, children were expected to deal with different expectations and role patterns (Galanaki, 2004).

Orbach (1998) contended that the need for individual freedom and a rise in vulnerability often ended up in close proximity. This was even more the case in recent decades now

that the social benefits system was undergoing a process of austerity, with cuts in welfare facilities a necessity. Knorr-Cetina (2001) agreed that increasing numbers of parents were unable to keep themselves going and build a network of meaningful contacts around them which would benefit their children. At the same time, government policy made a greater appeal to individuals to cope independently, thus increasing the importance of good informal social networks and informal social support to meet the needs of all age groups (Jordan, 1996).

The impact on personal well-being and threat to societal functioning can be reason enough to view loneliness not exclusively as a private matter but also as a societal issue. Research has found that children who are part of social networks are more active in societal life as an adult, participating more in volunteer work, providing more informal care to their parents in later life and being more involved in all kinds of societal organisations (Burger, 1995; Hymel, Tarulli, Hayden Thompson and Terrell-Deutsch, 1999; Larson, 1999; Galanaki, 2004). Burger (1995) analysed this as being important to society because this societal participation forms a breeding ground for social activity and involvement with the 'weaker' and 'dropouts' of society. Conversely, Galanaki (2004) argued that if grown-up children are no longer part of regular society, they could lose contact with the norms and values prevailing in that society - values that are essential for social integration and societal stability. Hortulanus and colleagues (2006) supported this position, adding that those who do not participate in the labour process and are unable to build a supportive network in their private life as an adult end up outside of society, in a social as well as a societal sense. Furthermore, this category of people who cannot manage on their own would probably not be assertive enough to present their interests and needs to professional agencies. Thus, by alienating their social and societal environment, their attachments within it would keep dwindling. The adult loner might therefore be designated as belonging within a new form of social inequality (Hortulanus *et al.*, 2006).

1:7 RATIONALE FOR STUDY

In the past, most of the focus in social policy at local level has concentrated on battling societal disadvantages and thus material issues. Governments have tended to emphasise

societal participation and the assumed active involvement of citizens (Atkinson and Heritage, 1984; Heller and Rook, 2001). More recent goals, such as coping independently and taking personal responsibility, have been defined mainly in the light of societal participation and active involvement (Buchanan, 2000; Pescosolido and Levy, 2002; Glasser, 2003). Mental health institutions are oriented specifically towards severe mental problems. Institutions such as Social Services, the police, housing corporations and municipal health services usually only intervene after the situation has taken extreme forms, for example, if public health or public order is threatened. Attention to social competency at a young age such as pre-adolescence and a properly functioning social network could prove to be a decisive condition or point of reference for the success of assistance in other areas of life. In terms of social policy, more knowledge about the needs of loners and therapeutic intervention at an age young enough to really make a difference would allow for better recognition of the value of preventative measures, anticipation of risk factors and the relief or elimination of 'the loner syndrome' that is already there.

Measures to deal with the unmet needs of 'at risk' children have already begun. In response to Lord Laming's report (2003) into the tragic death of Victoria Climbié, the Government developed the Every Child Matters strategy along with a new statutory framework defined in the Children Act 2004. This was a culmination of many private and national research pilots. The Children Act 2004 signified one of the most fundamental system-wide changes to Education and Social Care in over sixty years. The Act established a duty on all services for children and young people to work together to better meet their needs and to ensure that children and young people themselves participate in the shaping and improving of services. The principle function of this particular study with relevance to workplace usage will be to promote awareness of the views and interests of socially isolated children and, in particular, to encourage all persons working with children in this category to take account of their views and interests. It is intended to provide feedback to the Secretary of State through Cornwall County Council on the views and interests of children classed as loners.

The Children Act 2004 also established that each Local Authority must create a Children's Services Authority through the integration of the current Local Education Authority and Children's Social Services. The Children's Services Authority (CSA) has

been required to appoint key personnel to lead the implementation of services over the next two years and will be fully operational by 2007. Meanwhile, Cornwall County Council, after consulting with young people in the County, has established its CSA under the name of services for Children, Young People and Families. Lead members for Children, Young People and Families were designated on the formation of the new County Council after the General Election in May 2005. A phased transfer of responsibilities from the existing services took place throughout 2005 and 2006 and the early part of 2007. Responsibility for Children's Social Services was handed over in August 2005 and for Local Education Authority functions on 1st April 2006. The new service is one of Cornwall's largest, employing nearly eight thousand staff including early years workers, SureStart staff, social workers, teachers, teaching assistants, youth workers, welfare officers, psychologists, health professionals, special needs specialists, advisors, inspectors, support staff, premises staff, foster carers and many more.

The key purpose of the initiative was to find new ways for all of these professionals to work together to improve outcomes for all children and young people, including ones who may be reluctant to come forward. Outcomes in terms of the 'whole child' has meant that all health professionals had a responsibility to work with children and young people in terms of five key outcomes identified in the Act: being healthy, staying safe, enjoying and achieving, making a contribution and enjoying and achieving social and economic well-being. I have promoted all five outcomes throughout its implementation as core conditions that could be used with reality therapy, whilst concentrating on enjoying and achieving social well-being as its key remit.

Fostering the welfare and safeguarding of children and young people has been seen as paramount in Cornwall. No less important though is the development of social skills which would give them the life choices that would improve their own health, intellectual and spiritual welfare so that they could eventually join in and contribute to a secure and sustainable community. I have advocated choices as paramount and chosen as the therapeutic tool a method - reality therapy - based on choice theory, described in Chapter 2. By maintaining the balance of the two interdependent services to meet the needs of the whole child, choices can remain multiple. Likewise, involving many fellow professionals in the shaping of a new service will better meet the needs of one hundred thousand children and young people in Cornwall for many years to come. When all

these long-term positive changes were set up in 2005, effective and sustainable packages to use with young people were being sought. Reality therapy is based primarily upon therapeutically meeting unmet needs. The new strategy has been, likewise, based on how to deal with unmet needs over a whole spectrum of difficulties that therapeutic workers become faced with on an almost daily basis. I have argued that reality therapy is the way forward with Cornwall's 'forgotten many' - implementing the fifth core condition of the Every Child Matters agenda - and an effective method for lead professionals to implement.

1:8 RESEARCH AIMS AND OBJECTIVES

Aims

I have framed my research question to focus on introspective reflection by asking: 'How do I engage more effectively with pre-adolescent loners in group therapy?' To expand and try to answer the central research question, the following more specific questions have also been formulated:

1. What were the advantages and the conflicts / tensions of my role as practitioner-researcher?

2. What were the differences between the successful and unsuccessful outcomes of the group programmes?

3. What did I learn from undertaking practitioner-centred research which will improve my practice as a therapist?

Objectives

1. To identify, through the Social Inclusion Survey (Frederickson and Furnham, 1999), children in the three selected schools who were considered to be loners.

2. To implement a group therapy programme at each school based on 'My Quality World Workbook' and 'The Quality World Activity Set' by Carleen Glasser (1996) and specific themes linked to the concepts of reality therapy.

3. To gain an understanding of both individual participant experiences and my own role within the group therapy, thereby creating theory from my personal learning.

1:9 THE TARGETED AGE GROUP

Whilst accepting that the period of pre-adolescence varies from child to child dependent on the age of the onset of adolescence, I have generalised it as the years of ten and eleven for the purpose of this study. This may only cover two years of a child's lifetime, but it spans a period of massive and significant development (Bee, 1992; Kurtz, 1996; Ball, 1998; Borland, 1998; Coleman, 1998; Galanaki, 2004). 'Growing up' has meant having to cope with important new social and cognitive tasks just when major physical and physiological changes are taking place (Palmer, 1997).

Kurtz (1996) recognised that over a very short period of time, a young person has to embark on puberty with all the bodily changes this brings, increase their understanding and experience of the world, develop new ways of thinking, respond to the anticipated stress of having to change schools, become increasingly independent, rely more on friends than family and, perhaps, give some thought to their future (Kurtz, 1996). Expanding on this, Coleman (1998) spotted that, at the same time, he or she was being bombarded by the media, advertisers and the youth culture. Thus, in many senses, the pre-adolescent was encouraged to grow older younger (Coleman, 1998).

Agreeing with this view, Borland (1998) advocated that the majority of ten and eleven year olds did not get enough attention by adults in these almost 'forgotten years' and that the starting point for understanding the pre-adolescent stage would appear to be to ask the young people and their carers themselves. Borland (1998) found that most ten and eleven year olds appeared happy and reported no more than their fair share of worries. However, some situations, mostly 'common everyday happenings', were more

likely than others to make them worried, sad or fearful (Borland, 1998). These included falling out with friends, being bullied or teased by peers, being told off by parents, adults breaking their promises, actual or potential separation of parents, sibling disputes, perceived favouritism or unfairness by teachers or parents, illness and death of close relatives or fears of what to most adults were imaginary things and situations of danger (Borland, 1998). Borland (1998) concluded that these worries, fears or areas of sadness were due to the needs of these young people not being adequately met at pre-adolescence and that children with poor social skills were the most vulnerable. No therapeutic suggestions or solutions were offered.

1:10 SUMMARY

This chapter has concentrated on the sociological and psychological factors which appear to have some influence on the circumstances of pre-adolescents who are socially isolated. It has also briefly highlighted my own interest in this field and my reasons for wishing to explore in greater depth how children classed as 'loners' can be helped within a therapeutic environment.

CHAPTER 2

LITERATURE REVIEW

The real voyage of discovery consists not in seeking new landscapes
But in having new eyes – Marcel Proust 1871-1922

Contents

2:1 INTRODUCTION

This review focuses on the loner from a therapeutic perspective. The first section examines the literature which pinpoints the nature of social withdrawal and the importance of a sound therapeutic relationship. Cognitive-behavioural therapy (CBT) is then conceptualised before effective group therapy is investigated in depth. Finally, the specific therapeutic method of reality therapy is explored. Although a little-researched branch of CBT, it was primarily chosen because of its specific concentration on meeting needs. The effectiveness of reality therapy as the chosen model for this study has been considered, highlighting that this particular research is unique in its field within the UK.

In the search strategy, databases between 1960 and 2008 were probed in the search for relevant literature. Key words have included Control / Choice Theory, Reality Therapy and Internal Motivation. 8173 listings were discovered under ERIC for Control Theory but not a single entry under CINAHL, PREMEDLINE, BEI, BIDS PsycINFO or the ISI Web of Science. There were 364 listings under Psych. Lit. Many different forms of Control Theory were listed in ERIC: rational, classical, action, social, learning, feedback, gate, self, and power control theory. The largest number of listings pertained to the work of William Powers. The only Glasser Control Theory listings (14) were written by Glasser himself. None of these were research related. Under Choice Theory there were 1394 listings on ERIC under such titles as rational, public, social, and formal choice. Under Reality Therapy the listings rose to 2803 and these proved to be the only totally relevant sources of information on the entire internet system. The journal entries in ERIC OF 299 listings under Intrinsic Motivation vs. 219 listings under Stimulus Response Psychology meant a turn in behavioural focus. However, Behaviour Modification had 1355 listings. There were no Control Theory entries related to Intrinsic Motivation listings. Searches on many databases proved totally fruitless. ISI Web of Science, CINAHL, PREMEDLINE, BEI and PsycINFO produced nothing at all of relevance. Wide use was made of Library and Information Services. The four main gateways providing access to e-journals were used - Science Direct, Swetsnet, JSTOR and Synergy.

As a member of the Glasser Institute, a limited amount of 'grey' literature was made available such as unpublished theses, reports and minutes of meetings. Of 257 hand-searched articles in important journals such as the Journal of Reality Therapy, the

International Journal of Reality Therapy and the International Journal of Choice Theory, some of which had been ordered from the USA, only 9% were research related. Few of those were conducted in standard form. This is in contrast to other professional educational and psychological journals in which 99% of the articles were research driven. The Resources Guide: An Accompaniment to the Journal of Reality Therapy did contain a Control Theory / Reality Therapy research section. These references were minimal in number and most were again related to Powers' research.

Resources guides for other American journals in education, psychology and psychotherapy proved, by contrast, more helpful. Many focused on more generalised issues around loneliness and social isolation, although rare finds did produce articles and conference data relating specifically to reality therapy. The specific journals which were used have been listed in appendix i. British journals had even sparser acknowledgement of reality therapy and have been, likewise, added to appendix i. It was thus concluded that American research in the specific area of reality therapy, small as it was, far outweighed British interest and most resources pertaining directly to the subject of reality therapy were obtained from the United States.

Information gathered through subject area, and by widening the emphasis, proved much more satisfactory. An over-abundance of information, bordering on the edge of direct relevancy, proved problematic and much refining was necessary. The sites were re-searched systematically with generic terms such as 'pupil mental health', 'emotional well-being', 'social and emotional literacy' and 'social competence'. Other more specific terms such as PSD (personal and social development), SEBD (social, emotional and behaviour difficulties), guidance and pastoral care have also been used. In addition to databases, sites such as DfES, Joseph Rowntree Foundation and the websites of charities working in related areas were accessed. The British journal articles and textbooks came into their own on the non-specific topic areas researched such as cognitive-behaviourism, emotional behavioural difficulties, emotional literacy, social isolation, loneliness, self-esteem, social competence, bullying, autonomy, motivation and relationships. The BIDS Education Service, in these wider subject areas, had thousands of entries as well as a personal library of hundreds of books and articles that is owned in a professional capacity. Lastly, 'thumb searching' was also used where the bibliographies of relevant papers were examined for further promising literature.

2:2 THE NATURE OF SOCIAL WITHDRAWAL

Socially withdrawn children of pre-adolescent age and younger have hallmark characteristics which are of therapeutic interest, in that they tend to engage almost exclusively in passive or active solitary play and may appear shy or avoidant. According to Harrist, Zaia, Bates, Dodge and Pettit (1997), there are several subtypes of social withdrawal for the purpose of differentiating between children who actively avoid playing with other children, those who want to play but are fearful or anxious, those who simply prefer not to play with others, and those who are rejected by their peers. However, other researchers such as Wasserstein (1998) have delineated the subtypes differently, based on varying methods of appraisal. It would seem, therefore, important to examine the nature of social withdrawal as it may be suggestive of possible skill sets and interventions.

According to Rapport, Denney, Chung and Hustace (2001), the type of withdrawal under which a child may be categorised has a role in determining risk level for later behavioural problems. For example, children who would rather not engage in social activities with other children may tend to have well-developed social skills but prefer not to use them. Harrist *et al.* (1997) found that children who were extremely shy and displayed signs of social anxiety or peer rejection demonstrated that their social problem solving skills were poor relative to their same-age peers. These deficits would therefore appear to be closely linked to later aggressive behaviours and aggressive responses to hypothetical social situations. Wood, Cowan and Baker (2002) expanded on this view, establishing a link which could be seen in very early childhood.

The most salient correlations over several studies (Kupersmidt and Cole, 1990; Rapport *et al.*, 2001; Baumeister, Twenge and Nuss, 2002; Wood *et al.*, 2002; Leary, Kowalski, Smith and Phillips, 2003) suggest that peer rejection is the form of social withdrawal that is associated most frequently with aggressive behaviour and predicts later aggressive behaviour. Hart, Keller, Edelstein and Hofmann (1998) also found that children who do not have ample social interactions, whether voluntary or involuntary, are at risk of failing to develop social problem-solving skills and moral judgment. Baumeister *et al.* (2002) backed this finding, adding that rejected children were more likely to behave aggressively than accepted, popular children. From the therapeutic perspective, these researchers found that this may be because peer rejection adds the

components of anxiety and anger. They warned that a combination of limited social interactions, anxiety and anger might foretell later violent behaviour (Baumeister *et al.*, 2002). Additionally, Kupersmidt and Cole (1990) studied pre-adolescent peer status as related to later externalising behaviour problems and found that rejected pupils were more likely to be suspended from school than the non-rejected. In addition, they were three times more likely to have contact with the police than average children, twice more likely to become truant and disproportionately more likely to drop out of school or be put in young offenders' institutions than other children. Even in this study, early childhood aggression, alone or with withdrawal, predicted later externalising behaviour problems more reliably than withdrawal alone (Kupersmidt and Cole, 1990).

Conversely, Kagan (1989) identified social anxiety disorder (SAD) as being characterised by intense fear of ridicule and embarrassment in social situations leading to avoidance of feared situations. Albano and Barlow (1996) expanded on this view, recognising that a single event in a child's life that could be perceived as traumatic, such as public rejection, making a major mistake in front of peers, or being bullied or victimised could lead to a full expression of pre-disposition for social anxiety disorder.

The notion of pre-disposition suggests there may be biological or psychological characteristics within individuals which make them more susceptible to social anxiety. Calkins and Fox (2002) suggested that self-regulatory processes were important influences in personality development and behavioural adjustment, and that a specific deficit might be an underlying cause of social withdrawal. Kopp (1989) had proposed that emotional regulation facilitated healthy adaptation to the environment and allowed learning and growth to occur. With exposure to the environment naturally came situations which caused emotional distress and anxiety. The ability to regulate natural emotional responses to environmental conditions then helped determine the degree to which healthy coping strategies could emerge (Kopp, 1989). Volling, McElwain, Notaro and Herrera (2002) described this self-regulation as a child's ability to manage feelings, thoughts and behaviours across a variety of physical and social contexts in a way that is adaptive and flexible. Perry (2001) found that optimal development of affective self-regulation required repeated exposures to controllable challenges which taught the child that there was often a delay between initial distress and satisfactory resolution.

Lengua (2002, 2003) and Lakes and Hoyt (2004) found that children learn more effectively when they felt attached to their schools, peers and teachers. Weissberg, Resnik, Payton and O'Brien (2003) added that equipping young people with social problem-solving and self-regulation skills might foster that level of attachment and comfort, thus facilitating their learning in general and, specifically, of skills related to interpersonal functioning. Agreeing with the findings of Baumeister *et al.* (2002), Weissberg *et al.* (2003) postulated that when socially withdrawn children did not receive interventions to remediate skill deficits, there was a risk that their patterns of behaviour could affect later generations. They found that social withdrawal and its associated behaviours could be passed down from parent to child through a variety of mediating factors.

Retrospective studies have explored the connection between child-rearing practices and social anxiety disorder and have found that adults with the disorder recalled their parents as fostering social avoidance and isolation by limiting social activities, even with close friends and family members (Spence, Donovan and Brechman-Toussaint, 2000). It would seem that school personnel often did not know the family dynamics that may have influenced the development of social withdrawal, so a better understanding of what to look for in children is warranted (Spence *et al.*, 2000).

2:3 THE THERAPEUTIC RELATIONSHIP

The working relationship with youth has been identified by several practitioner-centred researchers as the most important tool a child and adolescent therapist can rely on (Corey, Corey, Callanan and Russell, 1992; Friedberg, Friedberg and Friedburg, 2001; McLeod, 2005). As early as 1979, Beck, Rush, Shaw and Emery stressed the importance of active interaction between client and therapist, with the therapeutic alliance or working relationship being a key element to effective cognitive behavioural therapy (CBT) and cognitive behavioural group therapy (CBGT). Since that time, experts such as Mennuti, Christner and Freeman (2006) have asserted that a positive, authentic connection between therapist and client / group participant can produce an opportunity to make notable change and to enhance overall outcome. The "working alliance" was also identified as the most important tool in effecting therapeutic change

by Bordin (1979) in his influential work. He outlined three important components to its effectiveness, including (1) an agreement on goals, (2) an agreement on assigned tasks, and (3) the development of a personal bond. Bordin (1979) stressed that in order for intervention to be successful, therapists needed to attend to these components and monitor them throughout therapy - as one should not assume that just because a positive relationship has developed that it will be maintained. In the group context, Christner, Stewart and Freeman (2006) highlighted that the development of bonds related not only to the relationship between the therapist and each child, but also between each of the group members as well. These dynamics would appear to play an important role in the comfort level of each participant to engage in the process of therapy, to the extent that change would be possible and lasting, and that would facilitate group cohesiveness and shared responsibility (Christner *et al.*, 2006).

Malekoff (2004) warned that when conceptualising the needs, participation and progress of each group member, therapists needed to consider the influence of their own cognitions on the functioning of group members. Just as the emotional and behavioural responses of participants would influence one another, so would these factors of the group facilitator. Yalom (2005) observed that, as clinicians, we often took for granted that we were just as likely to possess our own less-than-entirely-accurate perceptions that could negatively impact our responses. When conducting group therapy, Freeman and Dolan (2001) emphasised that it was especially important to be mindful of our own beliefs related to our competencies and abilities, as well as the intentions, motivations, behaviours and abilities of our group members. Many practitioner-centred researchers have stressed how the group setting creates a very different situation with an additional set of challenges to individual therapy (Corey *et al.*, 1992; Friedberg and McClure, 2002; McLeod, 2005; Christner *et al.*, 2006; Mennuti *et al.*, 2006). These challenges could activate underlying negative beliefs such as 'I am not competent enough' which would otherwise be less of an issue in a one-to-one situation (Christner *et al.*, 2006).

Effective therapy with pre-adolescent group members would appear to rest upon three essential considerations: the participants who compose the group, the therapist responsible for conducting the group and the setting in which the group occurs (Smith, 1998; Long and Averill, 2003; McLeod, 2005). Careful attention to each factor is important in order to assume the most beneficial treatment possible, as each element

enhances or inhibits the others (McLeod, 2005). An effective therapist must consider variables such as age, gender, educational level, developmental level, culture, ethnicity, socioeconomic status, personal attributes, psychosocial strengths and weaknesses, the presenting problems and the levels of co-operation and motivation (Cohen and Rice, 1985; NFER, 1995; Mental Health Foundation, 1999). Other variables relating to the therapist include skill level, personal attributes and approach to the role assumed, as group success initially rests on the role of the therapist (Bates, Johnson and Blaker, 1982). Weiner (1983) emphasised that therapists must also recognise that growth and change are the result of their modelling and the progressive interactions of group members as they gain insight and skills. Therefore, therapists must monitor these processes and guide in the direction of conceptualisation as needed (Weiner, 1983; HEA, 1997; McLeod, 2005). Finally, the importance of the setting cannot be minimised because it bears a close relationship to group outcome (Cohen, 1993; Albano and Barlow, 1996). These practitioner-centred researchers emphasised that the setting must support the role of group treatment by commitment to the treatment goals and process. This should include practical considerations to accommodate the group, but especially the commitment of the organisation to support both therapy and therapist (Cohen, 1993; Albano and Barlow, 1996).

2:4 COGNITIVE-BEHAVIOURAL THERAPY FOR LONERS

According to Kendall, Chu, Pimental and Choudbury (2000), children who were socially isolated or ostracised might interpret the world around them based on distorted views of social interactions, such as the notion that people would remember their inadequacies, judge them for saying the wrong thing, or that any interaction would lead to humiliation. In some cases, some of these perceptions may have been accurate, especially in cases where the child was bullied. Persistent avoidance of social situations, whether voluntary or involuntary, was reinforcing and never allowed the individual to habituate to anxiety-provoking encounters (Kendall *et al.*, 2000). A CBT model for social withdrawal would include changing coping strategies from avoidant to active, such as thinking and planning solutions, and exploring and restructuring underlying beliefs that govern behaviour. Prins and Ollendick (2003) viewed this shift in thinking as increasing a person's sense of success, thus enhancing psychological adjustment.

Many influential practitioner-centred researchers believe that, following referral for problems with social interaction, the specific strengths and weaknesses of each child should be assessed and their cases conceptualised based on therapy related to the CBT model (Freeman and Dattilio, 1992; Albano and Barlow, 1996; Beck, Beck and Jolly, 2001; Friedberg and McClure, 2002; Freeman, Pretzer, Fleming and Simon, 2004; Christner, 2006). All these clinicians agreed that the majority of children who were isolated or ostracised experienced anxiety - either as the primary cause of their isolation, which is the case with SAD, or as a result of it, such as in cases of peer rejection or underdeveloped social skills.

Vassey and McLeod (2001) found that anxious children tended to process information about the world incorrectly. They favoured more threatening interpretations of ambiguity relative to their non-anxious peers, and they overestimated the likelihood of danger in the future. Anxious children also demonstrated enhanced memory for threatening information. Lundh and Sperling (2002) found in their research on post-processing of socially distressing events that people who experienced social anxiety processed events in negative ways following the event. This backed the findings of Harrist *et al.* (1997) who had already established that socially isolated children were frequently anxious about interacting and looking foolish or experiencing rejection, so they avoided social encounters in their entirety.

To develop social problem solving skills, Adalbjarnardottir (1995) identified four steps which individuals could use to solve interpersonal problems: (1) definition of the problem (2) generation of alternative strategies (3) selection and implementation of a strategy and (4) evaluation of the outcome. He examined how well children who were withdrawn performed on these tasks (relative to control groups) and found that more socially withdrawn children had deficits in perspective-taking ability. They also generated fewer and less complex alternative solutions to each social problem. Lease (1995) added that children were usually aware, on some level, of their inability to negotiate social situations effectively and this decreased their sense of self-efficacy. They also had lowered outcome expectations and failed to develop strategies to improve their success. Adalbjarnardottir (1995) highlighted that children could have negative social experiences due to their inability to understand and integrate the perspective of other people. This inability was highly correlated with peer rejection.

Both cognitive deficits (Cric, Hoffman, Gaze and Edelbrock, 2004) and language disorders (Greene and Doyle, 1999) can significantly affect the capacity to understand the benefits of affective self-regulation. Marlowe (2000) posited that as language was so important in mediating cognition and behaviour, children with aberrant language would have greater difficulty in learning to predict the outcomes of activities and events, and they were more likely to fail to mediate their experiences with sufficient specificity. Verbal self-regulation was therefore seen as a critical achievement in regulating internal affective states (Kam, Greenberg and Kusche, 2004) and self-guided private speech, according to Vygotsky (1986), was a sign that children were bringing their behaviour under control of thought. Ayduk, Mendoza-Denton, Mischel, Downey, Peake and Rodriquez (2000) researched the ability to regulate emotions under psychosocial stress. They found that many children were unable to focus attention to details of the situation. Lengua (2002) also emphasised that children with social anxiety often were not able to shift attention to less threatening aspects of the environment.

2:5 GROUP THERAPY

William Glasser (1965) recognised that pre-adolescents developed within and through relationships with others: they needed the appreciation and recognition of others to develop positive behaviour through self-respect and self-confidence, and people from their personal network could provide this appreciation. Myers (1999) expanded on these early findings, establishing that contact with others offered individuals of all ages a social identity and feelings of belonging that would greatly influence the values and norms they developed and the behavioural choices which they made. CBT groups with children who are socially isolated or ostracised have rarely been studied for their utility, despite evidence which suggests that problems such as social anxiety are most effectively treated in group settings to create a sense of belonging (Freeman *et al.*, 2004), and social skills training is nearly always completed utilising other people as models to practice and generalise newly acquired skills (Segrin, 2003).

CBGT has been found to be an excellent adjunct to other therapeutic interventions, and has been shown to reduce social skills deficits in teenagers with a variety of other psychological disorders (Vickers, 2002). One of the major benefits of group therapy for

pre-adolescents is that it offers a more realistic environment for individuals to learn about and change their negative behaviour than therapy conducted on an individual basis (Yalom, 2005). Group therapy situations present interactions that, for many children, might provoke experiences of anxiety, anger and other problems. As a result, group work would be much more likely than individual therapy to provide the kinds of variables that trigger and reinforce these behaviours, allowing for direct observations that more accurately represent the functioning of group members. Piper and Perrault (1989) believed that, in general, almost everyone could profit from group treatment. However, Stone (1993) pointed out that there could be individuals whose behaviour and goals did not coincide with the mutual benefit of others, or whose social skills were very limited. Those individuals with severe psychopathology or antisocial tendencies could present problems in developing group cohesion. Therefore, therapists should remember that group therapy was not possible with every individual (Stone, 1993).

Mennuti *et al.* (2006) also emphasised that, while rare, such children ought not to be included in the typical group and / or the therapist must be aware of the potential difficulty that any child with a severe emotional disturbance might present in a group that was not comprised specifically of similar peers. It was suggested that careful initial assessment would usually keep the problem from arising unexpectedly, and would allow for a better fit of individual needs and goals for all group members when the degree of pathology, skill levels, maturation and social skills were considered (Stone, 1993; Mennuti *et al.* 2006). Leahy (2004) highlighted that each member of the group should be assessed as to their readiness for successful group participation and potential for contributing to the group process. Christner *et al.* (2006) suggested that, where time was limited for this task, even a short individual session would pay off greatly in beginning a successful group. The therapist would then be in a position to appraise the status of the individual and tentatively determine which negative behaviours seemed most important to address with each member (Christner *et al.*, 2006). White and Freeman (2000) and Yalom (2005) suggested that an individual session with each participant would allow the therapist to enter the first session without becoming subject to any unknown factors that could have disastrous consequences, and which could have been foreseen, as well as afford each group member with enough information to make transition into a (perhaps) unknown situation more successful from the onset.

Although initial screening can help identify problematic situations which could arise in group treatment, many negative behaviours may not make their appearance until the dynamics of the group bring them forth (Yalom, 2005). Gans and Alonso (1998) identified the most difficult individuals as those whose personality and character challenged the general goodwill of most group members. While this might not be fully expected in most young children and adolescents, it can appear as full-blown pathology. This phenomenon often can occur because process in group treatment may uncover or bring to the surface problematic situations such as abuse or neglect (Silverstein, 1997). Kotter (1994) felt, for this very reason, that the task of leading a group was far too complex to be assumed adequately handled by one therapist working alone. Using one therapist should not be considered optimum for effective group interaction to occur. Using two facilitators allowed for greater objectivity and observation, as well as better conceptualisation of the process and interactions within the group (Kotter, 1994). Interestingly, decades earlier, CBT-orientated practitioner-centred researchers Rosenbaum and Berger (1963) had identified many psychoanalytically oriented texts and articles as dealing - perhaps more insightfully - with how high-trauma children could be better managed by a group therapist 'flying solo'.

2.5.1 SUBTYPES AND TREATMENTS

Individual characteristics of each child are an important consideration in forming a group because, for the group to be most effective, the children must be able to benefit from one another. For example, sad or depressed children may self-isolate, making their participation in a group minimal. When delineating the different subtypes of social withdrawal, Harrist and colleagues (1997) suggested that, for this sub-type, another appropriate option such as individual psychotherapy or a group for depression might be more appropriate.

Likewise, a child who had been actively rejected by his peers might be socially isolated for poor impulse control, socially inappropriate behaviour and difficulty viewing social situations from another child's perspective. This could be irritating to other children, thus resulting in peer rejection (Harrist *et al.*, 1997). Treatment for this type of child might involve cognitive and behavioural techniques to facilitate impulse control, as well

as social skills training. Adalbjarnardottir (1995) warned that therapists would be wise to expose withdrawn children to controlled social encounters to allow them to practice their social skills and proposed that a group therapy model would be well suited for this purpose. Harrist and colleagues (1997) agreed that role playing, rehearsal of skills, increase in environmental structure and providing the child opportunities to engage in small group activities to foster success were all appropriate treatments for such a child.

Calkins and Fox (2002) noted that many withdrawn children had difficulty monitoring their behaviours for efficacy and often did not take into account the effect their behaviours were having on other children. This required that children be taught self-monitoring routines, which they could learn through modelling and regular practice. Segrin (2003) also found that social skills training helped children learn how to listen and look for the social cues from other people and choose an appropriate response that helped them to reach their goal in the social encounter. A group programme should therefore be modified and tailored to meet the particular needs of each child, with specific goals based on each child's area of skill deficit (Calkins and Fox, 2002; Segrin, 2003). Freeman and colleagues (2004) highlighted that an important factor would also be the nature of each participant's isolation as children who actively self-isolated but had adequate social skills would require a different intervention programme from children who required social skills training. They emphasised that children in group therapy must have similar goals so that they could learn from one another and identify with each other's experiences (Freeman *et al.*, 2004).

Marlowe (2000) suggested that children who could not effectively self-regulate their feelings and behaviours were not in the habit of thinking before they acted and needed to be taught to think routinely and think systematically. It was suggested that children could be taught language skills as they related to the systematic instruction of social problem solving skills and strategies as well as developmentally appropriate emotional awareness (Marlowe, 2000). An effective therapist would seek to bring thought and feeling into awareness so that the children understood the connection and felt empowered to influence change over their behaviours (Marlowe, 2000).

2:5:2 ENCOURAGING CLINICAL CHANGE

Being part of a social network has been shown to offer young people the possibility of forming social relationships within that group and to experience personal involvement, intimacy and friendship (Bullock, 1992; Galanaki, 2004). Additionally, the social interaction with others, the 'comfortableness' and the pleasure of 'being together with others' is widely believed to have positive effects on personal well-being (Bowlby, 1973b; Doll, 1996; Rotenburg and Hymel, 1999; Galanaki, 2004). Doll (1996) categorised being part of a group as meaning that a young person was able to create and share a vision of reality with others, thus becoming less bothered by feelings of insecurity, whilst confirming socially desirable behaviour. Rotenburg and Hymel (1999) scrutinised social relationships made within groups in an empirical study which found that being a part of a group provided social support, a basic condition of existence. The researchers argued that this social support did not have to be constantly present but the expectation that, in times of need, a young person could count on help and support from others was seen as crucial (Rotenburg and Hymel, 1999). 'Instrumental support' was classified as when members of the group offered advice or concrete help to solve a problem, such as material or practical help that met the immediate need of the involved person (Rotenburg and Hymel, 1999). On the other hand, categorised as 'emotional help' was the feeling group members might have that others cared about them, that attention was being paid to their experiences and feelings and that they could talk about personal problems. Thus, social support was seen as providing a protective factor when problems arose (Rotenburg and Hymel, 1999).

Buchholz (1997) identified pre-adolescents from the personal network as being able to help to control emotions such as stress by changing the stressful situation, by changing its meaning or by alleviating the emotional reactions to it (Bucholz, 1997; Leahy, 2004). Based on this premise, some researchers have posited that social relationships might only influence personal well-being in a stress context, whereas there would be no positive influence at times in which no dramatic events occurred (Cohen and Wills, 1985; Castells, 1996; Badr, Acitelli, Duck and Carl, 2001). Others stated that social relationships contributed to psychological well-being regardless of the stress level (Billington, Hockey and Strawbridge, 1998; Wells, 2002; Ledley *et al.*, 2005). Wells (2002) believed that in a stressful situation, significant others might offer immediate help, assistance, distraction or emotional regulation. However, in normal social

interactions, members from the group would usually be capable of offering intimacy, company, the feeling of belonging and support for personal aspirations. Most importantly, Rubenstein and Shaver (1982), Vaux (1988) and Wells (2002) saw social relationships as not only central to solving problems or offering help in crisis situations, but also in strengthening positive feelings.

Some theorists have focused on the negative consequences of social relationships (Heller and Rook, 2001), although the negative *effects* have been hardly investigated (Myers, 1999). Heller and Rook (2001) found that while social relationships, in general terms, contributed to a young person's emotional well-being and mental health, they could also be burdensome and limiting. Behaviour of members of the network could cause extra stress or could form a basis for negative social comparisons (Myers, 1999; Heller and Rook, 2001). Likewise, a person could belong to a group whose members encouraged socially deviating or unhealthy behaviour (Scott, 1991; Heller and Rook, 2001). When young people were not able to meet the role expectations within the group they belonged to, there was no appreciation from the members of the network and this had negative consequences for personal identity and self-respect (Heller and Rook, 2001). Additionally, Scott (1991) discovered that the social support offered did not always meet the need: the help might have been inadequate or offered in a way that undermined the competence of the recipient, making him or her dependent (Scott, 1991).

Greenhalgh (2000) also identified that a socially isolated pre-adolescent was often surrounded by an 'aura' of hopelessness. They might have become used to being put-down by adults and so they might be accustomed to thinking negatively about themselves and their capabilities. Insults, sarcasm and emotional blackmail were 'pitfalls' to be avoided (Smith, 1998). Faber, Mazlish, Nyberg and Templeton (1995) suggested techniques such as letting lonely pre-adolescents overhear something positive being said about them, reminding them of past accomplishments and giving them chances to depart from a limiting role by giving them a new role to perform (Faber *et al.*, 1995). Balson (1992) also highlighted the fact that socially isolated children often heard more negative than positive self-statements from the adults in their lives and so they learnt to 'talk to themselves' in these negative terms too. Greenhalgh (2000) later

argued that this problem could be counteracted by showing them how to congratulate themselves when they had achieved their goals.

Evertson, Emmer, Clements and Worsham (1997) found that all children, regardless of many variables, needed friends. Their study defined friendship as a voluntary, ongoing bond between individuals who had a mutual preference for each other and who shared emotional warmth. They concluded that, in studying loneliness and friendship, there were three issues to be considered in relating to peers. These were the extent to which children felt included or excluded from their peer group, who within the group had a given status as a leader and who was a follower, and whether the individuals in the group felt any lasting affection for one another (Evertson *et al.*, 1997). A sense of cohesiveness allowed pre-adolescents to accept others and trust their peers with their ideas and feelings. When they felt supported in this way, it was found that the group was viewed as more acceptable, learning was valued and there was more willingness to put in effort and take intellectual risks (Evertson *et al.* 1997). However, the other side of the coin was pointed out by Rubin (1980) who argued that isolated and unhappy teenagers could negatively affect the atmosphere of the group, provoke discipline issues and limit the activities on offer to that particular group. Varma (1990) expanded on this point by adding that there was a secondary consideration. Aggressive and impulsive children might become increasingly unpopular with their peers as they got older, as the typical child would feel only affection for those on whom they could depend and whose behaviour was predictable (Varma, 1990).

2:5:3 OBSTACLES TO CLINICAL CHANGE

In order for group treatment of social deficits to be as effective as intended, Segrin (2003) emphasised that the participants must have the cognitive ability and attention span to learn the techniques and strategies taught in the group. Some children with profound learning difficulties, for much the same reason as they did not develop interpersonal relationships on their own, might not benefit from the more sophisticated training programmes (Segrin, 2003). The model for group therapy assumes that not only are the children benefiting from the brief individual time they each receive from the therapist in the group setting, but they also benefit from each other. The ability to

participate actively on some level is a hallmark of group therapy (McLeod, 2005). In settings or groups where the children's cognitive abilities preclude complex tasks, the therapist must focus the sessions on behavioural techniques and relaxation training (Segrin, 2003; Freeman et al., 2004; McLeod, 2005).

Segrin (2003) warned that group members needed to also be motivated to try something new and learn ways to improve their interpersonal success. Consequently, children with low motivation, antisocial personalities who preferred to avoid relationships, or those who chose to self-isolate might not benefit from social skills training or therapy groups. Those problems were better addressed first in individual therapy, at which point it could be determined if the child was ready to integrate into a group. If a child was integrated too soon, not only did the child not benefit, but also the other group members might be hindered (Segrin, 2003).

Friedberg and Crosby (2001) found that group therapy limited the amount of time each child received direct interaction with the therapist relative to individual therapy. Vernon (2002) added that the therapist must possess adequate behaviour management skills and the ability to maintain structure if the group was to stay on track. A single participant could undermine and disrupt the greater goals of the group. Freeman and colleagues (2004) highlighted an example of a child with social anxiety. If that child was unable to tolerate the distress of being in the inherently social group setting, it might affect the other children's interactions. If severe social anxiety incapacitated an individual, this also decreased the likelihood that the child would willingly attend. Freeman *et al.* (2004) suggested that this could be avoided by carefully conceptualising each child's case and determining if group therapy was the best intervention at that time.

2:5:4 EFFECTIVE THERAPY

Loneliness has been classified as occurring when individuals perceived a discrepancy between two factors, their desired and achieved levels of social contact (McMullin, 1999; Neenan *et al.*, 2000; Ledley *et al.*, 2005). According to Leahy (2004), the cognitive-behavioural therapist would generally take the view that it was useful in therapy to help children become more comfortable with being alone before, or

concurrent with, initiating friendships. A view postulated by Ledley *et al.* (2005) was that there was a danger that, unless at ease with aloneness, 'loners' might overwhelm potential friends with their 'neediness' out of a desperate fear of being alone. Many researchers have found that lonely children are often depressed, inactive, unstructured and lack energy (Liebmann, 1986; Chodorow, 1991; Padesky and Greenberger, 1995; Gelder, 1997; Neenan *et al.*, 2000; Wells, 2002; Leahy, 2004). Ledley *et al.* (2005) added that some 'loners' feared that something terrible might happen that they would not be able to handle.

In order to determine exactly why a child might be so discontented, Beck, Rush, Shaw and Emery (1979) claimed that the cognitive-behavioural method could elicit their automatic thoughts whilst they were alone. They considered that many young people were blocked from pursuing relationships and from deepening them because they considered themselves undesirable in many respects (Beck *et al.*, 1979). Looking further into this, Albano and Kearney (2000) found that pre-adolescents who were alone had reported automatic thoughts that they were, for example, unattractive, unlikable, dull or boring. Thus, these children tended to believe that these faults were basic to their personality and therefore unchangeable (Albano and Kearney, 2000). These researchers felt that CBGT should test out the hypothesis that other people had avoided them because they were dull, ugly and so on (Albano and Kearney, 2000). With the therapist's guidance, lonely young people would be made to recognise that they had had friends in the past who liked them and that they might be over-generalising from a few instances of rejection (Albano and Kearney, 2000).

Expanding this view still further, Friedberg, Crosby, Friedberg and Friedberg (2001) found another way of dealing with this was to ask such children to list their positive qualities. In this way, the therapist could sometimes identify underlying assumptions such as the notion that "It is essential to be beautiful, brilliant, lively and witty in order to have friends" (Friedberg *et al.*, 2001). Stallard (2002) reiterated this point adding that, through questioning, pre-adolescents often realised that they themselves would not insist on these qualities in selecting friends, and therefore other people might not either. If serious faults did exist, the child would be shown that most personal characteristics were not innate but could be learned and unlearned (Biddulph, 1993; Hollon and Beck, 1994; Friedberg *et al.*, 2001; Stallard, 2002; Reinecke, Dattilio and Freeman, 2003).

Beck *et al.* (1979) found that one of the most common blocks to making friends was a set of thoughts expressing a fear of embarrassing oneself in front of other people and of not knowing what to do or say. Kendall (2000) agreed, describing such thoughts as often leading to social phobia, accompanied by many other symptoms of anxiety. Some children might interpret these anxiety symptoms as indicators that they would lose control, go crazy or be physically ill (Kendall, 2000). Other socially phobic children were identified as being engaged in a 'spectatoring' behaviour, a process in which they could not stop observing themselves whilst they were with others (Papageorgiou and Wells, 2003). Often they had become so focused on how poorly they were 'performing' and so self-conscious that they were not able to participate in or enjoy social encounters (Papageorgiou and Wells, 2003). These researchers found that an effective technique was to ask children for *evidence* that other people were constantly examining and evaluating their behaviour. Furthermore, the therapist could assist them by questioning the assumption that they would be rejected or ridiculed if they made a social faux pas. Would *they* stop being friends with someone who acted in an awkward manner (Papageorgiou and Wells, 2003)?

Some lonely children might not have appropriate social skills in their repertoire for handling certain situations. They may have reported being ridiculed and rejected by others yet not know why (Spence, 1994). Reinecke *et al.* (2003) described how, in cases such as this, the cognitive-behavioural therapist would model more desirable types of behaviour and ask the young person to try and incorporate them in the context of a role-play. Through practice, the child would begin to get more positive feedback from others (Reinecke *et al.*, 2003). Albano and Kearney (2000) found that some lonely children had difficulty relating to others because they did not understand how other people thought - their own thinking being very idiosyncratic. The therapist would educate these children regarding conventional attitudes towards many areas of life and train the young person to listen more carefully to what other people were saying (Albano and Kearney, 2000). Empathy could be learnt, although the process was often difficult (Albano and Kearney, 2000; Friedburg and McClure, 2002). This was because a significant number of lonely children have been found to suffer from a profound mistrust of other people. They were often bitter about the world, yet felt painfully isolated (Friedburg and McClure, 2002). These children often shared maladaptive assumptions about other people being selfish, only caring about themselves and taking advantage of everyone

else (Friedburg and McClure, 2002). The therapist might try to help in two ways. Kendall (2000) suggested that factors in the child's life could be reviewed supporting their view that people were uncaring. Stallard (2002) added that the therapist might then enquire whether these few examples were adequate *evidence* to generalise about the rest of the world. The therapist could suggest that the young person 'try out' a few more people to see if their assumption was totally accurate (Kendall, 2000; Stallard, 2002).

Reinecke *et al.* (2003) recognised that a second important strategy would be for the therapist to probe continually for the child's thoughts about whether the therapist could be trusted. Ideally, 'loners' would be brought to realise that they were placing the worst possible interpretations on many of the therapist's actions and that alternative explanations were more plausible. If children trusted the therapist, then their view of the world at large might begin to change as well (Kendall, 2000; Stallard, 2002; Reinecke *et al.*, 2003). Once the lonely young person has developed a solid base of satisfying casual friends, the next step would be to select the most trustworthy among them and begin the process of self-disclosure (Friedburg and McClure, 2002). Temple (1997) emphasised the importance of self-disclosure because the first step towards intimacy was often regarded as the sharing of private thoughts and feelings with other person. Friedburg *et al.* (2001) devised a number of therapeutic exercises for children using guided self-discovery. They recommended that, in this situation, the therapist would encourage the child to find another young person who was safe and comfortable, often of the same sex, and who had already expressed an obvious interest in becoming closer friends (Friedburg *et al.*, 2001). However, Friedburg *et al.* (2001) acknowledged the dilemma that existed; lonely young people often had difficulty with self-disclosure. They frequently had a stream of thoughts about their inability to communicate because they were different from others, no-one could understand them and people would reject them if they disclosed their weaknesses or 'shameful' thoughts (Friedburg *et al.*, 2001).

Other research also highlighted that constricted children might express the opinion that they had no right to burden other people with their problems (Deblinger and Heflin, 1996; Stallard, 2002). To test these thoughts, Stallard (2002) suggested that the therapist might play the role of the child while the child played the role of a friend. As the therapist disclosed some of the child's 'secrets', the child listened and responded (Stallard, 2002). Almost inevitably, it has been found that children report that they feel a

great deal of understanding and caring for the therapist during the disclosure, not disgust (Deblinger and Heflin, 1996; Stallard, 2002). They often concluded from the role-playing that their private fears were not so terrible after all and that they could probably enhance intimacy through self-disclosure (Deblinger and Heflin, 1996). The pre-adolescent would also begin to recognise that other people were not so different and were able to understand and empathise (Deblinger and Heflin, 1996; Kendall 2000; Stallard, 2002; Reinecke *et al.*, 2003).

Friedburg and colleagues (2001) found that a significant number of chronically lonely young people set unrealistic expectations for the small amount of friends or acquaintances they might have. Thus these 'loners' would be viewed by others as rigid, uncompromising, stubborn, inflexible, demanding or moralistic (Friedburg *et al.*, 2001). Such children, however, would rarely view themselves this way. Instead, they often saw themselves as asking other people to do only what "everyone would agree was right" (Friedburg *et al.*, 2001). Subsequently, when friends failed to do what was "obviously" correct, these 'loners' might feel angry, insulted, frustrated and disappointed in their friends. As a result, Friedburg and colleagues (2001) contended that when the underlying assumptions of such young people were uncovered, it could often be found that they strongly believed in certain absolute standards of right and wrong and therefore were intolerant, or totally unaware, of differing views held by others (Friedburg *et al.*, 2001). Reinecke *et al.* (2003) supported these findings, adding that 'loners' might have recognised differences of opinion as valid but still felt that they should not have to tolerate behaviour they disliked. Such young people with unrealistic expectations would actually choose to be alone rather than accept faults in their friends (Reinecke *et al.*, 2003). The therapy could now follow one of two paths. The first would be to help the child see that there were rarely absolute standards of right and wrong, and that other people were validly entitled to live according to different rules (Beck, 1995; Ledley *et al.*, 2005). The second path would be to have the young person contrast the disadvantages of continually demanding that expectations be met and becoming frustrated with the benefits of tolerating faults and accepting other children's points of view (Friedburg *et al.*, 2001; Reinecke *et al.*, 2003). Most pre-adolescents would eventually be able to accept certain flaws as a reasonable price to pay for achieving companionship (Friedburg *et al.*, 2001; Reinecke *et al.*, 2003).

Hart and colleagues (1998) also found that children lacking flexibility were likely to have unsuccessful social encounters, which might lead to either peer rejection or active avoidance of social situations. This isolation would result in decreased opportunities to develop and practice social skills, thus perpetuating the problem. By increasing exposure to social situations that enhanced moral and social judgment, moral reasoning could also be enhanced and this development might, in turn, lead to heightened curiosity and insight, as well as increase motivation to learn new social skills (Hart *et al.*, 1998).

2:6 THE SPECIFIC METHOD : REALITY THERAPY

Logically, reality therapy has belonged among the generic cognitive-behavioural systems of therapy (Wubbolding, 2000). It is viewed as similar to another member of the cognitive-behavioural camp, rational emotive behavioural therapy, developed by Albert Ellis (Sewall, 1982). Reality therapy and rational emotive behavioural therapy have shared the principle that outside forces do not cause stress, depression, anxiety, or any other disturbance (Temple, 1997). The theories have overlapped in their belief that the current life of the client was paramount and endless scrutinising of every past experience was fruitless. However, reality therapists have emphasised choice as a theory to more effective social behaviour rather than implying that a change in thinking was a pre-requisite (Temple, 1997). Reality therapists see thinking as only one component of the whole social behavioural 'big picture' (Glasser, 2000; Wubbolding, 2000).

In practical terms, it has always been important to help 'loners' focus on the current realities of their lives (MHF, 1999; WHO; 2004). William Glasser (1965), the founder of reality therapy, believed that five internal forces, or needs, motivated all human beings - the need for survival, love and belonging, power, freedom and fun. These human needs were innate, not learned; general, not specific; and universal, not limited to any specific race or culture (Glasser, 1981). Glasser (1998a) frequently referred to them as 'generic instructions'. He contended that in all their actions individuals, whether socially alone or not, sought to maintain or add to a need for belonging, power or achievement, fun or enjoyment, freedom or independence, or what humanists might refer to as self-actualisation (Maslow, 1968). However, needs were not seen as a

hierarchy but were analogous to the legs of a chair, which functioned most effectively when the chair was balanced on all its legs (Johnstone, 2000; Wubbolding, 2000).

Glasser (1965) argued that our most important current realities were the need to love and be loved and the need to feel that we were worthwhile to ourselves and others. He contended then - and still contends today (Glasser, 2003) - that the continued failure to meet these two needs satisfactorily has been the basis of most long-term psychological problems, unhappiness, an array of physical health problems and, indeed, much of what is referred to as mental illness (Lynch, 2001; Glasser, 2003). Recently influenced by the writings of Lynch (2001) and additionally, from his own observation and practice Glasser (2003) confirmed that, by enabling clients to take responsibility for their own social behaviour, rather than accepting they were victims of their own impulses, their past history, or other people or circumstances around them, they were able to make dramatic changes (Johnstone, 2000; Lynch, 2001; Glasser, 2003; WHO, 2004).

2:6:1 THE ORIGINS OF REALITY THERAPY

Originally named 'control theory', Glasser's revolutionary new theory stated that the human brain functioned like a control system such as a thermostat, which sought to regulate its own behaviour with the desired result of changing the world around it (Glasser, 1965). He postulated that humans were born genetically coded with powerful internal forces and that their behaviour attempted to satisfy these forces and thus control their life (Glasser, 1965; 1980). Vital functions, such as hunger and thirst, influenced social behaviour but were not the dominant forces that drove social behaviour in day-to-day living (Glasser, 1980). Glasser saw the more dominant forces as needs which arose in the conscious centres i.e. love, power, freedom and fun. He believed humans could choose how externalities affected their behaviour. His belief was that fun was a primary reinforcer of learning and learning, for its part, was chiefly concerned with satisfying needs in new ways (Glasser, 1965, 1980,1985).

Glasser defined control as "....the way we must function to fulfil our needs" (Glasser, 1984, p. 43). Describing behaviour as a composite of doing, thinking, feeling and physiology, Glasser (1984) believed that when humans controlled the doing component,

changes in thoughts, feelings and physiology would follow. In control theory, individuals learnt that they could choose what they did and that they were responsible for their actions (Glasser, 1984). An awareness of basic needs was essential, enabling individuals lacking in social skills to focus their efforts on seeking behaviours which would satisfy basic needs rather than specific predetermined wants (Glasser, 1984). The goal of control theory was therefore to help individuals gain control over their lives. Glasser (1984) postulated that young people who were alone could effectively gain control by achieving an awareness of basic needs and by reassessing and relaxing rigid value systems. Subsequently, these individuals could increase the quantity and quality of social behavioural options which would satisfy their needs (Glasser, 1984). In 1996, Glasser changed the name of the theory to *choice theory* to fit its clinical and educational use and because of its emphasis on human behaviour as a choice.

Glasser (1986) ascertained that we interacted with our environment through the basic physiological need for survival. However, some parts of our world did not fulfil our psychological needs for love and belonging, power, freedom and fun. Consequently, we took this information and built inside of our minds a file of wants. These were specific images of people, activities, treasured possessions, events, beliefs or situations that fulfilled our needs. The conglomerate of these wants was the world in which we would like to live (Glasser, 1998a,b). Hence his term Quality World aptly described the collection of wants related to the five needs. Each of these quality images or wants was specific. So we could call these 'pictures' and refer to the conglomerate as the 'mental picture album' (Glasser, 1985). We were thus able to control ourselves from a mental file or picture album which showed us, moment to moment, what we needed and what we were attempting to match through our senses (Glasser, 1985; Palmatier, 1998).

Many of the original ideas for reality therapy grew out of William Glasser's work with 'delinquent' girls at the Ventura School (Glasser, 1965). According to Glasser (1969, 1972, 1985) reality therapy provided an excellent framework for creating the necessary balance between support and challenge for successfully connecting and intervening with isolated and challenging pre-adolescents. Nevertheless, Greene and Uroff (1991) found that there was a false belief that reality therapy was just common sense and therefore easy to put into practice. As the emphasis on relationship building was the core of

reality therapy, Wubbolding and Brickell (2000) concluded in their literature that it could be possible to erroneously misinterpret the delivery system as simplistic.

An environment which fostered a sense of connection for socially 'at risk' young people has been written about extensively by Glasser (1969, 1986, 1990a,b, 1992, 2000, 2003). He asserted that pre-adolescents had a basic need to feel connected at school. While relationships with peers were crucial, the relationship between a counsellor and a child was 'the soil' that enabled social learning to take place within the school context (Glasser, 1998). Likewise, when children shared a similar position in relation to school success or failure and regularly came together as a group, they began to develop sub-cultures (Palmatier, 1996; Glasser, 1998a, 2001). Through qualitative research over the course of one year based on small group case studies, Glasser (1998b) discovered that whenever children regularly experienced being 'differentiated' by organisations or in other circumstances, they tended to share their experiences and provided each other with mutual support. Such groups could then develop both friendships and their own perspectives - ways of thinking about other people (Glasser, 1998b). He concluded that as children bonded together, the cultures of each group tended to be affirmed more strongly (Glasser, 1998b). However, Glasser (2001) felt that social learning and the traditional educational system had been on a 'collision course' in recent years. He stated that the present ongoing technological revolution, which was bringing massive changes to all institutions caught in its vortex, held the power to alter our education system (Glasser, 2001). Glasser (2001, 2003) saw the key element of the integrated, multimedia, digital network as discovery - the empowerment of the human mind to learn spontaneously, independently and collaboratively without coercion. Such a new learning environment would be highly compatible with the natural functioning of the brain, with what we knew about why we behaved in a certain way and, in particular, with an individual's need to feel involved and valued (Glasser, 2003).

2:6:2 THE THERAPEUTIC POWER OF REALITY THERAPY

Central to the successful use of reality therapy in school counselling is the quality of human relationships (Corey, 2000). Glasser (1969) believed that pupils could be motivated to do high quality work and to behave responsibly if schools were democratic

and curricula met their needs. In order to do this, the most fundamental change to schools would be a move from bossing pupils to leading them (Glasser, 1998a). In recent times, reality therapy has been advocated as an educational/psychotherapeutic approach which fostered personal responsibility within individuals in order to meet this aim (Alexander, 2002; Allard and McNamara, 2004, WHO, 2004). The ethos of the approach has always been that while we might not be responsible for what happened to us, we were responsible for the way we dealt with what happened to us (Parish, 1987). Glasser (1986) emphasised that unnecessary external incentives could stifle a child's intrinsic motivation and interest, arguing that reality therapy should be more widely applicable as a source of motivation since it relied on intrinsic and not extrinsic control. This was so both in the classroom as well as in the therapeutic setting (Glasser, 1986). Likewise, other researchers observed that therapies would be effective and therapeutic progress maintained when children attributed their improvement to internal, personal factors and minimised attributions to external factors such as rewards or the therapist (Brehm and Smith, 1986; Johnstone, 2000). Since reality therapy sought to foster intrinsic control and personal responsibility, Lynch (2001) argued that it could expand Festinger's (1957) theory of cognitive dissonance which suggested that, once a judgment was made and a personal commitment declared, that internal pressure to follow through and fulfil that commitment was almost a certainty.

Rehak (1996) identified that once friends were made, relevant questions asked and judgments and commitments made, the therapist simply needed to 'step aside'. The goal of therapists now became to help others discover what they needed to do in order to get what they said they wanted (Parish, 1991; Richardson and Wubbolding, 2001). Self-evaluation and planning were at the core of current reality therapy techniques (Wubbolding, 2000; Glasser, 2003). Glasser frequently remarked (1965, 1981, 1984, 1985, 1998a, 2003) that the art of counselling challenging individuals, of whatever age, was to weave various components together in ways that led them to evaluate their lives and to decide to travel on 'a therapeutic journey' in a more effective direction.

Wubbolding (2000) had also observed that although self-evaluation was the heart of reality therapy, it was too often neglected by reality therapists. To this end he developed a pedagogical tool to assist in this process (appendix ii). However, Renna (1991) highlighted reasons why using Wubbolding's 'formula' was extremely difficult when

working with challenging 'loners'. Firstly, therapists often neglected to take the time to empathise with the struggles of socially-isolated youth and tried to view them through adult eyes (Renna, 1991). Secondly, the therapist might assume the path they 'should' take was obvious, but often it was obvious to everyone except them (Renna, 1991). Long (1996) expanded on this by reasoning that when therapists failed to meet such young people where they were, they could revert to habitual ineffective behaviours such as lecturing and judging their anti-social behaviour for them. Instead, it was important that the effective therapist utilised what the pupil brought to the session (Long, 1996).

However, Katz (1995) agreed with Wubbolding (1988) that, rather than challenging the merits of a stated goal, the reality therapist could encourage the young person to assess whether their current social behaviour was helping them reach that goal. Overall it was agreed that pre-adolescents with social and emotional difficulties would feel best about themselves and their abilities when they were meeting meaningful challenges and putting in some real effort (Wubbolding, 1988, 1991, 2000; Renna, 1991; Katz, 1995; Long, 1996).

The earlier writings of Whitmore (1980) should perhaps be considered alongside this view. Whitmore (1980) had always been concerned that if the children did not understand the concept and did not value the task, they would come to believe that learning was meaningless and full of traps which they could not predict. Conversely, tasks with too much challenge might cause them to worry that they might not be successful and, as a result, they might not want to invest energy in them (Whitmore, 1980). Petersen and Gannoni (1992) warned that the intensity of emotion displayed by challenging 'loners' could easily be a distraction and the therapist could easily become engaged in an angry power struggle. Likewise, Richardson (2001) pointed out that we should want these pre-adolescents to know that their anti-social behaviour generated anger in others. However, it was generally considered that young people, like all humans, tended to focus on one thing at a time (Peterson and Gannoni, 1992; Hersch, 1998; Richardson, 2001). Thus, if we gave consequences in a judgmental, angry way, it was very likely that they would focus on our anger or the feeling of being judged rather than their poor choice (Richardson, 2001; Shucksmith, McKie and Willmot, 2005).

Emphasis on an individual's choices has offered hope for those whose background would otherwise condemn them to school failure and unfulfilling relationships (Glasser, 1990b, 2001). Its focus on their present decisions, with optimism that they can change these to meet their own needs (without violating the rights of others), and gentle but firm guidance for doing so, has provided a clear framework for change and socialisation (Glasser, 2001, 2003). Glasser (2001) emphasised that the therapist could remove some of the heat from angry exchanges with children by not taking their rebellion personally, and remembering that they were only railing against the system. However, he recognised that it might be difficult for therapists to communicate about anti-social behaviour without resorting to controlling methods or imposing their own solutions (Glasser, 1986, 1990a,b). Edwards (1997) also recognised that it was difficult to avoid responding in a way that allowed pupils to make excuses for their behaviour. This finding was endorsed by Lewis (1997), who emphasised that pupils' own authoritarian ideas could undermine the effectiveness of Glasser's interventions.

2:6:3 THE GOAL OF A REALITY THERAPIST

According to Glasser (1980), psychological counselling or therapy should help individuals take more effective control of their lives by utilising fewer less efficient behaviours (which may satisfy some needs but also create others), and by replacing the less efficient behaviours with efficient ones (behaviours which satisfy one or more needs without creating new ones). Interestingly, the goal of educators is basically the same as therapists since they, too, seek to help individuals take more effective control of their lives (Glasser, 1984). Generally, however, both therapists and teachers have to realise that people will resist learning what they do not want to learn, but that teaching and counselling will become effective as soon as people who hurt have discovered they can learn a better way (Glasser, 1980).

Through the eyes of the reality therapist, most psychological problems appear to have roots in dysfunctional relationships (Hersch, 1998; Palmatier, 1998; Glasser, 2003). For young 'loners' therefore, school might be their biggest psychological challenge (Allard and McNamara, 2004). To many socially isolated young people 'still waiting for the start of spring' (Greenhalgh, 2000, p1) school can seem like a desolate winter.

Greenhalgh (2000) described the scene as being like a frozen landscape, which could be a very painful one where children often strove for distraction from the pain. In this context, pupil motivation has always been seen as crucial for learning (Pintrich and Schunk, 2001; Taylor, 2003; Allard and McNamara, 2004; Weare, 2004). In the field of motivating the child who stands alone, many experts have expressed enthusiasm for reality therapy (Anderson, 1989a; Tauber, 1990; Gordon, 1991; Newby, 1991; Cameron and Pierce, 1996; Gartrell, 1998; Greenhalgh, 2000; Wubbolding, 2000; Porter, 2001). Reality therapy was seen by all of these researchers as giving young 'loners' meaning and relevance in their therapeutic learning tasks which, in turn, boosted their self-esteem and self-worth. In the late eighties, Anderson (1989b) investigated motivation from a social learning perspective, finding that learners must expect to succeed and must believe that what they were learning was important and valuable if they were to be motivated. Blumenfield (1992) expanded on these ideas, adding that to promote a sense of value, young people had to be enabled to understand both *what* they are supposed to be learning and also *why* they were learning it. For learning to be effective, young people must have perceived the task with which they were involved as meaningful and important (Dweck, 1985; Glasser, 1992).

Muijs and Reynolds (2002) strongly believed that the value of any learning task would result from how that task related to what the child already knew and what they thought was important to them. However, Glasser (1992) believed that the task would only come to have value in the eyes of a young person if the connection between the learning task and its usefulness in helping them meet their current or future needs was pointed out. Iwaniec (1996) observed that a teacher who was able to effectively incorporate a clear statement of purpose into a lesson would particularly assist young people who felt estranged from school. Glasser (1992, 2001) saw this as building an essential bridge from past knowledge to enhancing the meaning of the learning task. In selecting and communicating to a group the purpose of a task, the teacher or therapist must make that purpose specific, believable and personalised for an individual (Schunk, 1991; Glasser, 1992, 2001). Wubbolding (1985, 1989) stated that therapeutic instructors had to know some of the pictures that young people had in their Quality Worlds and then articulate reasons for learning that were congruent with their interests and needs.

It was additionally pointed out that when a young person was able to make such connections between the learning task and their personalised goal, they tended to work harder and would attempt more difficult tasks (Pintrich and Schunk, 2001; Muijs and Reynolds, 2002). However, other researchers warned that if instruction did not provide a connection, then young people might be unable to make that connection themselves and hence be less likely to perceive any meaning or value to their activities (Iwaniec, 1996; Porter, 2001; Weare, 2004; Shucksmith *et al.*, 2005). Reality therapy stalwarts have argued that this therapy aimed to provide that vital, critical link (Good and Brophy, 1997; Glasser, 1992, 2000; Wubbolding, 2000; Richardson, 2001).

2:6:4 RESEARCH STUDIES IN REALITY THERAPY

I have been unable to find any studies directly linking reality therapy and social isolation. Over the past twenty years, the majority of studies have concentrated on the therapeutic value of using reality therapy with problems such as self-esteem, locus of control and social behavioural difficulties, but not directly connected with children termed as 'loners'. From searches of the nearest relevant literature, there are limited findings in favour of reality therapy with individual pupils or groups of children who have displayed inappropriate behaviour (Comiskey, 1993; Bonuccelli, 1994; Chung, 1994; Harris, 1995; Kim and Hwang, 1997; Kim, 2002; Loyd, 2005; Kim, 2006). There have also been a number of unpublished studies in self-esteem and locus of control from Korean researchers completing master's and doctoral programmes, identified by Kim and Hwang (2006). However, few other studies exist and these have all generated from either the United States or The Far East.

In the only qualitative study of near-relevance found, Bonuccelli (1994) attempted to answer the question of why one student in every four chose to drop out of high school. Bonuccelli (1994) studied eight female school dropouts using a matrix intergrating Glasser's (1965) five basic needs with Glasser's (1980) four identified reality therapy components of total behaviour (feeling, thinking, acting and doing) as a basis for interviews. The major finding of this study was that individuals based their decisions to drop out of school on their personal internal needs. Although some might criticise this study for choosing same gender subjects which could limit the generalisation of the

findings, Bonuccelli (1994) suggested that her study offered support for the proposition that the growing body of research on reality therapy needed even further enhancement.

Conversely, Comiskey (1993) investigated the impact of reality therapy in a tightly controlled study of nine pupils. She measured the effect of reality therapy on students' self-esteem, locus of control, school achievement, attitude towards school, attendance and classroom behaviour. Three groups of three students were set up, each receiving a different treatment over fourteen sessions. One group received reality therapy alone. The second group received reality therapy counselling combined with whole school support for the programme. The third group, a control group, worked on career development. After analysis of observation sheets and questionnaires, Comiskey (1993) reported significant differences in achievement, self-esteem, attitude and attendance. Reality therapy was found to be most effective when there was whole school support. This suggested that organisational change might be a necessary prelude for students to fulfil their needs. Comiskey (1993) concluded that a less coercive environment in which teachers could get close to students helped them fulfil their need for belonging. The results were especially effective because the new reality therapy-based school reorganisation made it easier for students to insert schoolwork into their Quality Worlds. The study also showed that reality therapy was an effective method of counselling on a short-term basis.

Chung (1994) investigated the effect of reality therapy in group therapy with male juvenile delinquents in Hong Kong. She selected reality therapy because the method offered a framework for working with a delinquent population that generally demonstrated not only socially unacceptable behaviours but also low self-esteem. Due to the destructive choices and negative behavioural patterns, the delinquent youth were typically impenetrable to counselling. Chung (1994) studied residents of two correctional institutions, one a local governmental operation and the other a non-governmental welfare agency in a quantitative study. She limited her study to twenty boys who were on schedule for release within three to six months. The mean age of the sample participants was 13.5 years. The experimental group had twelve weekly sessions of exposure to reality therapy in groups and the goals of the therapy were to enhance self-esteem, develop understanding of self, family and society and to enhance coping skills. The instruments included a self-designed survey, staff ratings, self-reports and

case records. The survey showed that those receiving reality therapy increased their self-esteem significantly, while the control group showed no significant change. Self-reports from participants showed that 65% of them said they had improved in their self-understanding and 60% improved in their social awareness. Also, 55% indicated improvements in social communication while 50% reported gains in self-confidence, selection of friends and problem solving. Finally, 65% suggested that the group therapy should extend to twenty sessions. Again, the results showed that reality therapy was effective in a short-term application.

Harris (1995) studied the effects of reality therapy on the predictors of responsible behaviour in teenage children using a quantitative approach. The experimental group of ten male and ten female students received reality therapy counselling as part of an adolescent pregnancy prevention programme, resulting in a significant increase in self-esteem, measured by The Harris Self-Esteem Scale (1995). Most importantly, it would appear, was the fact that the subjects learned to distinguish between responsible and irresponsible behaviours. Harris (1995) concluded that the participants' subjective self-evaluations had revealed that reality therapy had helped them make more effective choices.

Using reality therapy principles over a much longer term, Dryden (1996) conducted a research project on American schools, described by Glasser (1990a) as Quality Schools. Glasser created the concept of a Quality School in 1990 - a school where there was no failure because all its students were doing competent work and many were doing quality work. Students at these establishments were managed without coercion. A longitudinal approach, conducted over the course of three years with fifty school principals and fifty parent representatives - but no students, teachers or ancillary staff - using questionnaires, observation sheets and interviews, provided a clearer understanding of a group of schools that were in the early stages of a reform initiative. Results suggested that, even in these early stages, school principals reported some measure of progress in implementing the principles and practices that were congruent with the Quality Schools literature of Glasser (1969, 1986, 1990a, 1990b, 1992, 2000). Principals and parent representatives also reported a noticeable and positive impact on students, even though they were not directly involved in the study. It should be noted, however, that these results were pertinent to the American educational system and that we, in Britain, are in

much earlier stages of embracing emotional literacy as a core concept of learning, motivation and nurturing. Even in the growing field of emotional literacy, reality therapy is almost unknown in British academic circles.

In Seoul, Kim and Hwang (1997) conducted control group research based on the principles of reality therapy. The aim of the research was to investigate whether pupils developed as a part of their living pattern a sense of responsibility, co-operation, expression and sensitivity towards the feelings of others (Kim and Hwang, 1997). Based on a programme developed by Carleen Glasser (1996), the group programme named 'The Quality World Activity Kit' was administered. To apply this programme effectively, Professor Kim In Ja of Sogang University recreated the programme to adapt to Korean youth culture. The new programme was called 'Making the World I Want' (Kim and Hwang, 1997) and it was tested on a group of twenty-three fourteen year old girls to investigate whether or not significant change occurred in internal control and motivation for achievement. The programme was administered for eight weeks with a follow-up test which took place twelve months after the initial intervention.

The students were divided into an experimental group and a control group. For an analytical comparison, Kim and Hwang (1997) administered the programme "Making the world I want" to the experimental group, while applying just the usual reading programme to the control group. Results showed that there was a significant increase in internal-control during the eight-week programme. It was also observed that the experimental group showed a significant increase in achievement motivation due to the rise of internal control which, in turn, promoted self-responsibility. Kim and Hwang (1997) concluded that their study showed the reality therapy intervention to be one of the most effective positive change programmes currently available for middle school girls of Korean culture and values. Furthermore, they recommended that the study, investigating positive behavioural change in young people, should be wholly or partly replicated from a wide range of methodological interpretations in order to increase validity (Kim and Hwang, 1997).

Five years later, Kim (2002) conducted a study to ascertain the effect of a reality therapy programme on responsible behaviour at an elementary school level, using the

concepts of the five basic needs, control, responsibility, total behaviour and choice. An experimental group of thirteen children was used and a control group of twelve children, all from the fifth grade. The programme again lasted for eight weeks, fulfilling group activities based on play. Results highlighted that, by completing the Responsible Behavior Choice Program, children's internal control developed as well as an increase in responsibility. Kim (2002) concluded that if children participated in the programme, they would increase their internal control and responsibility so that they would develop the ability of controlling themselves.

In 2006, Kim and Hwang (2006) conducted a meta-analysis of Korean reality therapy and choice theory group programmes for self-esteem and locus of control, undertaken from 1986 to 2006. In the meta-analysis, forty-three unpublished studies were reviewed. Kim and Hwang (2006) referred to self-esteem as an individual's sense of his or her value or worth, or the extent to which a person valued, approved of, appreciated, prized or liked him or herself. Locus of control was defined as an individual's belief in whether or not he or she had the ability to bring about change through his or her own behaviour. The meta-analysis confirmed that reality therapy and choice theory group programmes were effective for improving self-esteem and internal locus of control within the Korean population. It was suggested that this research could contribute to a baseline model to study and develop further group counselling programmes using reality therapy and choice theory in Korea as these methods were effective interventions in improving lives.

In an unpublished manuscript, Loyd (2005) investigated the extent to which exposure to choice theory increased American high school students' perceived satisfaction in the four psychological needs of belonging, power, freedom and fun, using quantitative measures. Results suggested that the students' exposure to choice theory principles had a positive sustaining effect on their satisfaction in three out of four psychological needs. Loyd (2005) suggested that the study could be beneficial to educators as it could teach students to decrease disruptive and destructive choices and increase behavioural choices that effectively satisfied their needs. It was concluded that if differences were made in students' lives to the extent that they made less disruptive and less destructive behavioural choices, then the study had contributed to the goal of positive social change, within and without the educational system.

At this point in time, the latest research using reality therapy with children has been presented by Kim (2006). An examination was undertaken in South Korea to look at a group counselling bullying prevention programme where reality therapy was undertaken in order to focus on responsibility and victimisation of children bullied in the classroom and school. Participants in the treatment group attended the bullying prevention programme for two sessions per week for five consecutive weeks, whereas the control group received no treatment. Data collected immediately after the delivery of the treatment demonstrated higher self-responsibility levels than participants in the control group. The findings indicated that the reality therapy treatment programme effectively improved responsibility and reduced victimisation of children bullied.

2:7 SUMMARY

Practitioner-centred research has been reviewed throughout this chapter. The reader is first taken through an exploration of research associated with social withdrawal and then onto literature highlighting the importance of an effective therapeutic relationship. A general overview of cognitive behavioural therapy has then been explored before an intensive focus on group therapy, where its specific advantages and disadvantages have been discussed within the identified subtypes and advocated treatments. Encouraging change through effective therapy has been the bedrock of this review. In the final section, the chosen therapeutic method of reality therapy has been detailed. My aim has been to provide a comprehensive overview of all CBT-based literature, old and new, which is relevant to a therapist researching her own practice.

It has been shown in the literature that reality therapy, with its emphasis on choice, inner control and self-responsibility, is an under-researched but fundamental driver in working with pre-adolescent 'loners'. The research by Kim and Hwang (1997), reported in the final section of the literature, is hugely important to the present study. Their study has acknowledged the need for more global research using reality therapy to explore social behaviour. Replication from a wide range of methodological interpretations was recommended. It was interesting that every piece of scanned research from South-East Asia used purely quantitative designs and that Kim and Hwang (1997) acknowledged this as a possible weakness in validity.

CHAPTER 3

METHODOLOGY

If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music which he hears, however measured or far away - Henry David Thoreau 1817-62

Contents

3:1 INTRODUCTION

Within the counselling research community, there have been several calls for greater methodological pluralism (Howard 1983; Greenberg, Elliott and Lietaer, 1994; Goss and Mearns, 1997a,b). What pluralism means, in this context, is a willingness to employ either (or both) qualitative or quantitative methods in research studies, with the choice of method being determined by the research question and purpose (Brannen, 1992). The argument in support of methodological pluralism has been based on the position that different methodologies have different strengths and weaknesses (Brannen, 1992). The main strategy in the current research has been to use initially a quantitative measure as the basis for selecting group members for subsequent intensive qualitative analysis.

It was necessary to identify three groups of socially isolated children at three sites before the qualitative study could commence. A standardised Social Inclusion Survey (Frederickson and Furnham, 1999) using sociometric techniques was used which, it was felt, did nothing to detract from the qualitative existential stance of 'seeing' the world differently, as it commenced before any sessions began. While all sociometric assessment approaches have their own particular strengths and weaknesses, a persistent problem which has limited the practical feasibility of their widespread use has always related to the data analysis processes involved. Constructing traditional sociograms, as in a study by Taylor, Asher and Williams (1987), was found to be extremely time-consuming. By contrast, a study by Nabuzoka and Smith (1993) required a highly technical approach. I felt the Frederickson and Furnham (1998, 1999) method, on the other hand, had both sound technical and theoretical bases and was designed to be easily used and understood by children.

However, once the participants were identified, I wanted to observe children who stood alone from others using purely qualitative methods. The key focus has been the pre-adolescent who could not or would not mix with his or her peers and each child has been observed and analysed as an individual with unique wants and needs. My study has looked at their very special and individual needs by using three different primary schools as therapeutic bases within the county of Cornwall. The diversity of these schools has been marked by geographical location, socio-economic groupings, size and ethos. It was important that the schools contrasted as sharply as possible with one another in order to give as broad an overview as possible of differing environments

which could be applied more widely, if required, to other parts of the country. It was also key that the actual school environments were as different as possible in order to determine the efficacy of the use of reality therapy in different settings. Each school became a base for group therapy and, within each classification, three eleven-year-old children were chosen. The educational environment seemed the most appropriate setting as it was the largest social component in the lives of the children. The school setting would also provide me with valuable information about the emotional, social and behavioural functioning of the participants and specific details of social isolation. Therefore, group therapy within the three school sites had logical and practical utility.

3:2 AIMS AND OBJECTIVES

This study is an endeavour to answer my central research question: "How do I engage more effectively with pre-adolescent loners in group therapy?" Promoting positive social behavioural change has already been defined as encouraging participants to learn to satisfy their needs, thereby fostering a greater sense of inner motivation and subsequent well-being to enable them to become more socially competent (Balson, 1992; Smith, 1998). By questioning how my practice as a group therapist can be *more* effective whilst trying to instil positive behavioural change with loners, I am seeking to satisfy my own needs too. In exploring my own belief systems, values and vulnerabilities my aim is to improve the way I relate with others on both a personal and professional level (McNiff, Lomax and Whitehead, 2007). Through studying my own behaviour in the group situation, my goal is to learn more about my practice in order to evolve into a more effective therapist for this marginalised pre-adolescent population.

The objectives of this study are to use Frederickson and Furnham's (1999) Social Inclusion Survey (appendix v) to identify individuals who are considered to be isolated within three school sites, in order to gain an understanding of individual experiences of *participation* within each therapy group. This will be achieved through observation using the Child Profile Format observation sheet which I developed (appendix vii) and both structured and unstructured interviewing. Another opportunity offered by my study is to gain an understanding of individual *experiences* of positive social behavioural change within the reality therapy programme. The implementation of this programme

with each child in group therapy is based on Carleen Glasser's (1996) 'My Quality World Workbook' and 'The Quality World Activity Set' (appendix x) and specific themes linked to the concepts of reality therapy. Perhaps, most specifically, I want to reflect upon my own role within the programme and the personal learning I have achieved through being part of the wider therapeutic enterprise.

3:3 REFLEXIVITY

Qualitative research is a *personal* activity, involving a personal struggle to challenge assumptions and achieve understanding, and usually involves entering meaningful relationships with people who are the research participants. The intentionally personal nature of qualitative research is one of the characteristics that separates it from positivist research. In positivist research, the interests, passion and values of a researcher are put to one side: research is essentially a cognitive activity. In qualitative research, by contrast, the experience and identity of a researcher *always* influences the 'findings' that are produced. However, acknowledging the personal dimension of qualitative research, and knowing what to do about it are two quite different things, according to therapeutic researchers such as Steier (1991), Hertz (1997) and Parker (1999). Discussion of the issue of the personal nature of qualitative research has generally come to be referred to in terms of reflexivity. The idea of reflexivity implies a capacity for 'bending back' or 'turning back' one's awareness on oneself. No competent qualitative researcher would doubt that a capacity for self-reflection is a necessary component of effective qualitative researching, even if only at the level of thinking about how one's presence or manner might have an impact on people being interviewed or in therapy. However, the implications of the concept of reflexivity are potentially much further-reaching. Steier (1991) argued that the personal dimension of qualitative research can be so all-powerful that all a qualitative researcher does is reflect on self to the point where, in the end, there is " nothing out there" (Steier, 1991, p.10).

The question of reflexivity has special poignancy and significance for qualitative researchers in the area of counselling and psychotherapy. Therapy is an activity that has generated a multiplicity of ways of encouraging self-reflection (Morse, 1994; Punch, 1994; Kvale, 1996; McLeod, 2005) and has spawned an almost equal number of ideas

about the nature or structure of the 'self' that does this reflecting (Steier, 1991; Hertz, 1997; Parker, 1999). Yet published qualitative therapy research has been highly cautious about acknowledging reflexivity. According to Hertz (1997), this caution may reflect the lag between qualitative research in therapy and the pace of development in other social science and health disciplines. Steier (1991) argued that it might also arise from a realisation that reflexivity represents a potential conceptual 'minefield' which is perhaps best avoided as reflexivity is a contested notion in psychology. Agreeing with this view, Parker (1999) emphasised that, at the extremes, it could be readily seen that cognitive-behaviourists, psychoanalysts, humanistic psychologists and social constructionists would have quite different ideas about what it meant for a person to reflect on their own experience. Both Punch (1994) and McLeod (2005) concluded that it might never be possible to arrive at an understanding of reflexivity that could be used to inform practitioner-oriented research in counselling and psychotherapy.

Josselson (1996) highlighted one essential dilemma for the therapeutic researcher which can never be resolved. In any kind of in-depth approach, no matter how much the identifying demographic details of the person are disguised, the structure of their story, the specific 'linking together of events' that make them who they are remains transparent, at least for the participant-as-reader. The normal ethical procedure of informed consent, to be discussed later in this chapter, seems inadequate in relation to the possible consequences of publishing personal narratives (Josselson, 1996). Josselson (1996) widely commented on the 'dread, guilt and shame' (p.70) that goes with writing about others whilst recognising that the answer was not to turn away from qualitative methods but to be willing to embrace such difficult and painful emotions.

Conversely, Frank (1992) found that there were troubling moral implications of conducting and publishing 'distanced' research where the therapist tries to separate the therapy role from the research role. But Josselson (1996) insisted that there were equally troubling consequences of the attempt to reduce that distance. In either case, moral decisions were made. Thus, in my opinion, the adoption of a critically reflexive approach should involve a development of awareness about these moral dilemmas within one's own practice.

Clearly, research carried out by therapists on participants of a therapeutic programme raises a distinctive set of both moral and paradoxical dilemmas which need full reflexive consideration. The main ethical problem in this type of research arises from potential conflict between the therapeutic and researcher roles taken by the practitioner. As a therapist, the practitioner has a duty to act in the service of the well-being of the participant. As a researcher, the practitioner has a duty to collect data and make a contribution to knowledge and understanding. Much of the time, these roles may compliment and enhance one another. On some occasions, however, they may be in conflict. It is an essential condition of science that the researcher is detached and independent in gathering data. Yet, in qualitative inquiry, the researcher is an integral part of the data set; part of the process (Grafanaki, 1996; Heron, 1996) and cannot be considered separately from the culture, the context or the other participants. The investigator does not simply use tools; she *is* the tool (Polkinghorne, 1991); a 'bricoleur' (Denzin and Lincoln, 2000), a "professional do-it-yourselfer who creates a bricolage, a pieced-together construction of ideas" (Padgett, 1998, p. 18). Thus Guba and Lincoln (1981) have argued that, paradoxically, the passionate involvement of the researcher which might appear to result in a loss of rigour, actually increased the rigorousness of an investigation by enabling access to tacit knowledge.

Mariano (1990) highlighted that creativity and imagination was needed alongside scholarship and sensitivity to the ethical and political dimensions of qualitative research. Mason (1996) stressed that this view led to another paradox as the essential requirement of qualitative research was for the investigator to become totally involved in the material while, at the same time, having the ability to separate herself completely from it - so as to be able to stand back in judgment. McLeod (1994) emphasised that this required a reflexive stance and the capacity to self-examine and self-analyse. Additionally, Agar (1980, p.80) observed that "the problem is not whether the researcher is biased, the problem is what kind of biases exist." Wilkinson (1986) and Wolcott (1994) viewed bias vigilance as necessarily a continuous process in reflexive practice. While the traditional researcher is instructed not to bring their knowledge to bear upon data, the qualitative researcher in therapeutic work is obliged to have "an open mind, not an empty head" (Fetterman, 1989, p.11). Such a stance demands both professional and self discipline (Hammersley and Atkinson, 1983) and an ongoing awareness that the participants are the true experts on themselves (Kasper, 1994). Thus,

in therapeutic research, expertise does not reside, as in traditional science, with the researcher (Fetterman, 1989; Kasper, 1994; Morse, 1994; Patton, 1997; McLeod, 1999). Kasper (1994) found that there might be times when constraints conflict with professional judgment regarding how to proceed. Grafanaki (1996) agreed that these problems would escalate when the researcher was also the therapist, needing careful consideration in order to avoid major flaws in the effectiveness of the research.

In my study, as a preventative measure against making any potentially fatal flaws, all the original tapes, subsequent transcriptions and observation sheets with comments were given to the Ethics Committee Advisor who read the data, listened to the tapes and followed the transcriptions. The Ethics Committee (full details later in this chapter) felt this was imperative as there was, in their experience, a wide difference in levels of effectiveness between individual researchers who sought their approval. Using an independent and experienced 'judge' to cross-check the emergent themes ensured that the research findings were honestly reported and not twisted to fit any kind of pre-determined outcome on my part, as well as making certain that the safety of the participants was scrutinised.

To ensure even more credibility, the 'quasi-judical' approach of Bromley (1986) was taken in that not just one but two independent sources were given the opportunity to generate alternate interpretations and then to meet to resolve differences. This largely eradicated the problem of the dual role and giving a bias view of proceedings from a lone perspective. The children themselves were shown their own session transcripts and observation sheet at the end of school year follow-up session, where emergent themes and comments were provisionally written in the margin. Each participant was asked to comment on the interpretation of these themes and comments from the two adults who had analysed the transcripts. This was an enlightening exercise, causing many interpretations to be modified in the light of information from the participants who all, without exception, took a keen interest to ensure their words and viewpoints were not analysed out of context. I was equally mindful of concerns expressed by Josselson (1996, p.70) and made every attempt to minimise distress of participants by reporting sensitively and fairly, using reflexive practice at every stage and stumbling block.

3:4 REACTIVITY

Connected with reflexivity, but also distinct from it, is the problem of reactivity in counselling research (Pope, 1991). This would occur when the research process interfered with or altered what was happening in the therapeutic process. I was aware that the children could be asked to participate in a great many activities that involved self-exploration and learning that was not part of the actual therapy. If that were to be the case, the research might probably influence the results, even though the research activities might be therapeutic in themselves. Thompson and Rudolph (1996) highlighted that children might write comments because they feared who might read them or, conversely, sabotage the research by completing worksheets at random without thought and consideration when feeling hostile.

To overcome this potential problem, I ensured that my practical knowledge and ability to interpret from observation and transcription derived from many sources as well as reflection: culture, experiential insights and reading books and articles. I felt that the most relevant parts of the research study would be those where I was able to describe and then reflect on what was done with the participants. It was the descriptive and reflective material that could help to develop a wider 'repertoire' of practical knowledge, of what was possible, and what might happen, in different experiential situations. Borba and Borba (1982) emphasised that a nurturing of the therapeutic relationship between therapist and participant was also essential in order to avoid fear or sabotage. Bottery (1990) warned that the programme content also needed to be probed to ensure that it would provide maximum benefit in a therapeutic context and that it could not be manipulated in any way to cause psychological harm to the participants.

Another complication might arise from awareness of participants that they were being studied. Cartledge and Milburn (1995) asked what effect this awareness might have on the therapeutic relationship. A participant might believe at some level that they were special or had been chosen as my favourite (Cartledge and Milburn, 1995). In this case, the participant might strive to produce the 'right' (or 'wrong') material, or might even find a way of ending their session before time so I could write up notes. These issues would clearly interfere with the therapeutic task that would be sufficiently challenging without the addition of a new layer of intricacy. However, practitioner-centred research should not be abandoned. More studies are necessary if research is to become alive and

relevant for therapists (Polkinghorne, 1991; Pope, 1991; Grafanaki, 1996; Kvale, 1996; Mason, 1996; O Donahue, Fisher and Hayes, 2004). The implication is that great care must be taken by therapists undertaking research within their therapeutic practice.

However, reactivity is not just one-sided. The 'wounded healer' theory (Guggenbuhl-Craig, 1971; Rippere and Williams, 1985) proposed that the power of the healer (the priest or shaman in primitive societies, the therapist in modern society) derived from his or her inner experience of pain, loss or suffering. The presence of a 'wound' in the healer gave that person an excellent basis from which to understand and empathise with the wounds of clients / participants. A danger is that the wound of the healer could be exacerbated by the demands of those being helped, and the healer could be sacrificed for their benefit. The wounded healer concept makes it possible to understand the 'search for wholeness and integration' (Spurling and Dryden, 1989), which characterises the lives of many therapists and which makes it possible to transform the pain of negative life experiences into a resource for helping others. The counter-argument, of course, is that such people can be dangerous as they have pre-conceived agendas of change which may have actually nothing to do with the needs of the recipients (Buchanan, 2000) and they may not be psychologically ready to deal with the unexpected (Long and Averill, 2003). As the therapist, I will try to take the measured, balanced middle-ground, aware of all the pitfalls and problems but still guided on by a burning passion to delve beyond the surface, to make a difference to the life of a stranger because I am powerless in my own personal situation. Choosing to do a study of this type, it is always going to be essentially about me; my experience as a reality therapist; my perception of social behavioural change for the better, so life might be good again for maybe just one child because of what I am trying to do.

3:5 DEVELOPING A RESEARCH TRADITION

I am clearly grounded in the desire to make a difference in practice. An individual research study can be no more than part of a bigger picture or larger mosaic. Sometimes, it can be difficult to see where a specific piece of research fits into that picture. In the past, psychotherapy has been researched as if it were a drug. Researchers have looked at the active ingredients of the drug, how it affects different patients, what

the optimum dose might be, how it works in combination, and so on. But, like any metaphor, the drug analogy highlights some facets of the phenomenon it seeks to illustrate and hides others. Specifically, the drug metaphor significantly downplays the relationship dimension of therapy, the agency of the participant and the personal qualities of the therapist. To sideline these aspects of therapy is a serious omission. It could be argued that what is distinctive about therapy, as a form of helping in modern society, is that it is collaborative, personal and respectful, taking the desires of the participant as its starting point. Research which objectifies the participant (and even the therapist) by imposing the measurement strategies of laboratory science, runs the risk of misunderstanding the very nature of the phenomenon which it seeks to explain.

It is my belief that it is essential to develop a research tradition that is consistent with the practices and values of therapy. Some of these practices and values might include the idea of human agency, collaborative and dialogical forms of meaning-making, the importance of feeling and emotion, the role of language in constructing realities and the capacity for reflexive self-monitoring. I have chosen the methodology of participative / emancipatory action research in order to be as reflexive and clear as I can about the practical dilemmas and situations in which I might find myself. This methodology will allow me to explain fully my own involvement in the research, as a co-constructor of the knowledge that is produced, and to report on the difference that my research has made to my practice.

3:5:1 THE RESEARCH DESIGN : ACTION RESEARCH THEORY

Action research has a complex history because it is not a single academic discipline but an approach to research that has emerged over time from a broad range of fields. It poses the key question of how we go about generating knowledge that is both valid and vital to the well-being of individuals and communities as well as for the promotion of larger-scale democratic social change. Action research challenges the claims of a positivist view of knowledge which holds that in order to be credible, research must remain objective and value-free. Instead, it embraces the notion of knowledge as socially constructed and, recognising that all research is embedded within a system of values and promotes some model of human interaction, it challenges unjust and

undemocratic economic, social and political systems and practices. In a nutshell, action research is work in progress. Bradbury and Reason defined it as:

> "a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview which we believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities." (2001, p.1)

A key value shared by action researchers is an abiding respect for people's knowledge and for their ability to understand and address the issues confronting them and their communities (Rolfe, 1998; Alvesson and Skoldberg, 2000; Bradbury and Reason, 2001; McNiff and Whitehead, 2006). Values require action. Knowledge comes from doing. Action researchers therefore feel compelled to act collectively on and with that knowledge because action research must draw power from the premise that we can know through doing (McNiff *et al.*, 2007). In describing the difference between action research and other forms of inquiry, Bradbury and Reason (2001) highlighted the crucial difference as lying in the commitment of action researchers to bring about change as part of the research act. Fundamental to action research was the idea that the social world could only be understood by trying to change it (Bradbury and Reason, 2001). A respect for people and for the knowledge and experience they might bring to the research process, a belief in the ability of democratic processes to achieve positive social change and a commitment to action would therefore appear to be the basic values which underlay the common practice of being an action researcher (Rolfe, 1998).

Action research goes beyond the notion that theory can inform practice (Lewin, 1951). It recognises that theory can and should be generated through practice and that theory is really only useful insofar as it is put in the service of a practice focused on achieving positive social change. However, Gaventa and Cornwall (2001) recognised that theory had the ability to frame issues of power and identity and to suggest strategies for action and explanations for outcomes which had earlier left them puzzled. It also provided structures within their work which could be better understood, thereby improving their practice and providing a grounding for their attempts to take the next step (Gaventa and Cornwall, 2001).

3:5:2 THE RESEARCH DESIGN : ACTION RESEARCH PRACTICE

There are three action research designs which I could have used in practice: the understanding-action-evaluation (UAE) design, the evaluation-understanding-action (EUA) design or the action-evaluation-understanding (AEU) design, all of which have the power to resolve therapeutic difficulties. As I was particularly anxious to provide a platform for introspective questions about my own abilities, attitudes, skills, beliefs and knowledge, it seemed logical to select the latter of these choices as most appropriate:

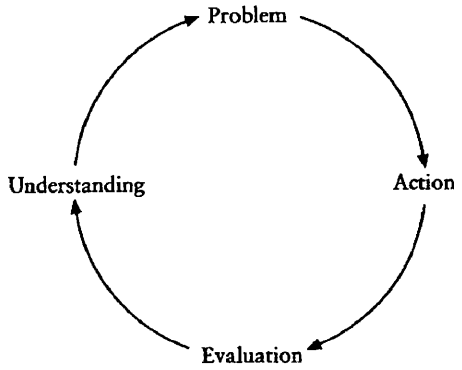

Figure 1: The AEU design

> "There will be occasions where an understanding of the problem is just not possible, and in order to break the vicious circle on these occasions, we might simply change our actions according to our intuition or professional judgement. In other words, we do what feels to be the right thing at the time and then attempt to understand our action by evaluating its effects."
>
> (Rolfe, 1998, p.184)

Having embarked upon an enterprise where I can have no idea about how each task will be received by such widely-differing participants, this choice of research design seems particularly appropriate because I cannot pre-plan unstructured conversations or moments of enlightenment (or disenchantment). I am aware that I will be entering an emotional minefield so I need a design which will allow me to test, modify, change and be more effective because of those changes to the presenting problem rather than already have some pre-fixed understanding which is, of course, impossible. My aim is that understanding will come instead from evaluation of my modified actions within an extensive array of therapeutic tasks which, by their very nature, will have evoked

emotional reactions. This understanding will result in new learning to utilise in future sessions and will inform my practice, enabling me to become a more effective therapist.

The AEU design also compliments my therapeutic method - reality therapy - which has the premise that change happens as a result of evaluating behavioural choices. Wubbolding (2000) likens these choices to compartments in a behavioural 'suitcase' which comprises of four elements: actions, thinking, feeling and physiology, making all behaviours *total behaviours*. Action research methodology also values change as part of the research act (Gavanta and Cornwall, 2001; McNiff and Whitehead, 2006). Fundamental to action research in practice is the idea that the social world can only be understood by trying to change it. In fact, all the theorising in the world would appear to be of little use without 'the doing' (McNiff *et al.*, 2007).

Glasser (1965, 1984, 1985, 1998a, 2003) has long held the same principles. While the skills used in establishing an environment conducive to change spill over to those used in the delivery of procedures, still there are clearly identifiable interventions that constitute the essence of reality therapy. Glasser (1998a) believed that the measure of a truly effective therapist was their ability to lead individuals to evaluate their lives and to decide to move in more effective directions. Wubbolding (2000) later developed this idea in a way that made it easy to remember. His 'Want, Do, Evaluate, Plan' (WDEP) formulation is a useful pedagogical tool for understanding and teaching the concept (appendix ii).

Being aware that there was a tried-and-tested reality therapy procedure (which appeared to be based on AEU principles) already in place (Wubbolding, 2000) - and to make the AEU design even more relevant to practice in the therapeutic community - I have amalgamated the WDEP practical framework within this design. Hence, it is my intention that the WDEP approach will be the basis of my own reflection-on-action, in which an action is taken

> "in response to an immediate problem, and is later reflected on and learned from.....The action is not based on a prior understanding of the problem. Rather, it emerges from an evaluation of the modified action."
>
> (Rolfe, 1998, p.185, 186)

I intend to use the WDEP framework within an AEU design by analysing data from each identified theme under four cyclonic sub-headings: Problem (W), Action (D), Evaluation (E) and Understanding (P). Each bracketed letter represents not an isolated procedure but a cluster of possible skills and techniques for assisting group participants to take better control of their own lives and thereby fulfil their needs in ways that are satisfying to them and to society (Wubbolding, 2000). Introspective reflection is also emphasised within these skill-sets to encourage therapists to evaluate their own performance and plan improvements to their practice for the next group / session:

Want What did the group member / whole group want? - The problem / sub-need.
Do What did I *(introspective)* do *(practice-based)?* An explanation of *my action.*
Evaluate What is *my evaluation* of the situation? A critical reflection of my own role.
Plan In light of this evaluation, what is *my new understanding*? How can I take my new understanding to the next group - in order to improve my practice?

It is through this process of therapeutic searching that something happens within the participant. A process of self-discovery, self-and-other-awareness, psychological and psychic equilibrium takes place. This way of working and re-searching not only influences the participant, but also has a profound effect on the therapist. Through listening, exploring, investigating, extrapolating, hypothesising, interpreting, reporting and recording, therapists can use these processes as cognitive (re)search tools.

3:6 SAMPLE

Silverman (2000, 2001, 2005) identified a number of strategies for constructing samples that provided a representative and unbiased sub-group from a population. Random sampling (e.g. including every third child on the class register) has been a standard approach that has been used in many educational research situations (Hopkins, 2002). However, as further identified by Hopkins (2002), there might be occasions when random sampling would not turn up enough representatives of particular groups (in this

case socially isolated or ostracised children) that were of theoretical interest. Silverman (2000, 2001, 2005) suggested a useful alternative to be stratified sampling, in which the population was divided into sub-groups or strata, and a random sample selected from each stratum. Denzin and Lincoln (2000), in an examination of random and stratified sampling, found that these methods were only possible when a researcher had a fair amount of knowledge and control regarding the research population as a whole.

For the purposes of this study, I was looking for schools and, within those schools, children of a similar age. I decided to select the class containing the oldest Key Stage 2 children at each of the three selected primary schools. On average, these Year 6 classes would consist of approximately thirty boys and girls in fairly equal proportion. Sample size was deliberately kept low. Three pre-adolescents from each school was considered the most useful group size in order to concentrate qualitatively in depth on each personality and the many differing behavioural trends of each of these individuals. It was decided to use purposive sampling to select schools which would provide three very different types of children from varying socio-economic backgrounds who all had two common links - all were in their last year at primary school and all were socially isolated or ostracised from their peers. Whether this was an indicator that all had social behavioural difficulties was to be investigated in the forthcoming research. In qualitative research, therapy groups may be selected because they are typical, because they are extreme subjects (e.g. comparing the most and least successful participants from a set of people who all received the same type of therapy) or because they are theoretically interesting (Wolcott, 2001). The three schools which took part in both the pilot study and the main study were chosen because they were considered to be as diverse as was possible to find within the Cornish landscape.

The first therapeutic site was a small rural school near a major fishing port and tourist area. There were 136 children on role when the research was carried out. The second was a medium sized school, with a role of 280, in an area of high unemployment and large-scale social problems. The third, with a role of 390, was a large primary school and situated in a large affluent naval town. Access was negotiated with the Headteacher through a formal interview where representatives from the Boards of Governors were present. I decided to label the therapy groups 1, 2 and 3 for ease of recognition, based on the size of the school setting - Group 1 being the smallest, Group 3 the largest.

Having studied the literature (Halinan, 1981; Kindermann, 1995; Frederickson and Furnham, 1998, 1999) and considered the pluralistic stance (Howard, 1983; Greenberg *et al.*, 1994; Goss and Mearns, 1997a, b), the Social Inclusion Survey (Frederickson and Furnham, 1999) was chosen to select children to take part in the study. The copyright holder of the chosen instrument needed to ensure the integrity and reliability of the data that their assessors produced was not compromised by children being over-exposed to the same tests. To this end, to promote the ethical use of assessment, I was firstly questioned and finally sanctioned by nfer-Nelson to use The Social Inclusion Survey (Frederickson and Furnham, 1999).

Two questionnaires were employed with this technique (appendix v), which indicated how well a pupil was accepted within a class or other group at school, providing information about pupils' social acceptance and inclusion without singling the pupil out in any way (Frederickson and Furnham, 1999). Halinan (1981) identified the possibility of social rejection and victimisation as a concern which had arisen in the past, but both Kindermann (1995) and Frederickson and Furnham (1998) argued that sociometric questionnaires, in recent times, offered an unobtrusive means by which pupils' social inclusion could be monitored.

The two parts of the Social Inclusion Survey which I selected were developed by Frederickson and Furnham (1999) and consisted of a short questionnaire on which there was space for the names of each pupil in the class or other relevant group to be written. Opposite each name were four circles, one containing a question mark and the others containing a smiling, a sad and a neutral schematic face. On the *Like to Work* (LITOW) questionnaire, pupils were asked to tick the face which showed how much they liked to 'work with' each person at school - the smiling face to indicate classmates with whom they liked to work, the straight-mouthed face to indicate classmates with whom they didn't mind whether they worked or not, and the sad face to indicate classmates with whom they preferred not to work. Pupils were asked to use the question mark category to indicate any classmates they did not know well enough to decide how much they liked to work with them. The *Like to Play* (LITOP) questionnaire was identical in format and instructions to the LITOW, with the exception that the acceptance criterion used was 'play with' rather than 'work with'. I felt it more appropriate to verbally

rephrase the 'play with' to 'go around with', being highly aware of the 'street cred' factor with Y6 pre-adolescents (appendix v).

The Social Inclusion Survey did not offer any explanation for the reasons for social rejection but it did provide a sensitive and convenient measure of social acceptance and inclusion and was regarded as having screening, monitoring and evaluation functions (Frederickson and Furnham, 1999). The Social Inclusion Survey would, subsequently, be used again at the end of the reality therapy programme to evaluate changes in social acceptance in each group participant.

The confidentiality of the process was verbally emphasised in language appropriate to the age of the pupils. The questionnaires were completed individually and not shown to others or discussed with them either during or after completion; the set-up of the room during administration reflected this feature. The standard procedure recommended by the Social Inclusion Survey manual was strictly adhered to. I entered the name of each pupil for social acceptance identification onto the scoring sheet. Then I sorted the questionnaires into those completed by boys and those completed by girls. The numbers of smiling, sad and neutral faces were tallied and entered separately for same sex, opposite sex and whole class / group. The number of questionnaires which had one of the faces ticked (but not the question mark) was entered in the 'total number of faces ticked' column. A table was then consulted to obtain a cut-off score from the total number of faces ticked. Where the number of sad faces received equalled or exceeded the cut-off score, the pupil was described as being rejected with the group concerned on the criterion used (work or play) and I wrote 'rejected' in the 'social acceptance' column of the scoring sheet, and likewise for the other types of faces. The 'social acceptance descriptor' column on the scoring sheet provided a differentiated profile of social inclusion across the groups (same and opposite sex peers) and school contexts (work and play), which were sampled by the LITOW and LITOP. An example may be examined in appendix v.

It was essential that each pupil's profile was interpreted in relation to the opportunities present in his or her educational environment and the characteristics and attitudes of the peers who were completing the questionnaires (Frederickson and Furnham, 1999). Sometimes, following the use of sociometric techniques, labels such as 'popular' and

'rejected' have been used to describe individual pupils (Hallinan, 1981). It was important to appreciate that such terms provided an index of an individual's present position within particular social contexts and those labels should not be used as if they described individual characteristics (Kinderman, 1995).

3:7 ETHICS

Most forms of counselling research contain ethical dangers according to McLeod (2001, 2003, 2005). The purpose of the reality therapy programme was to help the pre-adolescents and to empower them to help themselves. However, I was highly aware that the process of counselling might often require disclosure of confidential information, experience of painful memories and emotions and the taking of decisions that might affect other people. I resolved to take great care to ensure that this risky process did not bring harm to the participants. It was easy to see that the research process might lead to information about the participants being disclosed, especially to curious Headteachers or parents who might feel it was their right to know. If that were to happen, painful feelings could be resurrected and the relationship of trust with the therapist could be damaged (Ely, Anzul, Friedman, Garner and Steinmetz, 1991).

An application for ethical approval was initially made to Cornwall County Council. The application to the County Council directed the planned research proposal to the Cornwall Learning Forum, a new Research and Development Unit run by the local authority. Here I sat in front of a multi-agency ethics panel from Education, Health and The Child Protection Unit run by Cornwall Social Services to explain the intended project, its aims and the ethical dilemmas which needed to be considered. The outcome of this meeting was that the educational consultant to the County Council was designated to supervise the project and report back on any concerns to the panel. Verbal approval was given on the understanding that British Association for Counselling and Psychotherapy ethical framework guidance on good practice was strictly adhered to (BACP, 2002).

The dual role of researcher as therapist was acknowledged but not regarded as unduly problematic by the Ethics Committee. Their concern centred around the possibility of

dual relationships of a different kind, which might arise when the practitioner might have two kinds of relationship concurrently with the children. The concern was that if the child viewed me as a teacher-figure, they would feel compelled to agree to anything because they were conditioned to 'do as they were told'. This was overcome by assurances that the children would be on first-name terms with me, the relationship would be carefully explained and the child's rights under the 1989 Children Act demonstrated at all times. The committee was reassured that BACP specific guidelines for working with children would also be used as the ethical framework for this particular study and that every step would be made to ensure that the child would experience a unique relationship with me which would not be compromised by the unwanted intrusion of others such as parents, carers or teachers. This relationship would be known as the therapeutic alliance and would be built exclusively upon trust. Keeping the relationship exclusive would mean not allowing others to intrude or be included without the child's permission. Consequently, preparation of each pre-adolescent and their parents / carers for participation in the programme required specific attention because there was clearly an ethical issue involved.

The parents / carers had care and control of the child, yet in the study it was essential that I needed to build an exclusive relationship with the child. Parents might feel very threatened by that and the situation might be aggravated in cases where these adults might be using public health services or the services of large non-government agencies. Some parents / carers might feel disempowered and overwhelmed by the system even though individual workers might have tried to create a personal consumer-oriented service. Such parents / carers might be worried by the suggestion that they would not be fully included in the research process. It was decided that the ethical issue could only be addressed satisfactorily if I was clear with parents / carers about the nature of the therapeutic alliance and gained their acceptance of what was required, as advised by Walbridge and Osachuk (1995).

Therapy would generally be a new experience for both the pre-adolescent and the parents / carers. It was felt that the adults would be more likely to have a satisfactory level of comfort and confidence in the process if they were fully informed about my need to maintain an exclusive relationship with the child. Additionally, I felt that it would be helpful to warn parents / carers that, at times, their child might not wish to

disclose information arising from a reality therapy session. It was reasonable to expect that these adults might feel anxious and believe that they might be left without information which they should rightfully know. The Ethics Committee stressed that it was important to reassure them that, in time, they would be given all the information that was important for them. However, they needed to understand that children often had great difficulty sharing important and private information and that such sharing needed to be done when the child was ready and felt safe about sharing.

Rekers (1984) highlighted that a therapeutic researcher should be aware that sometimes, particularly at important points in the therapeutic process, a pre-adolescent might develop behaviours which would be worse than the presenting behaviours apparent at the commencement of reality therapy. It was agreed with the Ethics Committee that, in this situation, it might be helpful to warn parents / carers that there might be a period of improvement soon after reality therapy began which would be followed by a setback or deterioration in behaviour. I was assured by the panel that passing general information of this nature to other adults would not compromise the exclusivity of the therapeutic alliance. However, to pass on specific details of a reality therapy session, without the child's agreement, would certainly compromise exclusivity. When asked how trust would be built up, I felt that as the child's confidence in me (as therapist) increased and my understanding of the pre-adolescent became broader, the trust which the child experienced would become stronger. This trust would be reinforced by the knowledge that fears, anxieties and negative thoughts towards parents, events and situations would not be disclosed to the parents / carers, family members or teachers without the child's agreement. I have a strong personal belief that a child should always have a right to privacy, but I acknowledged that it might be sometimes difficult for others to accept this. Clearly, it would be a priority aim to enlist the support and encouragement of parents, so that each pre-adolescent might feel free to talk openly with me. I felt that if I was open with parents / carers about the nature of the therapeutic alliance, parents would be more receptive to truly support the reality therapy programme. It was deliberately planned to try to build a trusting relationship with the parents / carers in the pre-adolescent's presence. Thus the exclusivity of the therapeutic alliance would be maintained, the child would be fully aware of the parents / carers acceptance of that relationship, and would be given permission and encouragement to participate.

Questioned on how a pre-adolescent might gain maximum benefit from the reality therapy programme, I responded by acknowledging that a permissive environment had to be created in which the child felt free to act out and gain mastery over feelings in safety. The child would be made to feel safe to make disclosures with the confidence that doing so would not have repercussions or consequences which might be emotionally harmful or damaging. The issue of confidentiality was involved here and will be addressed later in this chapter.

I felt that for a pre-adolescent to feel totally safe, structure was required in each session. Structure would hopefully give each child a sense of security and predictability during reality therapy sessions. It would also allow me to remind the child that indulging in repetitive non-purposeful activity would reduce the amount of time for constructive work. Structure would include the setting of behavioural limits and the giving of information about the expected length of each session. Additionally, the child needed to be prepared for the termination of each reality therapy session. It was intended to set limits to protect the child, myself and property from damage. Before any reality therapy began, all pre-adolescents would be given three basic rules to which I would ask them to make a pledge. Firstly, the child would not be permitted to injure himself / herself. Secondly, the child was not permitted to hurt the other participants or me. Lastly, the child was not permitted to damage property. It would, furthermore, be made clear that there were consequences for breaking the rules. If the rules were not complied with then the reality therapy session would end. However, the child would be welcome to come back to the next session without reprisal or further reprimand. By using the three rules only, avoidance of having to control and parent a child during a session would be achieved. It was also hoped that a uniquely therapeutic relationship might be created where the child had been given permission to be himself / herself with little restraint.

Another concern raised by the Ethics Committee was the vulnerability to bullying or unkind remarks by classmates who had participated in the test and might have guessed the reason for the child's absence from the classroom. This was overcome by informing the class that the sheets they had filled in were to be studied and three 'lucky' children would be selected to help in a piece of research. It would be fun and very enjoyable but was totally confidential. The reasons for filling in the sheets were played down with the emphasis on needing to find special people who could be trusted. I was aware this might

influence any post-tests, but I felt it was more important to protect the vulnerability of the children.

Finally, the danger of asking too many personal questions was raised as a possible concern. It could be argued that inquiring about a child's family and background was a useful way of getting to know the child and the child's world. Although this approach was valuable, the Ethics Committee felt it needed to be used with care or it could be intrusive. The child might fear being asked to disclose information which was private and / or too scary to share. If this did happen the child might feel intruded upon and might withdraw into silence or engage in distracting behaviour. Similarly, it might be considered to be too risky to use information which has already been gained from interviewing significant adults in the lives of the pre-adolescent. When the child discovered that important information had been given without his / her own consent or knowledge, he / she might feel threatened, vulnerable and uncertain about how much more information I might have. This could lead to partial or even total disempowerment. The Ethics Committee felt that to intrude on the child's world in this way was likely to contribute to anxieties about participating in the research and about being in the therapeutic alliance. Thus, thoroughly and without bias, the probable results of performing all these aspects of the reality therapy study and their resultant outcomes in given ethical dilemmas were carefully assessed with the Ethics Committee. A procedural pathway was eventually chosen from conclusions reached which would maximise the ratio of good over harm in all aspects of the intended programme.

3:8 AUTHENTICITY AND CONFIDENTIALITY ISSUES

The relationship between counsellor and child in counselling is primarily about connecting with each child in the group and staying with their perceptions (Geldard, 1993). Bandler and Grinder (1982) found that pre-adolescents saw the environment in which they lived quite differently from the way their parents might have seen this environment. My job as therapist was, therefore, to join with them and to work from within their framework (Bandler and Grinder, 1982). This needed to be done without judgment, affirmation or condemnation (Millman and Schaefer, 1977). These findings made it clear to me that, when working on a reality therapy programme with children,

an environment should be created where the pre-adolescent could feel safe enough to share very private thoughts and emotional feelings. In order to feel safe, a level of confidentiality was required. This confidentiality, and its limits, should be discussed with the child early in the relationship building process. Inevitably, Wolin and Wolin (1993) warned that there would be times when the child might share information which needed to be shared with others: for example, if a child disclosed sexual or physical abuse. However, to disclose this information inconsiderately, or without giving consideration to the impact of disclosure on the child might lead pre-adolescents into believing that they had been betrayed.

To overcome this possible dilemma, it was decided that, at the very beginning of the reality therapy programme, the child would be told that whatever was said was private and that information would generally only be disclosed to parents or others with the child's permission. It was made clear that they would not be identified by name in written research evaluations but labelled by a letter from their name, not necessarily the first one, followed by the group therapy site symbol of 1, 2 or 3 in brackets. This format would be rigorously followed throughout the study. The children would be asked to make a bond that they would respect confidentiality within each group. Likewise, they would be told that information would only be given to parents / carers and teachers with their permission. However, each child would be warned that there might be times when it was important for information to be passed on. In such circumstances, the child would be told that this was to be discussed first with them to ascertain how and when the information could be shared with others. In this way, I hoped that the child would not become disempowered but would have control over the way in which disclosures were made. It was also important to explore the positive and negative consequences of a proposed disclosure so that the child had full awareness of what outcomes there might be. The child's anxieties about sharing information would also need to be dealt with. However, it would be ethical and most desirable to give the child control of the timing and conditions surrounding the disclosure such as asking them if they would like to tell their parents / carers themselves, or if they would like to be present when told by someone else.

Confidentiality also related to the disclosure of a pre-adolescent's intra-personal issues to the family, particularly to their main care givers. I hoped these young people would

agree to the sharing of such information with others if they thought that positive changes might occur as a consequence. Of course, I realised that care must also be taken to explore with children the possibility of negative aspects of disclosures. As a general rule I decided that, unless imperative, I would accept the child's decision to share or not to share information.

3:9 PROCEDURE

The next stage of the research journey was to identify which schools were most suitable to meet the criteria of the planned study. I decided that the county of Cornwall should be the designated overall sample area. Living and working there generated personal knowledge of the variations in socio-economic locations and schools located within. Cornwall was a hugely diverse area both socially and economically, so there was simply no need to look further afield. My aim was to provide group therapy at one school from a highly populated area, one school from a small rural environment and one from an economically deprived part of Cornwall that the tourist rarely saw.

Letters addressed to the Head Teacher, introducing and discussing in brief detail the intended aims of the study, were sent to three initial schools (appendix iii). Appointments were set up with the three prospective schools. Two out of the initial three enthusiastically agreed to let their school take part. These two schools represented the small rural community and the area of decay and high unemployment. The Head of the first school approached in the highly populated area was unwilling to participate due to concerns about the possible 'unsettling' effect of the intended programme on specific pupils. I then identified a second possible school within the sought category. However, the Head felt that there were no significant problems of social inclusion within his school. Finally, a third school which was identified within this category agreed to participate.

All three Heads did not require individual letters to go out in advance to every class member's family. I was uneasy about this as I felt the children were not being given a choice and took advice from the ethics committee consultant. Her view was that parental permission for the sociometric testing was not required as it was agreed that the

testing would be done during lesson time and the school would sanction authorisation as part of the school programme. Once the testing was complete and the participants identified, I would return to discuss the children with the Head and take in a letter to give to parents or carers - by necessity, 'out of the blue' - asking for signed authorisation to work with their child, as well as asking the children themselves. This format applied in both the pilot and the main research. The three schools would participate in both studies.

When nine children from the three schools were identified as being socially isolated or ostracised from analysis of the sociometric tests, a letter was sent out to their main carers explaining the purpose of the study and enclosing parental and child consent forms (appendix iv). Meanwhile, as suggested by O'Neill (1998), each child was sensitively interviewed in a quiet area of the school to gauge their own personal feelings about being part of the project before asking them to sign at home. It was made clear that they could choose, without any repercussions, to decline from being part of the study. The main carers - a mixture of two-parents, single-parents and grandparents - were also given the opportunity to meet with me and ask questions. I also emphasised that the research was being undertaken for a Ph.D and their child was being asked to contribute towards that end. However, eight out of nine parents gave permission enthusiastically and offered 'back-up support' because they felt that the involvement of their child would be beneficial to their general well-being. One parent refused permission because they did not see why their child should be used as a 'guinea-pig' for my personal gain, as they saw it. Subsequently, another child was substituted who had an almost identical score to the others. Clarity was made a top priority from the outset of this project, followed by full verbal information as identified by Lincoln (1990), Gladding (1992) and Corey, Corey and Callanan (1993) and discussed at length with the Ethics Committee. This included the frequency and duration of the sessions, the child's individual responsibilities, confidentiality, goals of therapy, the risks and benefits, opportunities for questions to be asked and the paradoxical position of the researcher evaluating her own practice.

During the planning stages of the study, I felt it was necessary to carry out a pilot study. This would provide information on aspects such as how long it took participants

to complete the intended worksheets, whether any items or instructions were unclear, whether anything obvious had been left out, and whether the task evoked emotional reactions. I intended to use one pre-adolescent from each of the participating schools. The sociometric test was given to the whole class and results plotted on the Social Inclusion Survey, with the same age group and criteria for selection as would apply later in the main study.

The timing was carefully monitored, as the main study was a programme covering one complete school year. The academic year commenced every September, so it was essential for the pilot study to be undertaken in the preceding summer term, thereby allowing sets of different children to be used. A time scale of three months was designated, as the schools did not complete important examinations (Key Stage 2 SATS) until early May and were not willing for the pilot study, with the exemption of the initial testing, to proceed until this work was completed. A one-day follow-up would finalise the pilot project at each school after four weeks, taking the time-scale to early July. Follow-up interviews using structured questions would also be conducted with each Head, class teacher and teaching assistant.

The sociometric tests were given to each class in April and immediate analysis was done so written parental consent could be obtained. A letter was sent to each identified set of parents or guardians. Permission was sought, where appropriate, from both parents if divorced. I began the study in mid-May, spending a week in each school. The selected pupil had one hour of reality therapy counselling each day for five consecutive days in a quiet room where privacy could be obtained, to allow for the dual requirements of both confidentiality and the use of a tape recorder. The rest of the day was used to observe the participant in the classroom situation and 'hanging around', to prepare equipment and to interview the Head, class teacher and the teaching assistant.

3:10 METHODS OF DATA COLLECTION

I chose a multi-method approach for my study. By using three different methods of data collection, my intention was to produce more reliable evidence (Huberman and Miles, 1994; Denscombe, 2000). The methods for data collection were divided into three broad

co-ordinates: use of questions and interviews, use of worksheets and use of fantasy and image to collect data. From this wide source of data, it was my intention to reflect upon my own role in the process (Edwards and Talbot, 1994) and to develop sensitive and appropriate reality therapy interventions suitable for vulnerable children. As recommended by James (1989), they were based, to a large degree, on unplanned informal conversations.

3:10:1 DATA COLLECTION TOOLS

Data collection tools included audio tape-recording backed up by observation sheets and field notes. Parry (2001) advocated the use of a battery-powered micro-cassette player as unobtrusive, recording permanently all verbal communication with accuracy and speed. Non-verbal communication and visual signals were also acknowledged as vital (Feltham, 1998). The field notes on emotional reaction and body language throughout each session were made specifically to fill in 'the missing gaps', as recommended by Elliott, Slatick and Urman (2001). Additionally, I devised an observation sheet as a child profile format for each participant (appendix vii). This has been detailed in the following section on worksheets and observation. Field notes were also kept when observing tasks performed by worksheets or creative activity. Geldard and Geldard (1998) highlighted that paper, books, music and narrative cassette tapes and CD's, dressing-up clothes, puppets, clay, crayons and paint could and should be used to provide stimulation and variety for children in therapy. Examples of these activities and other data collection tools can be examined in the appendices xi, xii, xiii and xvi.

3:10:2 USE OF QUESTIONS AND QUESTIONNAIRES

It has been suggested that at every stage of data collection in a programme of inquiry using reality therapy techniques as process, the needs of the participants should be addressed though, according to Glasser (2003), it was not possible for all needs to be consistently met to the same degree. I aimed to ensure that the need for belonging would be met in the initial stage in that everyone would feel included in the group. Perhaps the most important question of all would be the first one - 'What does everyone

want from the group experience?' Semi-structured 'total behaviour' questions would be asked at this exploratory stage about the life direction of each individual group member, specific behavioural actions, ineffective and effective self-talk, feelings about being in the group and feelings about how they saw their world and others in it saw them, and even physiological behaviours. In the transitional stage of group development, the power need would be addressed when anxiety, conflict and resistance might surface in various situations. As recommended by Weare and Gray (2003), time would be allowed for careful listening, assuring, and then reframing possible conflict and resistance from negative to positive. Unstructured questions would be employed to search for collective answers amongst the participants in order to identify recurring themes within a firm but flexible working structure.

Before commencement of group therapy, I planned to informally interview and record the Head, class teacher and teaching assistant using unstructured questions. However, structured questions would be asked as a follow-up after one month and again at the end of the school year, in order to evaluate the effectiveness of the therapy and perception of positive social behavioural change in each pupil. Interviews with parents / carers would begin with an informal discussion, where the process was explained, how the child might benefit and issues such as confidentiality defined. Everyone would be asked to agree to an informal tape-recorded interview using unstructured questions to identify problems at home and behavioural characteristics which might not 'come to light' in the school setting.

After one month and the end of the school year they would be invited to informal interviews once more, where they would also be asked to evaluate their perception of social behavioural change in their child by structured questioning. Some participants, for a variety of reasons, might not want their participation discussed with their carers. However, other participants might openly encourage dialogue on their behalf, so interviews would be individually designed and the majority of information would be given in general rather than specific terms, in order to protect confidentiality. Most importantly, the participants themselves would be asked to self-evaluate their perception of personal change following therapeutic intervention, by means of a short questionnaire using structured questions, at one month and the end of the school year.

3:10:3 USE OF WORKSHEETS AND OBSERVATION

Identical worksheets would be used with the three groups to help me observe the interaction of the participants in their 'raw' form. A core principle of reality therapy has always been that the way in which we behave is not random and that behaviour always had a meaning and is symptomatic of that meaning (Glasser and Glasser, 1999). I developed the child-profile format (appendix vii) in order to observe individual behaviour whilst interacting with the group. This format consisted of three sections. Firstly, I was looking for evidence of anxiety and ability to cope. In this section statements such as 'dominates group situations' or 'is a victim of verbal abuse' were put into one of the five categorised columns: not clear yet, hardly ever, sometimes, very often and usually. The next section studied the capacity of the pre-adolescent to acknowledge and work on difficulty. Phrases such as 'accepts responsibility for own behaviour' or 'able to acknowledge own difficulties' were rated using the same categories. The last section looked at the pre-adolescent's ability to work on tasks. Statements for me to reflect upon included 'can aim for quality of achievement' or 'can be cooperative with peers in group situations'. I then closely observed behaviour by ticking one of five boxes next to each ability or difficulty: 'not clear yet, hardly ever, sometimes, very often or usually'. As the weeks progressed, participants sometimes would move from 'hardly ever' to 'sometimes' to 'very often'. Each progression was carefully noted in both field notes and by dating the appropriate columns.

Worksheets would also be used to help the participants think about their current behaviours and their consequences, to recognise alternative behaviours and to make choices about how they intended to respond to particular social situations in the future. The worksheets, additionally, would give the pre-adolescents the opportunity to examine their own responses and choices without pressure from others. Once they had chosen appropriate skills for use in particular situations, they could be helped to devise a plan of action. In this plan, the participant would need to decide on the various situations of their environment. Thus, hopefully, they would be able to think about ways in which to generalise learnt social skills into the various settings of their unique and individual environment. Worksheets would act as a springboard for discussion, because their intention was to draw out and focus thoughts about particular issues or behaviours.

3:10:4 USE OF FANTASY AND IMAGE

Having considered the benefits of using image and fantasy in communication and development (Adamson, 1984), I planned a comprehensive programme to allow the children to engage in open-ended imaginative work which would explore social behaviour from reality therapy perspectives. I decided that the programme for this study would include art imaging, fairy tales / puppet work and clay work (appendices xi, xii, xiii and xvi). An imaginary journey would also be included in the therapy because I believed that it could be an additional useful therapeutic tool. However, I was aware that instigating an imaginary journey was a very powerful technique and, as such, it needed to be used with care.

Taking the participants on an imaginary journey would involve telling them the outline of the story and allowing them to fill in the details from their own imagination and experiences. Thus, when they were guided on the journey, the scenes would be created along the way but the participants would be left to create in their imagination the people, objects and activities within the scene. Consequently, they would be provided with an opportunity to create scenarios which were projections of their own inner world, in total privacy, and they would be encouraged to explore the most personal themes and ideas which emerged spontaneously from within themselves. As advised by Schaefer and O'Connor (1994), as they moved through the journey, memories, emotions and fantasies would be triggered so they became aware of them and could work through them safely within the group process.

Stories, myths and fairy tales have always played an important role in stimulating emotional development. Wilson (1983) suggested that good literature was a rich source for the study of human feelings and behaviour, and argued that in listening to or reading stories, children could extend their experience widely to include a variety of people and circumstances. A Dream Evaluation questionnaire was also created (appendix viii), as I recognised that dreamwork might play a role within the reality therapy context. I became later aware that these tools, in stimulating emotional development were, paradoxically, in some respects promoting what they sought to measure.

3:11 THE PILOT STUDY

The emphasis of the pilot study was to test the research design and materials which have been described. Worksheets, which I adapted for British children, from the US version of Carleen Glasser's (1996) 'My Quality World Workbook' and 'The Quality World Activity Kit' were used in the same way as the Korean version, adapted by Professor Kim In Ja of Sogang University (Kim and Hwang, 1997). Choices and choosing different behaviours to get needs met were also talked about. Ongoing emerging themes such as happiness and anger were discussed and future positive social behavioural goals planned. Interaction with the participants was totally unstructured around ideas that were developed from the worksheets, allowing for themes to be used from the previous day to supplement and build on the present-day discussion, thus giving the study rigour. Using art therapy within the context of reality therapy was explored, using paint to produce meaningful images, thereby illustrating basic behavioural needs. On the last day an individual social behaviour plan was developed. A check-list was used to estimate whether this plan had a reasonable chance of working. In the follow-up, the participants were asked to complete a journal, self-evaluating their plan, their social behaviour patterns and their general feelings.

The pilot study highlighted change with the participant from Group 1 as differences in social behaviour were informally observed by the Head, class teacher and teaching assistant when interaction with other pupils occurred. However, a difficult pupil left school during this period and this could have had a behavioural influence. There was no noted change in the social behaviour of the other two pupils. All three schools felt that five consecutive days was not enough to facilitate an indicative change in social behaviour. Where there was no lasting improvement, a temporary improvement was noted, but that quickly slipped back due to lack of reinforcement. It was apparent that, for the main study commencing in the autumn, the therapeutic time needed to be doubled and given over a wider time-span. I decided to work weekly instead of daily over an initial period of ten weeks, with follow-ups after one month and then again at the end of a full school year.

Some important omissions were identified that needed to be added to the main study. All three sets of parents involved in the pilot study, whilst understanding ethical limitations, expressed a wish to have been more involved than merely giving consent.

This would have had the advantage of giving the participant a second avenue for expressing their feelings and receiving 'back-up', if they had wished to take up that choice. The parents, likewise, would have had the opportunity to offer more valid support, as their understanding of the study would have been greater. The pilot study, therefore, illuminated the need for a parent interview both at the commencement and the end of the study, although I was aware that confidentiality was sacrosanct and parental involvement could be problematical in safeguarding therapeutic boundaries.

I felt that a specific post-therapy questionnaire rather than a journal would have been more useful to help the children express their views on the therapy more fully and relevantly. I realised that the journal (appendix x) was limiting in space for older children and did not direct them to specifically discuss the therapy and resultant change. Additionally, a copy of the action plan should have been given out at the end of the five consecutive days so it could have been put somewhere prominently (or secretly) to remind the participant of the agreement which they shook hands upon.

The follow-up session illustrated the point 'out of sight, out of mind'. Reinforcement was found to be a key issue with all three participants; the short period of therapy not being enough to build upon the foundations put into place in two out of three children. These two pilot study participants said that they would have preferred to work in a group situation, especially when participating in methods such as art imaging. They felt they would have discussed their images more freely and expressively if they had been interacting with one another.

This confirmed to me that the main study would be more applicable and valid if small groups of three were used from each school. However, most importantly, I realised that peer acceptance needed to be recorded at the end of the therapy and not just through the Social Inclusion Survey (Frederickson and Furnham, 1999) at the start of the process. I decided that, as well as using self-evaluation questionnaires and interviews with parents and school staff, the SIS (Frederickson and Furnham, 1999) would be re-applied at the end of the school year to assess peer acceptance over the longer term.

3:12 DATA HANDLING AND ANALYSIS

The interview data was subjected to the three-stage analysis method described by Miles and Huberman (1994): data reduction, data display and conclusion drawing. I listened to each tape, transcribed it personally and read each transcript through several times in order to be familiar with the data. During transcription, attention was given to the participant's rate of speech, tone of voice, level of expressed emotion, and emphasis given to specific words or phrases. Transcripts were then read again in their entirety to gain an overall sense of the participant's experience. When transcription had been completed, I contacted participants individually and provided them with the opportunity to review the transcripts, to add information, and to clarify any errors or omissions, as recommended by Parry (2000).

One tape-recorded interview was conducted per session with the three participants as a group using an unstructured format. After careful analysis of the participant's feedback from the pilot study trials, I modified the interview format from semi-structured to unstructured to allow participants an increased sense of comfort and trust. This would be achieved by encouraging the participants to tell 'their story' and to discuss their previous therapeutic experiences. I anticipated that sometimes only one person would talk; sometimes the three children could vie for attention and the conversational intercourse might be rapid and intense. Ten sessions would be recorded for each therapy group. Additionally, a follow-up recording would be made at one month and at the end of the year to identify progression. All adults concerned with the welfare of the child such as parents / carers, class teachers, teaching assistants and Headteachers would also be informally interviewed before and after the study and asked to complete post-therapy questionnaires. The conversation recorded from each group session, in addition to participants 'telling their story', whether responses to the unstructured questions, comments made during an activity session or in reply to worksheet data, would be transcribed verbatim to text for analysis. The intent of the analysis would be to obtain a set of themes that captured the essential qualities of the participant's experience. Sentences or phrases would be excerpted from the transcripts, paraphrased and complied into themes in an attempt to understand the participant's meaning. Artwork and creative writing would also be scrutinised for emergent themes which might arise from my personal interpretation.

After the generation of thematic clusters, they would be validated by referring back to the creative evidence and the original transcripts to determine if they had omitted anything or suggested anything that was not implied in the visual work / transcript. Studying transcription would involve scrutiny of each participant's responses by taking into account the content and meaning of the specific statements as well as the context of the whole interview (Riley, 1990). Next, redundant material would be discarded until themes that reflected the domain of the participant's experiences had been identified. I would then evaluate these statements within the context of other work done with the participants to identify overlap and repetition. Thematic clusters would identify common themes and the shared structure of the experience. Final transcription drafts and analysed occurrent themes were given to the chief advisor to the Ethics Committee in order to elicit other lines of thought and enhance reliability.

3:13 VALIDITY AND OBJECTIVITY

One of the tenets of action research is that research that is conducted without a collaborative relationship with the relevant stakeholders is likely to be incompetent. It is not merely about 'doing good' but also about doing things well (Bradbury and Reason, 2001). The respect action researchers have for the complexity of local situations and for the knowledge people gain in the processes of everyday life has made it impossible for us to ignore what the 'people' think and want (Gaventa and Cornwall, 2001). From this initial respect, based on both democratic and empirical principles, action research has been able to move on to the affirmation that it is much more able to produce 'valid' results than ordinary or conventional social science (Bradbury and Reason, 2001; Gaventa and Cornwall, 2001). This is because expert research knowledge and local knowledges are combined and because the interpretation of the results and the design of actions based on those results involve those best positioned to understand the processes: the local stakeholders (Sherman and Torbert, 2000).

Further, action research can meet criteria of validity testing more effectively than do most other forms of social research. Action research projects test knowledge in action and those who do the testing are the interested parties for whom a base result is a personal problem. Action research meets the test of action, something generally not true

of other forms of social research. Conventional researchers might worry about objectivity, distance and controls. Action researchers worry about relevance, social change and validity, tested in action by the most at-risk stakeholders. Rolfe emphasised that undertaking rigorous and objective research was not the prime goal of the practitioner-centred researcher:

> ".....true objectivity is impossible even in the hard sciences, and when we try to judge the practitioner-researcher's analysis against some scientific 'objective' judgement of whether a clinical improvement has taken place, we are, in fact, merely comparing two subjective accounts, two different views of an essentially unknown process. The very notion that there is some objective criterion of clinical improvement which the practitioner-researcher's professional judgement can be measured against is therefore naive and incorrect." (1998, p.195)

3:14 THERAPY : SURROUNDINGS AND ATTITUDES

Group 1 school site was located in a large parish in England in acreage terms, covering both the north and south coasts of Cornwall, and yet the village school had a role of only 136. The area had a history of farming and agriculture. From a social and economic point of view, the children attending the school at this present time were predominantly middle class, although there were working class children. Since the school moved to its existing site, the school population had changed. There were now more parents who commuted to the larger towns but chose to live within the parish. There was only one other school in the catchment area and it was situated on a different coast and even smaller in size. The Headmaster described the strength of the school as being the way the staff used their own initiative when it came to dealing with the children and their parents. He felt their weakness could be for that same reason. He believed that when you had a staff good at working on their own initiative, you had to make sure that, as a whole, the school functioned in a similar mind. There were no specific provisions for counselling at the school and the staff were expected to provide a 'listening' service. The Head was enormously enthusiastic about the value of counselling and was trying to obtain funding to sponsor an ancillary who had been trained on a basic course. The Healthy Living Partnership Scheme allowed schools to bid for some money to pursue interests directly related with healthy living. Counselling would fall within that auspice.

In 1999, it became a statutory requirement for every school in England to develop a school behaviour policy. At Group 1 school site, the first step was to call a meeting of the parents. There were a number of parents who, previous to this legislation, were getting (as the Headteacher put it) 'a bit hot under the collar about how the school was dealing with bullying'. The school felt that the only way around the problem was to get together to help the parents express what they wanted to say and to try and create ways for everyone to solve the issues involved. A year was spent consulting parents, governors, ancillary staff, teachers and pupils and putting together the codes of behaviour that were appropriate for the school community. Specific rewards and sanctions were also identified so that everybody had a clear idea of what was going to be used. At the time of the research project, that had been in place for two years.

Individual behaviour plans were also developed. These were pastoral programmes for children on the point of exclusion. They involved identifying certain behavioural targets that the school wanted the pupils to achieve and these would then be discussed with the child and the parents. The Head quoted examples such as 'when angry, I will not use physical responses. I will confine myself to verbal responses' and when feeling cross 'I will go and tell somebody' so the staff knew when a child was 'about to blow'. The school looked for cognitive behavioural change because the staff wanted the pupils to understand the reason why this sort of thing was important and how they might think differently to change behaviour patterns.

In 2002, a quiet room was introduced. This was a place children could go to if they felt threatened or about to respond inappropriately. There was no need to tell staff. The idea was that if the child was not where he / she was supposed to be, he / she would be in this room. The Special Needs Education Co-ordinator (SENCO) had never been used to implement behavioural policies and that role was defined as being strictly for learning difficulty support.

Group 2 school site was situated in a mining town in decline since the closure of the tin mines, contraction in the export of mining engineering and reduced activities in textiles and other mineral working. Despite the falling job opportunities, people kept coming to Cornwall from other parts of the country. The continuing rise in population was met,

therefore, by rising unemployment. There were some strong environmental reasons for many relocations to Cornwall, with people anxious to escape 'the rat race' and seeking a quieter, saner way of life. This shift of population had a great impact on the community. There was a real trauma in Cornwall generally as buoyant house prices had, until very recently, allowed prospective in-migrants to sell their homes for handsome profit, facilitating a move to Cornwall which would still leave cash in the bank.

The site was built in 1976 on a former cricket pitch. The area was a tough part of the region with high crime statistics. The school had ten classes of average size and was geared to the philosophy of 'tough kids and interesting families'. The Headteacher acknowledged that the school catered for 'the lower end of the market' socially and economically, with only two children from professional families within the entire school population of 280. The school had 33% integrated special needs children with a large number of children on free school meals and was part of an Education Action Zone. This was funded by the DfES as a means to raise standards and promote self-esteem in schools. It was formed in 2000 and 32 schools in the area were amalgamated into it. All these schools performed below national norms and the main reason identified was the behaviour of pupils. There was additional funding available if the school was willing to try out a variety of new ideas and Case 2 had additional funding towards their Special Needs team. The school behaviour policy had implemented the release of the SENCO to Pastoral Manager whose role was to look at all the behaviour issues throughout the school and to manage the support staff and the lunchtime supervisors. The emphasis was on getting the whole school policy working effectively right through and the Pastoral Manager was in charge of keeping that behaviour policy up to date.

The school had many active counselling strategies in operation, such as anger management groups, behaviour groups, dyslexia groups and additional literacy support. It wanted to be the first school in Cornwall to host a nurture group. They were frustrated that financial 'red tape' had thwarted these plans. The school also had a 'cooling off' room, where there was the opportunity for children who found life difficult to go and talk to someone. Unlike Group 1 school site, where only a room was provided, this school also had two SEN staff, who had done a basic counselling course. The Headteacher was adamant that if social problems were not dealt with, the National Curriculum went 'out of the window'. He acknowledged that running out of class was a

common occurrence and wanted, desperately, enough staff so there was always someone there to run out to. At the moment, there was counselling every afternoon for two half-hour sessions run by the SEN staff. The Headteacher would ideally like to have seen one member of staff attached to every two classes. The counselling provision that was in place started in 2002, due to a general recognition by staff of some severe needs both emotionally and behaviourally in pupils. Since implementation of the counselling scheme, a problem had started to arise in terms of numbers. The school was finding the younger children and those who were more emotionally upset were the ones most likely to gain and that, for some older children, it had been left 'almost too late'. Dealing with feelings was top of the agenda and a key priority of this school.

Group 3 school site originated back to 1828. The site was originally constructed alongside the church, a large and imposing piece of architecture which dominated the skyline in the centre of a thriving military town. The area was affluent and was dominated by a naval base. The present school was a split-site school. The infant department moved to the present site in 1958 and the junior school was built in 1963. The infant school was a voluntary aided church school and the juniors an ordinary county school. In 1983 they combined and the new school became voluntary controlled. This differed from a voluntary aided school, where a lot of funding came through the church and the church had an input through the governors. With a voluntary controlled school, although the church had an input with a certain number of governors and control of the governing body, the school was funded purely as a county school through the LEA. Today a quarter of the governing body were church representatives. The school was built on the edge of a large council estate and near the married quarters of the naval housing estate. In addition, there was impressive private housing in the catchment area, thus enticing a mixed intake of social and economic classes. The school had 14 classes; two in each year group, making it one of the biggest in Cornwall.

The behaviour policy of the school, along with the other schools, had been in place for about three years. Nothing of significance had been updated since its original implementation. The Head said that each class made time during the week for circle time. A school council had been introduced, which would give the children some input into what was needed around school and what should be done around school. In the

infant department there was a scheme, called a buddy scheme, where older children went and helped the younger children at playtime and introduced them to games and played with them. There was a similar scheme in the juniors called playground pals. This involved a group of older children who had been trained by staff to supervise playground games. They went out at playtime and had certain areas where they went and played certain games. There was also a weekly theme. One week the hoops went out and it would be hula-hoop week. Another week, another theme. Rewards and punishments were also highly on the agenda. Smiley faces could be earned for good behaviour. Children could collect them to gain a prize.

When asked about counselling provision at the school, the Headteacher looked a little bewildered. Clearly there was no existing counselling provision at all although he operated an 'open door' policy. However, there was one staff member who had recently gone on a basic counselling course and the Headteacher was keen to use her for future referrals to avoid calling in the Educational Welfare Officer. The Head said that sometimes this person came to the school to see specific children or, in one or two specific cases, suggested someone who would be better to do it. There was also another occasional visitor from the educational wing of Social Services. He mentioned a girl whose parents were divorcing and Social Services came in to talk to both mum and the child. The Head readily acknowledged that counselling provision within the school would be very useful and was obviously aware of the shortfall in this region. However, he admitted that he was not trained to talk to people at a deep level and neither were the teachers. Over the years, his role had been one of marriage guidance counsellor, social worker and general listening ear. He felt there was a role either for staff to become more qualified or, better still, somebody else to be available, who was not a member of staff, able to cover the schools in the catchment area.

3:14:1 THERAPY : THE PHYSICAL ENVIRONMENT

The study sessions were conducted during the autumn term of 2002 over ten weekly sessions in a room designated each time by the Head. The subsequent follow-ups in January and July 2003 were also at this venue. Sociometric testing was conducted each time within the classroom setting. The researcher was given no choice of location, other

than asking for continuity of room each week to try to establish a secure base. The study, in all cases, had to 'fit in' with the routine of the school timetable and had to be conducted during term-time within school hours. Each session lasted for one hour.

3:14:2 THERAPY : THE GROUP PROCESS

As it was a generally accepted assumption in the literature that a key area of difficulty for socially isolated pre-adolescents would be a lack of capacity to work and play with others in groups (Whitaker 1985; Mongan and Hart 1989; Greenhalgh 2000), I was keen to explore this supposition, whilst being highly conscious of possible presenting problems along the 'therapeutic journey'. For this reason, group members were kept minimal so that participants could hold onto their own sense of individual identity, as suggested by Bion (1989). I felt that large groups might have the tendency to arouse - in both myself and members of the group - feelings that the group was held together somewhat tenuously and that conflict and tension could relatively easily break out. A sense of group cohesion could have easily changed into a dynamic of 'everyone for himself / herself' and this could have created a difficulty for group members in retaining their own sense of individual boundaries. In my experience, the larger the group the more emotionally 'primitive' it tended to be. Another factor which might have inhibited the development of a group was a spatial one. Given a large sized group and the space in which it would physically operate, individuals might not have always registered the effect of their contributions on others which, in turn, could have made them feel angry or shut out. Equally important, as highlighted by Schmuck and Schmuck (1997), was the consideration that if a tight structural framework was not in place, a large group could frequently break down into smaller groupings, either spontaneously or through conscious decisions of the members.

3:14:3 THERAPY : THE ALLIANCE

When working with children for therapeutic purposes, my concern was not to produce beautiful pieces of work for visual presentation or to push children to complete handouts without time for reflection and discussion. I encouraged spontaneity

throughout, in order to explore each group member's experience of their Quality World in a personal and open-ended way, with no pre-determined 'right way'. Additionally, when pre-adolescents undertook therapeutic work, I realised that they might be extremely sensitive to my sincerity and this study would be no exception. Therefore, whilst a child engaged in a creative task, my task had to be to remain available to respond to a request for support and, at the same time, be aware of intrusion. Each participant needed to feel safe enough to immerse himself / herself in the task. Care was needed not to suggest what 'pictures in their heads' the participants should make, as it was essential that the ideas should be entirely their own. A key element in this process would be the manner in which I accepted what emerged from the unstructured dialogue, showing unconditional respect to each child.

3:14:4 THERAPY : THE PROGRAMME

The reality therapy worksheets were based on the U.S. group programme devised by Carleen Glasser (1996) 'My Quality World Workbook' and 'The Quality World Activity Kit'. A similar programme to this study was developed by Professor Kim In Ja of Sogang University (1997), converting the sheets to suit Korean youth culture. I, in turn, redefined its use yet again to suit British pre-adolescents. The programme was renamed *Examining and changing unhelpful social behaviour.* Worksheets were used in the first, second , sixth, seventh and tenth meetings and again in the follow-up session.

Session 1. In this session the five basic needs of reality therapy would be explained through the first worksheet, examining how the participants were both alike and different. The children would then complete the worksheet 'How much of what you need do you already have?' The main purpose of this was to make the group express both orally and on paper how, when and where they felt satisfied with the five basic needs and with their behaviour. The children would be asked to list the people, activities or groups they were involved with, categorising them into legs of an illustrated chair on their worksheets, which stressed that the seat was their survival (appendix x).

Session 2. The groups would be helped to find out how their basic needs could be satisfied by completing the worksheet 'How can you help yourself get what you really

need?' On a subsequent worksheet they would be told about the Quality World and asked to describe a real world situation in their life that definitely did not match the 'picture in their heads' of a Quality World. Subsequently, they would be asked to draw a picture of what it was like when they did not get what they wanted (appendix x).

Session 3. Each group participant would be given four sheets. The first one was a large heart with 'I love and belong' underneath. The second one was a star, displaying the message 'I'm proud of me'. The third sheet was a butterfly - 'I have a mind of my own' and lastly there was a smiley face - 'What I enjoy'. These were taken from 'My Quality World Workbook' by Carleen Glasser (1996) and vastly enlarged to use in this different context (appendix x). The participants would be given a wide choice of paints, coloured sand, material and glue and left to immerse themselves without my aid or ideas. Time would be allowed at the end of the session for discussion of the emerging themes from this artwork (appendix xi). When working with art for therapeutic purposes my concern was not, as has been said, to encourage production of beautiful works of art but with painting spontaneously, exploring each participants experience of the world in a personal and open-ended way, with no 'right' way of doing it.

Session 4. Fantasy work would be used with the research group in Sessions 4 and 5 of the programme. In Session 4, the participants would be helped through listening to a story to evaluate their own lives and to provide a model for imitation as well as motivation for change. The chief use of bibliography (Glasser and Wubbolding, 1995) was that it allowed each individual to learn to clarify what they wanted from the world around them, a core principle of reality therapy. In choosing the book for this session, I was again influenced by Wubbolding (2000) who recommended 'The Fairy Tales of Oscar Wilde', especially 'The Selfish Giant' as a fitting choice for the pre-adolescent age range. After reading 'The Selfish Giant' to each group, the moral of the story would be discussed and what it conveyed therapeutically. A list of affirmations that the giant could have made might be drawn up, such as 'I am responsible for everything I do' or 'I am lovable and capable with lots of friends'. The groups would then be asked to write the story of their lives in the form of a fairy tale, using fairy-tale characters to represent the major influences. The most important part of this exercise was that each participant would be asked to finalise the story with a happy ending to convey positivism, purpose and hope, and then to enact it for the rest of the group.

Session 5. It was planned to introduce six puppets to the groups for use in multi-functional roles. There was a wizard, a witch, a pirate, a nurse, a boy and a girl. A puppet theatre was to be set up and every group member would be asked to act out their story which had been written the previous week. Sometimes the nurse might double as mother, teacher or grandmother; sometimes the pirate could be elder brother or step-dad. The possibilities were endless (appendix xii).

Session 6. The overriding theme of this session was to be: 'Is your road taking you where you want to go?' The discussion would be on choice and choosing behaviours. The groups would be asked to discuss the consequences at the end of every road by filling in a worksheet of a road with three forks. At the start was a racing car labelled 'choices'. The participants would be asked to consider a personal dilemma where a choice was involved and to illustrate it on the worksheet. They would then be asked to self-evaluate whether they were happy or not. They would be given a worksheet containing three blank flags with coloured poles. Each group member would be asked to put choices which made them angry into the red flag, choices they did not care one way or another about in the green flag and choices which made them happy in the yellow flag. They would be guided to self-evaluate their pictures in their minds with what they had in the Real World. Finally, time would be put aside to describe and illustrate a time which was not happy because the picture they saw in the Real World did not match the picture they had in their Quality World. The participants would be asked to recall a time when they did not get what they wanted and to describe how they felt (appendix x).

Session 7. Consideration was to be given in this session on obtaining immediate goals and future goals. I would encourage the participants to talk about excuses, which would help them to realise that making excuses was not the way to achieve what they wanted. It was important to decide if this 'want', which Glasser called 'Quality World' (1985) was attainable or not. Here the planning had to be simple, immediate, specific and genuine. The worksheets would allow the participants to plot purposive action courses to reach their various goals, both immediately and in the future (appendix x).

Session 8. Creative play was to be explored through the medium of clay. I intended to ask each group member to produce a large-scale model of 'myself and my world'. They might make family members, friends, enemies, pets or 'significant others'. Every

participant would have a large board and enough clay to make at least six people. The children would be urged to think carefully about the positioning of the completed models on the boards in relation to both themselves and each other. When this task was complete, the group members would be asked to reposition their models again, this time to the criteria 'Myself and the way I would like my world to be', emphasising positive visualisation (appendix xiii).

Session 9. The song *I Can See Clearly Now* by Johnny Nash was to be played to each group. I carefully selected this particular song because it conveyed a positive message of hope over despair in its words and had an uncomplicated rhythm for pre-adolescents to remember. Likewise, the basic needs for survival, love and belonging, power, freedom and fun could be discussed in relation to the words of this inspirational song. I would encourage the groups to discuss how imagining the attainment of a goal or activity was the first step in its actual attainment, even for a person too shy to try or lacking confidence to begin. Time would then be allowed for the group members to compose a 'rap' song formulated around the basic needs; the subject matter being entirely their choice (appendix ix). To conclude this session, I would play the groups a guided meditation tape of an imaginary journey, based on confidence building and 'the way I would like my world to be'. They would lie in a darkened room, making themselves comfortable with cushions. At the end of the tape, visualisation of purposive action plans for the future could be discussed and dream questionnaires completed (appendix viii).

Session 10. The groups would be given individual planning sheets to write specific action plans. They would be told on the sheets that if what they were doing now was not getting them what they wanted, they needed to plan on paper what else they could do instead. I would give each participant a checklist to see if their plan had a reasonable chance of working (appendix x). Each group would then re-gather after one month to discuss whether their plans had worked. Journals would be completed to record individual thoughts on being in group therapy and they would be asked how they felt now the programme was over (appendix x). Finally, every participant would be asked for permission to visit again at the end of the school year for an oral assessment to gauge the overall success of the programme.

3:15 SUMMARY

In this chapter I have tried to highlight the advantages of using an action research design as well as exploring the many potential obstacles within reflexivity / reactivity / ethical issues. Tables 1 - 3 overleaf draw together all the elements which have been discussed to visually show the points of intervention at various time points and to illustrate how and when data was collected. The scene has now been set for an in-depth analysis of themes which have emerged within the categories of Glasser's five core needs.

TABLE 1 POINTS OF INTERVENTION (PRE-MAIN STUDY)

TIME POINT	WITH WHOM	MEASURES	RESULT
Pre-Pilot Intervention	Ethics Committee	Interview with Panel	Permission to proceed
	Headteachers	Introductory letters Informal interviews	Permission to use school for study
	Y6 Pupils	Sociometric tests - SIS (Frederickson and Furnham, 1999)	Identification of potential children
	Headteachers	Letters to parents of identified children via schools	Establishment of one participant within each school
	Parents / Carers	Telephone conversations	Written consent
	Participants	Informal interviews	Written consent
	Headteachers Class teachers Teaching assistants	Informal interviews Transcripts	Understanding of three chosen participants
RT Pilot Intervention			
5 sessions x 1 hour 5 consecutive days	Participants	Worksheets Art therapy Action plans Transcripts	Visual / audio data
After 1 month evaluations	Participants	Journals Transcripts	Visual / audio data
	Headteachers Class teachers Teaching assistants	Informal interviews Transcripts	Audio data

TABLE 2 POINTS OF INTERVENTION (MAIN STUDY)

TIME POINT	WITH WHOM	MEASURES	RESULT
Pre-RT Intervention	Headteachers	Discussion of planned changes arising from pilot-study feedback	Preparation for main study
	Y6 Pupils	Sociometric tests - SIS (Frederickson and Furnham, 1999)	Identification of potential children
	Headteachers	Letters to parents of identified children via schools	Establishment of three participants within each school
	Parents / Carers	Informal interviews Transcripts	Written consent Family information
	Participants	Informal interviews	Written consent
	Headteachers Class teachers Teaching assistants	Informal interviews Transcripts	Understanding of nine individuals in overall study
RT Intervention			
Session 1	Participants	Worksheets Observation Sheet Transcripts	Visual / audio data
Session 2	Participants	Worksheets Fieldnotes Transcripts	Visual / audio data
Session 3	Participants	Art therapy Fieldnotes Transcripts	Visual / audio data
Session 4	Participants	Psychodrama Fieldnotes Transcripts	Visual / audio data
Session 5	Participants	Puppetry Observation Sheet Transcripts	Visual / audio data
Session 6	Participants	Worksheets Fieldnotes Transcripts	Visual / audio data
Session 7	Participants	Worksheets Fieldnotes Transcript	Visual / audio data
Session 8	Participants	Art therapy Fieldnotes Transcripts	Visual / audio data
Session 9	Participants	Music therapy Dream Questionnaires Transcripts	Visual / audio data
Session 10	Participants	Worksheets Observation sheets Transcripts	Visual / audio data

TABLE 3 POINTS OF INTERVENTION (POST-MAIN STUDY)

TIME POINT	WITH WHOM	MEASURES	RESULT
Post RT Intervention			
After 1 month evaluations	Participants	Questionnaires	Visual data
	Parents / Carers	Structured interviews Transcripts	Audio data
	Headteachers	Structured interviews Transcripts	Audio data
	Class teachers	Structured interviews Transcripts	Audio data
	Teaching assistants	Structured interviews Transcripts	Audio data
6 month gap			
End of school year evaluations	Participants	Questionnaires	Visual data
	Parents / Carers	Structured interviews Transcripts	Audio data
	Headteachers	Structured interviews Transcripts	Audio data
	Class teachers	Structured interviews Transcripts	Audio data
	Teaching assistants	Structured interviews Transcripts	Audio data
	Peers from Y6 Class	Sociometric test - SIS (Frederickson and Furnham, 1999)	Visual data
Summer holidays Independent data evaluations	Participants (At home)	Typed session transcriptions Folders of written work / art work	Authenticity Best practice
	2 Members Ethics Committee	Typed session transcriptions Folders of written work / art work	Authenticity Best practice
3 months later Evaluation of evidence to formulate new theory	Director - Center for Reality Therapy, Cincinnati, US	Informal interview and study of roughly formatted written analysis and diagrams	Authenticity Best practice

CHAPTER 4

THE ANALYSIS CHAPTERS

Through the unknown, we'll find the new
- Charles Baudelaire 1821-1867

4:1 INTRODUCTION TO THE ANALYSIS SECTION

The emphasis of my therapeutic interventions throughout the analysis will be on breaking down each problematic cycle by administering different therapeutic techniques. As I move around each Action, Evaluation, Understanding (AEU) cycle using Wubbolding's (2000) Want, Do Evaluation, Plan (WDEP) format, my aim is to attempt to make sense of each intervention and learn from the resultant positive and negative behavioural changes. Throughout, my emphasis will be upon effecting positive social behavioural change with pre-adolescent loners in group therapy and engaging more effectively in future cycles as a result of my new understanding within the previous learning curve.

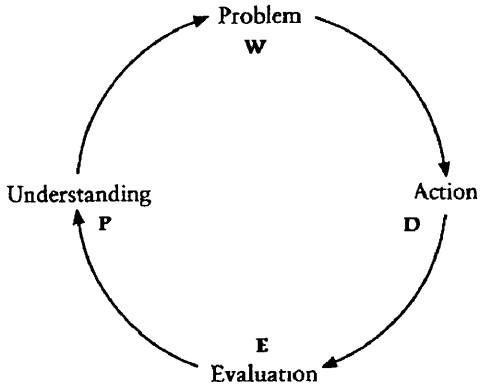

Figure 2: An amalgamation of WDEP within the AEU design

4:2 THE CORE THEMES

The keystone to understanding and developing reality therapy is the acknowledgement of Glasser's (1965) needs structure. Glasser (1965) postulated that all human beings were motivated to fulfil the psychological needs of belonging, power or achievement, fun or enjoyment, and freedom or independence as well as one physiological need of survival or self-preservation. In other words, everyone was driven by five basic needs which dominated total behaviour. An individual chooses functional or dysfunctional behaviours to fulfil a currently unmet need (Glasser, 1965). In taking a thematic

approach, therefore, I felt it was imperative to use the five core needs of Survival, Love and Belonging, Power, Freedom and Fun as a starting place from where I could develop sub-themes within each one. Thus, each separate analysis chapter (5-9) is a development of one of these core needs where sub-themes are contained within.

Reality therapy is a specific system that helps individuals define specific wants related to their five generic needs, evaluate their behaviours and make concrete plans for fulfilling their needs. The sub-themes were thus derived from specific wants / problems which became apparent throughout the course of the programme. For example, the therapy groups were closely observed interacting within the sessions and specific abilities and difficulties were recorded on the Child Profile Format (appendix vii). Sub-themes were also gathered from close scrutiny of transcripts and close analysis of art therapy models, image paintings and drawings, fantasy work recorded by the participants using fairy-tale story-writing and photographs of puppet work. I was deeply aware that my own personal interpretation would always be highly subjective, so meaningful discussion and debate was encouraged with both the participants and the Advisor to the County Council in order to make more valid assumptions.

4:3 INTRANEED CONFLICT

Wubbolding (2000) highlighted the importance of expanding the need system to include intraneed conflict. He recognised that not only can one need conflict with another, but one aspect of a need can exist in a state of tension with another aspect of the same need. Chapter 10 contains all the needs within this study which appear to fall within that category. For example, on the surface 'feeling happy' would appear to fall within the Fun need. Yet 'feeling happy' might also fit as well into Love and Belonging. Likewise, 'achievement' could suggest both the need for Power or the drive towards discovery, which would place it within the Freedom need. There were many times when the participants, the Advisor to the County Council and I could not agree over allocation of sub-themes into the appropriate need. Chapter 10 was created as a compromise.

CHAPTER 5

SURVIVAL NEEDS

To awaken the will is to awaken the feeling that one is responsible to life for something, however grim the circumstances might be
- Victor Frankl 1905-1997

Contents

5:1 INTRODUCTION

Survival is seen as a generic instruction written into the genes of all living creatures (Glasser, 1965; Maslow, 1970). Surviving loneliness, chosen or otherwise, over which a child might or might not have some control, could never adequately be described by looking at statistical data at certain ages or within certain characteristics. The use of non-technical formats, on the other hand, has provided material which is strongly integrative and richly dimensional, as recommended by Wolcott (2001). These have included personal narratives and displays of social behaviour 'off the record' portraying the complexity of the human condition merely trying to survive.

Table 4 illustrates the sub-themes within Survival needs and shows, by means of a cross, those participants who were identified within each sub-theme.

TABLE 4 IDENTIFICATION OF PARTICIPANTS - SURVIVAL NEEDS

SURVIVAL	M1	L1	G1	K2	L2	E2	E3	K3	B3
Inability to cope	X	X	X	X		X			X
Anxiety			X			X		X	
Giving up personal power		X	X				X		X
Stress			X					X	
Self-harming behaviour				X	X			X	
Severe unhappiness			X			X		X	

5:2 INABILITY TO COPE

Problem

(W) Six out of nine group participants displayed an inability to cope in the presence of other children. Group 1 children appeared to be the most vulnerable possibly because, geographically, they were the most socially isolated (Heller and Rook, 2001; Hortulanus *et al.*, 2006). However, it would seem that the children from all three groups were using a wide variety of strategies to mask their worry about how other adults and peers

perceived them. In particular, K(2) and B(3) would employ anti-social behavioural techniques to get themselves noticed by adults and achieve a 'desirable' result. K(2)'s ultimate goal appeared to be obtaining undivided adult attention away from the other two members of the group. However, she was such a complex little girl that building a relationship with her was extremely difficult and time-consuming. She had no trust and her impulsivity made her a difficult child to warm to. Deep vulnerability could be seen in her eyes which were usually wide and scared. She gave momentary glimpses of her inability to cope with others when she would squeeze my hand, giving me the learned non-verbal clue that she wanted more exclusive time alone. As she was a member of a therapeutic group, of course this was not possible. This led to guilt on my part because I instinctively knew, almost immediately, that this would have been the best course of action for such a damaged individual.

B(3)'s agenda was gaining popularity with peers by playing the buffoon to younger children who were not threatening and would not laugh *at* him but *with* him. He was such a sad, lonely boy that he also wanted to form a therapeutic relationship with me very badly. In fact, the bonding sessions became part of his new world. His enthusiasm was electrifying and could be overwhelming. For example, when the sessions were over and it was time to leave, he always lingered behind. After only the second session, I quickly became aware that he was using it as an emotional crutch and an opportunity to display helpless behaviours to an attentive audience:

> "I tried to do my best but I had a bad headache. I'm glad you liked my worksheet. You did like it, didn't you? You weren't just saying it?....Tell me again you liked it.....and can you do up my laces because my head is aching from all the brainwork? I'm pretty rubbish at thinking out stuff." B(3)

On the other hand, G(1) and E(2) coped by retreating into their own private worlds. For G(1), this was a safety net to avoid questions which he knew might cause social concern and ultimately threaten the security of his fragmented family. For E(2) it was one of fantasy and make-believe to disguise his sense of loneliness:

> "I've got masses of mates me. Mainly from the film world. Kids who are cool and have dads who are film stars. I don't need to look for drop-outs from round here. I'm cool, they're cool. I hate it round here."

E(2) lived in a delusional world of his own. By surrounding himself with fantasy and images of greatness - which then became so real that he believed, or pretended to believe - that it was all true, E(2) was able to cope with life as it really was. In hindsight, I should have withdrawn this boy from the group as soon as this became apparent. He was showing severe mental health problems, way beyond the scope of this study. The therapist in me knew this was the most ethically correct action but I was struggling beneath the researcher's hat because I wanted this research to succeed without any hiccups. So I acted in much the same way as E(2), by pretending it was not a real concern, by sweeping my reservations under the carpet for the sake of my science and the sake of my progress.

Action

(D) In the literature, Greenhalgh (2000) described pre-adolescents who were lonely and unable to cope with being this way as often being surrounded by an 'aura' of hopelessness. He described how they may have been put-down by adults and so became accustomed to thinking negatively about themselves and their capabilities. Smith (1998) highlighted that insults, sarcasm and emotional blackmail were 'pitfalls' to be avoided. Thus, the focus of working with the six children who were unable to cope was to empower them with as much personal responsibility as they were able to cope with (Richardson, 2001).

Evaluation

(E) I realised that some participants were exposed to far more risks than others and that some tended to be able to cope with them whilst others failed miserably. My belief was that the participant's own actions and behaviour did much to shape and select the environments they would later experience. In other words, following Glasser's guiding principles (1992; 1998a,b), participants had a certain amount of choice with regards to what happened to them. This choice was in the nature of how they thought about what happened to them and what they chose to do about it. However, as Palmer (1997) argued, 'growing up' meant *having to cope* with new social and cognitive tasks just when major physical and physiological changes were taking place. Kurtz (1996) backed this view, recognising that *expected* increases in independence meant added pressure

just at a time when puberty was beginning. In this situation, I believed that an inability to cope was not a generic characteristic that worked in the same way regardless of the type of adversity. Agreeing with Richardson (2001), I felt that developmental aspects, timing, prior life experiences and social context could all have been influencing factors. It was clear that I needed to build up a deep understanding of each individual in their own right. They might be in a group environment, but every one of them appeared - at this stage - to have their own unique needs.

Understanding

(P) The reality therapy intervention was therefore not designed to take a 'one-shot' approach to increasing the ability to cope. It had to be developed appropriately to meet the developmental and experiential needs of each of the six individuals. The strength of reality therapy in this scenario was that it was so flexible that it could be adapted to suggestions from other disciplines. Working on recommendations by Faber and colleagues (1995), I endeavoured to counteract the negative 'unable to cope' labels which some children may have given themselves by providing opportunities to highlight exceptions to these labels. Subtle approaches such as letting the children overhear something positive being said about them, reminding them of past accomplishments and giving them chances to depart from a limiting role to a new role all had the power to enhance coping capabilities throughout the duration of the programme.

The new learning for me was that I was working with a far more complex set of individuals within the group situation than had been anticipated or planned for. I might need to adapt the programme accordingly and work in a more unstructured way to accommodate quick-decision changes.

5:3 ANXIETY

Problem

(W) The interpretation of the term 'anxiety' as a survival need, for the purpose of this study, was the tense anticipation of threatening but vague events and a feeling of uneasy suspense. One boy from each group was seen to display anxiety traits - G(1), E(2) and

K(3). I observed that all these boys spent an overly-long time thinking about their set tasks; thinking about intrusive ideas that were not relevant to the task and directing attention towards their bodily sensations. They also showed a reduction in task-relevant thoughts during times of anxiety as well as speaking about being unable to concentrate.

Although all three children were very anxious, only one lived in a state of perpetual fear. G(1) had many transcribed comments around anxiety and the therapeutic bond. In the first session, when discussing confidentiality, he stated:

> "I might be able to tell you things when I know it's okay and I can trust you, but I won't talk in school. Too many eyes and ears my mum says.....yeah." G(1)

G(1) was initially terrified to open up about his home background for fear that social services would part him from his mother. He had huge bags under his eyes which he said was due to lack of sleep. His whole persona was hunched up and he seemed to be overburdened with worries. When asked if he was worried, he hesitantly replied:

> "I am worrying that my mother has remembered to pay the electric bill. We had a final notice and I know she gets her allowance from the post office today - if she gets up at all to get it. I do hope she'll be sensible and pay the bill straight away and not leave it, or the money will just disappear..... I know her..... I can't say anymore." G(1)

E(2) had similar anxieties to G(1) because his home life was equally chaotic. Both parents were mentally ill and living apart. E(2) lived with his mother, a virtual zombie through prescription medication, and older siblings who were heavily into drugs, drink and crime. His anxiety about any kind of emotional attachment in therapy would appear to come from a defensive position (Bowlby, 1969, 1973b). I sensed that E(2) had adopted a self-imposed awareness that he should not come too close, so the fantasy life in which he indulged was his way of distancing himself. In psychological terms, his imagination appeared to be able to take him to the emotional core of a difficulty (Greenhalph, 2000) and, hopefully, would lead him through it:

> "Under these clothes are invisible swords to slay enemies and evils which try to hurt me. I can win any battle against any monster as long as my armour is in place and ready for action." E(2)

K(3) was reported as having a need to please by his class teacher and this process naturally occurred in the therapeutic situation. His anxiety was that confidences would be broken and that his parents, of whom he was terrified, would be told what he disclosed:

> "We don't talk a lot in our family. Mum says only fools go blabbing. She warned me to be careful not to tell you how we live. She said she would tell you what she wanted you to know. She'd be very angry if she thought I talked about her." K(3)

Action

(D) I noted another warning sign because lack of trust in the process would hamper positive results. In the literature, Borland (1998) found that most children of pre-teen years appeared happy and would report no more than their fair share of worries. However, it was recognised that some situations, such as illness of relatives, were likely to make a pre-adolescent worried, sad or fearful. I needed to remember that both G(1) and K(3) were adult carers and that E(2) had no responsible adult to care for him. Borland's study concluded that worries, fears or areas of sadness were due to the needs of young people not being adequately met and that children with poor social skills were the most vulnerable. In my study, each of these boys was coping as best they could under the circumstances in which they found themselves. However, in my heart, I reaffirmed that E(2)'s anxiety had developed into something far more sinister and, perhaps, it was already 'too late' to be able to help him in this short time-frame.

Evaluation

(E) Borland (1998) had no therapeutic solution so I needed to evaluate if a reality therapy intervention could possibly help. I felt it might be particularly useful for K(3) who used hypochondria as a way of expressing his needs. He had insisted during early therapy that the windows had to be opened for fresh air or closed in case he caught a cold, according to his mood. He was unable to relax because even the chair he was sitting on could collapse and cause him injury or be full of unseen germs. So great was his fear of infection that he lifted or carried objects with deliberate care. A key strength of reality therapy is that it can be adapted to almost any circumstance or need.

The first step in the intervention in these circumstances was to 'connect' K(3) with his Quality World (Wubbolding, 2000) so that he would recognise that he had an excellent health record, unlike his father. A discussion was encouraged so that K(3) could recognise the links about why he was full of intrusive and disturbing anxiety about his well-being. Through an improvised psychodrama with his group, he was guided to make a clear distinction between these fearful events and his pervasive anxiety about his own health. The psychodrama was based on defeating fear with FEAR (Face Everything and Recover). The principle of facing up to fear until anxiety reduces is one of the cornerstones of reality therapy and, indeed, the whole cognitive-behavioural movement (Temple, 1997; Glasser, 2000; Wubbolding, 2000; Friedburg *et al.*, 2003). This was successfully implemented by discussion alone with G(1).

Understanding

(P) Successful outcomes were achieved at Groups 1 and 3 because the participants *wanted* to change. However, E(2) deliberately tried to sabotage any discussions pertaining towards him and pointedly refused to participate in psychodrama. This highlighted that reality therapy will only be successful when there is a willingness to participate. I believe that E(2) was too fearful of 'being exposed'. He was safe in his own make-believe world where no-one could challenge or hurt him. For me, a sense of guilt prevailed again as I realised that psychodrama might not have been an appropriate measure to use with such a damaged child. I should, perhaps, have concentrated on more mainstream approaches because psychodrama was a powerful tool. Had I, in fact, even added to E(2)'s insecurity and subsequent anxiety by being so thoughtless? What was the compulsion to use different therapeutic tools? Was I afraid that my study might be deemed not good enough, not exciting enough, not creative enough? If this was the case, I am indeed guilty of using the participants for my own ends.

5:4 GIVING UP PERSONAL POWER

Problem

(W) The theme of giving up personal power was of significance for Groups 1 and 3, where two children from each group were identified. Personal power fitted under the

survival 'umbrella' rather than the power need because loss of personal power proved to be a very desperate situation for the four identified participants. I felt that what these children experienced as their sense of being a person was made up of a series of badly thought out ideas about who they were, what their life was and what the world was. These constructions did not appear to be an accurate reflection of reality but a set of guesses about reality. When life had gone along as the participants had expected it to go they assumed their set of guesses was an accurate reflection of reality but, whenever they discovered that they had made an error of judgment, they felt the threat of being discredited as a person.

L(1) frequently displayed how he needed to keep in control by being reticent to bond within the group. Control or lack of control proved to be a big issue throughout the sessions. He felt that by engrossing himself in the therapeutic intervention his personal power would be diminished:

> "I don't always feel in control whilst I'm doing this stuff, even though I have to say it's usually great fun - as long as we don't have to be *that* nice to each other. But losing control bothers me. It's like being hypnotised, I imagine. Things happen and you just let them. I don't feel comfortable with that..... so maybe I shouldn't get too involved." L(1)

G(1)'s thinking was on a similar wavelength to L(1):

> G(1) "....it's down to me. I do it all. Don't mind, but got to keep my wits about me and be very careful. I do have a purpose to all this graft you know."
>
> R "What is that exactly?"
>
> G(1) "Keeping my family together. What's the point of being alive if you are taken off them? Who would I have then? The trees?"

None of the children from Group 2 had an issue about giving up personal power because all reported feeling powerful in their own right. Each child projected an aura of self-confidence and a self-belief in their own importance. It was often difficult to conduct a session successfully with this group when there was continually a clash of very individual personalities all jostling to make their own special voice heard:

"Other kids are afraid of me in this school because I belong to a gang and because I have what it takes..... and I ain't losing it either. Can't handle me they can't." L(2)

"I am omnipotent. The super hero. You stupid people better respect that!" E(2)

"What I say goes at home. My mum does what I want or I just scream until she does. I like my own way. No-one tells me what to do or say." K(2)

E(3) enjoyed being indulged by others and being on the receiving end of surprises and treats. She willingly relinquished her own personal power in order to play a feminine submissive role:

"If K(3) or B(3) want to look after me then that's fine. I love being looked after. Having doors opened for you and all that malarkey. My gran says it should be expected and that is how I want to be treated." E(3)

B(3) had many issues under this theme, stemming from fear of his father, who ran the household like a police training school. He would often reiterate that he did not want his dad to know anything about the confidences he might choose to share:

"I get quizzed about everything. They want me to repeat almost line by line what everyone said and then what you said. Firstly, I can't remember and secondly, even when I can, I don't want them to know anyway. But they make me feel like I *must* say, like they are still in the police and they have to know." B(3)

Action

(D) In the literature, Friedburg and McClure (2002) classed children who put up defences as often being bitter about the world and suffering from a profound mistrust of other people. They found that such children often shared maladaptive assumptions about other people being selfish, only caring about themselves and taking advantage of everyone else, which enhanced their own sense of loss of personal power. A strength of reality therapy intervention in these circumstances would be that its 'evidence-based assumptions' could be put into practice. Kendall (2000) suggested gathering 'evidence' that supported these views that people were uncaring. Stallard (2002) added that the

reality therapist would then enquire whether the few examples the therapist might have were sufficient *evidence* to generalise about the rest of the world. The reality therapist would then suggest that the young person 'tested' a few more people to see if their assumption was totally accurate (Kendall, 2000; Stallard, 2002).

Evaluation

(E) By following this course of action, I found that I was able to challenge the children with negative thinking errors and enable them to examine their negative thoughts more closely by self-evaluating:

- Can I prove that my thought is 100 per cent true?
- What are the effects of thinking this way?
- Is my thought wholly logical or sensible?
- Would people whose opinions I respect agree that this thought is realistic?
- What evidence exists against this thought?
- Is my thought rigid or extreme?
- Am I thinking realistically or are my thoughts being biased by how I feel?

Another strength of reality therapy used in this way is that this procedure is simple but not simplistic (Glasser, 1969, 1972, 1985; Wubbolding and Brickell, 2000). I asked them to consider their negative or unhelpful thoughts in the light of the preceding questions, encouraging them not to give glib 'yes' or 'no' answers. Instead, I emphasised the benefit of thinking things through and writing down challenges to their unhelpful thoughts.

Understanding

(P) The next step would be crucial to raise social competence and self-worth. I asked the participants to generate alternatives for each unhelpful thought, attitude and belief by writing down a flexible, non-extreme, realistic and helpful alternative. The questions were designed to generate some alternatives to their current understanding:

- What is a more helpful way of looking at the situation?
- Do I encourage friends to think in this way?

- When I am feeling okay, how do I think differently?
- Have any past experiences shown me that another possible outcome exists?
- What is a more flexible or less extreme way of thinking?
- What is a more realistic or balanced way of thinking that takes into account the evidence that does *not* support my thought?
- What do I need to think in order to feel and act differently?

I explained to the children that some thoughts were more stubborn than others, and that they would not turn their thinking around completely in one go. I also encouraged them to think of themselves as *training* their minds to think more flexibly and constructively. However, through taking this course of action, I came to the realisation that some intrusive thoughts were actually made worse because catastrophic thoughts did not pass through everyone's minds but were instead challenged. It was hard to accept that reality therapy did have weaknesses and was not always going to be the magic answer in every situation. My learning has been that I need to reflect more at the onset of therapy rather than when it is too late and be less driven by my enthusiasm.

5:5 STRESS

Problem

(W) One boy from Group 1 and another from Group 3 were identified as suffering from stress. Both boys had similar situations and backgrounds as both were the carers for dependent adults and were shouldering highly inappropriate levels of responsibility, it would seem, at far too young an age. Neither boy reported enjoying any sense of childhood. For example, in sessions with Group 1, L(1) and M(1) generally displayed irresponsible and attention-seeking behaviours whereas G(1) was often unresponsive. Often he would look miserable and be deeply pensive:

> "I feel like a snowman sometimes. I can't move because the snow is binding me, and not always wanting to move because people like snowman, and that's a nice feeling. But then things happen, like the sun coming out or other people tampering with me, and I'm ruined." G(1)

Greenhalgh's (2000, p.1) 'frozen landscape' proved to be a very appropriate and accurate description for him and often G(1) and those who worked with him, strove for distraction from the stress which would, at times, overwhelm him:

> "I get all the best jobs in class. Mr.....seems to really rely on me to help with people not so cool at maths. It makes me feel good that and helps me forget some things which don't seem to go away and stress me right out." G(1)

K(3), who played a significant role in caring for his disabled father, would sometimes appear tearful and, at other times, be bad-tempered or snappy. Seemingly more emotionally vulnerable than G(1), often he would become troubled or withdrawn:

> "I don't know what is the matter with me today. It's like a windmill is going around and around inside my head. I'm confused and upset, but for no particular reason. I just feel like a mountain of pressure is rolling onto me and I'm getting buried underneath." K(3)

Action

(D) In the literature, Heller and Rook (2001) identified members of a child's social network as causing extra stress or forming a basis for negative social comparisons. They categorised these relationships as burdening and limiting. The answer in Bucholz's (1997) view was to change the stressful situation. However, in both cases, this did not appear to be practically possible. It would seem to be only on a psychological level that any change could be pursued.

Leahy (2004) suggested that a stressful situation could be altered by changing its meaning or by alleviating the emotional reactions to it. Several writers, in the literature, suggested that social relationships contributed to psychological well-being, regardless of the stress level (Billington *et al.*, 1998; Wells, 2002; Ledley *et al.*, 2005). By reinforcing social competence, maybe the 'chores' could become less wearisome (or even fun) if a friend came along to help push the wheelchair and give moral support to K(3) or helped G(1) to share some of the responsibility by simply 'being there'.

Evaluation

(E) My concern was to work specifically with G(1) and K(3) on their feelings and behaviours associated with their extreme stress levels. I evaluated that different issues affected each boy in various ways and how they dealt with stress was unique to that individual. The intervention was formulated around a belief that stress might externalise itself in many forms. Whether the stress was manifested from school related issues, family, past experiences or future concerns, it all had a way of creating 'knots' inside the participant's mind and body. G(1) and K(3) might have had a picture in their head of being freed from their familial afflictions, though they would have yet to clearly self-evaluate whether what they were doing was working. It seemed that they were trapped within a cycle of ineffective behaviours that kept them returning to their unresolved issues because they had not confronted the pain. Bringing these issues into their awareness might cause them more pain in 'the short run' because they would have to spend so much time and energy repressing them. Then they would confront the issue, and the pain they had worked hard at repressing would filter into their body and mind.

A strength of this reality therapy process is that it can help children unfold underlying thoughts and behaviours that have been helping them squelch these issues and find a way to live with them, extinguishing the fear within their mind. By continual self-evaluation, G(1) and K(3) would be able to bring their fear closer and closer to themselves and observe all the actions, feelings and psychological effects that they had been using to push it away. Having unlocked the fear of facing this issue, they could then begin to reorganise their behaviours, having increased their ability to evaluate whether what they had been doing had actually been provoking more pain and anxiety 'in the long run'.

Understanding

(P) It was realised that to aim to eliminate stress from the lives of the participants completely was unrealistic, but this should not be viewed as a weakness in the therapy. Rather, I hoped that they could learn how to experience each moment as it unfolded and understand the stress so they would have more control over choosing their behaviours when they were feeling pressurised. For my part, I needed to ground myself. Change *was* possible but there were certain dynamics over which *I* had no control. G(1)'s

mother was not suddenly going to make a miraculous recovery because her son was having therapy; K(3) was still expected to help his mother in the caring role. The best which I could hope for would be that the *acceptance* of the stress and acceptance of *help to alleviate the stress* would lighten its burden for these two boys. My heart went out to both of them and I needed to remind myself that I was their therapist, not their mother. At times, I had to force myself to step back from becoming too emotionally involved. That could never, should never be my role. Any transference issue between this situation and that of my own vulnerable son, whom I was unaware needed help until it was too late, needed to be reflected upon and learnt from.

5:6 SELF-HARMING BEHAVIOUR

Problem

(W) Two participants from Group 2 and one from Group 3 were identified under this theme from their displays of impulsivity and immaturity which created constant crises. Being somewhat blasé about self-harm - perhaps to shock - the Group 2 girls described their situations in relation to the physical environment:

> "This room is like where they shoot up on the landing at home. I like sticking a compass in me wrist..... don't look so shocked, I ain't on heroin yet" K(2)

> "The place is a dump but no different to anywhere else. Everywhere I hang out or have to be is filthy. Hang on, if I bite myself so I bleed - and rub the wall - ha, ha, it's even dirtier now!" L(2)

K(3) was the only other group member who had indirect thoughts pertaining to self-harm. When talking about his life with his father, he made a reference to the word 'hang' and was unnervingly fond of using this inference in many statements during the course of our time together. For example, he described his home as:

> "empty, no life, no colour. Sort of place you could hang yourself." K(3)

His non-existent circle of friends was depicted with equally depressing description:

> "I'll be swinging from the rafters, at the rate I'm going, before I even get one good mate. Oh well, at least he can cut me down!" K(3)

Action

(D) In the literature, Katz (1995) emphasised that it was important to utilise what the pupil brought to the session. K(3) brought very little but there was much scope with the two Case 2 participants. Long (1996) and Wubbolding (2000) went further, agreeing that rather than challenging the merits of a stated goal, the reality therapist could encourage a young person to assess whether their current social behaviour was helping them reach that goal. Glasser (2003) added that children identified as showing extreme thoughts or behaviours would feel best about themselves and their abilities when they were meeting meaningful challenges and putting in some real effort.

Evaluation

(E) For both Group 2 girls, an occupational hazard of reality therapy was to recognise that, despite sincere efforts, good ideas and desperate intervention, these two girls would probably not be amenable to favourable responses because they were historically too damaged or committed to destroying themselves. Together with the dreadful physical environment in which therapeutic work was expected to take place (and recognised by the girls themselves), I evaluated that an unflagging optimistic and idealistic attitude was necessary in order to never give-up. There was also a realisation that some pre-adolescents required more time before they would begin to use, rather than continue to abuse, their potential. Concern for the welfare of L(2), K(2) and K(3) meant assuming an unconventional approach because there were times when it was necessary to intervene to protect the children from harming themselves. Much strength was needed not to be consumed or destroyed by the rage, anger and sadism of the two girls from Group 2 when they felt hurt or betrayed by each other or by E(2). Once the three children had been helped to experience some of the strong emotions associated from their pasts, the focus of the therapy would be to question them with regard to beliefs which could be troubling them, The aim was for the three children to be able to discard self-destructive beliefs and to replace them with more adaptive beliefs.

L(2)'s self-destructive belief was that she was no good, and that is why her father assaulted both her and her mother. Unfortunately this belief was reinforced by her recognition that she was not liked at school and that her relationship with her mother, for whom she had no respect, was dependent on her being 'nice'. L(2) was encouraged

to look at other pre-adolescent behaviours and to recognise that all children were sometimes 'nice' and sometimes not. Working on replacing L(2)'s self-destructive beliefs by more positive beliefs included work on her self-esteem. This was done by providing her with evidence of her strengths discovered during the therapeutic process, by using reality therapy worksheets and providing opportunities for creative expression.

Understanding

(P) Initially, the reality therapy intervention was viewed by both L(2) and K(2) as an 'enemy scheme' which was designed to deprive them of their pleasurable pay-offs. Therapeutic efforts to provide a corrective emotional experience were perceived as interfering and being intrusive. The girls were unable to bond or even 'collaborate' therapeutically because of their distain for each other, coupled with disrespect of adult authority. The intervention tried to adopt active and directive techniques to convince them to channel their intense, potentially annihilate feelings into constructive and creative activities. However, this was largely to no avail. The therapy appeared to be too weak for such profound abnormality within Group 2.

My personal feelings also played a significant part. I found it difficult to have empathy with two females who showed such utter disrespect towards me. I wanted to revert many times to my previous occupation as a primary-school teacher and discipline them. My therapeutic principles of unconditional positive regard were often challenged and pushed to the limit. I approached the sessions at Group 2 with dread because I had no idea what new drama would be waiting for me. I simply did not want to be there. I am sure that my negativity must have surfaced, even though I did my best to act positively. I also hated being in such a depressing physical environment. How could I expect positive behaviour when the setting I had agreed to had no respect for its inhabitants?

It was different with K(3). He had a quiet dignity and we met in a convivial atmosphere. It was so hard to remain objective and set my personal feelings to one side because I enjoyed being with him and he found the therapy helpful, despite bringing little to the session (Katz, 1995). But was this not something more to do with *my* attitude towards him and the pleasant surroundings? Was it therefore me personally who was influencing

- directly or indirectly - success or failure in the therapeutic alliance? It was important that I address these thoughts and dilemmas with total honesty.

5:7 SEVERE UNHAPPINESS

Problem

(W) One boy from each group was identified as displaying symptoms of severe unhappiness. G(1), E(2) and K(3) were sometimes observed mentioning to others how unhappy they felt when, in fact, they might have been feeling dispirited, disappointed, irritated or sad. On the other hand, it is possible that one or all of the boys might have been more severely affected as 'victims' of reactive depression, which could arise when a person had a personal reason in their life to be depressed.

G(1) was not allowed to be a child. He lived as an adult, was unable to play and had 'the world on his shoulders'. Goossens and Marcoen (1999) pinpointed the experience of sadness as closely related to unhappiness and that seemed to be true with this boy:

> "It's such a shame my mum can't be like other mums. It makes me feel down too when I watch her looking so miserable as she lies around all day. I want to make it right for her, but I can't." G(1)

> "I feel so very unhappy when people are mean to our family. We try hard to be a good family, but lots of people don't seem to really understand and that makes me feel really sad." G(1)

E(2) came from a family history of depressives and lived with his mother who had bipolar disorder. Unlike G(1), who took control of his situation by assuming personal responsibility, E(2) was unable to follow this course of action. Being the youngest of a large dysfunctional family may well have contributed to E(2)'s sense of hopelessness and inability to personally make changes. It appeared to be easier to fantasise than face the stark reality of his lack of care and powerlessness to change his grim situation:

> "You don't want to see my house! Man, it would stress out the Pope. Nobody does any clearing up so it's dirty, well filthy and I can write my name in the dust on our sideboard. I can feel my mood go down to my shoes when I get home from school. I tried to tidy up one day and got clobbered for it. Ughhh! ...I prefer the company of my little friends from other planets than stay there." E(2)

K(3), as carer to a disabled father, was desperately lonely. Unlike G(1), who appeared to be a 'natural loner' (Rapport *et al.*, 2001), K(3) minded very much that his situation dramatically reduced his opportunities for social interaction. His limited emotional capacity, coupled with a very low opinion of himself, meant that he was unable to cope with any form of criticism or peer rejection. Whereas G(1) would cope by brushing off negativity towards himself and E(2) would retreat into his own world to avoid reality, K(3) appeared to take the full brunt of his hurt and anguish head-on :

> "If I was a new boy coming to my school, the last person I would want to associate with is me. I can never think of things to say at the right time so people walk on and find someone more interesting." K(3)

> ".....shouted at me in the playground that I was a loser. I went into the toilets and cried. It was like a knife going into my body." K(3)

Action

(D) In the literature, Sullivan (1953) and Weiss (1973) recognised that deep unhappiness caused through loneliness could be a 'driving force' that motivated young people to initiate social interactions, despite the anxiety such interactions might hold for them. Larson (1999) did not agree, contending that true unhappiness could only create a state of hopelessness and unalterable futility. Maybe the social climate, which has inevitably changed since the earlier studies, means this is true. However, Glasser (2000, 2003) would dispute Larson's findings and agree with Sullivan (1953) and Weiss (1973). A strength of using reality therapy in this scenario would be that it emphasises the meanings unhappy people attach to events and is able to break down specific problems to look at new ways of thinking about that problem. It was important to ascertain thoughts about some bad choices and missed chances of friendship.

Evaluation

(E) To find out how each boy felt about what had happened required careful listening, with the attitude that what each boy had to say held great importance. The participants were told that unhappiness arose from the way they lived their lives. The strength of this way of thinking was that, if unhappiness was something which in some way the children

had created, they could change and cease to be unhappy. The first way to begin change implementation was to examine the meaning which each participant attached to any sort of event. This influences the emotional responses they have to that event. Positive events normally led to positive feelings of happiness or excitement, whereas negative events typically led to negative feelings like sadness or unhappiness. However, I explained that the meanings they attached to certain types of negative events might not be wholly accurate, realistic or helpful. Sometimes, their thinking might lead them to assign extreme meanings to events, leaving them feeling disturbed. The word 'disturbed' was used to describe emotional responses that were unhelpful and caused significant discomfort. It meant that an emotional or behavioural response was hindering rather than helping them to adapt and cope with a negative event.

I then explained that the way they might think and feel also largely determined the way they acted. If they felt severely unhappy, they were likely to withdraw and isolate themselves. However, if they were just anxious, they might want to avoid situations that they might find threatening or dangerous. Their behaviour could be problematic for them in many ways. For example, they might experience isolating and mood-depressing behaviours such as staying in bed to excess or actively not seeking friends which would only go towards increasing their sense of isolation and maintaining their low mood. Or they might use avoidance behaviours such as avoiding situations they perceived as threatening. This could be events such as attending a social outing or speaking aloud in class, depriving them of the opportunity to confront and overcome their unhappiness.

Understanding

(P) A strength of this type of reality therapy intervention is that by discussion and writing down their problems, participants were able to differentiate between thoughts, feelings and behaviours and the *trigger* event. This was the *activating* event, the real external event that had occurred, a future event that they anticipate occurring or an internal event in their mind, such as an image, memory or dream. From identification of the activating event, the participants were encouraged to study their *beliefs*. These might include their thoughts, their personal rules, the demands they made on themselves, the world and other people and the meanings that they attached to external and internal events. Lastly, they thought about *consequences*. These might include their emotions,

behaviours and physical sensations that accompanied different emotions. Thus, the reality therapy intervention was able to successfully emphasise the role of the personal meanings that the three boys gave to events in determining their emotional responses.

In critically analysing my role as therapist, I would conclude that I was trying to implement perhaps too much text-book therapy in situations where too many variables came into play. On reflection, I could not successfully apply the *same* therapy to a boy who accepted his lot, one who was in total denial of his problems and another who broke his heart over the most trivial of scenarios. G(1), E(2) and K(3) had very deep, contrasting problems which they dealt with in different ways. My main difficulty was that I was aware that the therapy was having no impact on E(2). He did not want to listen. Maybe he *could not* listen and maybe I did not appreciate that well enough at the time because, by the end of the session, I had grown tired of his negativity. I need to recognise and learn that successful therapy *has* to be a two-way process. With G(1) and K(3) it was. With E(2), I felt no further forward at all. I believe that I mirrored the same pattern as E(2) and gave up too easily. It was, maybe, the easier option to generalise that he was beyond help. I need to be aware of this in my future alliance with this boy.

5:8 SUMMARY

Analysis of this theme has already identified many differences between the group members and how they reacted to participation in various reality therapy interventions during the course of the designated programme. The loose structure allowed this to happen and has illustrated that therapist flexibility was essential to meet need as and when it appeared. Very few of the reality therapy interventions described in this chapter were planned in advance. I attempted to 'go with the flow,' as all experienced therapists are encouraged to do, in order to give maximum benefit to each participant. I have not given up hope for any one of them yet, although there were times when the therapeutic bond, which I tried so hard to develop, was tested to its maximum. Maybe this is why my reflections have shown that I am still too rigid in my approach at times and perhaps not always mindful enough that each child is a unique but damaged individual.

This chapter has also highlighted that I was becoming too emotionally involved at times, especially with vulnerable boys such as G(1) and K(3). Even as a committed cognitive-behavioural therapist, I cannot afford to be blinded by possible transference and counter-transference issues, and I must remain vigilant to that possibility.

CHAPTER 6

LOVE AND BELONGING NEEDS

He who is unable to live in society, or who has no need because he is sufficient for himself, must be either a beast or a god
- Aristotle 384-322 BC

Contents

6:1 INTRODUCTION

In those parts of the world where survival is taken for granted, the need for love and belonging is a prominent area of dysfunction. Creatures high on the evolutionary scale attempt to congregate and have the need for belonging. Because of this need, Wubbolding (2000) argued that human beings were able to learn to co-operate and function as a unit. In his view the family unit, the school, outside clubs and religious organisations could be seen as among settings where young people could attempt to find belonging (Wubbolding, 2000).

However, Badr *et al.*, (2001) disagreed with this perspective as being too general, highlighting in the literature that pre-adolescent 'loners' were unquestionably more self-dependent and less able to fall back on traditional social connections. Heller and Rook (2001) agreed, describing the character of society as changing as more and more children become socially isolated, and observing that the effects showed themselves in dealings between this small section of the community and the general social environment. Also backing this view, it was noted by Galanaki (2004) that many of these particular children were thrust into trying to cope with many different role patterns and expectations when their own role models and personal circumstances were chaotic.

Glasser (1972) recognised that, as we are no longer living in a society consumed with mere survival, we should be seeking to fulfil our identity needs. Healthy relationships could be externalised in many ways such as parents modelling appropriate behaviours and providing a secure atmosphere for children. In his current teaching (1998a, 1998b, 2000, 2003) Glasser also emphasised the importance of focusing on relationships in all therapeutic interventions. Whether the relationship was at home or at school, he emphasised the *quality* of a relationship as fundamental (1998a, 1998b, 2000).

In this study, a wide range of behaviours sprang from the desire of the participants to connect with each other, even though many of these connections were socially inappropriate. When emotions were not contained, the results could be extreme. Table 5 overleaf has highlighted these sub-themes and identified the participants within each category.

TABLE 5 IDENTIFICATION OF PARTICIPANTS - LOVE AND BELONGING NEEDS

LOVE & BELONGING	M1	L1	G1	K2	L2	E2	E3	K3	B3
Withdrawal		X		X		X		X	
Lack of co-operation				X	X	X			
Inner rage				X	X				
Attention seeking	X	X		X	X	X	X		X
Violence - striking out		X		X	X				
Desperation for friends	X	X				X	X	X	X

6:2 WITHDRAWAL

Problem

(W) Four out of nine participants demonstrated withdrawal issues around a sense of love and belonging. It seemed that when the children in all three groups were dealing with strong emotions or difficult issues, they tended to naturally deflect away from dealing with their pain or they withdrew into silence. For example, L(1) was a natural loner who found integration into the group particularly harrowing. He found it difficult to mix and was reluctant to share either his time, his thoughts or his material possessions with the other members of the group. I honed in on his love of fishing, a solitary pursuit, in order to facilitate his imagery and hopefully enhance group rapport:

R "I see from your clay models that you like fishing."

L(1) "Yeah....(long pause)....especially trout fishing."

G(1) "Aren't trout easier to clean than some other fish?"

L(1) "You're right. It's because they don't have scales....I just take my knife and cut up their belly from the rear to the gill. I strip their guts with one swipe."

I also interpreted the unobtrusive question by G(1) as authentic involvement between a very withdrawn individual and another group member who was isolated from a slightly different perspective. It was exactly the type of interaction I wanted to encourage.

Likewise, E(2) was another boy who deliberately distanced himself by refusing to have anything to do with the clay modelling process, making excuses such as saying it felt 'disgusting' to touch and made him feel sick. Withdrawing to a world of fantasy was a much safer option. He tended to live in his fantasy world even when in the group situation and seemed reluctant to do anything which was real or challenging:

> "I will not touch that clay. I don't like doing things, only thinking things." E(2)

K(2) was so threatened by social interaction that her usual ploy was to sabotage it. She refused to make eye contact and the only time she interacted in any way was to join forces with another group member against the third one. Her need for sabotage appeared to come from extremely low self-esteem, which almost inevitably affected her adversely whenever she experienced troubling events or trauma. I suspected that her outlook on life was possibly linked to previous abuse:

> "It bugs me when you smile, L. Everyone has a shit life, so why are you smiling? Me and E don't do smiling, do we E? No-one likes him and everyone hates me, so I don't smile, no, no." K(2)

K(3), on the other hand, experienced feelings of withdrawal through a different perspective again. The whole experience of group interaction had overwhelmed him as he was not used to sharing ideas and having his contribution dismissed by other group members. When he was asked to interact as a group to write a rap song, he was totally unable to cope. He ran into the toilet and refused to come out; his behaviour appearing to be influenced by deeply-felt insecurities and family responsibilities which were overburdening him:

> R "Can you explain to me how you felt when you were asked to interact with the others?"
>
> K(3) "It's just something that comes over me.....I feel vulnerable.....as if the others will be able to look inside me and see I'm a load of rubbish..... If I join in, I'm setting myself up to fail."
>
> R "You are using very adult language. Has anyone told you those things?"

K(3) "Mum, Dad, Gran...We don't need anyone else, they always say. Best just take care of ourselves."

R "That isn't strictly true, is it? You seem to be the one doing a lot of the caring."

K(3) "My mother screams at me when I say things like that.. I have to cope at home but at school, when I'm back to being just me, I go to pieces and the sharing stuff gets too much, so I do what I can't do at home, hide away."

Throughout the programme, I was able to observe that all three boys dealt with supposed threat by withdrawal such as hiding, daydreaming or refusing to talk. Interestingly K(2), who was the only girl in this category, displayed somewhat different emotional behavioural traits in that, whilst still extremely withdrawn, she delighted in being physically destructive. E(2) was destructive only in fantasy, slaying many enemies on his computer, but this did not mutate into the world of reality. L(1) assumed his power by catching fish, putting himself in control of their destinies.

Action

(D) In the literature, Winnicott (1965) described how it was essential to develop a capacity to join in, to contribute and to benefit from various group activities for healthy social maturation. However, Youngblade *et al.* (1999) recognised that these social skills were not always easy to master. Clay modelling of families was therefore introduced into the reality therapy programme to examine these viewpoints, promoting discussion about each child's perception of love and belonging within their families through a practical activity to encourage creative expression.

Evaluation

(E) The reality therapy intervention was successful with Groups 1 and 3, with both groups verbally interacting and bonding in the process. (An artwork example is illustrated in appendix xiii). However, the clay modelling did not achieve the desired effect with Group 2 school, in particular with E(2). L(2) and K(2) regularly ganged up on him, making fun of him and calling him 'uncool' and a 'loser'. This was particularly

noticeable during the clay work because E(2) would have nothing to do with touching the clay. During this group conflict, E(2) turned to me for support, stating he was no good at doing that type of activity, before withdrawing into his shell through body language and refusing to speak anymore. Harmony of a kind was restored to the group, on this occasion, by my suggestion to make a sculpture which would convey how E(2) was feeling at that moment. He was angry with the other two group members and proceeded to pound the clay into the shape of a boy with his head turned away. A conversation then proceeded:

R: "What was it like to make a sculpture of you feeling.....like you do right now?"

E(2) "My sculpture boy is telling the other two monkeys in this room to get off my case. He is angry like I am."

I evaluated that, by exploring E(2)'s current experience through reality therapy, I could help him to get in touch with his 'here and now' experience and provide an opportunity to tap into his current feelings and thoughts. By sharing his feelings and experience, I hoped that his sense of withdrawal from the group would be removed and that he would be given a purpose. This was partly achieved within this intervention, but it was limited in success by time restrictions when taking into account the severity of the withdrawal symptoms.

L(2) successfully created a family montage but was unable to share experiences with the other group members as K(2) likewise had issues which surfaced during this intervention. A group of family members was quickly assembled in rough form, with little thought for defined features. Almost as quickly, K(2) smashed every single model to pieces, flattening completely the replica of her father and then spitting on it. When asked to express how she was feeling, she withdrew eye contact and formed herself into a small ball, making a squealing sound and rocking herself backwards and forwards. Despite being clearly distressed by the experience, she refused all tactile or verbal support and remained totally withdrawn until the end of the session. This type of interaction would appear to have been too forceful at too early a stage with a child psychologically damaged to this magnitude. I can therefore conclude that art therapy

within a reality therapy intervention can be highly successful with children not experiencing a deep sense of withdrawal. The 'socially phobic' type, identified by the Mental Health Foundation (1999) and Long and Averill (2003), certainly applied to K(3) as he avoided social interaction because of an irrational fear of drawing unwelcome attention to himself. However, by talking about his creative work, K(3) found that he was able to break down his irrational beliefs and enjoy the praise given by other group members.

Understanding

(P) The use of powerful art therapy was inappropriate to use with those most psychologically vulnerable and, in fact, possibly increased their tendency to withdraw still further into individual defence mechanisms. Kopp (1989), Cohen (1993), Smith (1998) and Galanaki (2004) had all identified the capacity to be alone as perhaps the 'acid test' of mental health and it had become clear that E(2) and K(2) were both unable to deal with their solitude. They handled their defences differently but both coping mechanisms were, in themselves, self-destructive. In both cases withdrawal behaviour might, at times, have been adaptive because it helped them to cope. However, such avoidance interrupted the therapeutic process and could be observed as the child's resistance. When this resistance occurred, I had tried to be careful not to pressurise either child to continue, but instead help him / her to deal with the resistance in an acceptable way. In the case of K(2), after the clay work session had officially ended, a one-to-one conversation, using reality therapy techniques, was initiated to explore further the relationship with her father and her painful reactions. The intimacy of this conversation revealed a child protection issue, where confidentiality had to be broken so that outside agencies could intervene. In cases of this extremity, a weaker therapeutic intervention may not have had the ability to 'draw out' such an important revelation.

I am aware though that this cannot be used as an excuse. My personal learning has been that I was too forceful and rigid in my belief that this form of art therapy could break resistant behaviour, without consideration that maybe it might just break the vulnerable child instead. My own child had loved working with clay - but these were other people's children. They could not, and should not, have been compared.

6:3 LACK OF CO-OPERATION

Problem

(W) All children from the three groups showed an immense need to be liked and to feel a sense of belonging. However, the ways in which this was projected varied immensely and identified a total polarisation between Groups 1 and 3 and Group 2 in attitudes. Lack of co-operation was never a problem with either Group 1 or 3. The children were always welcoming and often would display visible signs of excitement when I appeared on site. Despite a range of social and emotional difficulties within both groups, there was a good friendship bond between group members, growing weekly as the sessions progressed. Likewise, there was an equally strong therapeutic alliance with both groups and a respect for boundaries. For example, M(1) would wear her 'special clothes' to our meetings, which she clearly welcomed:

> "Can you come in more often than once a week? I don't mind what we do as long as we can meet as a little group like this. It's so cosy." M(1)

E(3), who loved art, would bring in cards which she had made at home with pressed flowers or a poem to say 'thank-you'. B(3) showed his enthusiasm by waiting at the school gate in order to be the first to spot my car. In fact, E(3) and B(3) were so willing to please that I felt their enthusiasm was, at times, almost too overpowering.

L(1), G(1) and K(3), whilst socially isolated from their peers, spoke of finding security and having fun within the group dynamic. Even K(3)'s shyness and feelings of being sometimes overwhelmed did not prevent him from showing enthusiasm at each therapeutic meeting:

> "It is so lovely to be really listened to. The other two never make fun of me and I feel I can say what I like without worrying I'll be sneered at. That's worth a million pounds to me." K(3)

Group 2 could not have been more different. The participants were all too busy competing for attention to worry about boundaries or respect. Many of the sessions were sabotaged through appalling behaviour because the participants did not like each other and did not want to work together in a group. I noted that their negative behaviour

seemed to draw them temporarily together because it gave them a distorted sense of belonging in that they were all being so disruptive. Often at the start of a session one or other of the group could not be found because they had decided to run off or simply could not be bothered to remember to attend. I observed that their need to be liked was so intense that usually, when one member was being particularly difficult, the other two would 'play the good guy'. On one occasion, K(2) overturned a desk when asked to participate at the start of the puppet show. This act of defiance led L(2) and E(2) to join ranks and act like 'a pair of little angels' for the rest of the session. In another incident, K(2) impulsively threw pencils across the room because she could not see the point of the worksheets. When 'the point' was calmly explained, she settled down and actually enjoyed the session. This, in turn, caused L(2) to vie for attention as she could not bear to see K(2) being praised for her efforts:

L(2) "If I do what she done, do I get treated real nice like her?"

R "You've been fantastic today. Let me see your sheet."

L(2) "No, I'm going to screw it up. Then you can be nice to me too when I have to put it right. Hey, E.....am I better than K? Prettier? Cleverer? Less fat? That ain't hard mind."

However, the two girls were not the only misbehaving participants. On one occasion, E(2) left his desk to go the cloakroom and threw water from a pot over the other two who were, at this point, sitting quietly filling in worksheets. This caused a punch-up and much verbal slang. When E(2) was separated and held until the situation had calmed down, he was asked to explain why he had felt the need to upset the group dynamic:

"No point just sitting here writing. I like real action like the computer men. I couldn't see the point so I thought I'd have some action like them." E(2)

Action

(D) In the literature, Temple (1997) and Friedburg and colleagues (2001) identified that the sharing of private thoughts and feelings with another person was a key step towards intimacy within group work of socially isolated individuals. Following their therapeutic lead, I planned to undertake some guided self-discovery within the remit of the reality

therapy intervention in order to bond the groups more closely. I was aware that certain children from Groups 1 and 3 often felt they had no right to burden other people with their problems. However, I felt that once communication was opened up and encouraged, the benefit to them might prove enormous.

Evaluation

(E) Deeper friendships did evolve, as predicted, especially between L(1) and G(1), M(1) and L(1), B(3) and K(3), and E(3) and B(3). On the other hand it was suspected, even before commencement, that the reality therapy had only a marginal chance of success with Group 2. To overcome these doubts, in their therapeutic intervention, I was guided by the findings of Deblinger and Heflin (1996) and Stallard (2002). These researchers highlighted in the literature that working with children in denial of their real issues needed very careful handling. Stallard (2002) suggested that the therapist could play the role of the child while the child played the role of a friend. As the therapist disclosed some of the child's 'worries', the child listened and responded. Stallard (2002) found that, almost inevitably, children reported increased caring for the therapeutic union during the disclosure, concluding that their real fears were not so terrible after all. This scenario worked well after K(2)'s angry outburst before the puppet show. I role-played K(2)'s response back to her and she was able to comment objectively on the behaviour involved which, in turn, helped her to calm down and think rationally about her actions.

Understanding

(P) The reality therapy appeared to be successful in this context, even with profoundly disturbed children, in enabling the participant to 'step out of their own shoes' and observe behaviour as a detached phenomenon, analysing more appropriate responses. However I was aware that I had probably shamed K(2) by my action. She had become very subdued as she listened to herself screaming. This was my evidence and she could make no excuses. It did appear superficially effective but I have to ask myself: at what price? I remember as a small child being highly shamed by a bullying father because I could rarely meet his exacting standards. He would mimic my foibles and embarrass me in front of others who would laugh at my inadequacies. I grew up hating him and that hate remained almost until his death. Here I was, in some ways mirroring his actions, in

the name of therapy. Does that now mean that my father was right all along and I have grown up bearing a misplaced grudge or does it mean that I have become the very thing I despised about him, using my greater power over a weaker individual? Shame is probably the most debilitating of emotional weapons. In the long run, my action may have inadvertently caused further smouldering hate in K(2) and an escalation of war.

6:4 INNER RAGE

Maybe, not surprisingly, the theme of inner rage only surfaced in Group 2, where two out of the three participants were identified. Variability in the perceptions of the two children filled with inner rage appeared to exist when they felt no-one cared or could be trusted. From my observation and analysis of transcribed comments, I assumed that if K(2) and L(2) perceived me as not caring for them and not being concerned for their welfare, they would deal with this by withdrawing socially, not completing tasks, missing school and acting ineffectively and irresponsibly. In other instances, however, they worked diligently on a task and contributed to the therapeutic alliance, showing many signs of purposive activity and trust. However, frustration sometimes manifested itself through negative behaviours towards E(2) or each other.

In the literature, Baumeister *et al.* (2002) identified inner rage within social isolates as reflecting traits of narcissism, meglomania and hostility. Thus, the lonely person retained infantile feelings of personal omnipotence, was egocentric and wanted to show off before an audience in order to 'show others up'. This classification was a perfect description for L(2) and K(2), who were both observed as being inwardly angry and displaying huge deficiencies in the need for love and belonging. It was interesting that both resentment and regard towards me showed themselves at different times and stages during the therapy:

> "What's the point of all this mumbo jumbo stuff? My head is on my neck and there ain't a door to it today. There might have been one yesterday and there might be one tomorrow, but today the door is staying closed." L(2)

> "Sometimes I want to see you, sometimes I don't. Sometimes I like being here, sometimes I don't. You seem to care about me, but why should you?" K(2)

Action

(D) Inner rage would appear to have a link with the theme of withdrawal for K(2) in that, when she decided to withdraw, her behavioural displays of sabotage always appeared to be stemmed from feelings of rage deep within. Evidence can be found in the literature which suggests that it is imperative that participants trust their therapist (Reinecke *et al.*, 2003). It was my intention to bring Group 2 participants to realise that they were often placing the worst possible interpretations on many therapeutic actions, despite my own self-doubt about some of my inner motives. There was no problem with mistrust in the other two groups. Kendall (2000), Stallard (2002) and Reinecke *et al.* (2003) all advocated the view that if the children trusted the therapist, then their view of the world might begin to change as well. When working with K(2) and L(2) on inner rage causation, my aim was to help them gain mastery over past events and current issues by using psychodrama in order to go forward to a purposive future.

Evaluation

(E) Looking therapeutically at the girls behaviours, it was easy to observe that expressing anger off or on 'the stage' might be the first reaction that most people might tend to use to deal with inner rage. When the girls expressed their anger they had the false impression that they were venting their anger and so it had to be good for them. Therefore, when introducing physical exercise in the form of psychodrama, they might have been led to believe that their inner rage would go away after they had worked their bodies to exhaust and dampen the feelings inside of them. However, I was aware that if they were using methods which might push the inner rage away, they were only going to be relieved of this inner rage in the short-term. Eventually, once they had had time to think and rest, the inner rage would manifest itself once more. What may have occupied their minds as a raging issue could then attach itself until they had understood the factors that might be causing them to feel "angry enough to bust" L(2).

Understanding

(P) In this scenario, a strength of the therapeutic intervention was that I was able to use behavioural techniques to show the girls that there were two ways they could express their anger - internally, or internally and externally at the same time. However, when the

most effective way to deal with conflicts was analysed in conversation, it turned out to be neither of them. L(2) always appeared blissful and outgoing but said she was really unhappy despite wearing a 'psychological mask' that displayed complete balance. This was explained to her to be an example of expressing inner rage internally because she exhibited little or no expression of unhappiness. This could have implied that she was in denial or was displaying this behaviour to deal with the affliction. The conflicts were therefore creating internal struggles, and the consequences of the inner rage-related effects might have eventually developed into disorders or disease within her mind or body if left unchecked. On the other hand, K(2) always seemed to be depressed and displayed deep anger impulsively, allowing her unhappiness to manifest itself and thereby she expressed her behaviour internally and externally at the same time. It had to be understood, however, that her inner rage-related issues were always rooted internally within her mind and body. They began there, and she would always be affected internally when these issues had attached themselves within her consciousness. Whether she chose to express her feelings externally was only another ineffective behaviour which she chose to deal with the issues.

In the actual psychodrama, the two girls were asked to work together to simulate an event which would allow them to experience the feelings of control which they may not have experienced in previous instances. The first hurdle was that they refused to work together, such was their need for individual 'glory' and to be the most loved and well thought of in the group. However, both girls agreed to use media individually, allowing for the creation of imaginary environments in which there could be powerful roles. They took on multiple roles as they enacted scenes where they became omnipotent, defenders of a righteous cause and all enemies were slain. This reiterated the findings of Friedburg *et al.* (2001) in the literature, who found that the majority of socially damaged young people believed in absolute standards of right and wrong and therefore could be intolerant of differing views held by others. L(2) created a play around domestic violence where she was the perpetrator and revenge was bloody. K(2) enacted a fantasy in which she was a magic fairy with the power for initiating good or evil over the whole world. In both cases power issues were involved but underlying the need for power was a far greater and consuming need - the need to feel loved and to belong. The success of subsequent conversation within the reality therapy intervention was that it helped both girls see that there were rarely absolute standards of right and wrong.

A major breakthrough in breaking negative thought patterns was in getting the girls to acknowledge and agree that other people were entitled to live by different rules; a key concept identified by both Beck (1995) and Ledley *et al.* (2005) in the literature. A major breakthrough which I personally needed to overcome was that, despite a session based on developing trust, my trust of them was far from cemented. I was expecting from them something which I still needed time to develop. My new learning has been that these dual standards were not only highly hypocritical but unrealistic.

6:5 ATTENTION-SEEKING

Problem

(W) Seven out of nine group participants were identified under this theme. Interestingly, the only two children who did not attention-seek were the two carers of dependent adults, G(1) and K(3). These boys tended to go into deep bouts of depression rather than show-off. For the others, it would appear that an important aspect of being in a group situation was the need to vie with one another for attention. For each group member, it was important that the therapeutic relationship should have a strong flavour of exclusivity so that each child was able to experience a unique relationship in the therapeutic environment. However, this was a difficult dilemma. Firstly, by the very nature of the fact that the children were in group therapy, they were unable to have a therapeutic relationship not compromised by the unwanted intrusion of others. Secondly, the participants had personal perceptions of themselves which were not the same as the perception of others.

Group 2 participants identified with extreme measures such as violence or sabotage, respecting no boundaries. No group member was able to share, unless it was in the context of causing a third member pain, by joining forces to plot their discomfort. Their focus was continually on individual attention. When they did receive this, such as when another group member was ill or suspended, that participant positively thrived, displaying a huge need for a sense of belonging:

> "It's nice not having that mad cow here. Glad she got sent home. The Head....he hates her as much as me. I ain't bothered about him (E2)...he's off on another planet most of the time anyway. Cosy, ain't it?" L(2)

Other children who were desperate to be liked and gain friends, such as M(1) and E(3), thought that they could gain popularity by being 'street-wise' and trendy. M(1) loved to show off. On therapy days she would make an effort to come to school wearing trendy clothes, shades, jewellery and footwear. She tried to be 'super cool' in front of the two boys, which did eventually work for her as a close friendship developed with them, especially with L(1). E(3) was a show-off who had developed the 'skill' of attention-seeking as a rebuff to her extreme loneliness. She had experienced a traumatic childhood and now had no contact with her mother, a heroin addict, as well as only seeing her father on infrequent visits. She loved to talk about her past and used her pain to gain sympathy amongst strangers.

L(1) and B(3) tried to be aggressively assertive in order to attention-seek. This almost always backfired on them because, like Group 2 participants, they had no respect for boundaries and their behaviour was viewed by outsiders as totally 'over the top'. Both boys would push themselves towards others, only to find it was they who were pushed away before very long, adding to their sense of rejection. L(1), who could not have cared what he wore or looked like, would show off by constantly doing karate moves and bragging about how fit he was. B(3) was the eldest son of police officers who had a cynical view of life and never let B(3) out of the front gate unaccompanied. He was allowed no friends through his front door and therefore felt 'excommunicated' from his peers in the local community. Thus, at school, his behaviour had become extreme in his attempts to find friends:

> "At playtime yesterday no-one wanted to know me. I asked to join in several games and everyone told me to get lost. That made me angry, especially as one boy called me a loser. So I refused to go away and deliberately disrupted his game until he was boiling over. Now he knows how I was feeling." B(3)

Action

(D) In the literature, several studies have highlighted that lonely children can be intensely self-focused (Moustakas, 1961; Albano and Kearney, 2000; Galanaki, 2004). An individual example was B(3), who was unable to see how his forceful behaviour in the playground was alienating him still further. He believed that drawing attention to

himself was the only way to gain peer respect. Similarly, I concluded early into the therapeutic intervention that group interaction was perhaps a mistake with the damaged individuals within Group 2, as all were completely self-focused. Adalbjarnardottir (1995) identified being unable to focus attention effectively as a severe behavioural dysfunction with social isolates who attention-seek through a sense of inner despair. Taking the lead from Hart *et al.* (1998) who identified heightened self-focus as a major social behavioural defect, I decided to initiate discussion, whenever the opportunity might present itself, about how self-focus could be observed by others as inappropriate and unacceptable.

Evaluation

(E) The common factor spotted amongst all the children identified under this sub-theme was that they were unable to think flexibly. Placing demands seemed to be at the heart of their emotional problems. They used extreme and rigid words such as 'must', 'should', 'need', 'ought', 'got to' and 'have to'. When spoken to others, these words caused anger and offence and often resulted in physical actions being instigated. We discussed the inflexibility of the demands which they might put on themselves, the world around them and other people. I explained that adapting to reality could sometimes be difficult. For example, by believing that they *must* have the approval of their peers, they were forcing themselves to be anxious in social situations and driving themselves to try and win everyone's approval. They might think because they had tried to be friendly towards others, the others really *ought* to be just as friendly in return. However, their demand might be unrealistic. Other children were governed by their own priorities, so they might feel hurt about their peers not acting the way they might themselves.

The reality therapy intervention then proceeded to illustrate how holding *flexible preferences* about themselves, other people and the world in general was the healthy alternative to inflexible demands. The children were guided to see that, rather than making demands on themselves, the world and others, there were techniques which they could employ to help themselves. Paying attention to language was especially important. Words such as 'must', 'need' or 'should' could be replaced with others such as 'prefer', 'wish' and 'want'. Approval seeking could also be limited. The children

were encouraged to see that they would feel more confident in social situations if they held a *preference* for approval rather than viewing it as a dire need.

Understanding

(P) It was important to understand that the world did not play to their rules. In fact, I emphasised that other people tended to have their own rulebooks. So, no matter how much they might value friendly behaviour, their peers might not give it the same value. The success of the therapy with B(3) was that he quickly understood that if he could give others the right not to live up to his expectations, he would feel less hurt when they failed to do so. However, success was only partial with members of Group 2. They found listening very difficult, no matter what the context was. Their understanding and analytical abilities were also limited because they appeared to shut out positive suggestions, as all they were used to was blame and criticism. A possible weakness of the reality therapy intervention, in this situation, was that it was expecting verbal dialogue and responses from subjects unable to engage on that level of sophistication. Psychological barriers to any form of help or change were consistently being raised.

It was hard to work with such negativity or gauge how much impact the therapy had made with Group 2. I admit to feeling impatient with them, especially when I was clearly noticing change within the other two groups. Why was I not making the same impact with Group 2? What did I need to do differently? It was, perhaps, this reluctance and fear on my part to radically alter and modify the programme to accommodate their severer needs which caused us all to stand-still. I was starting to feel a failure and aware that soon, staff members at the school site might regard my presence as worthless. Maybe the children sensed that they were slowly breaking me. It was imperative that I banish my feelings of incompetency and self-doubt.

6:6 VIOLENCE - STRIKING OUT

Problem

(W) The three participants identified under this theme - L(1), K(2) and L(2) - were engaged, whenever possible, in purposeful conversation to illustrate that their violence,

and the violence of others towards them, was a chosen behaviour in the desire to solve problems. When the origin of this choice was analysed, it was found to derive from their learning. In all groups, over all backgrounds, the children had been previously instilled with the parental belief that when confronted with a problem, a show of personal violence was the best solution.

L(1) was reported by his Head as being prone to violent interaction with other class members. He said that he could identify with The Selfish Giant (Session 4) because the giant was misunderstood in the same way as he was. He was able to reflect that his height, his stature and his keenness to be part of a gang always worked against him because he tried to join in too enthusiastically and, invariably, ended up accidentally hurting someone. L(1) talked about how The Selfish Giant was like that, a huge man whom everyone was afraid of. It was that same fear that caused the giant to be lonely:

> L(1) "Just like my hamster on his wheel. The giant's life went round and round, didn't it?"
>
> R "How did he break the cycle?"
>
> L(1) "By looking at his life differently?..... Maybe planning changes and doing something about it? Yes, sorting it out for himself...Then it got better and he was happy in the end."

Both girls in Group 2 were reported by the Head as being prone to displays of striking out and other forms of violence. If it was not pencils or other readily-to-hand implements, K(2) would run to the cloakroom in a frantic search for 'weapons'. She was a psychologically damaged girl, caught in the 'crossfire' of much parental trauma:

> "My mum says my dad is evil and I must watch he doesn't snatch me. He says it's her and she's ruined me. I hate them both - best way. My gran used to say that actions spoke louder than words..... so here's to you dear parents - wack, wack (shouts and punches desk with fist). Hope it bloody hurts." K(2)

Impulsive behaviour such as this was so destructive to the group dynamic that, many times, it would have been easier just to have removed her from the group. However, in the rare times of being alone together, there was no sign of violence and the need to strike out. This only occurred when she was competing for her right to be noticed.

L(2) had been pinpointed by the Head as a victim of suspected abuse in his pre-therapy interview. He stated his concern that she had been a witness to many incidences of domestic violence within the home setting and this information was confirmed by her mother, who spoke of living in perpetual fear of her estranged partner, the father of L(2). Interestingly, and rather surprisingly, L(2) had a natural hatred of all women and was usually violent towards other females, a trait she may have learnt from her father:

> "Me mum's a weak woman. She can't say no to anyone and she can't stand up for herself. So I walk all over her because she deserves it. I'll never be weak or stupid like she is." L(2)

It was confirmed by the Head that L(2) was violent towards her own mother and had beaten her up on several occasions when money had been denied her. At the parental interview, it was observed that the mother was clearly afraid of the repercussions of her daughter's wild and impulsive behaviour but was reticent to criticise.

All three identified children additionally loved to watch reports of real-life murders on the television news and had faced bullying and threats on the streets. They had, therefore, come to believe that brutality and crime were a constant threat to them, even in the reasonably remote county of Cornwall. For these children, violence had become the solution to this threat. They were taught by their parents that, even if not the best or first solution, striking out was a solution to be utilised when all else failed. These participants had all been victims themselves of spankings, slapping or hitting by parents who appeared to be too frustrated to know what else to do.

Action

(D) During worksheet sessions over the course of the therapy the children were shown that, in attempting to meet their needs in the real world, they might behave to match their ideal picture of what was fulfilling with what they had. It was important to understand the many roots of anger and violence now unleashed upon society. When the need was to love and belong but the participants had no effective behaviours to fulfil their needs, I empathised that it was frustrating. I also impressed upon the children that if they did have images which met their need but the 'pictures in their heads' were

unfulfilled, they had to behave to meet these needs. If they had no pictures which were available, they would continue to behave inappropriately. They would then give up on the responsible and choose irresponsible actions to give them a sense of control.

Evaluation

(E) It was important that the identified participants understood that violence was a symptom, but choosing to be angry was a common response as it was chosen to help meet unfulfilled needs. Irresponsibility was also analysed as a way to deal with frustration. We concluded that sometimes this was the best that someone could do at the time. The children were shown that people chose violence to indicate that they were giving up on their problem-solving plan, and choosing the only alternative they perceived was available to them. We discussed that they normally would choose the best available behaviour in every situation. This behaviour might not be what others would choose but it was their best attempt to fulfil their needs. Many times, if children had additional information about available resources, another choice would be made.

Understanding

(P) A strength of the reality therapy intervention was that it could successfully convey that in every society, in every therapy group, a channel existed, an outlet through which the forces accumulated in the form of aggression could be released. This was the purpose of including creative tools such as psychodrama and art into the therapeutic intervention. However, by following this thought-process, the three children could identify that they did what they did to meet their needs. Paradoxically, they chose violence because it helped them to meet their needs. In the literature, this dilemma was explained by Friedburg and McClure (2002), who found that violence was triggered through feelings of anger, awkwardness or emptiness, caused by loneliness. When the cause was eradicated, the negative emotions which were used to fulfil unmet needs could be replaced with contentment, ease and social competence. A key strength of the reality therapy intervention here was that it was able to provide a solid foundation for self-evaluation and appraisal of behavioural reactions to unmet needs in order to create positive change. Ledley *et al.* (2005) recognised this as important because, generally,

pre-adolescents were unable to acknowledge that their suppressed loneliness was the direct cause of the defensive behaviour it triggered, such as striking out in frustration.

I found it heart-wrenching to analyse these emotions with the children. Many excuses for inappropriate behaviour registered as repetitive memories. Parental influences had clearly been a dominant factor in influencing their reasoning. So what part had I played in my own child's decision to strike out in frustration by taking flight? What had been his unmet needs? How many times had I asked myself that question? Now it had re-emerged and still I had no answer. Maybe I never would.

6:7 DESPERATION FOR FRIENDS

Problem

(W) In the literature, Peplau and Perlman (1982) recognised that a child's acceptance into a group depended heavily on his or her own capacity to regulate anxiety, impulsive behaviour and frustration. Quite clearly, members of Groups 1 and 3 had difficulty with this. In Group 1, two out of three children displayed symptoms of anguish over not being able to acquire new companions. There were also physical considerations, compounded with their inability to regulate their extravert behaviour, which appeared to have some bearing on their loneliness. M(1) was transported to her school from another town because her parents, both professionals, wanted her to enjoy the intimacy of a small rural setting. Ironically, this worked against her because all her peers lived near the school. Both M(1) and L(1) revealed a strong need to be more popular with their peers and internal anxiety when this did not manifest itself:

> "The more pretty I try to make myself, the less the other girls seem to want to know me. I only have two friends. Well, they aren't really friends, but I do know them. Oh, I do worry and wish they were my friends as they're so cool." M(1)

> "I always try to join in games on the tennis court at break, but people just scream at me to go away. All I want to do is join in. When they won't let me I get stressed right out and hit them because it isn't fair." L(1)

L(1), the solitary fisherman, spoke about how fish were his real friends because they did not hurt him. All Group 3 participants appeared to be desperate for friends because of

home circumstances. As none of them were able to control the inner anxieties and frustration caused as a result of this, their isolation became even more apparent. Like M(1) and L(1), all were able to talk rationally about their problems, displaying a quiet sense of despair at having so few friends. Having a disabled father who needed peace and quiet in the house, K(3) was used to creeping about and not being 'in the way'. His character had developed into a type of Uriah Heap persona, afraid to do almost anything and 'ever so grateful' if anyone at all would play with him:

> "I played a really good game of football yesterday with some boys in the next class down. They let me play because their usual opponents had been messing about in class and had been kept in. It was really kind to let me join in." K(3)

E(3) was over-indulged by her grandmother in compensation for her difficult start in life. This made classmates resentful and rejecting. She loved to brag about her pony in the desperate hope of being admired but it always seemed to have the opposite effect, although she was unable to see it. B(3) was just a lofty buffoon, acting the clown in order to draw attention to himself. His character had similarities to E(3), in that he was initially unwilling to observe that his behaviour was making him look a laughing stock and children were laughing *at* him not *with* him. When he did eventually become self-aware of the impact of his actions, he abandoned the junior yard and found comfort in playing with very young children from the infants section because they laughed at his silliness, without putting too deep an interpretation into his actions.

E(2), the only member of Group 2 to admit wanting friends, sank into fantasy when confronted with any sort of reality. Again, the long distance of his home to those of other children was an isolating factor. However, interacting with this boy was very different because he was seldom anxious, frustrated or impulsive, unless directly 'attacked' by the other two group members. His ability to cope with isolation had degenerated into a more disturbing level of concern. Some days he appeared to be in a trance, unaware of stress or pressure because it was too painful to face, rarely able or willing to recognise or embrace reality. On other days though, noticeably in the group situation, he appeared euphoric and his behaviour would then manifest itself in impulsive risk-taking. He was one of a large family, headed by parents who both had severe mental health problems. This contributed to the bullying he experienced at

school and the reason his appearance was different to that of a 'normal' eleven year old. He spoke of "millions of mates" but this, like most other things, was just part of the fantasy world in which he had surrounded himself. He loved to brag and tell outrageous lies, masking an extreme loneliness within:

> "I'm going to America for the weekend. My dad has got friends in Hollywood so we can go anytime and meet all the stars. We go once a month usually." E(2)

Action

(D) A weakness of any reality therapy intervention is that, in a short-term programme, work with severely maladjusted children such as E(2) will be limited in success. I wondered whether this boy could be in a state of bipolar affective disorder (manic depression) and whether psychiatric help might be the only true solution. Peplau and Perlman (1982) highlighted that peers would naturally reject others who were impulsive or disengaged and this would create a negative cycle, as having fewer opportunities to socialise would lead to slower social learning. As social competence played a pivotal role within the programme, conversations were initiated throughout many of the sessions to help participants self-evaluate the truth of their beliefs (such as 'everyone hates me') and to assess the usefulness of their current behaviours (such as 'I must push myself onto other people and force them to like me because I am desperate').

Evaluation

(E) Firstly, the children were asked to describe their problem as they perceived it, including their *safety behaviours* - the measures they took to try to prevent their feared catastrophe. The children were encouraged to think deeply about how their behaviour to acquire friends negatively affected their lives. The next step was to encourage them to formulate their predictions by deciding what they thought might happen if they tried out a new way of thinking or behaving in real life. They needed to self-evaluate a way of putting this new belief or behaviour to the test in a real-life situation. Everyone was encouraged to try to devise more than one way to test out their prediction. Finally, again through self-evaluation, the results needed to be examined to see if the predictions had come true. If they did not, the children were encouraged to check out what they had learned from the results of the experiment. Each participant was encouraged to rate the

degree to which they believed a prediction would come true on a percentage between 0 and 100 at the start and then re-grade at the end after the results had been self-assessed.

Understanding

(P) Again, I found myself inadvertently branding E(2) as a no-hoper and predicting mental illness because he had not, so far, responded to my interventions. I had observed his parents and was forecasting the same outlook - but was this not the easy way out? I have already reflected upon my responses to this boy - and still it haunts me. Was E(2) really too far into the depths of unreality or were my interventions misplaced, shallow and meaningless? I know the answer. Group therapy was the wrong treatment. E(2) needed individual therapy designed to break down his own particular fantasy defences, seemingly based upon a deep fear of aloneness. He needed special time devoted solely to his unmet needs. He needed someone to be a special adult in his life, upon whom he could depend and someone who could dig beneath his defences in a caring and unthreatening way. Group therapy was not going to work. I was therefore knowingly wasting my time and, much worse, his time and commitment because I was seeking to make research comparisons, whilst knowing that they were hindering the very thing I sought to obtain - meaningful change. As Josselson (1996) recognised in the literature, I was therefore guilty of using E(2) for my own ends because, as an experienced therapist, I already knew the over-challenging interventions and therapeutic confrontations would not be successful with him. I was even more troubled by a fear that the reality therapy programme might be making things worse. Did I really have the right to continue and cause this child further harm and suffering? I should have publicly voiced these concerns but I held back. I now see that I was morally wrong.

6:8 SUMMARY

This chapter has brought my deep sense of self-doubt to the fore. However, reality therapy has been seen to be working its magic. A clear strength would appear to be that it has promoted a sense of self-responsibility which was achieved, with all the participants from Groups 1 and 3, in every intervention within the theme of love and belonging. Conversely, the perceived 'authoritarian' ideas that go hand-in-hand with

responsibility made little headway with members of Group 2 who rebelled, to a greater or lesser extent, within every intervention. As none of the participants had sophisticated verbal skills, this might be seen as a weakness of the therapy with this group, because the expected responses involved being able to orally respond with competence.

CHAPTER 7

POWER NEEDS

Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. It is our light, not our darkness, that most frightens us
- Marianne Williamson 1953-

Contents

7:1 INTRODUCTION

The fulfilment of the "distinctively human need of power" (Glasser, 1998a, p.37) is often attributed as a major source of conflict in our society today. Thus it is important for all multi-agency professionals to assist individuals to fulfil their need for power without diminishing another's right to do the same. Another aspect of power within the therapeutic context is a participant's need to have inner control of their lives. If these lives have been overly regulated from the outside, it can be expected that rebellion will surface through anti-social behaviour, apathy or other negative symptoms. This proved to be the case within this study. Six themes were detected under the need for power. Only one - assertiveness - had aspects which could be viewed in a positive light. The other five themes - street cred dependency, immersion in possessions / clothes, bullying, gang membership and social isolation all centred around the conflictual side of misuse of power or negative interpretations derived through loneliness.

According to Heller and Rook (2001), membership of groups such as gangs might constitute a new family for many lonely and alienated youth. This would appear to be the case in this study where gang membership, for certain individuals, sought to fulfil personal power needs of a fairly desperate nature. All identified lonely children felt a need for affiliation, a joining together with others of a similar background. Gangs could satisfy power needs by offering the possibility of 'making it'. Risk-taking behaviour and the belief that gang members were invincible also satisfied the need for power.

In the literature, many researchers have recognised the importance of personal power, used appropriately, in order to satisfy an individual's inner needs and experience of personal involvement (Bowlby, 1973b; Doll, 1996; Rotenburg and Hymel, 1999; Galanaki, 2004). In the following analysis of sub-themes, both the positive and the negative aspects of power have been examined. Table 6 overleaf has been formulated to illustrate participant involvement within each sub-theme. It can be observed that L(2) was identified in every category. Another obvious aspect is that all participants identified themselves as being socially isolated, although some were initially more reticent than others to admit to this.

TABLE 6 IDENTIFICATION OF PARTICIPANTS - POWER NEEDS

POWER	M1	L1	G1	K2	L2	E2	E3	K3	B3
Assertiveness	X			X	X		X		X
Street cred dependency	X				X		X		
Immersion possessions/clothes	X				X		X		
Bullying	X	X		X	X				
Gang membership		X			X				
Social isolation	X	X	X	X	X	X	X	X	X

7:2 ASSERTIVENESS

Problem

(W) In the literature, Spence (1994) and Doll (1996) found that there was a possible link between loneliness and low risk-taking. In this study, five out of nine participants were observed as being over-assertive during group sessions. Interestingly, and further backing these claims, the children who were under-assertive were perhaps the most lonely individuals and those least prepared to take any form of risk. G(1) was reluctant to assert himself for fear of exposing his fractured family. E(2) used fantasy to escape having to be assertive in the real world. K(3) was extremely shy and nervous. All three boys were shouldered with home responsibilities in that they all had needy parents and all experienced social isolation because of this. The one difference was that, at school, G(1) relished being given responsibility and would do anything for his class teacher, although he would never push himself forward. In group sessions he would always be attentive and agree to do all tasks, although he never volunteered for anything. E(2) and K(3), on the other hand, hid in their own worlds. E(2) tried to leave his classroom at every opportunity. In the group situation, he refused to do clay work because he could not bear to touch it and would normally sit in a daydream. K(3), a clever boy, never put his hand up in class or volunteered for anything. His class teacher commented that it was sometimes hard to remember he was there at all. On one occasion during therapy, he hid in the toilets rather than face being in the spotlight. To a lesser extent L(1), whilst not categorised as having particularly assertive tendencies, was normally unaware of the effects of his sometimes agitated behaviour:

"I got sent to the Head yesterday. I just got frustrated with this kid because he wouldn't play with me." L(1)

M(1) was observed as a frequently angry individual, who used assertiveness to push herself onto others when she felt her needs were not being met:

"It makes my blood boil when I think of the effort I put into trying to play with.....She just ignores me so I squeeze my face tight into her and show her my teeth. She says I don't intimidate her but I know I do...and I don't want that. I want us to be friends." M(1)

She had to be shown that being assertive meant being selective or prudent at times; undesirable consequences could be avoided if she remained silent or took a low-key approach in certain situations. Likewise, both L(2) and K(2) were observed as being over-assertive in order to meet their needs. Assertiveness awareness was not easy to use with either of these group members because they had emotional blocks that prevented or hindered the learning and application of behavioural skills. I was frustrated there was not more time to correct their misconceptions, remove their blocks and assist them to learn new skills. The act of positive rather than negative assertion would have allowed them to make a stand when it mattered - that is, when they were called upon to bear more than their fair share of the emotional costs of living in harmony with other people. E(3) and B(3) were both observed as being over-assertive in their desperation to gain more personal power:

"I gave.....a thump yesterday because she tricked me. I gave her some pastilles if she would play with me. She got the sweets and scarpered. I went mad as she tricked me. I'll wring her neck if she tries that on again." E(3)

"If I'm not allowed in a game then I destroy the game by capturing the ball and running off with it." B(3)

On the other hand K(3), rarely showed many visible inward or outward signs of assertion or spoke of the need for more power over his life. However, on one occasion, he spoke of how he felt ashamed and angry with himself for his perceived weakness in not challenging the boy who sat next to him in class when he had not repaid a loan. Unable to contain his frustration any longer, he verbally lashed out at him and then felt guilty about his angry outburst:

"I shouldn't have lost my temper and behaved so badly." K(3)

Action

(D) The therapy focused on helping the participants to stand up for themselves in situations of actual or potential conflict. It also involved positive initiations such as giving and receiving praise and learning to accept faults and limitations without self-condemnation. In the reality therapy intervention, an important task was to identify areas of interpersonal difficulty, establish goals for change and then undertake an assessment of each participant's present functioning in those areas. It was recognised that the children could not usually engage in behavioural skills acquisition whilst emotionally disturbed. Therefore, it was key to assess for the presence of primary emotional blocks to assertiveness such as anxiety. In addition, there might be secondary emotional problems i.e. emotional difficulties that could have arisen as a result of the individual's inability to tackle the primary problem.

Evaluation

(E) After observing K(3)'s out-of-character angry outburst, I realised that his scenario was a typical example of secondary emotional problems. When blaming himself for 'behaving badly' because he was asking for his loan to be repaid, he had returned to his unassertive state, which then reinforced his reluctance to speak up again. Having uncovered these emotional blocks, I used the cognitive-behavioural ABCDE model of emotional disturbance and its remediation to remove them:

- A (activating event) imagines his friend getting angry and rejecting him when he asks for his money back.
- B (beliefs) "I couldn't bear losing his friendship as I have so few friends."
- C (emotional and behavioural consequences) anxiety and procrastination.
- D (disputing beliefs) "As desperate as I am for friends, I don't want a friendship based on exploitation. If he does reject me, I can bear this and learn to do without friends like him as well as persist in trying to get my money back."
- E (effective outlook) asks for money back and deals with any adverse outcome.

Understanding

(P) The model demonstrated to K(3) and the other members of his group that his emotional and behavioural disturbance at C was largely caused by his beliefs at B and not the situation at A. This was the principle of emotional responsibility, i.e. largely self-induced. By disputing D or questioning those self-defeating beliefs in a variety of ways, K(3) was learning to become more effective at E, looking after his own interests (though, of course, there was no guarantee he would get his money back). With regard to K(3)'s shame and guilt, he could use the ABCDE model to challenge the ideas that he was, respectively, weak and bad for behaving as he did. These secondary and tertiary problems had to be dealt with first as they could interfere with K(3)'s efforts to tackle the primary emotional problem. Once the emotional difficulties had been addressed, K(3) could focus on the behavioural skills he needed to acquire. Likewise, when his emotional problems had been ameliorated, assertiveness skills would hopefully reassert themselves spontaneously.

In the following session I was delighted to learn that all of K(3)'s money had been returned and, additionally, he had received a bag of sweets as a gesture of friendship. K(3) was so touched by this act that his whole persona visibly changed. My new learning has been that even the smallest action can alter negative thinking and emotions to make a positive change. How permanent this might be remains to be seen. However, the emotional 'lift' has been two-sided because I have also benefited. My previous self-doubt about my competence in such a specialised field has been temporarily abated as I experience a positive therapeutic outcome. The study now appears to be making progress in ways which could never have been planned.

7:3 STREET CRED DEPENDENCY

Problem

(W) Across the groups, none of the boys cared about street credibility. It appeared to be a strictly female pre-occupation. Three out of nine children, one girl from each group, related to this theme. M(1) placed a great deal of importance to her standing within the group. It was highly important to her that she was liked by the other two boys. Her way

of increasing street-cred was to buy small gifts from her local surf shop for them so she would be thought of as 'super cool'. She also immersed herself in the latest surf clothes to impress them. She was thrilled to learn that music therapy was part of the programme and informed the group that she was 'an authority':

> "It must be rap. Rap is a message to parents and other old people that they do not understand our wants and they're holding us back. You can say it in a song but you couldn't say it to their faces or you'd be for it. Rap is like a secret code for the young and people with real street cred; ones out there doing it." M(1)

L(2) was part of a gang of older children outside school which gave her street-cred within school, although not within the group. This was observed as possibly being because K(2) was not into fashion or trends and E(2) appeared to be too wrapped up in his fantasy world to even notice her or her latest wardrobe, many items of which were dismissed as 'something I just nicked.' As she 'hung around' with older teenagers it was important to her to use this power to show-off whenever the opportunity presented itself. Thus she willingly took the lead when asked to compose a rap song. Involvement in this activity seemed to refocus L(2) from grim reality to the world or mind of someone else. She later commented that she had never listened to the actual lyrics but to the hook, which was a repetitive statement, and to the beat which gave the song power:

> "I love sorting this for our group. Give me the power man! I'm the Queen of Rap. Look at me in my smokey club!.....Rap music is.....way so powerful that it can influence even them lot.....(the other two).....who have weak minds. I want everyone to see me rapping.....I'm so cool." L(2)

E(3), on the other hand, was an over-indulged girl who flounced around in the latest fashionable item in which she had been indulged. She initially believed her fashion accessories would increase her chance of making friends and found it hard to understand that true friends might not interested in material possessions but in her personal characteristics. She always vied to be the centre of attention and was easily hurt if she perceived her peers as not accepting or liking her. She openly admitted that she needed to be 'king pin'. When composing rap music with the group, she instinctively took the lead, regarding herself as someone who knew all about music and what was 'in':

"There is always a message in music, whatever sort it is. I can hear that message as I'm so switched on. My gran says I'll make it big time when I'm older. You've either got it or you haven't. I know what's going on out there." E(3)

Action

(D) As all three girls believed that having street cred depended on the type of music they listened to, and all felt that their music represented the spirit and sense of their generation, I felt it was essential to include music therapy as part of a holistic programme. In recent times music therapy has, within the realm of reality therapy, been highlighted as a powerful and non-threatening medium because its use often evokes a unique outcome (Kendall, 2000; Wubbolding, 2000; Glasser, 2003; Leahy, 2004). All the groups were asked to express their wants from the session on music therapy. Clearly the multi-music form which was commonly termed 'rap' was the only credible choice. As a 'warm-up', they all listened to the words of *'I Can See Clearly Now'* (Johnny Nash), but this sound was too outdated in their eyes to earn any street-cred at all. Attention was therefore turned to the wide-ranging multi-musical form of rap.

Evaluation

(E) As well as having 'rap authorities', four out of the nine children admitted that the lyrics were lost to them. They would repeat the words without actually knowing what they were saying because all that really mattered was the street credibility ultimately gained. As M(1) and E(3) were able to lead through their knowledge of rap composition, much street cred was gained and they clearly revelled in using the session as a showcase for their talents. During Session 9, each group was asked to compose a rap song centred around their understanding of the basic needs. (The Group 1 version has been reproduced in appendix ix). Interestingly, all nine children loved working through the medium of music and evaluated the session as particularly successful.

Understanding

(P) The strength of this particular reality therapy intervention is that it appealed to everyone right across the board. Even Group 2 worked together as a united team.

Composing a rap song to express need as a group activity was a sound and accepted choice with these group members because rap was 'cool', 'street worthy' and a universal language. If I had anticipated the general resistance to activities which I would receive from this group, I would have planned more music sessions because here, at last, I had found some common ground amongst members. In hindsight, I should have recognised this and changed their programme of activities to take advantage of something which held their interest and was actually getting them to communicate with one another. Perhaps the overall outcome might have been different if I had abandoned the planned programme and acted more spontaneously.

7:4 IMMERSION IN POSSESSIONS / CLOTHES

Problem

(W) One girl from each group - M(1), L(2) and E(3) - was observed as gaining personal power through their outward persona. Both M(1) and E(3) were affectionate girls who often would buy trinkets for their fellow classmates in attempts to gain popularity. L(2) was a different type of child, preferring to receive through stealing, rather than to give.

M(1)'s clothing appeared to reflect her best attempt to meet her needs. As a girl who was not given much freedom at home, M(1) loved to wear clothes which expressed individualism and creativity. She matched expensive tops with holey jeans; put her hair in pigtails and yet sneaked on lipstick. Surrounding herself with small ugly mascots made of fur, which she called her family, gave her permission to love / chastise them and hold ultimate power over them. This compensated for a low self-esteem and a belief that she herself was ugly and unlovable:

> "I don't know why the boys don't like my little family. Is it because they're so gross? (Hugs mascots). Ah, mummy loves you anyway! It isn't nice when people make fun of you because you look yucky. I know that... but if you look different they forget to tell you those things because they are so totally amazed by the way you look....that's me!" M(1)

L(2) had been in trouble with the police several times for shoplifting as she had an insatiable appetite for the latest fashions, which her single-parent mother could not

afford to buy. She was physically mature for her age; very tall with long blond hair. She always looked immaculate in school and was continually brushing her hair. She explained that "some clothes are just to die for" and that being caught stealing was a hazard she was prepared to take. She blamed her mother for being poor and refused to accept that her actions were irresponsible, bragging of shoplifting as giving her power over the store:

> "I seen this lovely top the other week. Didn't look to see how much it was. Didn't matter whether it was a tenner or a hundred pounds; I was having it. I nicked it in the changing rooms when the assistants changed over for lunch. Got to time it just right. I've got the better of them. Bit of a game really but it gives me a buzz." L(2)

Unlike L(2), E(3) came from a wealthy background and was indulged by her grandmother. She had similar characteristics to M(1) in that she loved bright colours but her passion was collecting memorabilia from her favourite bands which, she explained, helped to compensate for her murky past:

> "I hate black and brown. Those colours remind me of funerals and mud when it is pouring with rain. I don't want any more rainy days. Just bright happy sunshine times with lots of music playing to make me want to dance." E(3)

Action

(D) In the literature, Coleman (1998) spoke of how pre-adolescents were encouraged more and more by the media, advertisers and the general youth culture to grow older younger. Certainly this description applied to M(1), L(2) and E(3). As all three girls were observed as highly creative, my aim was to show them that better use could be made of their time than immersing themselves in material pursuits with negative consequences, especially when law-breaking was involved. In order to do this, it would be necessary to help them overcome low self-esteem by accepting themselves; abandoning perceptions that they were only as worthwhile as their social achievements, attractiveness or financial standing amongst their peers. The reality therapy approach to tackling low self-esteem was to boost it by removing self-rating such as "I'm a failure so I need to buy friends", "I am not respected unless I dress in a certain way" or "I'm

worthless so it doesn't matter if I end up a criminal." Unconditional self-acceptance would mean untangling their self-worth from external measures of their value as a person. It was important to impress upon each of them that people were ever-changing, dynamic, fallible and complex creatures. Humans had the capacity to work on correcting less desirable behaviours and maximising more desirable behaviours. In short, they had the ability to develop self-acceptance while still endeavouring to improve themselves, if they so chose.

Each participant was given a pack of self-adhesive notes and asked to find a large, flat surface. They were asked to write down a characteristic which they, as a whole person, possessed and stick the word or phrase on their surface. It was important to keep encouraging them to do this, jotting down all the aspects of themselves that they could think of until they ran out of ideas. They were then asked to step back and admire this illustration of their complexity as a human being, accepting their fallible natures and valuing their uniqueness.

Evaluation

(E) For M(1) and E(3), accepting the existence of personal shortcomings enabled them to understand their own limitations and identify areas they might wish to target for change, making the therapeutic intervention a success. However, it was felt that the 'dice was more loaded' when dealing with L(2), as she was continuously transgressing her personal moral code. Behaving in an antisocial manner made it more difficult for her to accept herself. However, it was emphasised that she could. By encouraging her to accept herself, she was more likely to learn from her mistakes and act more constructively - which was in both her interest and in the interest of those around her. She needed to take personal responsibility for her inappropriate behaviour. In order to do this, it was important to make her understand that rather than just accepting she was a bad *person* who had no control or responsibility for her actions, she must try to accept that she was doing bad *things*. I explained to L(2) that self-acceptance was about taking personal responsibility for her less good traits, actions and habits. It was also about targeting areas that she both *could* and *wished to* change and then taking the appropriate steps towards change. Self-acceptance was not about saying: "I'm human and fallible. Therefore I just am the way I am, so it is okay to go on shoplifting. I don't need to think

about changing anything." L(2) was, at baseline, worthy and acceptable, but some of her behaviours and attitudes were simultaneously unacceptable. Work was done together on accepting her overall self on the basis of her intrinsic human fallibility, so that she was prepared to judge *specific* aspects of herself.

Understanding

(P) For all three girls, accepting themselves had two interesting implications for overcoming emotional problems and personal development. Firstly, they were able to understand that they were equal in worth to other human beings, which helped to reduce emotional pain. Secondly, because they would not be distracted by beating themselves up, they would be better able to focus on coping with adversity, reducing disturbance and self-improvement. Although work with L(2) would have benefited from more intensity, overall the intervention was successful and achieved its desired outcome.

I would have liked time alone with L(2). I know how living with domestic violence can affect you psychologically, not because I am a therapist but because I was once a victim. Many times when she spoke, I instinctively knew what was coming next - and why. I really wanted to help this girl, but the group dynamic meant that I could never give her the intense therapeutic input which was necessary. Indeed, I have been staggered by how many conversations with different group members have sent my own psyche into freefall. It has made me question whether perhaps the whole study is really an investigation into the complexity of my own personality as I recognise bits of myself in each and every participant.

7:5 BULLYING

Problem

(W) Four out of nine group participants identified with this theme, which has been placed under the need for power because the children who were bullied or were bullies themselves were observed as having issues around too little or too much control. All four children tried to buy or grab control, regardless of the feelings or wishes of others.

All displayed clear symptoms of having little control and so used misguided behaviour to try to rectify this. In the literature, Chung (1994) worked on control issues with residents of two correctional institutions, using reality therapy to increase self-esteem and thereby decrease misuse of control tactics. Chung (1994. p. 76) cited one particular case where a boy analysed, through reality therapy, his own evasive and irresponsible behaviour and frankly disclosed it to staff, thus regaining power and control together with personal respect, a behaviour valued highly in the Chinese culture. It was felt that work of a similar nature was clearly needed with M(1), L(1), L(2) and K(2).

M(1) and L(1) both said they were bullied; L(1) admitting being a bully himself:

> "Sometimes I get so desperate to be heard that I try to force people to do things because they can't see it from my point of view. Then I'm accused of being the bully - but I'm not! I just want to be noticed and valued for what I believe in and think is right." L(1)

M(1) left herself open to abuse by trying to buy favours. She was taken advantage of in that, as time went by, the demands made on her became more and more excessive. So desperate was she to obtain new friends, that usually these demands were met:

> "I know deep down that I'm a fool - I'm not that stupid - but being a fool is better than being on your own. I know all about being on my own!" M(1)

K(2) said she was bullied by the whole class because no-one liked her and denied any self-bullying when she was challenged over this in light of the Headteacher's comments. L(2) was bullied for a different reason and looked close to tears when we discussed the subject. She disclosed that boys called her a 'slapper' because she wore short skirts but said she did not care. Her body language told a very different story, suggesting that her perceived image had been created from fear of social isolation:

> "All I do is dress nice so the gang I'm in will like me. If I looked like a spastic they wouldn't let me be there. So I look nice. Right gear and all. Then I'm called a slapper. Can't bloody win. Still, I don't care." L(2)

Action

(D) Much use was made of unstructured questioning during work on bullying with all four children, such as exploring why some of the children felt the need to bully. The reality therapy programme, in looking at preventative strategies, emphasised that the basic problem of dealing with bullying was how to induce a person to freely acknowledge that he or she was treating someone who was less powerful than themselves unfairly, and then to act constructively with that person. Did the participants think the way to do it was to demand an apology, to say they were sorry? All replied that under duress such a response was rarely sincere. They were then asked what, in that case, could be the alternatives?

Evaluation

(E) By confronting people with the consequences of their actions in a non-blaming manner, it was generally evaluated that this would be giving those concerned the opportunity to reflect on what they had done. There was, of course, the implication that what was done was wrong. Most participants were enthusiastic about this approach and discussed it at length, self-evaluating choices, whilst painting their need images in Session 3. In the particular case of L(1), he was quickly able to recognise how his intimidating behaviour was only, in fact, alienating him from possible friendship groups. By working with him on behaviour changes, he was able to realise that he needed to use assertion techniques rather than aggression to achieve his goals. M(1) enthused that she thought this approach was useful because there was an absence of the finger pointing, fist-waving denunciation which was characteristic of most encounters between those who would change things and those prepared to resist. Additionally, in-depth discussion with her illustrated that true friendship could not and should not be bought, allowing her to self-evaluate new patterns of thinking and behaving to overcome her loneliness.

Understanding

(P) The strength of this reality therapy preventative strategy was that it clearly illustrated that real change in human relations could only come from inside. Nonetheless, K(2) reflected that real bullies had no empathy, highlighting a possible

weakness in this approach. However, L(2) thought that the 'no-blame approach' would work as long as in the hands of people who knew what they were really doing. I was delighted to see both girls acknowledging bullying as a cause for concern. They were able to talk with conviction about a topic which affected them both. My new learning was that I had to ensure future activities encouraged constructive debate, such as this. I had proved that K(2) and L(2) *could* have a rational conversation as long as their interest was sustained and they were made to feel that their contribution was important.

7:6 GANG MEMBERSHIP

Problem

(W) Only two out of nine children belonged to a gang, one from each of Groups 1 and 2. In both cases, their needs were identified under the power need rather than love and belonging as both participants talked openly about their need for power when becoming involved with their gang. L(1) thought it was important to maintain close ties with the leader. He spoke of how his 'friends' were willing to 'backstab' other gang members in order to reach the status of gang leader. This role was to control the membership in the group and to dictate dress, activities and attitudes. In order to safeguard his position in the gang, L(1) described how, when he felt he did not belong, he felt helpless and had no sense of control over his environment:

> "The gang is everything to me. Respect from the younger boys and an expectation to do something *amazing* from boys my age or older. I don't seem to get that at school. It's like I don't exist or matter there. That's how I feel, anyhow. Without the gang now, I would feel lost because I would have no power to make changes for myself. I'd be stranded. Up the creek without a paddle, as my dad is always saying." L(1)

L(2) was the only group member to belong to a gang and this seemed to reinforce her sense of personal power. She spoke about the institutional factors within her school which contributed to a feeling of estrangement and failure:

> "My school is all about success and we have to go along with all that. But it's hard when you're crying inside but you don't know why. That feeling inside

makes you stop and then you fall behind, so you become a dumb-bag because they don't want to take time to know you - the real you. It's easier to drop out from their cosy little fairy world where everything falls neatly into place and find something that is real and fight each other for it." L(2)

Action

(D) I designed the reality therapy intervention to include work on the positive aspects of belonging to a group rather than a gang, where there was no leader, and decisions were made by the whole group democratically. I felt that, to avoid feelings of alienation and loneliness, L(1) had gravitated to subcultures such as gangs in an effort to ease the frustration of not belonging and to enhance his personal power. He regarded himself as failing so tended to seek his 'own sense of belongingness' outside of the mainstream in a more anti-social context.

At the Group 2 site, there was an emphasis on ability grouping and tracking which indeed appeared to create an 'in group / out group' mentality. Instead of promoting a sense of belonging, the policy of tracking labelled and socially isolated the 'dumb-bags' even more into a sub-culture which eventually became hostile to the academic goals of the school. L(2) had confided that being in a gang made her feel popular and her interpretation of popularity was based on the attention and visibility which she received from other gang members:

"The nice part of being popular is that everyone knows who you are." L(2)

Bullock (1992) and Galanaki (2004) found that being part of a social network offered young people the possibility of forming social relationships within that group and experiencing personal involvement, intimacy and friendship. I felt that L(2) needed to be part of the gang culture through having a low opinion of self-worth, so much discussion whilst writing a rap-song centred around valuing uniqueness, which showed itself in the final lyric drafts. As an icebreaker, I asked L(2) to name someone who was *exactly* like her. I explained that the correct answer was no-one, because human beings were quite unique and that they alone were possessors of their own idiosyncrasies.

Evaluation

(E) All groups evaluated that taking themselves overly seriously was not a successful path to obtaining good mental health. I encouraged the children to discuss their favourite comedy programmes and films, where we concluded that much of what made them funny was the way the characters *behaved*, the mistakes they made, their social blunders, their physicality and their personal peculiarities. I explained that when you laugh at these characters, you are not being malicious - you just recognise echoes of yourself and of the entire human experience in them. Furthermore, you are unlikely to put down these characters on the basis of their errors. The participants should therefore give themselves a similar benefit of the doubt.

Understanding

(P) A strength of using reality therapy in this way was that by accepting the existence of personal shortcomings, the children would come to understand their own limitations and identify areas which they might wish to target for change. By undertaking a creative activity such as song-writing, they were reinforcing these thoughts as they analysed their own needs together with strengths and limitations within these needs. The joint effort required for this task meant that they were communicating openly about their own needs without any form of dominance or power struggle.

In the literature, Scott (1991) identified that social support did not always meet the need: the help might be inadequate or offered in a way that undermined the competence of the recipient, making him or her dependent. The strength of the reality therapy intervention was that it centred on self-evaluation, so it was impossible to undermine anyone because *they* were in control of the therapeutic process. This was illustrated by the following lines from L(1), which Group 1 participants decided should be placed under the power need category of the rap song:

> "If you can make it
> Through the night
> There's a brighter day
> Everything will be alright
> If ya hold on
> It's a struggle everyday
> Gotta roll on." L(1)

The lyrics were interpreted as meaning that even when adversity strikes, one should never look down but attempt to look up because, at the end of the darkest tunnel, is a little light. For L(1) personally, he had quickly come to understand that real power was not obtained by putting others down to be gang leader, but in shining through with 'your own personal light.' Thus the success of this reality therapy intervention was that I was able to concentrate on the positive aspects of belonging to a group rather than a gang, where there was no appointed leader and where decisions were made naturally by the whole group, hence promoting democratic and socially beneficial teamwork. The session was a success. My own light was shining brightly.

7:7 SOCIAL ISOLATION

Problem

(W) Unsurprisingly, all nine children were identified under this theme. For the majority of the time, both Group 1 and Group 3 participants appeared to be very lonely and anxious children, socially isolated from their peers. All were very open about their sense of isolation and anxious to try anything which might help them become more popular. On the other hand, all Group 2 children were highly defensive, displaying bravado as masks to conceal their true emotions and feelings. Unlike the other two groups who readily acknowledged their isolation, Group 2 appeared to be either in denial or in dismissive contempt of their loneliness. In the literature, Flap and Völker (2004) identified two specific groups of 'at risk' social isolates: children in isolated environments where no potential friends were available - G(1), M(1), E(2) and K(3) - or children with emotional problems which caused them to be shunned by others - L(1), L(2), K(2), E(3) and B(3).

Looking at examples of these specific groups, G(1) readily acknowledged his isolation:

> "Sometimes playing games seems trivial. I can't relax. I'm always thinking about my mum and hoping she's okay whilst I'm gone. Anyway, I'm too tired most of the time to play. That's about being carefree and having a laugh. I don't always feel I have much to laugh about...that's why I keep to myself. But I don't really want that...I feel I'm in a no-win situation. Either way I end up on my own as.... if I don't look out for mum she won't be able to manage at home, so I'll end up on my own away from her." G(1)

K(3) said that he knew he was shy but he could not help it because he had no friends at home and no-one seemed to notice that he even existed in school:

> K(3) "I'm Mr Anonymous, me. That's how I feel... I used to sit at my desk and put up my hand to answer questions in class but Mr.....never picked me to answer.....so I just gave up trying. It was like he was looking straight through me and I wasn't there.....That's how it is in the playground too. Kids are desperate for people to make up a side for football or basketball. I stand there and they look beyond me and around me, never at me...as if I was invisible."
>
> R "What does that feel like?"
>
> K(3) "It feels like I don't exist because I don't matter to them. Nobody wants to be my friend and it hurts really badly...so I just sit there on my own and I think that is the way it will always be."

Within Flap and Völker's (2004) second categorised group, L(1) said he was shunned by others because of his height. This made him feel isolated, as other children the same age were wary of his 'power'. Paradoxically, this very power which he craved thus appeared to be the barrier to his friendship forming:

> "I feel like the lonely giant in the story you told us. I am powerful in size but... I can't make that power work for me. It seems to...well, put other kids off." L(1)

K(2) spoke of loneliness but that she did not care:

> "I hate everyone at school so what do I care that they hate me back? Yeah, I don't like being on my own but it's too bad, it's their hard luck." K(2)

B(3) spoke about not being able to understand why people avoided him and how he sometimes became "so desperate" that he would bring sweets to school to try to buy friends:

> "I know I need to find a better way of making friends. Then at least there will be some point in me getting up in the morning...and they'll stop pretending I'm not there, just the Mars bars." B(3)

Action

(D) By introducing skills to modify social isolation, it was necessary to build a structure of social competence techniques to measure the quality of the children's relationships with other people, as judged by others and themselves. Outcomes such as popularity amongst the peer group, number of friends, invitations to parties and feelings of loneliness were all long-term indicators of social competence. Short-term indicators of social competence would be reflected through the more immediate outcomes from social interaction, such as the satisfactory resolution of a conflict, being accepted to join in a game, or the impression created upon others immediately after an interaction.

Evaluation

(E) Through in-depth discussion, I established that many factors appeared to influence the degree to which the participants obtained positive outcomes from their interaction with others. Some of these related to the non-social characteristics of that child such as, in the cases of L(1) and L(2), sporting prowess or physical attractiveness. The way in which all the participants behaved in interactions with others also had a marked impact upon their social competence and demonstrated a strong need for interaction work within the reality therapy programme which would aim to show the children how to respond in ways that would make positive outcomes more likely.

In the very first session, the relationship between basic needs and behavioural interaction was explained. On worksheets the children were asked to recall and analyse their relationships with all the people, activities and groups they were involved with. The analogy of a chair was used to illustrate that their survival was like the seat of a chair - the core - and the people with whom they interacted could be represented as being the legs, which hold that core together. The children were asked to list these people in the legs of the chair under the basic needs of love and belonging, power, freedom and fun if they were able to fulfil that need.

Understanding

(P) The strength of this approach was that it was designed to 'break the chain' of social isolation. The intervention was reinforced in Session 2 and 3 by using worksheets again

to consider the Quality World and pictures in their heads. The overall aim was to ascertain how all the children could effectively help themselves to get what they really needed. They were asked to draw pictures inside a large globe representing their Quality World of a real world situation which definitely did not match the picture of what they wanted in their Quality World. Afterwards, they were asked to state exactly what they wanted in their Quality World. Important questions followed:

- What are your feelings when the pictures do not match? Do you have any physical symptoms? What is your body talk?

- What are you thinking about when your pictures do not match?

- What are your actions? What are you doing?

- Now decide: Is what you are doing above helping you?

The basic needs of freedom (butterfly), power (star), love (heart) and fun (smiley face) were drawn into visual symbols (appendix x). In each one the participants wrote "I will..." and described what they would do *that very day* to fulfil some of that need.

I quickly established that immediacy was the key to a successful outcome. By insisting that action needed to be taken *now*, I was discouraging procrastination. Yet could I learn from this myself? I am master of the 'tomorrow' culture - setting aside vital tasks through fear of a negative outcome. This fear often keeps me locked in a state of non-being. When my own loner ran unexpectedly into the night, my response was to sit in his room for two weeks staring at the wall. I was immobilised. Finally, I got myself together and took action - too late. What right do I have to lecture others, smaller and weaker than me, on taking immediate action? Perhaps it is my own life experience which makes the task all the more urgent. I want to do the right thing, say the right words, be there when I am needed. Does this passion make me a more effective therapist or a person who should be a million miles away from such vulnerability? The truth is that, *this very day*, I do not know the answer.

7:8 SUMMARY

Table 6, at the beginning of this chapter, has clearly highlighted the importance of the theme of social isolation above all other power needs. A key strength of using reality therapy to challenge social isolation and its 'side-effects' was that participants were now more likely to think and feel differently about themselves as a result of regaining some personal power. By letting other people see through their behaviour, that they expected to be treated as a person of worth, they were also more likely to affect their own evaluation of themselves and what they were capable of.

Of course, a drawback to this way of working is that there is no guarantee of success. Other children might be indifferent or hostile to the participant's declaration of rights as they might see them as an infringement or negation of their own rights. In these types of situations, compromise might not always be possible and the participant's newly-acquired assertive skills could quickly turn into anger and resentment when people might not respond in the expected way.

Whereas it might be assumed that participants from Groups 1 and 3 would respond by sinking deeper into depression within themselves, I was aware that Group 2 participants were likely to respond very differently. A pattern has already started to emerge which differentiates Group 2 from the other two groups in terms of behavioural reactions, attitudes and opinions.

CHAPTER 8

FREEDOM NEEDS

We are all in the gutter, but some of us are looking at the stars
- Oscar Wilde 1854-1900

Contents

8:1 INTRODUCTION

Wubbolding (2000) classified the need for freedom as implying that if we are to function in a fully human manner, we must have the opportunity to choose among various possibilities and to act on our own without unreasonable restraints. Many children who recognise that they might need help in generating more satisfactory social relationships do not see that they are able to make choices, no matter how dreadful their loneliness. Finding satisfactory options to increase freedom, independence and / or autonomy should therefore be seen as a primary goal of reality therapy applied to counselling within the educational system as well as for society in general. Glasser (1998a) suggested that, as with the other needs, the external world puts natural and circumstantial limits on ways the need for freedom can be fulfilled. However, Richardson (2001) emphasised that no matter how dire the conditions of a person's life, the user of reality therapy and choice theory should believe that there was always a choice. This view backed the earlier findings of Parish (1991), who stated that the need for freedom provided the balance between the ability to choose and the attempt of others to impose their wishes. Within this context, the dilemma in exploring freedom needs presented itself to be: should the participants, who were all displaying signs of exceptionally low self-worth, be encouraged to 'bask' in small accomplishments achieved or be directed to further pursue other adventures? In the following chapter, the emphasis of the therapeutic interventions has been about maintaining a purposive balance between the two. When the participants were able to see a difference between what they desired and the input they received by way of their perceptual system, a choice would be generated, a behaviour which would directly affect the external world. Table 7 highlights the necessity of providing social skills therapeutic intervention in order to extend a participant's ability to behave in ways which will increase confidence to explore, ability to choose and drive to take chances socially and emotionally.

TABLE 7 IDENTIFICATION OF PARTICIPANTS - FREEDOM NEEDS

FREEDOM	M1	L1	G1	K2	L2	E2	E3	K3	B3
Fear of failure			X				X	X	X
Living in dreams	X	X				X	X	X	X
Living in fantasy						X			X
Development of social skills	X	X	X	X	X	X	X	X	X
Adult interest			X		X		X	X	
Peer inclusion					X				

8:2 FEAR OF FAILURE

Problem

(W) Four out of nine participants identified this theme as a deterrent to their personal freedom. G(1) and K(3) were both observed as having advanced comprehension, curiosity about a variety of subjects, high language development, flexible thought processes and high expectations of self. Both boys, as previously noted, displayed withdrawn behaviours and spoke of their perception of school as being unsatisfactory to meeting their needs. They reinforced this through escaping into more stimulating daydreaming or more need-fulfilling social interaction when they felt able, judging themselves critically and demonstrating behaviour to meet their picture of perfection.

Fear of failure was so real to G(1), that it acted as a deterrent to his personal freedom:

> "School makes me nervous. People might not like me if they think I'm stupid. I have to be careful what I do so no-one will catch me out being thick." G(1)

Yet he was a gifted and talented boy, unable to recognise his own special qualities:

> " I don't believe I have anything special about me. That's why I'm not important to anyone, not even myself. It's good not to be special, then you can't get hurt so much." G(1)

Often G(1) appeared both bored and worried, stating:

> "I never feel I am achieving much of any real significance." G(1)

K(3) was frightened of being judged negatively and feared failure. He was also daunted by his class teacher:

> "He's very, very strict. I just sit there and pretend I know it when I don't. Daren't say." K(3)

By contrast, E(3) and B(3) were highly influenced by adults but had no personal control over them and were often unable to live up to parental expectations of near-perfection. Although in awe of their class teacher, both children found school to be a 'safe haven'

and fully participated in school activities, to which they did have an element of control. However, their enthusiasm and sense of individualism was taken to extremes to overcompensate for their fear of failure and fears of standing alone. I viewed them as vulnerable, frightened, lonely but real selves, certain of rejection in a judgmental world.

Action

(D) If the goal of providing reality therapy was to facilitate full involvement and to increase opportunity for success, the participants had to be free to utilise their strengths in an autonomous and purposive way. The strength of the reality therapy programme was that it was designed to provide an opportunity to gain effective control of the participant's personal and academic lives. The programme demanded that all four participants who had a fear of failure took an active part in the remediation of their presenting problems. Using reality therapy meant that I was in a strong position to help them achieve this, being the most action-based of all the cognitive behavioural therapies. I saw the perception of choice as an essential component for these young people in taking effective control of their personal and academic lives. Another strength of using reality therapy was that, in combating psychological defences against fear of failure, I could empower the participants and, in efforts to do this, the word 'choice' would be repeatedly used. The degree of choice that the participants perceived as being available to them was therefore interweaved into many task discussions, facilitating thought process on the changes the children could choose to make in their behaviour.

Evaluation

(E) Much of the dialogue centred on the school surroundings and school personnel, which had a disempowering effect on the participants. A major component of my reality therapy programme was, conversely, that I did not give up on the participants but remained committed to facilitating the development of more effective behaviour. With willingness and the development of a repertoire of skills for meeting their needs, the goal of my intervention was that the participants might start to develop a 'success identity' in which they would begin to believe in their own capabilities. Using the reality therapy approach placed major emphasis on personal responsibility for the

development of action plans; my intention being to compensate for the problems of children who had a fear of failure.

Understanding

(P) The therapy was successful in facilitating the development of autonomy and responsibility in participants and, in so doing, ameliorated the tendency of the socially isolated individual to invoke the external factors of luck and task ease as explanations for success and failure. A perceived weakness of the therapy could have been that normal achievers usually tended to internalise success, whilst those who had behavioural problems or were socially isolated would tend to externalise success (Glasser, 1992). Such a pattern of attributions and self-concept would mean that individuals needed to learn to motivate themselves by internal forces. For the therapy to succeed, it was therefore essential that the participants 'took on board' that nothing they did was caused by something that happened outside of themselves (Glasser, 1998a). In the literature, Palmatier (1998) and Wubbolding (2000) clearly rejected the notions of internal compulsions and repression from childhood. Ledley *et al.* (2005) backed this view, describing many other counselling techniques as actually contributing to feelings of helplessness and dependency.

The advantage of structuring a reality therapy intervention to overcome feelings of negativity and fears about being a failure was that it ensured that the therapy had a significant impact on the child's perceived personal freedom and resultant power. Therefore, within the reality therapy context, less attention was placed on labelling the participants and more attention was placed upon identifying their interpretation of the problem. Careful consideration was firstly given to what was blocking need-fulfilment for them and then, subsequently, to the development and implementation of appropriate action strategies that could remove the block.

For Groups 1 and 3, I am certain that CBT principles such as this are 'the way forward'. However, I am starting to doubt whether it is the correct approach for the third group. Have I been right to completely dismiss other therapeutic ways of working? Were Palmatier (1998), Wubbolding (2000) and Ledley *et al.* (2005) right? Whilst asking 'who am I?' to doubt these revered academics, should I be more integrative, more

eclectic and apply more 'transtheoretical' concepts to my general approach? Doubts about the reliability of my deeply-held views and the core beliefs of my professional practice are beginning to emerge, despite huge CBGT success with Groups 1 and 3.

8:3 LIVING IN DREAMS

Problem

(W) Six out of nine children reported living in dreams as an important part of their daily lives. This theme was placed under the freedom need because, for many children, dreaming was a release from their daily solitude. Liebmann (1986) emphasised the importance of allowing children to freely explore their dreams and have guidance provided on imaginary journeys. Chodorow (1991) agreed with this view, adding that dreamwork could aid the bonding process of lonely children. Hence, the reality therapy dream evaluation questionnaires (appendix viii) evolved as a group process because it was a group activity where dream self-analysis was shared. The imaginary journey also aided the bonding process as the children cuddled up together on floor cushions to collectively share the experience of entering a magic garden together.

E(2) displayed a maelstrom of jumbled feelings, thoughts and potential actions that were in a constant state of reorganisation. He appeared to have little or no awareness that this was happening except when he was in this dreamlike state. He lived his life, for the majority of the time, unable to detach his dreams from reality:

> "My dad doesn't get about much now. He was a fighter pilot in the war and got injured." E(2)

> "When I'm not around it's because we go to Disneyland each month for a weekend. My family is dead rich." E(2)

The truth was that E(2) had never had a holiday away from home and his father was a severe manic depressive who had never worked because of his condition.

By contrast, the reported dreams of the other children from Groups 1 and 3 seemed to be creative attempts to deal with the frustrations of the previous day and, as abstract as

they might have appeared to be, they helped the children control their lives by resting their minds from inner turbulence. M(1) and L(1) discussed dreaming as an integral part of their daily routines. M(1) was adamant that her dream of being famous one day would come true and then everyone would want to be her friend, whilst L(1) said he was always dreaming of catching the biggest fish in the world:

> "When I'm curled up warm in my bed, half-awake and half-asleep, I can take myself to a different place in my head. I am walking along the quay like I do at weekends in my favourite gear...watching and waiting. That's how people get discovered and become famous. I'll try to catch the eye of a person who can help me to be different, be someone else. I'll know who it is when they come along because my instinct will tell me to smile and be noticed. Then things will be different. Just you wait. It won't always be like this, lonely and friendless."
>
> M(1)

> "I often dream that I've caught an enormous whopper. Everyone wants to see it and get to know me. I wouldn't have to look for a job. I'd spend my time listening to people praising me. That fish would be a real result." L(1)

All three participants in Group 3 placed great emphasis on their dreams. E(3) enthused about the Barbie doll she had at home:

> "I dream of growing up like Barbie. She is so pretty and popular." E(3)

Conversely, K(3) was able to recognise how he dreamed to blot out reality:

> "I pretend I'm in the castle and dressed in armour, fighting off all these soldiers. But they're trying to get to me to worship me as their leader. And I'm fighting them off. It's a good dream, isn't it?" K(3)

B(3) described dreaming of standing high on a mountain and below him was a little boy who was looking up and waving:

> "I was the one up the mountain and, at the same time, the little boy at the bottom looking up. I don't know how I made it up there, but every night I dream of how it could be." B(3)

Action

(D) Data gathered from the dream evaluation questionnaire (appendix viii) indicated that no participants were in effective control of their lives. It was explained to the children that even the most effective among them would find themselves frustrated by day-to-day irritations and setbacks. Just being alive, they would be faced with major frustrations and conflicts and, when stress levels were high, they were likely to have visited and utilised a reorganising system by dreaming. The groups were shown that, in so doing, when they were faced with painful choices they might be willing to accept challenging reorganisations and new ways to behave. Whilst dreaming, pain and frustration might have led the participants to closely examine the choices they had made and the changes they might now begin to assess and admit were necessary.

Evaluation

(E) I emphasised the importance of recognising the need for change and the need sometimes to make effective changes quickly. Using dreams as a guide to the creative centre, with careful questioning and the procedures that lead to change, it was possible to create a safe environment in which the children could self-assess and become the experts of their own dreams. E(3) and M(1) had spoken of nightmares, which helped them realise what they really wanted. There was discussion about how some nightmares suggested that presently-used organised behaviours might have been ineffective or even dangerous.

Understanding

(P) An advantage of dream analysis in reality therapy terms was that some nightmares might present strong emotions in the feeling component in such a way that more and better cognition could operate. B(3) had described how he had often come to school with a memory of a 'bad dream' which limited his ability to perform in school. He said that talking about his latest 'bad dream' within the security of his group had given him an opportunity to view the dream differently. We discussed how happier and more peaceful dreams could be an affirmation of current behavioural choices or even the suggestion of better behaviours in order to acquire the more satisfied state.

Another advantage of diagnosing dreams from a reality therapy perspective was that many dream scenes and vignettes might suggest ideas for effective and creative behavioural choice. Believing dreaming to be a reorganising process provided opportunity for Quality World and behaviour exploration. Most participants welcomed the exploration itself and reported that the disclosure, even when there was no immediate resolution, was useful.

Again, I realise that I have entered - almost by accident (or was it?) - the realm of psychoanalysis. I am wrestling with the ideas of dream experts such as Jung and trying to incorporate them within my CBT arena. There is much guilt about doing this, as if I am betraying someone or some hallowed principle. Again, I am coming around to the idea that I must be more flexible, not only in the programme content and suitability to participants but also to the idea that other therapies can be amalgamated successfully with reality therapy. It should not be used exclusively, as I have planned to do, when there is much to be gained - and learned - from other approaches.

8:4 LIVING IN FANTASY

Problem

(W) Dreams extended into fantasy in only two cases - E(2) and B(3) who were, in many ways, the most ostracised of the group participants. However, E(2) and B(3) were very different children. E(2) was often unable to differentiate between fantasy and reality, displaying worrying signs of - perhaps - mental illness:

E(2) "I'd like to melt into the computer and instead of being me I'd be Hercules. Have you seen him? He can blast anything away that comes between him and his goal. He's a winner - he just does it."

R "But surely Hercules is just a fantasy character? What about real life?"

E(2) "Hercules is real! My dad knows him. Yeah, I've seen him. He's magic!"

R "Where have you seen him?"

E(2) "In reflections in the sunlight. In shadows through alleyways. I see him all the time. Yet when I reach out to touch him he disappears."

B(3), on the other hand, did know the difference but chose very often to immerse himself in fantasy as an escape channel from painful realities which he was not able or willing to face. Galanaki (2004) identified emersion in fantasy as important for pre-adolescents who needed to develop an inner identity in order to free themselves from dominating factors. In B(3)'s case, this was the overbearing influence of his parents. He spoke of fantasising that, once he had climbed his mountain (8:3), he would be free forever. This was a boy who was never allowed out unaccompanied, never allowed to be free. The severity of his need for freedom had 'crossed the line' from dream to fantasy but it was 'keeping him going' in his quest for freedom:

> "I know that when I start to fantasise it isn't real, isn't true. But it keeps me believing that things could be different. Well, those are the good bits. Some bits can be scary and I don't work them out because I'm afraid I won't like it." B(3)

Action

(D) Wilson (1983) indicated the importance of using stories, myths and fairy tales in order to stimulate emotional development. Therefore, in Session 4, the children were asked to write their own fairy story. They were allowed to use as much fantasy as they needed in order for it to have a happy ending which could be acted out. In imaginative pretend play the groups role-played, identified with and effectively became a character, or some characters, in the drama. Wilson (1983) had argued that, for a fantasy to enrich the lives of troubled pre-adolescents, it had to give full recognition to their disturbances and suggest solutions to problems which might perturb them. Chodorow (1991) backed this view, describing fantasy work involving fairy tales as tools to stimulate experience and offer possibilities for difficult emotional tasks.

Evaluation

(E) Most group members found it easy to play roles of fantasy characters like fairies, monsters and superheroes. In their imaginative pretend play, the whole child was totally involved in acting out a character within an imagined situation. However, I noticed that these role-plays mirrored very closely the real-life situations of the children. Whilst Wilson (1983) had argued that a prevalent parental belief was that pre-adolescents should always be diverted from exploring chaotic fantasies, it seemed logical that part

of the reality therapy intervention should focus on actual fantasies, such as B(3)'s, because he was aware of their unreality but equally frightened by them.

Understanding

(P) The intervention with B(3) came about naturally, as a means of expression for his point of view and a channel of communication which would be acceptable to him, as advocated by Liebmann (1986). As an icebreaker, I asked why he was so seemingly tired. He volunteered the information that he was waking up in the night with the same disturbing thoughts. He described these thoughts as going far beyond a normal dream or nightmare. He could recall an ugly old man who came to him and told him to put his head on the shelf. B(3) described, without ever using the word, a guillotine. He then said that he woke up screaming in terror because, if he did not wake up, something terrible might happen to him. I suggested to B(3) that his fantasy might be about having restricted freedom and that something was about to happen that he did not want. He reflected that he always had that feeling at home, but not when he was at school. I made a proposal to him that the next time the ugly old man appeared in his fantasy and told him to put his head on the shelf, he was to say "no!" B(3) practised saying "no!" and was, in fact, able to do so the next time the fantasy sequence presented. He later reported in Session 9 the cessation of the fantasy and school personnel noticed a more attentive, rested youngster. The strength of the reality therapy intervention, in this circumstance, was its precision. Through a much more direct intervention, B(3) was invited to choose a different behaviour in the fantasy sequence. In this case, his chosen behaviour was asserting refusal. The reality therapy was successful in allowing him to see that he need not accommodate unreasonable demands and, with advocacy, he could learn to assist his healthy and reasonable wants.

This was another successful intervention with a Group 3 member, who digested reality therapy principles and learnt from them. I did not attempt this strategy with E(2) because my clinical experience told me that it simply would not work. E(2) was not just unwilling but *unable* to recognise that his fantasies were unreal. By the same token I was able to recognise that, if I had used reality therapy inappropriately with him (which it would have been in this instance), I would have found myself 'paddling backwards and gradually being pushed out of my depth'.

8:5 DEVELOPMENT OF SOCIAL SKILLS

Problem

(W) The development of social skills was an important theme with all nine children. Through careful observation, I recognised that the following characteristics typified all participants. Often they did not adapt their behaviour to accommodate the needs of others. They tended to choose less socially acceptable behaviours and had difficulty in predicting the consequences. Sometimes they misunderstood social cues or were unable to perform the social skills required for particular situations. Finally, they often had an inability to control impulsive or aggressive behaviour.

Using puppets to foster social skills turned out to be a revelation, as personal circumstances were every time reflected and mirrored in the theatre which evolved. G(1) saw himself as the pirate who punched the witch and the nurse so he could make his escape:

> "You think you have got me just where you want me, don't you...you wicked pair! But one day I will turn the tables on you. I will get my revenge for all the suffering you have caused me." G(1)

L(1) and M(1) used puppets frenetically, by contrast creating a positive uplifting ending to create a play between them based on a struggle for supremacy and freedom:

> L(1) "I could turn you into a frog, a sheep or a monster to scare you when you look at your own reflection. You must beg for your freedom!"
>
> M(1) "I have magic powers too, Mr Wizard! But I do not need to prove myself to you.... because I can fly away on my magic broomstick and be free."
>
> L(1) "What good is being free when you have no-one to share that feeling of happiness and power with as you drift along on your wind current?"
>
> M(1) "Climb aboard...don't sit on my cat! (laughter). You can share my broom and my life. We will fly away into the deepest cloud..... Let's not fight anymore. Let's be truly free."

Whilst being unwilling to engage in fantasy play, E(2) appeared to view the puppets as one step removed from his own negative experience, although his puppet work unwittingly brought the realities of his life very much into focus:

> "I am the wizard who rules the world. I have control over all of you (beats each puppet in turn). I do not need to lose myself in my magic. My magnificent presence is everything!" E(2)

Likewise, L(2) used the witch and the girl to sub-consciously illustrate through play her own home situation:

> "I will beat you, beat you. You are stupid and poor and bad.... You can only cry instead of being strong so you deserve to die - you poor pathetic female!" L(2)

L(2) saw herself not as the repressed girl but as the wizard who wanted to punish. Having previously spoken of witnessing domestic violence in her home circumstances, in her puppetry L(2) had taken over the violent role, mirroring her disrespect for a "weak" mother and for other females in general. This disrespect made forming a positive relationship with K(2) untenable. Likewise, K(2) used puppets to seemingly represent the effect on her of having a damaging male figure in her life. Many of the comments directed to the girl puppet by her wizard had sexual overtones:

> "Little girl, be very afraid of me. I am everywhere you go, watching and waiting. I want to take you to a dark cave, little girl. We will have fun there and your mother will never find out because if she did, you know I would kill you, don't you?" K(2)

With Group 3, many signals were displayed to suggest that all three participants needed to develop new social skills that were more appropriate to their situations. In her puppet work E(3) used the old woman who was continually hugged by the puppet child and then, within seconds, slapped:

> " I know you took me in when no-one else would have anything to do with me. For that I will give you a cuddle. But you are wicked and you put yourself first so I don't like you sometimes. Here...(slap)...that is for letting me down!" E(3)

These comments displayed a sense of confusion. E(3) clearly loved her grandmother but was still haunted by her past and became resentful when she was not always the centre of her grandmother's world. Similarly, K(3) used the pirate and the boy to represent issues with his disabled father:

> "I am going to push you overboard. Walk the plank! I need to free this ship from your presence. You have served our purpose but now....be gone!" K(3)

B(3) used his puppets in a more positive way, whilst at the same time illuminating his loneliness. All the puppets started out as friends and even though the witch and the wizard tried to split them up by trickery and deception, the remaining puppets stuck together and formed an even closer bond:

> "It seems that nothing we can do will break your relationship. We give up. Let's fly away into the sunset." B(3)

Action

(D) In light of the above observations, three components were identified to enable social skills training to be effective and useful. The reality therapy intervention needed to help participants gain clear ideas about what constituted socially adaptive behaviours. It needed to help participants discover how to use appropriate social skills and it was necessary to help the children generalise the skills learnt, so that they could be put into practice in the various social situations of the child's own environment. By using puppets (appendix xii), the witch was both wicked and caring who could also be mother, teacher or nasty female associate. The wizard was a magical character too but could also be a father, grandfather or threatening predator. The old woman was a kindly soul and represented a granny, teacher or neighbour. The nurse was the carer who could also double as a girl, mum, sister or older friend. The pirate was a rogue who could be a brother, stepfather or general baddie. Lastly was the little boy who could be a little girl or a sibling or a peer.

Evaluation

(E) A strength of using puppets as a reality therapy intervention was that they were easily manipulated, required little preparation and were familiar toys. Unlike imaginative pretend play where a child role-played, identified with and effectively became a character, using puppets could involve the groups using ideas separate from and external to themselves, although this rarely seemed to happen in practice.

Understanding

(P) The participants were able, without restraint, to attribute to the puppet beliefs, behaviours and personalities which might be different from their own. Each member of the group was able to project their own ideas onto the puppets, giving them personalities, choosing their behaviours and putting words into their mouths. Thus the positive goals of the programme, when using puppets in the development of social skills, could be seen as to gain mastery over issues and events; to be powerful through physical expression; to develop problem-solving and decision-making skills; to improve communication skills; to develop insight and to socially bond the groups together.

This did indeed happen with Groups 1 and 3. I noticed a camaraderie amongst members after using the puppets, which brought them to a new level of group social acceptance. The same was not true with Group 2. Each participant was unusually subdued after the puppet work. It was almost like the content of their personal theatre had been so poignant that they were left exhausted. This leads me to reflect once again on the appropriateness of activities which I presented to this group.

8:6 ADULT INTEREST

Problem

(W) G(1), L(2), E(3) and K(3) were, in many ways, the most independent of group members and yet the most emotionally vulnerable. Glasser (1965, 1984, 2000) postulated that all children sought a world in which they could experience the maximum amount of happiness and success and the minimum amount of pain, suffering and failure. Wubbolding (2000) reiterated this thinking, stating that it was a natural human tendency to create a Quality World. This world was made up of those people, places and experiences that made them feel that they belonged. This sense of belonging was then able to give them freedom. Adult interest was observed as being the key component for all four children to feel secure within themselves.

G(1) was an adult carer and was accustomed to an adult environment. He was the only one of his group who thought and acted like an adult; a boy who had learned to grow up quickly because of the deficiencies of his mother, to whom he was very protective:

> "I can't bear doing activities to which there is no point. Some games are so trivial and meaningless that I watch them and think how laughable they are. I'm almost glad when I don't get included because I grew out of all that childish stuff ages ago. I prefer to play chess with grown-up people like Mr.....(class teacher) at lunchtimes or I'll nip home to check on my mum." G(1)

Two out of three children in Group 3 found enjoyment by mixing in the adult world and engaging in the interest of adults. Like G(1), K(3) was also an adult carer:

> "I have to sit with my dad a lot when mum goes out and sometimes his friends come round. They tell me all about what they were like when they were young. Dad talks about his outside toilet and having a bath in front of the fire when he was very little, just like my granddad did. I love all those old stories!" K(3)
>
> I like being with my Grandma's friends. They are much funnier than my own, well those who could be my friends if they wanted to. I get taken places and treated to beauty therapies. Some girls in my class don't even know what half the stuff is.....but they haven't grown up like me." E(3)

L(2), on the other hand, controlled her mother by her negative behaviour learned from older peers. She was a streetwise individual and seemingly mature for her age, which may have been influenced by witnessing domestic violence throughout her childhood and being a member of an older gang:

> "E(2) and K(2) act like babies. They ain't fashionable or switched on like me and me mates. But I can control them because I know where it's at. I like that. I can show them how to get a life because I hang loose with kids who are really adults as they've packed in school and are doing their own thing." L(2)

Action

(D) All four children appeared to find safety from emotional pain by mixing in the adult world but, at the same time, I sensed that there was a sub-conscious resentment for taking away their childhood. In the literature, Larson (1999) identified lonely young people as falling within two categories. They either poured their hearts out to listeners, as could be found with L(2) and E(3), or kept their lives extremely private, as in the case of the two adult carers, G(1) and K(3). I felt that it was important to concentrate

therapeutically on attaining changes in the way the children perceived their adult-focused role before becoming emotionally overwhelmed.

Evaluation

(E) A strength of being able to use reality therapy in this situation was that I could help children, faced with adult responsibility, make emotional changes in order to facilitate an unburdening process. Whilst acknowledging responsibility as a positive attribute, too much responsibility too young is clearly unhealthy. For example, the adult carers could be encouraged to feel sad rather than depressed that they were not free in the evenings to mix with peers. Naturally, a perceived weakness of reality therapy in this context could be that feeling 'okay' or 'fine' might not fit the bill when dealing with a tough situation. However, practitioners Cohen (1993) and Weare and Gray (2003) would argue that feeling negative emotions about negative events *was* realistic and appropriate.

Understanding

(P) The two adult carers were encouraged to identify inspiration for positive change. I understood that their motivation might flag sometimes and that they might not ever be able to imagine overcoming their burdens. However, there were ways of encouraging positive thought such as pinpointing a role model who had characteristics they might aspire to adopt themselves. Both boys were individually asked if they knew someone who stayed calm, expressed feelings to others, was open-minded to new experiences or was assertive and determined. Whether real-life or fictional, alive or dead, known to them or someone they had never met, both G(1) and K(3) were able to choose someone who inspired them and was able to give them a model for a new way of working. With the girls who led adult-focused lives, it was important that they were both encouraged to realise that growing up too fast could often facilitate unhelpful patterns of behaviour and I urged them to regain some control of their speed into adulthood. A strength of using reality therapy in this type of 'cost-benefit analysis' was that they were able to examine the pros and cons of something that could help galvanise their commitment to change. L(2) and E(3) were individually able to self-evaluate the advantages and disadvantages of their behaviours, emotions, thoughts, attitudes, beliefs and options in the short-term, the long-term, for themselves and for other people.

Discussion about entering the adult world too soon made me self-reflective once more. Neither my son nor myself coped with the circumstances of our childhood and we both plunged into adulthood too fast. So are we governed by our genes or our environment? It is the age-old question. Reality therapy decidedly promotes the latter, but is it really so? I wonder how the children from this study will prosper in the future. Will they make it that far? I try to visualise Group 2 as adults - but I cannot. The canvas is blank.

8:7 PEER INCLUSION

Problem

(W) Despite having a condescending attitude towards her fellow group members L(2), the only participant classified under this theme, was willing to reach out to anyone who would befriend her, whilst making it clear that she needed to maintain her freedom:

> "I imagine I'm like a bird in the cloud, high up there so you can't see me. But I see you. Then I will swoop down and you can choose me to be your bestest friend. I will be anyone's friend ...anyone's.....as long as I can still fly away, still be free when I need to be." L(2)

Often schools have not provided a sense of personal freedom for many young people in modern day society (Glasser, 1992; McLeod, 2005). When L(2) did not feel included in the school community, it ceased to be part of her Quality World and she "did a bunk", running away back to her home territory, or imagined herself as the bird flying free in the sky. This was, she explained, because school had become an alien world where she felt rejected, frustrated and estranged. I observed that, as well as an enhanced need for freedom under these conditions, L(2) also had an underdeveloped sense of belonging in school, which may have been her reason for joining a gang outside of school comprising of much older children. Larson (1997) recognised this position, postulating that young people were often more adept at affiliating with adults than with peers. I also felt that L(2)'s alienation, estrangement and ultimate disengagement from her school setting might be because her school emphasised ability grouping and tracking which created the 'in-group out-group' mentality. Instead of promoting a sense of belonging, the policy of tracking meant that individuals were inevitably labelled, with the result that they became hostile towards the academic goals of the school. Additionally, the person-to-

person relationship which L(2) was unable to achieve with either the Head or the class teacher meant that she could not develop a positive attitude about learning or confidence in herself. Subsequently, there was no intrinsic desire to rise to the expectations of her teacher, fellow classmates or group participants.

Action

(D) In the literature, Evertson *et al.* (1997) discussed the three key issues to be considered in relating to peers. Firstly was the extent to which children felt included or excluded from their peer group, who within the group had a given status as a leader and who was a follower, and whether the individuals in the group felt any lasting affection for one another. The reality therapy intervention clearly needed to promote a sense of cohesion with an emphasis on accepting others and trusting peers with ideas and feelings, as advocated in the literature by Evertson *et al.* (1997) and backed by Perry (2001) and Galanaki (2004). The emphasis of L(2)'s behaviour development within the reality therapy programme would therefore be to focus her therapeutic education around the development of the total individual.

Evaluation

(E) I planned to instigate discussion with L(2) with an emphasis on 'people-building'. Mutual trust, respect, caring and co-operation would serve as the cornerstones of the therapeutic process. Peer inclusion had to involve the sharing of responsibility for therapeutic learning. It was vital to help her to feel empowered to make decisions and have choices, in order for her to develop her social skills and begin to feel happiness as well as sharing a sense of ownership for the activities of the group. However, in the literature Rubin (1980) and Wubbolding (2000) identified a possible weakness of the therapy used in this way, arguing that isolated and unhappy pre-teenagers could negatively affect the atmosphere of the larger group, provoke discipline issues and limit the activities on offer to that particular group. These fears did materialise, although a climate of respect was partially created. Simple acts of kindness conveyed a message of respect and illustrated that showing kindness might be the strongest of therapeutic tools in dealing with a child who had a history of neglect, rejection and abuse.

Understanding

(P) The strength of using reality therapy in this way was that use of respect, self-disclosure and kindness would dissolve the barriers of authoritarianism or pretentiousness that could destroy a therapeutic alliance. Instead I hoped that the therapy, used in a positive way, could create an atmosphere in which the participant chose to belong. An attitude of respect was felt to be especially important for a child such as L(2), who was in an emotional crisis and needed to have affirmed that I was there for her.

A 'lightbulb' moment has entered my head. I demanded respect from my own children when they were growing up. Yet I never thought about respecting them. After all, I was in charge. It was my house. They lived by my rules. My other two children had no issues and could cope, but not Stuart. Why did I not respect that? ....and him? He was different but I never respected that uniqueness. The scenario is playing out all over again, except this time it is with the groups. Two can cope; one cannot. Transference issues are glaring at me and cannot be ignored, so I will set aside my purist CBT stance. I cannot afford to 'lose' L(2) or the other two through ignorance and tunnel-vision. My own recall must act as a valuable learning curve.

8:8 SUMMARY

Just as social isolation was a key area for therapeutic intervention within power needs, the development of social skills has been illuminated as equally as crucial. All nine children were clearly identified as longing to be free from their personal restraints which could often immobilise them from making positive social contacts. Another distinctive feature which has become apparent throughout this chapter has been the increasing difference in reactions and responses between Groups 1 / 3 and Group 2. Reality therapy interventions have not always been successful with Group 2, with lack of time and depth of resistance because of psychological damage emerging as significant factors. On the other hand, the differences between Groups 1 and 3 have appeared to be marginal, with successful reality therapy interventions highlighting positive social behavioural progress in both cases.

CHAPTER 9

FUN NEEDS

It is an uneasy lot at best, to be what we call highly taught and yet not to enjoy:
To be present at this great spectacle of life and never to be liberated
from a small hungry shivering self - George Elliott 1819-1880

Contents

9:1 INTRODUCTION

From the start of a person's creation, the new-born infant will look for ways to enjoy a sense of comfort. Once this is achieved they should, in an ideal situation, be able to spend the majority of their time having fun (Winnicott, 1965). Glasser (1998a) highlighted that one of the first times an infant laughs is when someone plays 'peek-a-boo' with them. From this early beginning the ability to relate to others is learnt. Glasser (1998a) stated the importance of connecting fun to human learning. So what is to become of the child who has never been given the opportunity to learn how to interact with society and form relationships through play, who chooses not to play or has forgotten how to play?

This chapter will examine a number of sub-themes centred around the participants *inability* to play and to enjoy. Wubbolding (2000) stated that effective fulfilment of the fun need was gained by a child's ability to fight boredom, apathy and depression. The following sub-themes illustrate an inability on the part of many children to be able to succeed in that task. A key aim of the reality therapy interventions was helping the children have fun together, doing enjoyable activities as a group to build relationships and teaching the children to be able to laugh at themselves and at the foibles of others in an appropriate way. Having fun together could then be seen as an intimacy-increasing behaviour, which was so vital for a socially-isolated child to learn. Some of them had already conditioned themselves to believe that fun was a superficial, shallow idea which had no place in their own lives. I aimed to show these children that partaking in activities which were at least tolerable could lead to them abandoning or replacing current harmful compensating behaviours which could lead to depressing themselves or acting in destructive ways. Therefore, one of the goals of the therapy within this section would be to help the children fulfil the need for fun or enjoyment within reason and without infringing on the rights of others.

Table 8 overleaf illustrates that all the case participants have two, three or four behavioural difficulties within the detected sub-themes which, collectively, may be viewed as deterrents to having fun in positive, appropriate ways. The therapeutic interventions based on these sub-themes encouraged, where possible, intrinsic satisfaction which could be increased still further by making social contacts in

enjoyable ways and building satisfying relationships both within the group and within their Quality World.

TABLE 8 IDENTIFICATION OF PARTICIPANTS - FUN NEEDS

FUN	M1	L1	G1	K2	L2	E2	E3	K3	B3
Lack of physical activity			X	X		X		X	
Personal neglect			X	X		X			
Lethargy			X			X		X	X
Over-exuberance	X	X			X		X		X
Inappropriate humour	X	X		X					X
Mischannelled energy	X	X		X	X		X		X

9:2 LACK OF PHYSICAL ACTIVITY

Problem

(W) Four out of nine of the group participants were identified as doing no exercise at all out of school - G(1), K(2), E(2) and K(3). As identified by Long (1996) in the literature, these children were able to rationalise that lack of physical exercise was an attribution towards their feelings of social isolation and inappropriate behaviour. Lack of physical activity was placed under the need for fun category as three out of the four children - G(1), E(2) and K(3) - perceived taking more physical exercise would be a fun activity.

G(1) said he would like to start running in the evenings to "clear his head" but was not sure whether he could keep it up. The following comment suggested that maybe he had too much physical activity of an unhealthy nature for a boy of his years:

> "As soon as I get home from school I'm off down to the shop to get stuff for the evening meal. Then I've got to clean up. Then I make tea and then I clean that up. After that I just flop in front of the TV." G(1)

E(2) spent all his spare time in front of a computer playing fantasy games. He loved to play football but made excuses because of embarrassment in the changing rooms:

> "They all take the mickey out of my hair and tell me I'm scruffy. So I always make something up so I don't have to play and go through that afterwards. But I really miss kicking a ball around." E(2)

K(3) spent long periods of time in total inactivity but spoke about his desire to become more involved physically as he felt it would stop him worrying about trivial things:

> "I worry about everything. I can't help it. Mum is very strict with me and says I must be grown up because of my dad. So I worry in case I've done something wrong or it isn't good enough. I haven't got time to do any sport as I've too many chores to do. When they're done I spend my time worrying that they aren't done properly." K(3)

However, it was difficult to convince K(2) that exercise could be fun. She had a negative attitude towards physical activity partly because she had had unpleasant physical activity experiences as a small child and partly because she believed that exercise was a physically uncomfortable means (e.g. sweating, breathing hard, muscle aches) for getting what she wanted. Her earlier abuse appeared also to have affected her thought processes around forced exercises. Although highly overweight, she refused to acknowledge any mental or physical benefits:

> "I can't get started. I watch the others and think 'I wouldn't feel okay about that because it would be doing both my head and my body in.' Anyhow...something down inside always seems to block out the realness of it..... I can't really explain what I mean. I just comfort myself with things like crisps or chocolate." K(2)

Action

(D) As G(1), E(2) and K(3) were so responsive to ideas for increasing physical activity opportunities, I felt that the emphasis of this intervention should be with K(2) who had much more profound issues from the past to deal with. I sensitively suggested some pleasant exercise experiences which she could try, setting realistic goals which would help her lose weight and which would not lead to uncomfortable physical sensations.

Evaluation

(E) I emphasised to K(2) that commencing and committing to an exercise programme could help her meet her extrinsic goal of weight loss, but the key to continued exercise was in making the activity intrinsically satisfying. By attempting to make her understand how her programme could provide the intrinsic reward of fun, 'getting started' need not even then require extrinsic motivators such as weight loss. As she was still negative about exercise but determined to be thinner, I shared with her that, although she had not even realised it, she had begun the process of change already by simply discussing the issue.

Understanding

(P) In this type of situation, my approach was to place the responsibility of initiating action onto K(2) as I encouraged her to take control of her behaviour. My aim was to assist her to develop a realistic physical activity plan that was satisfying. This plan was then more likely to lead to motivated initiation and future adherence. I would use any excuses as 'ammunition' to ask whether an excuse was getting her what she wanted. A possible weakness of the therapy with such a damaged girl could have been that her learned hostility might even have antagonised the delicate situation further, as identified in the literature by researchers such as Peplau and Perlman (1982), Rotenburg and Hymel (1999) and Galanaki (2004). However, by using self-evaluation techniques, K(2) was able to remain in control - enabling the intervention to be successful.

I am still grappling with my feelings about K(2). Her hostility towards her fellow group-mates remains intense, yet I sense a very vulnerable soul desperate to be heard. I would have liked to have been able to conduct the remainder of our allocated time together as one-to-one sessions. That is what she needs because she is using high-defence strategies to mask a deeply troubled psyche. I do not have the time or the authority to give her the attention she deserves. Neither do I believe that reality therapy holds *all* the answers for her. This last intervention was successful but it only touched the surface of years of neglect and abuse. I am frightened that I will fail her in the long run and, in so doing, join the long queue of other professionals who have 'thrown in the towel'.

9:3 PERSONAL NEGLECT

Problem

(W) Three children - G(1), K(2) and E(2) - were recognised as having issues under this theme. My feeling was that personal respect, perhaps more than any other quality, would bring about a sense of pride in a child who was obviously lacking so much in the need for fun category. The antithesis of respect was personal neglect in this context and this theme appeared to have generated from a lack of appropriate physical activity and personal power.

G(1) was always on the defensive. He had conditioned himself to be the rescuer, neglecting himself through setting aside his own personal needs:

> "I know I haven't washed, okay? But I did wash the clothes and wash out the cat basket before I came to school. Just me that I didn't have time for." G(1)

For K(2), her issues were so raw that she had no personal regard for herself. She wore special spectacles which were broken and taped with elastoplasts so she could barely see out of them. After several sessions, when asked about them, she said:

> "They do get on my nerves. Mum has promised to fix them when we hear from my dad as he owes her money. In the meantime, I've just got to get on with this pair but I'm not bothered." K(2)

K(2) and E(2) both had identifiable traits of personal neglect which I observed on many occasions. However, unlike L(2), neither had the disposition for fancy clothes or the need to shoplift to achieve this. E(2) was usually bedraggled and dishevelled despite his effeminate haircut and eccentric mannerisms. He did not always seem to care that others were commenting on his body odour and filthy fingernails. His situation was so demoralising for him in both the home and school contexts that he confided one day:

> "No point at the moment. No chance of the bathroom at home as there are so many of us. As I am the youngest, I have to wait until last and then the hot water has run out. At school I get done in the toilets. So no point." E(2)

This remark suggested that whilst E(2) was often detached from reality, often he was only too aware of it. He was neglectful of his needs in the real world because he had no viable choice. His personal reality was just too painful to face. All three children had no self-respect because their adult carers had neglected them, thereby taking away their rights to be 'normal' children in a profound way.

Action

(D) The aim of the preventative strategy work here would be to ensure that each participant felt respected, affirmed and accepted as a fellow human being throughout the programme. By returning respect, a means could also be found by which unconditional positive regard could be communicated back to the identified participants. Nevertheless, it was important not to invade their privacy. Leahy (2004) had identified in the literature that 'crowding' to such a child could lead to even greater withdrawal and personal neglect. I felt that conveying respect would help to overcome this potential problem and represent a commitment to the participants as well as diminishing the power differentials that might have served as a barrier between myself and the participants.

Evaluation

(E) Respect for the participants had to be a vital component of the therapeutic alliance and a way to communicate that, although they were accepted for where they were right now, the therapeutic alliance which would build up throughout the programme could try to help them make better choices. An example of this was highlighted in Session 5 with Group 2. I arrived at the room used for therapy to find E(2) sitting there with the television on full volume and his feet resting upon the screen, rocking the television back and forth. A teacher was yelling at him with a loud and threatening voice; other children were screaming and running in and out of the building and E(2) was shouting back at everyone. It was pandemonium and still in the process of escalating. To remove E(2)'s audience and possible source of anger, I asked the teacher to remove the other children from the building. In the restored quiet atmosphere, I pulled up a chair next to E(2) and asked why he was so upset and what had happened. He immediately responded with a string of obscenities about the teacher and the other children. As he spoke louder, I spoke softer. I then moved the chair even closer to him before speaking:

"It is important that you are helped to solve this problem, but you cannot be heard over the television. Could you please turn it down a little so we can talk?"
(R)

Understanding

(P) A strength of using reality therapy in this way was that E(2) had been respectfully given the opportunity to self-evaluate his choices. He was not undermined as he could so easily have been; he was not further verbally assaulted. Consequently, not only did he turn the television down but he also removed his feet from it. By treating E(2) with calmness and respect, a potentially disastrous situation was averted. He was shown that his choice was valued which, hopefully, would increase his sense of worth, his sense of regard within a relationship and ameliorate his sense of self.

This had been a rare occasion where I had caught a glimpse of E(2)'s other world; his real world. It had made me realise that living in a fantasy world was often his conscious choice of coping strategy. On this occasion he *did* understand reality, but his brutal truth was that no significant adult appeared to care for him or even noticed that he had unmet needs, and he was aware of that. Sometimes, rather than re-entering his fantasy world, he tried to make a stand, screaming about anything and everything in the safety of his school environment because it was not safe to do so at home. He was crying out to be respected and listened to - properly listened to. Whilst being pleased that our therapeutic alliance had been strengthened on this occasion, I was profoundly aware that, in the long-term, more - and sustained - individual therapy would have better met his needs.

9:4 LETHARGY

Problem

(W) Four out of nine group participants reported a definite lack of fun in their lives. These four pre-adolescents - G(1), E(2), K(3) and B(3) - seemed to have accepted that there was no alternative and all displayed lethargic tendencies. G(1) was usually too worn out by home responsibilities and lack of sleep to be anything other than lethargic. His class teacher was concerned because he was always yawning and looking 'washed out'. When this subject was delicately broached, G(1) reflected:

"We've a really small house so I have to share a bedroom with my sister. There's a thin and wobbly bamboo screen to separate us; it's a joke. My sister is eighteen - a real pain. She plays CD's until two in the morning as she doesn't have to get up early. I can't sleep with so much noise, which she refuses to turn off or at least down. I've complained to Mum but.....oh well! So I get up feeling sick most mornings and my head feels like someone's hit it with a hammer. I have to make breakfast for Mum and get myself ready for school so I can't lie in like her. That's why I feel like a dope most of the time." G(1)

E(2) made the decision to choose being in a state of idleness as his preferred choice of being in the world and stated that doing absolutely nothing was, in itself, fun. He appeared to be lethargic about almost everything. I felt that this could have been linked to his apparent lack of parental care. He spoke of enjoying this 'state of vegetation', as anything which was not physically demanding or intellectually taxing seemed to be a welcome relief from the daily 'grind':

E(2) "I love staring out of the window, perhaps wondering if I might be the first person ever to see an alien landing for real. I love doing nothing."

R "Which need would you say you were satisfying when you are feeling this way?"

E(2) "I guess it is fun to me. Some people have fun in running around and half killing themselves..... Some have fun smashing up cars like my elder brothers. I just want a quiet time. No fuss, nothing to do...nothing at all."

By contrast, B(3) was a basically gregarious boy whose greatest pleasures appeared to be social ones, but few opportunities presented themselves because others recognised that he was unable to maintain appropriate social boundaries and preferred instead to reject him. He attempted to deal with this by acting lethargically, pushing against his natural instincts to interact. I noticed that both B(3) and K(3) displayed lethargic tendencies when they were unsure about how to proceed with a task. However, unlike B(3), K(3) was so lacking in confidence that, rather than push himself to ask, he would mentally retreat into a shell and hide away to avoid failure:

K(3) "Can I go out?"

R "Are you not feeling very well?"

K(3) "I'm no good at painting. I can't do that stuff."

R "Do you think that leaving the room is the answer? You look like you want to join in and have some fun.... When you run away from something you can't do, it just makes it all the more scary the next time you are faced with it..... Can you see that by making excuses you are stopping yourself from having some fun?"

K(3) "I want to do it..... but I don't want you and the others to laugh at me."

R "Do you remember one of the first group rules we made? .....We all laugh *with* each other but never *at* each other...That is one of our basic rules for having fun."

K(3) "Maybe I'll start with my butterfly..... Who has the yellow?"

The Mental Health Foundation (1999) and Long and Averill (2003) identified many children as 'social phobics'; lethargic through fear of the consequences of failure or doing something embarrassing publicly, thereby drawing unwelcome attention to themselves. However they believed that, given the appropriate encouragement, children such as K(3) were able to become motivated and pass what Cohen (1993) described as 'the acid test' of positive mental health, being able to pull themselves out of apathy.

Action

(D) I felt it was important to foster a sense of empowerment in order to try to annihilate the lethargic traits of some participants. In Session 6, for example, Group 1 participants were given worksheets on choice and choosing behaviours to fill in independently. The worksheets asked questions which required self-evaluation about whether each individual was happy or not. The three participants would usually move to different parts of the room to fill in an individual sheet. However, on this occasion, unusually all three group members were lethargic. They had just finished an unscheduled PE lesson and came to the session hot and tired. As they sat individually, it was noticeable that their concentration was waning badly. To address this difficulty, tables were quickly moved together and we lit a candle (an essential tool in any therapeutic toolkit), which we placed in the middle to concentrate thought. I asked the participants to stare into it and clear their minds of outside influences.

Evaluation

(E) In this session we worked together by discussing and filling in the worksheet. Because of his advanced academic abilities G(1) finished his work long before the other two participants. Casting aside his usual lethargic tendency to catnap or just stare out of the window, he moved closer to M(1), whom he knew had learning difficulties, and then began to help her. L(1) joined in after a few minutes, something he had never done before, and soon the three children were working as a tightly integrated unit. G(1) had provided himself with the intrinsic satisfaction of feeling needed and appreciated, reinforced through a different medium than his usual one. M(1) felt valued and gained a sense of worth in that G(1) had increased social contact with her. L(1) felt confident in that he could also make a valuable contribution, without his usual need to dominate proceedings.

Understanding

(P) The strength of using reality therapy in this way was that social relationships had been fostered and strengthened. G(1) had dismantled his lethargic traits and provided a way in which he could be instrumental in bringing together the group members as a united learning team, empowering each other and providing each other with a heightened sense of belonging as well as a warm feeling of fun. Perhaps I, too, should be learning a valuable lesson from this. I needed to question whether my own enthusiasm was as obvious with Group 2 as with the other two groups. Had I myself become lethargic in my attitude, so that my body language transmitted negative signals, reinforcing further *their* own negativity?

9:5 OVER-EXUBERANCE

Problem

(W) Over-exuberance was a highly identified theme within the group process as one participant vied with another for the highest status of either group 'clown' or group manipulator. Five out of nine participants were recognised within this description - M(1), L(1), L(2), E(3) and B(3). However, it was only L(2) who could be described as

truly manipulative, seemingly knowing no depths she would not reach to put down others in order to make herself feel good. She was always in high spirits and easily excitable, which contrasted quite markedly from the rather depressed aura of her group companions. I felt that L(2)'s over-exuberance stemmed from a background of witnessing domestic violence and the psychological impact that had on her in now needing always to be in control. This need for control appeared to manifest itself in her enjoyment of 'winding the others up':

> " What is that painting supposed to be, K? I know it's supposed to be a patterned butterfly but it reminds me more of your mother's boyfriend's sick on the steps most Saturday nights when he comes home from the pub!" L(2)

> "E, can you sit still? I want to draw you...you know why? Because I can't remember what a fairy looks like - hey, hey!" L(2)

In the literature, Spence (1994) recognised that often extremely lonely children resorted to ridiculing and rejecting others in order to form some sort of personal identity, being unable to see the inappropriateness of their actions. Albano and Kearney (2000) expanded on this concept, finding that some lonely children had difficulty relating to others because they did not understand how other people thought - their own thinking being idiosyncratic.

M(1) and L(1) very often made inappropriate remarks through sheer excitement about their task:

> "Your clay model (referring to L) looks like a right sad git, or could it be a starving African? I'm not sure if it looks upset or constipated!" M(1)

> "I'm hungry....I'm that haggard old giant in the story. Grrr! I need to go to G's house to find some food. But I'm not sure whether I'll get a good meal there as he (pointing at G) has to do all the cooking!" L(1)

Similarly, both B(3) and E(3) appeared to be highly insecure individuals who had a need to go 'over the top' in order to create attention, no matter how inappropriate:

> "Last week I got told off. All I was doing was laughing. I was laughing until I made myself feel faint. Then I *did* faint.....there in the playground..... and I got told off. Mr.....said I shouldn't have been laughing like that because I

was on my own. All the infants were watching me from their yard though and some thought I was putting it all on and being well cool." B(3)

"When no-one wants to know me, I fetch in chocolate bars to give to people who can make me laugh and *scream* with happiness. My grandma says it's okay because the end justifies the means, as she puts it. I love to be the most outrageous but you have to have others with you in order to be so!" E(3)

Action

(D) Challenging over-exuberance which was caused by inappropriate or self-destructive beliefs allowed the participants to replace them by more adaptive ones which could look at their options and choices. In this way, I hoped that using reality therapy would help the participants to normalise behaviour and generally calm down. The first step in challenging an inappropriate belief was to reflect back what I perceived to be their belief. For example, when L(2) said she believed she was to blame for her father hitting her mother, my response was:

"You believe that you are responsible for your father hitting your mother."

The next step was to help L(2) to test out the validity of the belief. To do this, it was necessary to identify to what extent the belief came from what others had told her. I then asked her:

"How do you know that it is your fault that your dad hit your mum?"

L(2)'s reply identified that her belief had come from her mother, who had told her directly that it was her fault. In this case, L(2)'s mother needed to be involved in the therapeutic process so that this belief could change. (This was, in fact, done through a home visit after the session with L's full permission). Alternatively, L(2)'s response might have indicated that her belief related to her own perceptions of the connection between her behaviour and her father's behaviour as she was a very physically aggressive girl herself. A strength of using reality therapy in this way was that the logic behind her thinking could be explored and she could be invited to consider alternative beliefs. This was done by asking her:

"If you hit someone, would it be your fault or someone else's fault?"

Evaluation

(E) The goal of the intervention would be to raise L(2)'s awareness of other possible beliefs which, in some way, she was overlooking or failing to identify for herself. Through the group process, she also would be able to compare her experiences with her perceptions of other group member's experiences. Another strength of using reality therapy in this way was that, by challenging the often inappropriate beliefs caused by inappropriate over-exuberance, information which was unpalatable would be brought into the participant's awareness.

Understanding

(P) The five identified children all needed to accept information that they might not want to hear. L(2) did not want to accept that her father was capable of behaving abusively and violently. Patiently, and with care, I was able to help her to accept reality. During this process, L(2) had wanted to own and accept responsibility for some parts of the events which had troubled her. Using reality therapy allowed me to help her to separate out those parts of the events for which she was responsible from those parts for which she was clearly not.

I understood this intervention only too well. For years I had convinced myself that I was responsible for creating both a tortured human being and the conditions which he found so hard to tolerate that he needed to run away. My blind vicar was the only person that I felt was not judging me. With his help, I underwent the same process which I had used with L(2), although I was not aware of it at the time, mentally isolating the issues for which I was responsible from others which were beyond my control.

9:6 INAPPROPRIATE HUMOUR

Problem

(W) Although M(1), L(1), K(2) and B(3) were often unable to use humour appropriately themselves, there appeared to be an imbalance produced in the child / adult relationship when humour had been used inappropriately; an adult having assumed an elevated position which was perceived by three out of four of the identified participants to be

superior. This would usually occur in class just before the group came to the therapeutic session:

> "Our class teacher made me embarrassed and then fuming. She said it was time her nuisances went to tell that poor lady their troubles. Then she said that she thought she'd better go too, 'having to teach that lot.' Thanks!" K(2)

> "I hate Mr.....He was laughing at me just before you came to collect us. He said he was coming to your class instead of me because he wanted to find out how he could stop his wife nagging him. He made me feel awful. None of the other children heard but still .....it was like I was some kind of freak who needed to be told how to.....well, just exist. It wasn't funny." B(3)

> "In Geography we were talking about how the tribes in the Amazon Rainforest use camouflage to disguise their homes. Mr.....said the tribes seem what they are not in order to protect themselves. Then, in front of the whole class, he said it was just like me with my behaviour. I could suddenly explode and scare him to death at any time just like they did to their enemies when they were threatened. Everyone laughed...except me!" L(1)

M(1) and L(1) themselves would use inappropriate humour to attract attention. Both children enjoyed 'acting the clown' which encouraged G(1)'s scorn as they tended to become louder and sillier:

> "I would like my world to be full of clay people who can't brag about all their friends! I'm going to do Mr.....with this spare piece of clay. Scowling! 'Hey blockheads', he's saying, 'I'm the most popular guy in town!' Quick L, give him a good right hook. That will flatten him, silly little clay man! Ha, ha!" M(1)

> "Do you think I'm a good singer? You know when you are cooking tea, G? Does your family have to sing for its supper, like those boys in Oliver that we watched? What would they sing? Food, glorious food? Can you imagine G's cooking being *glorious*? More like nauseous! Food, nauseous food, there's nothing quite like it!" L(1)

B(3) had the 'ability' to take his pranks one stage further than reasonably acceptable. He enjoyed being the class buffoon and acted that way throughout a large part of the group process in order to attract attention. When he was told to 'shut up' or 'give it a rest' by the other group members, he retorted by being even more outrageous at the next opportunity. His class teacher made the following observation:

> "I have watched B(3) out in the playground and it is quite extraordinary. He lollops around like a big bear on his own and then, suddenly, he will make a bee-line towards a particular group of children. He'll just barge right in and expect them to drop everything and welcome him in with open arms - which, of course, they don't do. He seems to have no sense at all of the rules of play. When he is rejected he gets bitter and he will plot his revenge on that particular group. I have watched him wringing his hands together and screwing up his face like some Shakespearian villain. He loves to play tricks on people, even me - but they are totally inappropriate and always go over the boundaries of common sense. Once he threw an entire bucket of water at me because I had been complaining in class that it was a warm day." Class teacher. Case 3 school.

More sinisterly, K(2) revelled in being directly threatening both verbally and through her behaviour, which she perceived as funny and which she knew drew attention to herself. Her inappropriate actions were so frequent that it became a normal pattern of behaviour for this girl who appeared to be totally unused to kindness and caring:

> " Don't you worry that you will wake up one day and be a *complete* loony, E? You live in a loony-bin with all those mad people. I think it's dead funny. At least when I'm grown up I can tell everyone that I knew this crazy boy. Explain to me what it's like E, or I'll stew all your bones in a big pot and eat them like Hannibal Lector. Go on, crazy boy, speak!" K(2)

Action

(D) In a diplomatic way, using reality therapy as the guiding principle, some of the teachers had to be made aware that they had put down the groups in shameful ways whilst attempting humour, laughing at the participants' problems, criticising and making fun of them. They also needed to realise that they had tried to compete with them in the 'pity' stakes in a totally inappropriate way.

Evaluation

(E) A strength of using reality therapy as an intervention, this time in informal conversations with the teachers, was that I was able to illustrate that when humour had been inappropriately used the result would be the internal experiencing of ridicule, shame, guilt, degradation, failure, embarrassment, weakness, cynicism or scapegoating by the participant. Without breaking confidentiality, by being made aware of unmet

needs and a child's ways of dealing with these unmet needs, each teacher was able to understand that the most hostile reactions of some participants appeared to occur when humour was not used genuinely by them or when humour was employed as a tool of power to the detriment of the participant.

Understanding

(P) I was aware that I needed to critically examine my own use of humour within the framework of my own therapeutic style to determine whether *my* humour was having the desired impact intended. Always there was a realisation that what might have been intended as humorous might not be received by the participant as such. Clear, clarifying discussion within the programme had therefore be undertaken to develop not only an effective therapeutic relationship but also a way in which the identified participants could be shown to use humour in ways which would not hurt or shame others, as they had been. The strength of using reality therapy as a cornerstone on which to base discussions was that I could encourage participants to take greater responsibility and control of their lives in respect of social contacts and relationship building, whilst still allowing them to include the development of appropriate fun needs into their daily lives.

Now I am older, I have learned to play much harder than when I was a child because I have come to respect the fragility and finiteness of life. Too many of my own peers have died early. Humour therefore plays a significant role in my life as my friends and I exploit each other's foibles and laugh at each other's tales of everyday stupidity, in much the same way as M(1) and L(1) had attempted. Many might consider our humour inappropriate. Sometimes it is. The difference between my scenario and the children is that, in my case, we are all established friends. We know each other well and our friendship is solid. We have lived through each other's triumphs and crises. By undertaking this study, I have come to realise that you cannot ***build*** a relationship by using inappropriate humour unless that relationship is already well-established and able to buffer the storm. Although acquaintances in class, suddenly the groups had found themselves thrust together. They needed time to establish intimacy for real friendships to develop and time to learn about one another and enjoy being together. Inappropriate humour by me, school staff or other group members played no part in that. Rome was not built in a day. Group 2 was still in battle and had not even arrived at the city gates.

9:7 MISCHANNELLED ENERGY

Problem

(W) Although six out of nine participants were identified within this theme, it was only the two girls from Group 2 who used energy in ways which were destructive to their relationship. As a result of their past experiences, they appeared to have learnt 'over the top' behaviours which were hurtful and unacceptable to others. K(2) appeared to have learnt to be excessively aggressive because she was not allowed to use her energy appropriately at home and was always kept indoors "in case my dad snatches me."

K(2) and L(2) spent most of the sessions fighting one another in an aggressive way by vicious backchat and character assassination. An example of the continual bickering was transcribed from Session 8:

> R "Your clay figures look rather sad K(2)."
> L(2) "Anyone would be sad, well suicidal, if they had to live in her family."
> K(2) "At least I've got a family and not just a mum who sits in front of a bottle."

On the other hand, the four participants from Groups 1 and 3 - whilst using energy inappropriately - did not intentionally cause anxiety to others, appearing rather to be consumed by self-interest. For example, M(1) and L(1) were highlighted as using an abundance of mischannelled energy during the group process, both being unable to sit still for any length of time. When this observation was made to them they both made similar replies:

> "My mum always says I've got ants in my pants. I can't sit still. I'd rather make a nuisance of myself than just sit in the corner. At least I know I'm still alive!" M(1)
> "I love zooming around the yard like I'm Superman or someone. I know I bash into people but that's the hazard of being supersonic! I need to let off steam. Just sitting in that classroom does my head in." L(1)

E(3) and B(3) spent most of their time promoting their own self-interest and showing off. B(3), in particular, had learnt to be excessively deceitful because he was "cooped up like a prisoner at home." Both children now needed to learn how to use their excess

energy differently. When I motivated them to partake in a new activity, their energy levels would visibly rise, often completely 'through the roof':

> "Oh, I love playing with these puppets. These are so, so cool. Hey, hey - I'm grabbing all the good ones so I can go first. These are just for me. Go away you two." E(3)

> "I'm going to cover all these need symbol worksheets in thick gooey paint, so all the colours merge together. I don't care if I make the biggest mess this room has ever seen. And.....I've got these fluorescent colours in my rucksack.....yes!!!.....because the door to the art cupboard just happened to be open as I was walking past the other Y6 classroom! My work is going to be special. Here we go - spludge!" B(3)

Action

(D) The logic behind my intended intervention was that if the participants could be shown that it would be a good decision to behave differently, channelling their energies more appropriately, then they would take risks because they would not be able to predict what might happen. Although I understood that it might well be easier for them to go on behaving as they had done in the past, if they made no changes they would continue to experience the negative emotions they already knew, whereas if they took a risk and behaved differently, then they could face new healthier emotional challenges.

Evaluation

(E) Clearly, making a decision was hard: the children had to cope not only with their own feelings, but also with other people's reactions. Hence, mischannelling energy appeared to be a welcome diversion from serious decision-making. B(3) particularly had difficulty in making decisions. I assumed that this was because he had been taught that there was always a right choice and a wrong choice by his police officer parents. It would be necessary to show him that, unfortunately, in real life, decisions were often complicated with differing options having advantages or positive qualities and also costs or disadvantages. B(3) needed help to understand that making decisions did not generally involve deciding between right and wrong or between black and white. Most decisions involved a choice between shades of grey.

L(2) was a girl who behaved in an angry, aggressive way and had been stubborn and uncooperative with adults. Because of these behaviours she had gained the respect of peers and had assumed a leadership role. The strength of using reality therapy with her in this context was that L(2) was able to gain insight into her behaviour and recognise how destructive it was for herself and for others around her. However, to give up her maladaptive behaviours would involve a loss: she might lose her leadership role, her power, and the respect and control of her peers. I helped L(2) to see that the decision about whether to change or not had to be more in terms of the things she would lose than the positive things she would gain. Unless I could validate the importance of L(2)'s losses, she would remain blocked from making the desired change in behaviours. In considering her options, she decided initially to suppress her anger, to be more cooperative, compliant and submissive, and to become a follower instead of a leader. However, it was essential at this point to introduce some new ideas so that L(2) had more choices. As an alternative to suppressing her anger, I raised the option of her dealing with her anger differently and being assertive. We discussed the concept of showing initiative instead of submissiveness and compliance, thereby enabling me to offer options to L(2) which would allow her to continue to gain respect from others, but in a different way, by using different behaviours.

Understanding

(P) The strength of using reality therapy in this way was that, as a consequence to all this, L(2) would be able to continue to exercise a leadership role and have an appropriate level of control in some situations. It needed to be noted, however, that these ideas were only suggestions for alternative options; the ethos of the programme was that she should never be persuaded. I well understood that L(2) was only likely to carry through on choices which she had made herself and which 'fitted' for her.

In the literature, Petersen and Gannoni (1992) highlighted the danger of a therapist getting 'caught up' in the high energy games which angry and damaged children could play. I was particularly aware of this with the girls from Group 2, especially K(2). As pointed out by Richardson (2001) and reiterated by Shucksmith and colleagues (2005), if consequences were imposed in a judgmental angry way, the reality therapy would focus on a child's anger or feeling of being judged rather than their poor choice. It was

important that my therapeutic environment remained warm and accepting of K(2), in order for her to self-evaluate the value of other less energetically damaging behaviours.

This was a paradox in itself. Whilst I, personally, could force myself to be welcoming in all weathers, the depressing physical environment and subsequent unwelcoming vibes it gave out was something over which I had no control. To accommodate their very complex needs, more than any other group, Group 2 needed a comforting place of sanctuary in which to heal and repair. I should not have dared to assume (which I did initially) that reality therapy could have made a difference to these damaged individuals when the general physical setting was always cold, austere and uninviting.

9:8 SUMMARY

This chapter has identified themes within varying fun need categories. The children from Groups 1 and 3 have been recognised as acting inappropriately because they have been self-absorbed and have needed to be shown how to increase personal enjoyment in ways which do not damage or cause further ridicule to themselves. Conversely, the participants of Group 2 (and particularly the two girls) have had issues where their primary aim has been to emotionally hurt one another, whereby gaining a 'buzz' from one-upmanship and shallow victory until the next spat.

Group 2 has now emerged a far greater challenge than the other two in terms of depth of intervention to provide damage limitation and being able to maintain unconditional positive regard within the therapeutic alliance. The concept of showing the children how to build better relationships in appropriately enjoyable and satisfying ways was very difficult to achieve with this group; each participant harbouring insecurities and grudges which only intense reality therapy could address over a seemingly longer period of time. It should also be noted that, for the first time within the programme, intervention with the class teachers was also necessary outside of the session. This was not pre-planned but was deemed to be vitally important in order to preserve the authenticity of the reality therapy work within groups.

CHAPTER 10

THE INTRANEEDS

It is the act of an ill-instructed man to blame others for his own bad condition;
it is the act of one who has begun to be instructed to lay blame on himself; and
of one whose instruction has been completed, neither to blame another, nor himself
- Epictetus 55AD - 135AD

Contents

10:1 INTRODUCTION

This chapter examines sub-themes which fall into Glasser's (1965) need categories from a dual aspect. Wubbolding (2000) recognised them as intraneeds. The previous analysis chapters have concentrated on sub-themes which fell naturally into one recognised need category or another. This chapter highlights all the sub-themes which appear less clear-cut, belonging to either interdependent or conflictive needs, as illustrated in Table 9.

TABLE 9 THE INTRANEEDS

SUB-THEME	1st INTERPRETATION	2nd INTERPRETATION
Value realisation	Love and belonging	Power
Achievement	Power	Freedom
Moral values	Power	Survival
Inner motivation	Freedom	Power
Self-esteem building	Power	Love and belonging
Satisfaction of emotional difficulties	Survival	Freedom
Drive to make friends	Power	Fun
Feeling happy	Fun	Love and belonging

The abundance of these intraneeds has been highlighted in Table 11, with every case participant from Groups 1 and 3 named within each category. The one exception was that no-one from Group 2 was identified under moral values. However, in all other categories, participants from Group 2 were classified. Therefore, the collective importance of this group of sub-themes cannot and should not be overlooked.

TABLE 10 IDENTIFICATION OF PARTICIPANTS - INTRANEEDS

INTRANEEDS	M1	L1	G1	K2	L2	E2	E3	K3	B3
Value realisation	X	X	X	X	X	X	X	X	X
Achievement	X	X	X	X	X	X	X	X	X
Moral values	X	X	X				X	X	X
Inner motivation	X	X	X	X	X	X	X	X	X
Self-esteem building	X	X	X	X	X	X	X	X	X
Satisfaction of emotional diffs.	X	X	X	X	X	X	X	X	X
Drive to make friends	X	X	X	X	X	X	X	X	X
Feeling happy	X	X	X	X	X	X	X	X	X

10:2 VALUE REALISATION

Problem

(W) Value realisation has been categorised as the realisation of purpose, self-value and worth. It materialised at all times, in all groups, when a task was completed successfully because participants could see the point of what and why they were doing it. All nine children also reported that they could find significance in knowing that they mattered to someone they cared for, someone who was deeply important to them. Only L(2) said she could think of no-one at all, even her mum, who was deeply important. She stated, however, that the therapeutic alliance was special and of value. She was encouraged to talk to her mother in the same way as she was sometimes able to open up in the group.

All children saw significance, self-esteem and personal power as closely linked, enabling them to relate effectively to others. Additionally, all endorsed the view that unless they felt they counted for something they were adrift and bereft of meaning and purpose; their disappointment in social roles resulting in painful reactivation of feelings of insignificance. B(3) spoke of children removing themselves from close proximity of him or expressing aversion or distaste. The children who lived every day with these feelings of insignificance - B(3), G(1) and K(3) - were noted as being at risk of internalising this negative mirroring of themselves. Discussion around value realisation included existential questioning by some participants to other group members and to me. Issues raised included:

> "What is the worth of my life?" G(1)
>
> "Does it matter?" K(2)
>
> "What is its meaning?" M(1)
>
> "What purpose does it have?" K(3)

It was important to all three members of Group 1 that their contributions to the reality therapy programme were valued. Likewise, I regarded their individual feedback at the end of sessions as being of high value:

> "Sometimes I feel alone, even within my own family. By moulding them in clay and moving the model of me to a new space, it made me feel listened to." L(1)

"I've enjoyed using these puppets and I loved it when you laughed at my play. I didn't think it was that good but I kept going because I could see that you were really into it." G(1)

"It was cool that you said I could paint my heart in those weird colours because I wanted them that way. Thanks for that - they're great." M(1)

Likewise, during the course of the programme, all three members of Group 3 were encouraged to talk freely about their personal values. All spoke of the need to see the significance of what they did and that their actions now and in the future should have some point or purpose:

"If you just do something because you're told to - and it's no use or value - you won't remember it." K(3)

There's a purpose for me taking my time. As well as enjoying it, I'm trying to do a good job. I get satisfaction from tasks like this (painting), especially as I can't seem to get it from people being friends with me." B(3)

"If I go further bit by bit...concentrating hard.... then eventually I'll feel proud about what I've done and I'll realise I've done something special." E(3)

All three members of Group 2 also felt that having a set of values was important to them, even though they were doubtful that they could keep them. This was a somewhat surprising reaction from children so highly damaged and often out of control. Like L(2), K(2) said she also valued the therapeutic alliance and the bond she felt existed:

"You're great you are. You still hugged me even though I gave you a hard time today." K(2)

Early into the programme, E(2) stated that there was nothing he had so far experienced which was of particular value to him. However, he felt there might be possibilities of 'good things' to be accomplished in the future:

"I'm looking forward to doing more of this therapy thingy..... so something might turn up for me that will make me feel different, more interested in taking risks about life and stuff. I'll know when something turns up." E(2)

Even L(2) said that she accepted values were important but was initially unable to relate her behaviour in the public arena to any kind of value realisation:

> "I don't see it matters if I'm great or awful. It's my thoughts, my behaviour. No-one else should be bothered about it. Well, they ain't.... because no-one else is important to me." L(2)

Action

(D) It may have seemed that the exploration of existential issues was being trivialised by using worksheets. However, I had to be mindful that the participants were only eleven years old and the emphasis of the reality therapy programme was on self-evaluation and exploring personal psychological pathways for themselves. Hence, in Session 6, each child was given a worksheet which asked: "Is your road taking you where you want to go?" They were asked to write three possible choices - or roads - which they could take in a situation they were worried about in their life. Next, they were asked to write what might happen or the consequences of taking each road.

In the literature, Whitmore (1980) had expressed concern that if children did not value their task or think about the consequences of each choice, they might come to believe that learning was meaningless and unpredictable. On the other hand, Allard and McNamara (2004) warned that too challenging a task might cause unnecessary anxiety, so I needed to maintain a balance between these two positions. However, the need for a sense of purpose was realised by everyone, which helped all the participants personally work out their own individual interpretations of deeper existential issues earlier posed.

Evaluation

(E) Through completing the worksheets, I found that all participants realised that their own life's purpose could be swiftly taken away by the incessant sorrow of feeling alone. I explained to them in simplistic reality therapy terms that the significance and meaning of life was not 'out there' somewhere; it was in the life that was actually being lived by them every single day. It was important to show the participants unconditional respect and to demonstrate that their choices mattered. In the literature, Anderson (1989b) and Blumenfield (1992) had reaffirmed this view stating that, in order to promote a sense of

value, young people had to be enabled to understand both *what* they were supposed to be learning and also *why* they were learning it. Both Dweck (1985) and later Glasser (2003) backed this belief, agreeing that for learning to be effective, young people must have perceived the task with which they were involved as meaningful and important. Therefore, a strength of using reality therapy in this way was that I was able to reaffirm to the participants that, at the end of the day, *they* were in charge of their own destinies. Guiding them into making their own choices needed to be a key component of a successful reality therapy programme.

Another strength of the therapeutic work within this context was that I was able to ensure that I knew some of the pictures that the participants had in their Quality Worlds so I could articulate reasons for learning that were congruent with their interests and needs. As Pintrich and Schunk (2001) and Muijs and Reynolds (2002) had emphasised, when a young person was able to make such connections between the learning task and their personalised goal, they would tend to work harder and attempt more difficult tasks. A weakness of the reality therapy could have been if the instruction had not provided that vital connection, because then the participants might not have been able to make that connection for themselves and hence would have been less likely to perceive any meaning or value to their activities, as warned in the literature by researchers such as Iwaniec (1996), Porter (2001), Weare (2004) and Shucksmith *et al.* (2005).

Understanding

(P) To overcome these possible hazards, I followed Glasser's (1992, 2001) guidelines, ensuring that all tasks set within Session 6 and at other times had value in the eyes of the participant. I consistently pointed out the connection between the learning task and its usefulness in helping to meet their current or future needs and always incorporated a clear statement of purpose into each session in order to build an essential bridge from past knowledge to enhancing the meaning of the learning task, as recommended by Glasser (1992). A final strength of working in this way was that, in selecting and communicating to each group the purpose of the task, I was able to make that purpose specific, believable and personalised to each individual, as recommended by Schunk (1991). Personally, working in this way helped me to become more effective as a therapist because I had enabled each child to realise that my therapy had personal value.

10:3 ACHIEVEMENT

Problem

(W) All nine participants were keen to achieve something out of the programme and brought that enthusiasm to the therapeutic alliance. This 'drive' categorised the sub-theme of achievement naturally as an extension of value realisation, emphasising again the need for a sense of something more than any one of the other needs could solely supply. However, whilst all participants from Group 2 expected 'a magic door' would be opened for them, simply because they had bothered to turn up, the children from the other two groups were more realistic about their options:

> "Now you've shown me how to get *proper* friends, I hope I can rely on myself not to screw it up." B(3)

> "Being here has shown me it's down to me to do the work, but it's nice you're here to show me stuff and help me sort it out." M(1)

All the children in Group 1 reported needing to see the point to their tasks and that, once they did, there was a sense of achievement in delivering that task:

> "I like making things out of junk materials for my bedroom. It gives me a really warm feeling deep inside that I've saved shedloads of money and done what I wanted to achieve when I lie on my bed and look at the things I've created.... from just odd bits and pieces really." L(1)

> "When there is a good reason to do a job, I'll do it." M(1)

> "There is always so little time. If I waste it doing pointless things I'll be angry because that'll be another day gone." G(1)

For Group 2, achievement was also linked to the sub-theme of mischannelled energy. All three children spoke of feeling they had achieved something when they had expended a huge amount of time and energy on an inappropriate activity:

> "I go down to the dump in the evenings with my gang. We get these old dustbins made of metal and we fill them with newspaper and then set fire to them. Then we run up the hill and sit there and watch them burn. That's a real achievement!" L(2)

"I feel brilliant when I get to another level on my games console. Like I could be or do anything." E(2)

"I spend a lot of my time writing letters to people I hate. It gives me a buzz because I can win over them by doing this. They can't get me because they don't know I've done it. I have four drawers of letters in my room. They don't get to see them but I can read them over and over again." K(2)

Group 3 members were able to talk freely about their hopes and dreams and what they hoped to achieve from their lives in a considered way:

" I want to discover something that no-one has ever thought about before. I can send myself off into a sort of trance so I can think deeply about what I don't know... but is staring me in the face." K(3)

"I want to earn lots of money so I never have to worry about it when I am an old lady. My gran is always on about it. I'll get the bucks early so I never have to moan." E(3)

"I want to be happy and have a lovely family and lots of kids. I want us to live in the country and have lots of fields to run about in. That is more important to me than lots of money." B(3)

Action

(D) When designing the reality therapy programme, I felt it was important to remember that, in the identified participants, there was a 'mixed bag' of personalities with the one commonality of being termed a 'loner'. I recognised that when pre-adolescents had undergone failure/s within a certain set of basic needs or 'support systems' within their lives they would be much more at risk of under-achievement. It was imperative, therefore, to follow Frankl's (1984) maxim from the literature which stated that lonely individuals needed to feel a sense of purpose in order to clarify what they wanted from the world around them. To accomplish this, I wanted to focus some aspects of the intervention on past achievements, whilst other parts could look at what the participants did not have in the present - but wanted for the future. My chance to implement this came in Session 7 when I was able to ask each group, in turn, what the two most important points on the compass were. Nobody knew. I replied that the first point of

significance was where they were now standing. I described how they could be anywhere with a map and a compass, but until they knew where they were, it would be impossible for them to plot a path that would get them to any particular destination. The second significant point on the compass was their target or destination, for if they did not have a goal they might walk around aimlessly, never finding anything worthwhile.

Evaluation

(E) A strength of using reality therapy in this way was that I could show the groups that attitudes and beliefs around what was achievable were very much like the points in the compass. The participants needed to carefully assess their present attitudes and beliefs to see where they stood with regard to themselves and others, and then they needed to determine where they ultimately would like to be. G(1) made the observation that attitudes and beliefs seemed to be like lens filters in cameras, to which I replied that they were actually in his mind and he must ascertain what *his* lens filters were currently saying. When B(3) remarked that he seemed to go through life with the feeling that he was wearing an invisible 'don't speak to me' sign, I pointed out to him that perceptions like that conveyed negative, pessimistic attitudes and beliefs which might easily prevent him from achieving his dream of gaining friends as long as they persisted. He was shown that, in contrast to his negative filter, he needed to adhere to more upbeat ideas or notions, which I introduced from a clear observation that the children were always blaming their circumstances for what they were. I spoke of not believing in circumstances, citing the people who got on in this world as being the ones who got up and looked for the circumstances they wanted and, if they couldn't find them, made them. To support this premise, the participants were given two scrolls on which to draw a map to one of their immediate goals and one to a future goal. They were asked to fill in where they would have to go or what they would have to do to get to their destination. To complete the task, at the bottom of the map, they filled in what they actually would have *achieved* if they were able to meet that goal.

Understanding

(P) The strength of this intervention was that each participant was able to decide how important it was to achieve their goal and this was reinforced by asking them to

visualise their achievement on a scale of one to ten - one being of low importance, ten being highly meaningful. Perhaps I, too, need to ask myself how important it is for me to *achieve my goal* of successfully implementing a research programme. I have no hesitation in scoring 10 - it is everything to me to complete the research according to the rules and not to stray from my pre-set course of action. Yet this viewpoint raises conflict and tension in my role as a therapist. Morally, I should be modifying the programme for Group 2 in almost every practical session and subsequent intervention *despite* the fact that it is part of a research study. I am aware of that, but I choose to do nothing because I do not want to sabotage the outcome. However, this same outcome which I am so determined to achieve, is always going to have a negative result *because* there has never been any modification.

10:4 MORAL VALUES

Problem

(W) The goal of working on moral issues was to help group members discover and develop their capacity to make moral choices on the basis of individual sets of values. Six out of nine participants identified moral values as important; all members of Group 2 not viewing the subject with any relevance or significance at all. Within this group, I would have to challenge each child who attributed his or her actions to fate and was in denial of personal responsibility. On the other hand - in Groups 1 and 3 - all participants would be encouraged to look at, and acknowledge the purpose of, the destructiveness or constructiveness of their behaviour in the totality of their present lives.

Groups 1 and 3 felt moral values were an important part of life. A good example was highlighted after Session 4 when the moral behind 'The Selfish Giant' was evaluated:

G(1) "I liked the story of the Selfish Giant. He was a real good guy, wasn't he?"

R "Why do you believe that?"

G(1) "He knew he had a responsibility to help and that made him come through in the end...That couldn't have been easy for him when he spent so long just pleasing himself."

M(1) "But he made the right decision in the end because he had a conscience."

L(1) "Everyone benefited from his choice as no-one was lonely anymore."

None of the participants from Group 2 rated the value of morals as significant. In fact, I observed that morality had little or no bearing on their conduct or ways of thinking. K(2) was outrageous with both her cruel tongue and her conduct in many of the sessions. She had virtually no concept of what was right or wrong, acceptable or unacceptable. Her way of living appeared to have hardened her against 'attack':

> "It's better to attack first - get in there first - before someone attacks you. Nothing wrong in that!" K(2)

Likewise, E(2) was so wrapped up in his world of unreality that morality had little meaning to him:

> "Aliens, dragons and gorgons don't worry about consequences and all that stuff, so why on earth should I? In my world, it's everyone for himself." E(2)

A great deal of time was spent with L(2), who was already into petty crime, as I knew that her behaviour patterns needed adjustment before she ended up with an eventual custodial sentence. In this case, I believed that it was easier for L(2) to change her behaviour than to change her thinking and, once she had actually changed her behaviour, the thinking would naturally follow:

> "I just do things spur of the moment like. Sometimes after I think 'Oh my God!' but it's too late then. Anyway, I'm worrying about my own back - getting caught and that - not whether it's wrong or not." L(2)

Action

(D) In the literature, Parish (1991) maintained that children and adults were basically 'good', aiming for what they believed would elevate them. All participants discussed assuming control of their own destinies by taking inner control and self-responsibility instead of blaming external factors for their predicaments. Teaching the participants the language of inner control included recognising the value of phrases such as "I chose to do it" rather than "He made me do it", or "I'm depressing" instead of "I get depressed." A strength of using reality therapy in this way was that I could demonstrate to the children that emotions were not static conditions but behaviours which were generated

from within. I was also able to practice the transition from external control thinking to internal control thinking by using reframing activities. For example, every time someone said "I can't", I reframed their words to "I choose not to" or "I won't."

Evaluation

(E) This therapeutic intervention allowed me to concentrate on Group 2 members in an attempt to encourage self-evaluation of the appropriateness of their own moral behaviour. For example, L(2) had no remorse for her shoplifting escapades when she began the reality therapy programme. She would excuse her behaviour by stating that it was not her fault that her mother had no money. She had to look good so she had no other choice. I discussed with L(2) that, as human beings, we endure conflict in many aspects of our own and others' behaviour. Because of this, systems of ethics have been established to resolve conflict and regulate our moral behaviour. In this it is possible to find ways to fulfil our own needs without negating others' attempts to fulfil their own needs (i.e. the shopkeeper who has to earn a living). The problem arises when our needs interfere with others in their pursuit to engage in appropriate moral behaviour.

Understanding

(P) All Group 2 participants were shown, verbally and through sustained empathy, that what makes us human is that we have the ability to deal with moral issues, to make value judgements and take responsibility for our behaviour. Because of this, we are able to have an understanding of how to relate to others and how to be part of society. The children were left in no doubt that *they* were always responsible for their behaviour and reality therapy would always emphasise the morality of behaviour. When they might be held responsible for their anti-social behaviour, the issue of morality could not be avoided. This solidified their involvement in dealing with their behaviour. The strength of the reality therapy intervention within this context was that I could enable the participants to acknowledge the moral perspective, to deal with the issue of right and wrong, and then assist them to make choices that reflected living by those standards.

I wonder what my own son would have made of this. Has he ever reflected upon his own past behaviour or the ripples cast out through the consequences of his actions so

long ago now? Has *he* assumed responsibility for his life or does he live in an adult state of chaos, blaming every external misfortune upon me? I will probably never know.

10:5 INNER MOTIVATION

Problem

(W) All nine participants were identified under this category. When the therapeutic alliance was entered into, I observed that a sense of both inner satisfaction and inner drive appeared to prevail. Therefore, it was difficult to categorise which need category 'inner motivation' fitted best; both the intraneeds of Freedom and Power conflicting within Glasser's (1965) recognised needs.

It was necessary for me to explain to the groups that their motivation should not be about trying to score points over one another (an observable trait in early sessions) but about changing their behaviours in order to lead more satisfying lives. Group members were encouraged to think about how life did not always go as planned and that it was often necessary to be inwardly motivated in order to create the 'pictures in their heads' of what they really wanted in their Quality World (Glasser, 1996). This encouraged all the groups to talk about their interpretation of inner motivation, which was identified as a central component of their motivational drive. For members of Groups 1 and 3, the search for some kind of point or meaning appeared to be the key to inner contentment and inner motivational force. K(2) had a more negative interpretation:

> "I don't mind how hard I have to train as long as I am picked for the rugby team. I feel I belong in the team. We have fun and no-one cares that I have help for my behaviour when we're on the field. They only care that I am a really good player and that gives me a lovely satisfied feeling." L(1)

> "I run away from things in which I feel cornered, like being in our class assembly, because I don't want others staring at me. But then Mr.....made me the D.J. and in charge of all the technical equipment... so that's different. There's a point to me being there now and I know I won't be laughed at because it's a cool thing to do and I want to do it. That changes everything." K(3)

> "I'm motivated when I see a chance for me to be in there first, getting one over on the others, grabbing chances for me. There has to be a reason to do things." K(2)

Action

(D) I felt it was an important part of the therapeutic process for all participants to get to know themselves on a deeper level. I recognised that this might be painful for some, but I considered it necessary in order to get to the root of why ineffective organised behaviours were chosen in 'stressful' situations. I wanted to establish whether the participants were individuals who experienced stress or inner motivation. Once this was established, did they tend to over-dramatise their stress / motivation externally? Did they shut down and avoid a situation because it was too painful to think about, or did they increase their physical exercise to alleviate the symptoms of stress-related effects, hoping to drive them away?

Evaluation

(E) The worksheets which were used were designed to help the participants discover themselves so that they could have a more realistic self-concept. Throughout each group, the children were encouraged to discuss choices which they could make in order to enable their lives to be more purposeful. As socially isolated individuals, they were also asked to consider how they could make choices about when to do things by themselves and when to do them with others. This applied to the clay modelling, for example, which all chose to do individually or the puppetry, which was enacted as a whole unit but with individual strands which they made blend into the overall context. Throughout the whole of the reality therapy programme, my emphasis was on guiding the participants to become more aware of themselves. That was not to say that they did not know who they were, but I wanted to conduct a closer examination of their internal thoughts and behaviours which instigated their inner motivation.

Understanding

(P) A strength of the reality therapy was that, by helping the children to gain greater control over their lives, I could show them that it would not be necessary to look outside of themselves to find the answers. All the information they needed to know about themselves was there inside of them. Previously, they might not have looked close enough to understand the roots of their internal thoughts and behaviours which might

have manifested when they were 'stressed out'. By actually decreasing the amount of thoughts that filtered into their minds every second of the day, they were increasing their ability to focus on the present moment, the essence of life which many of them tended to miss.

And so to me. I was missing the moment too, except that at the time I was too engrossed in the trivialities of each session to look at the wider picture. I had been presented with the opportunity to make a real difference to many lives. Yet I was playing the game and not stepping outside of the box which I had put myself into. I was failing to unclutter my own head of irrelevances to concentrate on whether my actions and philosophies were actually working. How could I be sure that members of Groups 1 and 3 were not just going along with my ideas because they had been conditioned to unquestioningly do as they were told when in school? In hindsight, the essence of the present moment should have been my guiding star. Instead, the present moment was often lost, and with it opportunities to work instinctively on hunches, feelings, senses, unprepared journeys. Perhaps that capability is the mark of an exceptional therapist. I still have a lot to learn.

10:6 SELF-ESTEEM BUILDING

Problem

(W) All nine children were identified as mentioning issues around lack of self-esteem. Self-esteem was interpreted as the value the participants put on something which they had achieved. Every participant talked about feeling helpless and inferior, searching for a meaning to their lives, being incapable of improving their situation and having the belief that they did not have the personal resources to reduce their anxiety. This could be supported in the literature by researchers such as Doll (1996), who emphasised that feeling inferior immobilised action to redress a child's purpose in life and Rotenburg and Hymel (1999), who recognised that children often felt powerless to change their own destinies. However, all the children from Groups 1 and 3 were able to understand that they could self-activate changes to improve the way they felt about their lives. It seemed to be a comfort to Group 3 that being part of a special group was a 'safe' place, where they could say exactly what was on their minds:

"I always feel like a freak speaking in class, and there's no point to it, because I'm usually ignored anyway. Here, it's different because what I say counts and makes a difference." K(3)

"I would never admit to anyone in the class that I was lonely and felt left out. I would rather just cry where no-one can see me. But I can say those things here - because it matters here - and then I feel so much better." E(3)

Group 2 children, on the other hand, were clearly not self-determined individuals who could act as the primary causal agent in their own lives because they were unable to make decisions and choices regarding the quality of their lives. Instead, they believed their lives were totally influenced by external influence and interference:

"The way I behave isn't down to me.....my brain takes over and operates all my switches. It's no good people saying I'm in charge, because I'm not. I'm just a boy robot looking for an earthling adventure." E(2)

"I can't help the way I am. No-one thinks I'm up to much anyway...and I know that too... so does it matter if I'm normal or outrageous? No point to any of it when you're nothing." L(2)

Whilst all children within Groups 1 and 3 were able to identify plans of action to reduce the discrepancy between what they perceived they had and what they wanted, everyone from Group 2 was adamant that there was no choice and that they had to leave their own destiny to fate:

"It doesn't worry me that the others think I'm crazy and that. I know that Him up there made me like this for a reason. What that reason might be?....dunno. But there is one." K(2)

Action

(D) All participants, and especially Group 2 members, were shown through verbal discourse and illustrations on a white board that building self-esteem meant making decisions through invoking choice: they needed to choose a direction leading to action, they would learn as they went along and would be able to see themselves as originators of actions in their lives. I needed to highlight that children with good self-esteem would

share the same basic set of skills and be able to define goals for themselves, taking the initiative to achieve these goals. I recognised that the children needed to gain as much control over their lives as was individually possible and that developing the opportunity to play a central role in determining their own fate would be crucial to building their self-esteem. For those participants who were ready to succeed, set achievable goals and confront their problems, I knew it was important to take the appropriate measures within the programme to increase the likelihood of success. Rather than developing intricate plans for achieving overly-ambitious goals immediately, I would encourage the children to start with well thought-out, manageable plans-of-action that might be followed up with other achievable goals. Finally, and possibly most importantly, I recognised that progress might only be measured in small increments. Children with low self-esteem were used to people having lowered expectations of them, so they would not naturally persevere and take risks in the learning of new skills, as illustrated by Group 2 children. However, I recognised that never giving up on these children would be crucial for effective intervention.

Evaluation

(E) In any school structure in which only a few might truly satisfy their needs, I evaluated that the rest might turn in their frustration away from schoolwork and towards both self-destructive but need-fulfilling activities. When they became involved in self-destructive activities and 'did wrong', their self-esteem would then suffer accordingly. This was particularly true if there was little effort on their part to correct their behaviour. Therefore, the therapy concentrated on how the participants acted, thought, felt and reacted physically - the four components of Glasser and Glasser's (1999) 'behavioural suitcase'. As all the group members loved cars, an analogy was made to driving a car on the road of life. All participants were told that they had four wheels to get to their destination; where they wanted to go. They were their 'behavioural wheels', all moving at the same time. The children were asked to write down how they were choosing to behave and to identify what the wheels were doing, such as the thinking wheel could be worrying or remembering, the acting or doing wheel might be talking or running. Finally, as with a real car, they were asked which of the wheels could they control the most - front (thinking and doing) or back (feeling and body language).

Understanding

(P) A strength of using reality therapy in this way was that I was able to demonstrate examples of responsible and irresponsible behaviour as well as build self-esteem in ways which had meaning to each child. However, a possible weakness could have been that, as with any programme, genuine choice or responsibility could only occur for participants when they combined action, or doing behaviours, with motivation to be successful. Therefore, to overcome possible failure, I encouraged the participants to feel powerful, possess a sense of self-worth and meet their needs in ways that were not at the expense of others. The strength of this approach was that I could demonstrate that successful people learnt to know what they wanted. They were also able to decide upon major goals, develop specific plans to attain them and determine the benefits that reaching these goals would bring.

My own personal reflection has to be whether I am meeting *my* needs at the expense of others. Like Josselson (1996), who spoke of guilt at 'using' vulnerable people in research, I am continually aware of the frailties of some group members. Just one insensitive move on my part might destabilise them even further and could set them on a totally destructive pathway. Again, the old adage returns: at what price success?

10:7 SATISFACTION OF EMOTIONAL DIFFICULTIES

Problem

(W) All nine participants recognised that the satisfaction of emotional difficulties was important to them. Members of Groups 1 and 3 appeared to link the satisfaction of emotional difficulties with ultimately being happy and less socially isolated. The emphasis for these children would be to give them a sense of direction along the 'emotional highway' in the hope that their fears around loneliness would be diminished, whilst empowering them to be more assertive and confident in expressing their emotional needs:

> "I like to talk about things which *really* matter. When I do that, I still feel lonely yet, in a funny sort of way, I don't feel so bad about it because I realise that I'm just like a little speck of dust in this big wide world. It's amazing how nothing and important we can be at the same time." K(3)

"It gives me a nice warm feeling deep inside when I realise that there are people who care about me and want to help me feel less wobbly inside my head." M(1)

"At home, we never talk about our feelings.... so this might be difficult for me. I want to do it though.... because often my feelings aren't good ones and I want to be able to deal with them." L(1)

Group 2 members, on the other hand, were unable or unwilling to recognise that their emotional states could be internally changed. The emphasis with them needed to be on direct or indirect encouragement in order to confront their negative feelings and be more in control, thereby finding some sort of meaning to growing up:

"There is a part of me that wants to run away each time a session is due because I'm scared to show my feelings in front of people who could use things I say to hurt me. But when I arrive, that seems to disappear and I just focus on the purpose of why I'm here. It's hard though, as usually I've been dealing with invasions from the Outer Stratosphere." E(2)

This statement portrays a clear picture of just how complex the mental health needs were within this particular group. L(2) and K(2) similarly appeared to be looking for answers to their emotional difficulties. K(2) was observed as having virtually no concept of inner control as she tore around the room cursing, swearing and blaming everyone in the external world for her emotional difficulties. L(2), on the other hand, would satisfy her emotional needs by gratifying her craving for material rewards. She relished any praise that was given to her, unlike K(2) who was so mistrustful that she appeared to see praise as a way to break her:

"Why did you say my worksheet was good? No way. It's rubbish. Got to be because I did it. Here....(scribbles all over it)....not so good now, is it? Ruined!" K(2)

Common to all groups was the emotion of fear. I recognised this as possibly the greatest obstacle to overcome when confronting intense emotional barriers. To break them down, I wanted to illustrate how everyone could tap into the true consciousness of their own minds with the purpose of alleviating pain by bringing it into their awareness. They could then transform each and every feeling by understanding how it developed and

how it attached itself within their mind and body. I would encourage all group members to stop fighting imaginary demons and to confront their emotional feelings. When all the children were able to understand that many of their fears were unfounded, they would be able to make more effective choices in their belief systems so that their emotional difficulties became largely eradicated:

> "I don't like to think about what I would like, what would make me more content. I have things in my head which I'm frightened can't be changed." G(1)

> "I know that my emotions are still all over the place - but I'm beginning to understand why and I'm not so scared any more. When the purpose of something is explained, why I get so upset and behave as I do, it's like the light bulb you talked about going on in my head." E(3)

Action

(D) In order to work on satisfying emotional difficulties, I wanted to help the children feel more comfortable with their feelings and fears, as advocated by Leahy (2004). Likewise, Ledley *et al.* (2005) emphasised that unless emotional difficulties could be satisfied by close examination of thoughts and feelings, these difficulties could manifest in 'neediness', which might overwhelm potential friends and result in heightened emotional difficulties and feelings of worthlessness. The participants were shown that, in reality therapy, there were three types of 'sensations' that were associated with their thoughts and feelings, denoted by a colour:

- Yellow - a positive feeling.
- Green - a neutral feeling.
- Red - a negative feeling.

I explained to the children that when they experienced a yellow, green or red feeling entering their mind and body they would be, at this stage, completely non-judgmental about whether it was a good, bad or neutral thought. When merely feeling, a person could just observe that they were having a positive feeling, a neutral feeling or a negative feeling. Conversely, once they became attached to the feeling, they would start to lose control over their actions and the feeling was likely to become more intense. In reality therapy terms, they were being driven by their 'feeling wheel' because of their

choice of behaviours which they believed would help them gain control of themselves. The red negative feelings were filtered into their control systems and they became attached to them by continuing to use their organised behaviours. They now were unable to let go and be non-judgmental towards the feelings, which consequently constrained their ability to create and re-organise new and more effective behaviours.

Evaluation

(E) The strength of using this reality therapy technique would be that the participants would become non-attached by identifying and observing the actual feelings that were associated with their behavioural systems in the present moment, bringing them into their awareness. The ability to identify the frustration signal was a principal component in the reality therapy programme. What the child did next was the key to their development as individuals who exhibited control over their choice of behaviours. Satisfaction of emotional difficulties heightened the participant's awareness of what they were doing in the present moment so that they were effective at looking at, and evaluating, their behaviours. I could also demonstrate to the participants, through verbal discourse and the creative activities, how to deal with emotional difficulties by confronting and reorganising their behaviour. Worksheets (appendix x) helped to show the children that their conscious reasoning minds knew that negative feelings such as anger, fear and regret were not wholly acceptable to themselves or society, so ways had to be found to repress them and to push them into remote areas of consciousness.

Of course, a possible downside to result from this could have been that the participants might have created defence mechanisms which denied the existence of these negative feelings, giving the impression that they had peace within themselves, in order to avoid possible suffering. I needed to be aware that their deep unpleasant thoughts (internal formations) would always be looking for ways to manifest as destructive images, feelings, thoughts, words or behaviour. I planned to overcome this potential problem by looking at their innermost fears and examining them one by one. This gradual release was important. The children had to start by peeking into those fears that were tucked within their consciousness and merely observe them to see what they did. It would be necessary to be completely non-judgmental about each feeling or thought, whether good or bad. The children might then realise that this was not so bad and want to look further

or deeper. They had to realise that the fears had not changed in themselves, but they had been able to observe them, thereby having more control over them.

Understanding

(P) By using reality therapy in this way, understanding was reinforced and the participants were empowered to be confident in facing their emotional issues and choosing behaviours that would help them to move beyond the attachment. The pain or thoughts might still exist with the same intensity, but now the participants had learned how to live with it and stop fighting what they feared. Hopefully, they would not be afraid anymore of all the feelings associated with the emotional issue, if it entered their minds. They would have learnt to confront these feelings, being more in control over what they would do if they arose again.

My nagging doubt is that this intervention might have been too powerful for some children gripped in a state of fear. For example, when living in almost total unreality to satisfy emotional difficulties has been a long-preferred option, could I reasonably have expected E(2) to *instantly* confront his feelings? I have been starting to feel that I have been running away with myself. Perhaps I need to improve my pacing and question whether this highly confrontational style was too much, too soon for some children. With Group 2, should I have even gone there at all?

10:8 DRIVE TO MAKE FRIENDS

Problem

(W) The drive to make friends was a sub-theme identified by all nine of the participants. Although many of the children were labelled 'loners', which often might imply some kind of choice about wanting to be alone, most of the children, except G(1), had not deliberately chosen their status and most, apart from G(1) again, were keen to use this study as an exercise to help them make friends:

> "How do you get other kids to notice you? Maybe I need to make them see where I'm at; that it's something much deeper with me." M(1)

Once the children were able to identify feelings in themselves and others and could begin to express their feelings appropriately, they were more likely to think about how to remediate their actions:

> "There is a boy in my street at home who is everything I would like to be. He looks cool, acts cool and is dead clever and popular. I ignore him, even though he's been okay to me, because it's easier to take rejection when you're the one that gives it out first. I know that isn't really the answer though. I wish I knew what it was. " K(3)

In the literature, Orbach (1998) contended that as children grew older, interaction would become more focused on peer acceptance and intimacy. Knorr-Cetina (2001) added that friendships would tend to move from being physical (with a focus on actions) towards relationships with an increased awareness of the feelings and emotions of others. Both L(1) and M(1) spoke through use of analogy to illustrate how having friends was an important factor in their lives:

> "I would rather be living in a squat with a load of mates than living in Buckingham Palace and thinking I had no true friends at all." L(1)

> "I dreamed last night that I had created this beautiful picture. It was hanging outside a beach hut on a small tropical island. Everyone who saw it was totally bowled over by it and I was told that I was a very special person. Everyone was my friend. Then I took my painting to a big city, miles away from the island. It was hung amongst lots of other beautiful paintings. So then nobody noticed the painting anymore..... and I was so lonely again that I slashed it to pieces." M(1)

Two sets of the group participants became best friends - G(1) and L(1), K(3) and B(3), which meant that these four boys began to demonstrate commitment to each other. Aggressive interactions tended to decrease when this happened and their friendships tended to involve more verbal interaction. At this stage, it was important for the group participants to be able to communicate adaptively or, according to Galanaki (2004), they would not be able to establish satisfying social relationships in the longer term, as appeared to be the plight of K(2) and the other Group 2 members. All Group 2 members were observed as lonely children who were driven to an acute need for friends, but who had little idea of appropriate channels to pursue in order to achieve their goals:

"My computer men are my friends. The reason I love them is because they don't answer back. I've worked that one out for myself - but I'd rather have real ones." E(2)

K(2) and L(2) felt that friendships only evolved on their terms and neither were willing to compromise:

"I choose who I hang around with; whether I want to know them or not. If they tell me to get lost, I usually work out a plan to get them because no-one rejects me and gets away with it. I'm the dealer, my rules." L(2)

"Most kids around here are thick and I hate them. I want friends who do my stuff when I say." K(2)

Action

(D) The programme was aimed at helping the groups to be able to assess and manage risks, whilst re-evaluating how they saw relationships progressing and whether they really wanted to move forward with them. Giving the groups an awareness of the process of relationship building would also allow them to linger in any part of their evaluation process. Some children might decide that they wanted a particular friendship to stay at a certain stage. Time could then be used to develop or reconsider a friendship before moving on. Free conversations of this nature were encouraged during practical sessions. A strength of using reality therapy in this way was that I was able to encourage the children to self-assess whether a friendship met their needs involving emotional decision-making. This could be done at any stage of the process and the group could be encouraged to explore whether they wished to progress with a particular relationship. As the group became familiar with what I was aiming to achieve, they would begin to understand that one of the most important aspects of all good relationships was pacing. Pacing, in this context, was a participant's ability to keep emotional pace with another person as the relationship moved through its various stages. The children would learn that they were free to set the pace, or to follow the pace of the other person.

Pacing, naturally, was a problem with children from Groups 1 and 3 in particular. Such was the desperation to make friends that the majority of group members wanted to rush in as fast as they could. Only G(1) held back. The important point which I needed to

emphasise to everyone was that they needed to be flexible enough to move forwards or backwards or to choose to keep the relationship at any point, providing the other person was in agreement. During the course of the discussion, the groups were asked:

- Do you give more than you get in friendships?
- Is your confidence and trust abused?
- Are friends you do have (if any) not really 'there for you' when you need them?
- Do you do most of the compromising with your friends?
- Does it seem almost impossible to make new friends?

Evaluation

(E) Answering 'yes' to any of these questions suggested that the 'give and take' element of the relationship had gone awry and / or that the participant might be wanting more (or less) from the other child than was realistic. As each group practised and acted upon friendship skills, they would hopefully become more confident in their ability to develop and keep relationships. As well as the children from Groups 1 and 3 developing friendships both outside and within their groups, another strength of using reality therapy in this way was that I could encourage the development of confidence in their own decision-making and social development which, in turn, would enhance self-esteem generally. However, Group 2 members did not develop any new relationships and needed more time to 'take on board' the messages which clearly resonated with the other two groups.

Understanding

(P) With all groups in the final session, I discussed the notion that if what they were doing was not getting them what they needed, they should plan what else they could do instead. As each group identified making friends as a major priority for the future, we developed a joint action plan on the whiteboard with each participant contributing ideas.

Figure 3 overleaf was developed with the members of Group 1 as levels of intimacy within friendship groups were discussed:

G(1) "I have lots of acquaintances, people I acknowledge if I see them but then walk on. Making an acquaintance into a friend is hard."

L(1) "That bit is the hardest thing. Once a person is your friend, you can make him into a good friend by taking his side in a fight."

R "Why does it have to be a fight? Is there a better way to behave?"

M(1) "If that person was one of your most trusted friends, you would take their side even if you thought deep inside that they were wrong. I would jump into a burning fire for a most trusted friend....if I had one."

G(1) "I think you should make all the circles shades of blue - like water - and there should be a bridge from the outside, where you have no-one, right across the water levels, to the core where all the *real* friends are."

R "Do you think it would be easy to cross the bridge?"

G(1) "I guess it would depend on how badly you needed to get across."

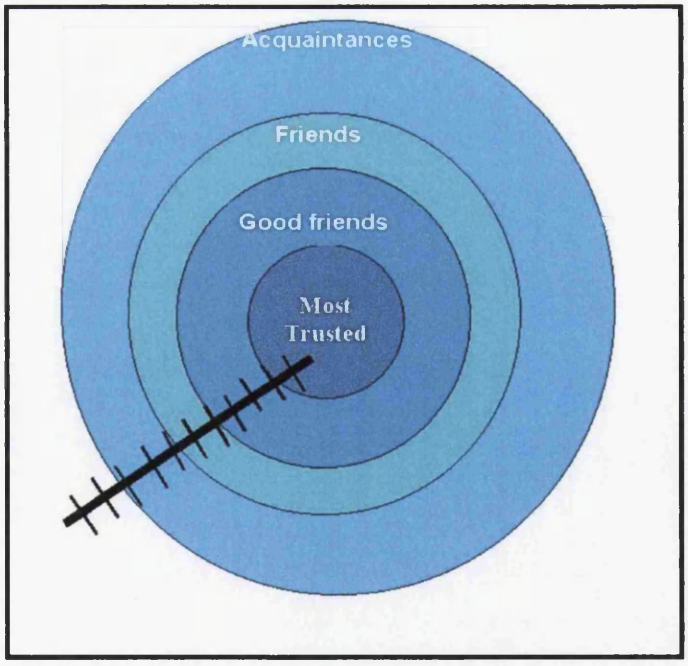

FIGURE 3: THE FRIENDSHIP JOURNEY - GROUP 1

What was my personal learning? It had to be that business and pleasure cannot mix. All the children wanted so badly to be *my* friend, to share something much more than our weekly meetings. They constantly asked about my life and what I did in my spare time. If I could have opened my front door at a weekend to any one of them - even members of Group 2 - they would have been there. Maybe the saddest reflection of all is that I probably needed them as much as they needed me. They filled an abyss which had been empty for a very long time. *They* were looking for any lifeline to grab and many of them were depending upon me. But what would *I* do when the study was over and it was time to say goodbye? How will I feel when the final word is tapped onto the printed page? Has this whole enterprise been about research or about something much more profound? I am almost afraid to answer what I fear I already know.

10:9 FEELING HAPPY

Problem

(W) The majority of participants defined happy children as not the ones allowed to do exactly as they pleased whatever the consequences, or those trained to display only impeccable behaviour and the 'acceptable' face of childhood. Instead, happy children were described as loved and loving, allowed to be children and given the guidance they needed to flourish. Analysed deeper within groups, it was also decided that happy children were loved for who they were; children who appreciated their worth and the worth of others; children whose feelings, needs and development was understood; children who were shown how to be caring and considerate and children who developed the confidence and understanding to make the best of themselves and who had the resilience to deal with problems and the capacity to delight in life. Certainly, all nine participants reported enjoying themselves at the therapeutic sessions, with each group member agreeing that it made them happy that someone cared or that the sessions made them happy because they were fun. Indeed, one of the indirect but fundamental aims of the project had to be that the participants would both enjoy and gain fulfilment from it. In the literature, Myers (1999) highlighted that learning would only be achieved when the learner could see the sense of the learning. Heller and Rook (2001) added that children must be aware of what they were trying to achieve and the enjoyment to be gained from it. Although this theme could have been placed in the need for fun section

as an obvious choice, there were statements and observations which suggested that feeling happy was a much deeper need than superficial gratification activities.

All Group 1 children said that being able to relate to others would make them very happy. M(1) added that adversity in life had taught her to be grateful for the many blessings normally taken for granted:

> "I always try to be as happy as I can. There was a horrible drink-drive advert on the TV where a little girl was killed in an accident. I couldn't get her out of my mind for ages because she looked like me. Even though my life has often been quite sad, I can still smile at other people, still have another crack at life." M(1)

G(1) was able to reflect on the deeper meaning of what it was to be truly happy:

> "Happiness can be something simple like sitting gazing into a real coal fire or flopping into a comfy chair when all your bones are aching. It's far more than just laughing or enjoying a treat. It's an inside sort of feeling.....a sense of something more than on the surface.....and when it can be shared, and there's a bond of some kind, I guess it could be extra special." G(1)

Interestingly, none of Group 2 children wanted to be particularly popular. However, they spoke of feeling a sense of happiness when they felt included or when significant adults took particular notice of them:

> "This boy in the next class said good things about me to.....because I helped him fix his computer. I was happy all day after that." E(2)

> "I'm happy when the sun shines and I'm sitting outside with mates enjoying it. No friends though and it's always raining.....nice thought though!" K(2)

> "My class teacher don't like me because I'm useless at caring about other people, but I always work harder for her and feel better in myself when I feel that what I'm doing matters to *her*." L(2)

Instead of giving herself a negative label such as 'I'm useless at caring', L(2) was encouraged to see that this statement could be positively reframed into 'Sometimes I'm not as considerate as I would like, but overall I am a kind person.' The members of

Group 3, on the other hand, stated that their greatest happiness could be achieved by becoming more popular and thus less lonely. Like Group 1, they too were able to relate to happiness on a deeper level and understand that true happiness involved an element of gaining meaning and purpose to be completely fulfilled. One of the most poignant statements in the entire programme was made by B(3) during an exercise in the third session. He painted a picture of a boy with a walking disability bending over a stick (appendix xi) inside of the 'star' sheet which he had been given. B(3) was totally absorbed in his task, commenting as he worked:

> "I know the outside symbol of the star represents 'I'm proud of me' but I want to paint something deep within this star which I feel very proud to have seen. This is going to be a very special painting because what I saw makes me happy in a deep-down sort of way and will always stay with me." B(3)

B(3) described how he had been sitting under a tree with his father in the park one day when they spotted a boy the same age as B(3) on a flat lower level. The boy was alone and was teaching himself to walk with the aid of two sticks. He would walk a short distance, fall, wriggle about on the ground to retrieve his sticks, scramble to his feet and then continue with this exercise. The boy fell many, many times, continually repeating the procedures to regain control once more. B(3) described how he sat higher and out of sight of the boy, but he had no control over either his own feelings at witnessing such bravery or control to help the boy. He was highly moved by the scene he had witnessed which impacted upon the other two group members. The group decided that only the boy himself had control. It was his personal power which gave him the fortitude and courage to persevere, in order to achieve a true sense of worth and inner happiness.

Action

(D) My aim was not to tell the participants how to live their lives or to impose a regime which would lead down the happiness trail. Instead, it was to provide the children with a set of 'craftman's tools', a psychological kit of knowledge, skills, experience and expertise to give each one of them the information they needed to build on skills they already had, and the confidence and understanding to try new ones. The power of these skills would lie in their hands, with every single positive step likely to have a potentially

enormous impact on them and their relationship with others. Which psychological 'tools' they used, when they used them and what they created with them was uniquely theirs. An example of this was highlighted in Session 3 when I gave the children four worksheets (appendix x). The first sheet represented love and belonging and had a heart as its focus with the words 'I love and belong' underneath. The second sheet represented power with a large star underwritten with 'I'm proud of me'. On the third sheet was a butterfly to symbolise freedom stating 'I have a mind of my own' and, lastly, the fun symbol was a large smiley face with the words 'what I enjoy.' With a variety of creative materials at their disposal, I invited the children to use this medium in any way they wished. Unlike B(3)'s scenario, K(2) and E(2) drew pictures within the large symbols from a different perspective, making images in miniature which depicted traumatic events and, in these pictures, they were able to portray themselves as powerful or in control. By discussing how their interpretation of a symbol was represented and decorated, I could encourage both participants to alter the scene they had created.

Evaluation

(E) A strength of using creative symbols as an effective reality therapy intervention was that it provided a medium to enable the children to project outcomes which they would have liked for themselves and which gave them happiness. It was designed to draw out each participant's abilities, which they were largely unaware of, as well as be instrumental in helping them forge new abilities. By developing social skills and being included by peers, the newly empowered children might, hopefully, seek out even further new friendships, build up their self-esteem and satisfy many emotional difficulties. I hoped that this, in turn, could be viewed as positive, exciting and empowering in what was almost certainly the most important and rewarding feeling they would ever experience, that of true happiness.

Another strength of using reality therapy in this way was that I could show the participants that a life without problems was a fantasy and I could help them to recognise that important fact, because many of them had personal problems of such a magnitude that it was possible they could have 'drowned' in them. A possible weakness of using the therapy like this could have been that the business or motivational speaker's cliché: 'there are no such things as problems, only opportunities' could have

been experienced in reality by many children as persecutory and trite. Likewise, I recognised that if I encouraged the groups to move straight to solutions, long and tortuous struggles might be endured. It was important for me to be aware that participants sometimes *needed* to wrestle with - and even wallow in - problems before becoming unstuck enough to find their own appropriate solutions. Hence, I urged the participants to develop the mind-set that said problems could be *turned* into opportunities, or that some opportunities arose only *because* there was a problem.

All the groups were given a verbal exercise to determine whether their own personal 'glasses' were half-full or half-empty. I explained that the pessimist looked at glasses and saw them as half-empty whilst the optimist was pleased to see them as half full and was often just pleased to have a drink. From a series of illuminating discussions, I concluded that some optimistic children within the groups who suffered setbacks tended to attribute them to external causes that were temporary and could be changed. Other pessimistic children, on the other hand, tended to cast aside Glasser's (1998a) choice theory, believing instead that their setbacks were inevitable and caused by internal causes that were permanent and not amenable to change.

Understanding

(P) I was able to examine strong links between optimism, a change in thinking and creativity during the intervention. Working within this perspective enabled me to show the children that, even in the face of rigorous proof that there was no solution, a different way of defining the original problem *could* lead to a solution. All groups were shown that often when they believed there was no solution, there was a fallacy somewhere in the argument which they had used to convince themselves of this. Reality therapy logic showed them that creative thinking could jump across those barriers.

Finally, I asked the children to think of some suggestions for an action plan, based on reality therapy creative techniques, which might help with problem-solving and enhancing optimism and greater happiness. The formulated 'list' overleaf was produced from an amalgamation of ideas using reality therapy self-evaluation processes which the groups had collectively remembered:

1. Stop thinking about the problem for a time: come back to it fresh and do something different and unrelated in the meantime (Group 3).

2. Think of similar problems: come up with how you solved those problems and see if any of the techniques could be used to solve this new problem (Group 2).

3. Write down the problem: then translate it from words into images such as drawings, photo-montage or clipart, so that different vocabularies or styles of thought can be provoked, which might give insight into tackling a seemingly insurmountable difficulty (Group 3).

4. Explain the problem to someone else: telling someone who knows nothing about the problem can give a fresh perspective on how you might see the problem, or at least help you to explain it differently (Group 2).

5. Sleep on it: solutions or part-solutions occur to us when we stop looking for them (Group 1).

6. Dream on it: think about it just before you go to sleep. Have paper and a pen or a tape-recorder by your bed, because you may wake up with ideas which may seem wacky but which might help you solve the problem (Group 1).

7. Put up photos, images, pictures, words or phrases around your home which may trigger thoughts at odd moments (Group 3).

8. Begin with the end in mind. Imagine what a solution might look like: then you can work it backwards (Me).

I used many of the above techniques to help the participants find their own solutions to problems encountered during the duration of the study. All the groups concluded that the happier they were in their inner selves, the more sophisticated and creative they were likely to become in managing their emotions.

My new learning from this intervention goes back full circle. At the start of the analysis, I highlighted that surviving loneliness, chosen or otherwise, over which a child might or might not have some control, could never adequately be described by statistical data at certain ages or within certain characteristics (5:1). It would appear that, for all individuals within all groups, the key to overcoming loneliness - perhaps more than anything else - was gaining the ability to unlock the 'door' of social resistance in order to find inner happiness beyond. Acquiring optimism, a change in thinking and creativity could enable an unhappy child to survive loneliness and embark on a friendship journey (Figure 3), thereby crossing the bridge from obscurity to deep intimacy and happiness.

As I approach late middle-age, I still struggle to cross that bridge. I remember as a child bitterly sobbing because my playmates had abandoned me; as a young woman bitterly sobbing because my husband had abandoned me; as a middle-aged woman bitterly sobbing because my son had abandoned me. From my own personal perspective, happiness would appear to be far more about love and belonging than just having fun, as so often perceived by the unlonely. But could my intervention possibly begin to tackle something so indefinable, so unquantifiable? Being inwardly happy was undoubtedly like a magic elixir, the prize, the ultimate goal, the antithesis to loneliness.

10:10 SUMMARY

In this chapter it was significant that, with the exception of 'moral values', all group members were able to identify on similar levels within the intraneeds. This has helped to narrow the divide which had previously arisen between Groups 1 and 3 and Group 2. In the following chapter, I intend to critically look at that divide in the context of considering the aims of the study. Did all the groups benefit from the programme? Did some benefit more? What mistakes did I make? How can I learn from them? I hope this new learning will be my small but unique contribution to the wider academic arena.

CHAPTER 11

SOCIAL BEHAVIOURAL CHANGE

No amount of evidence can prove me right
And any amount of evidence can prove me wrong
- Albert Einstein 1879-1955

Contents

11:1 INTRODUCTION

It has become clear throughout the analysis chapters that the reality therapy intervention appeared to work with some success with Groups 1 and 3 but not with Group 2. All the procedures used indicated that no long-term positive social behavioural change seemed to have occurred with Group 2. The reasons for this will be fully examined to try to identify what was different about the children and their environment, drawing up conclusions based on the evidence presented throughout the analysis. However, it would appear that it is not possible to say if Group 2 children would have deteriorated anyway or whether the intervention actually contributed to their problems.

The focus in this chapter is to undertake both synthesis and integration of the analysis in order to facilitate discussion of my findings to address the research questions. After carefully considering the limitations of the study and the differences in peer acceptance over the course of the therapy, I have dissected the remaining chapter into three major sections in order to answer the research aims which branched out from my central question: 'How do I engage more effectively with pre-adolescent loners in group therapy?' The first section will look at the advantages and the conflicts / tensions of my role as practitioner-researcher. The second will scrutinise differences between successful and unsuccessful outcomes in the group programme. Finally, as I consider the new learning to emerge from undertaking practitioner-centred research, I will reflect on how my practice as a therapist has improved and how I could have engaged more effectively with the groups.

11:2 LIMITATIONS OF THE STUDY

As the journal approach (attempted in the pilot study) had been previously unsuccessful in obtaining answers of relevance, I felt justified in using tried-and-tested programme evaluative questions from previous clinical practice whilst recognising that a limitation might be that certain questions could be interpreted within the context of this study as somewhat loaded. I also specifically chose the sociometric test and style of presenting different written or oral questions because I knew it was effective from past experience of working with children, schools and families. However, sociometric tests do have their limitations and it is important that this is acknowledged. It should be noted that

Frederickson and Furnham (1998) had warned that it was common for primary age pupils to prefer not to associate with opposite sex peers and to feel inclined to tick all the sad faces, especially on the LITOP. In classrooms where there was a gender imbalance, pupils could appear to be rejected overall when they were, in fact, well accepted by the same sex peers with whom they actually played. In this study there was not an imbalance in gender in the three classes used for the testing. If there had been, pupils could have appeared to be rejected overall when they were, in fact, well accepted by same sex peers.

The 'social acceptance descriptor' column on the scoring sheet provided a differentiated profile of social inclusion across the groups (same and opposite sex peers) and school contexts (work and play) which were sampled by the LITOW and LITOP. Frederickson and Furnham (1998) argued that questions about whom the pupils would like to work or play with sampled major contexts for peer interaction in the school environment and were therefore likely to have greater content validity than more peripheral aspects such as 'would like to attend an after-school club with.' However, whether they actually had validity for any pupil depended on whether opportunities were provided for pupils to work together on assignments. If pupils were always set individual assignments separately from the rest of the class then a 'would like to work with' criterion would be unlikely to give a valid indication of their social acceptance.

This perspective applied to G(1) who, as a gifted learner, was set individual tasks of a higher standard than his peers in the classroom. Likewise, M(1) and L(1), at the time of the initial sociometric test, both had one-to-one support because of their behavioural difficulties and so were often isolated during group activities from their peers. As L(1) had made such "significant" progress during the course of the reality therapy from his Head's perception (Statement 64), his one-to-one helper was removed six months before the sociometric test was re-applied. This factor may have influenced results as he had acquired time to reconnect with peers and work independently in group situations.

These circumstances were not anticipated or foreseen before commencement of the study. Although only Group 1 peer acceptance results may have been affected, as the one-to-one support provided by the other two schools was in general terms and not specified to any one particular child, it could be questioned as to whether Group 1 were

differentiated from the outset by this factor. Working alone on specific individually-set work, working with one-to-one support away from peer groups or having the isolating support removed between sociometric test and re-test may all have had an influence on popularity status amongst peers and could have affected the overall findings of the study as a result, when peer acceptance ratings were judged alongside other criterion.

Finally, the difference between a therapist in clinical practice and one undertaking research must be re-emphasised as the matter of closure is addressed. The reason for the limited length of the intervention was that of the boundary pre-set by the research. This must be seen as a limitation because clearly none of the groups wanted to finish after ten sessions, as reported in later commentaries in questionnaires and interviews. In fact, therapeutically, Group 2 still had a plethora of obstacles to overcome before positive social behavioural change could occur, as will be discussed later in the chapter. In the literature, few studies could be found about how children felt about closure, but Kendall (2000) found that the majority of former child recipients of cognitive-behavioural therapies felt pride and a sense of achievement. However, personal satisfaction and fulfilment was lessened for many participants of this study because raw data such as paintings, clay models, stories and worksheets had to remain with me as evidence. This would rarely happen in good clinical practice, where the 'taking home' of such endeavours is valued as an integral part of the therapy (Adamson, 1984; Biddulph, 1993; Schmuck and Schmuck, 1997). Perhaps, with Group 2, the self-esteem raised by showing their efforts to others, may have made some difference in self-evaluation and how others perceived them.

11:3 CHANGES IN PEER ACCEPTANCE

I particularly wanted to assess the effectiveness of the reality therapy intervention from other children's points of view in order to further my own personal understanding of the implications of sociometric testing with this research population. I felt this new learning would, in turn, help to improve my practice as a therapist. The sociometric re-testing allowed me to measure changes in peer acceptance from the start of the programme to the end of the school year. Table 11 overleaf has recorded the scores from original sociometric tests in September 2002 and re-tests in July 2003.

TABLE 11 CHANGES IN PEER ACCEPTANCE

KEY: LITOP - LIKE TO PLAY (GO AROUND WITH)
LITOW - LIKE TO WORK
REJECTED - R
AVERAGE - A
POPULAR - P

NAME	SOCIAL ACCEPTANCE DESCRIPTOR **LITOP - Sept. 02**		SOCIAL ACCEPTANCE DESCRIPTOR **LITOP - July 03**		SOCIAL ACCEPTANCE DESCRIPTOR **LITOW- Sept. 02**		SOCIAL ACCEPTANCE DESCRIPTOR **LITOW - July 03**	
G(1)	Same sex	A	Same sex	P	Same sex	P	Same sex	P
	Other sex	R	Other sex	A	Other sex	R	Other sex	A
	Whole group	R	Whole group	A	Whole group	R	Whole group	A
L(1)	Same sex	A	Same sex	P	Same sex	A	Same sex	P
	Other sex	R	Other sex	A	Other sex	R	Other sex	A
	Whole group	A	Whole group	P	Whole group	A	Whole group	P
M(1)	Same sex	R	Same sex	P	Same sex	A	Same sex	P
	Other sex	A	Other sex	A	Other sex	A	Other sex	A
	Whole group	R	Whole group	P	Whole group	A	Whole group	P
E(2)	Same sex	R	Same sex	R	Same sex	A	Same sex	A
	Other sex	R	Other sex	R	Other sex	R	Other sex	R
	Whole group	R	Whole group	R	Whole group	A	Whole group	A
K(2)	Same sex	R	Same sex	R	Same sex	R	Same sex	R
	Other sex	R	Other sex	R	Other sex	R	Other sex	R
	Whole group	R	Whole group	R	Whole group	R	Whole group	R
L(2)	Same sex	A	Same sex	A	Same sex	R	Same sex	R
	Other sex	R	Other sex	R	Other sex	R	Other sex	R
	Whole group	R	Whole group	R	Whole group	R	Whole group	R
B(3)	Same sex	A	Same sex	P	Same sex	R	Same sex	P
	Other sex	R	Other sex	A	Other sex	R	Other sex	A
	Whole group	R	Whole group	A	Whole group	R	Whole group	A
E(3)	Same sex	A	Same sex	P	Same sex	A	Same sex	P
	Other sex	R	Other sex	A	Other sex	R	Other sex	A
	Whole group	R	Whole group	P	Whole group	R	Whole group	A
K(3)	Same sex	A	Same sex	P	Same sex	A	Same sex	P
	Other sex	R	Other sex	A	Other sex	R	Other sex	P
	Whole group	R	Whole group	P	Whole group	R	Whole group	P

Sociometric testing was not reapplied after one month - when questionnaires and interviews were undertaken - as a longer period of time was needed to reflect a true picture of peer acceptance. Over-use of such a measure could have weakened its effectiveness. I felt that peer acceptance, perhaps more than any other factor, was the true 'acid test' of the effectiveness of the therapeutic work which had been undertaken.

Group 1

Results from both categories of the Social Inclusion Survey highlighted a rise in peer acceptance for all group members, despite the possible limitations discussed in 11:2. In September 2002, there were a total of eight rejections on the social acceptance descriptor within this group. No group member was rejected in any descriptor in July 2003. This outcome indicates that reality therapy appears to have promoted positive social behavioural change sufficiently enough within this group to alter peer acceptance levels.

Group 2

For all three participants, there was no rise or fall in peer acceptance. In September 2002, there were a total of fifteen rejections on the social acceptance descriptor within this group. In July 2003, this number of rejections had neither risen nor fallen. This outcome indicates that reality therapy did not appear to promote positive social behavioural change sufficiently within this group to alter peer acceptance levels.

Group 3

Results show a rise in peer acceptance within both categories for all group members. In September 2002, there were a total of thirteen rejections on the social acceptance descriptor. However, in July 2003, no group member was rejected, highlighting that this group made the greatest rise in peer acceptance across groups. The outcome indicates that reality therapy has promoted positive social behavioural change sufficiently within this group to considerably alter peer acceptance levels.

Peer acceptance summary

In two out of three groups (Groups 1 and 3), positive changes occurred in individual peer acceptance following participation in the reality therapy programme. In addition, perceptions of change in peer acceptance were observed by the individuals themselves, their parents / carers and teachers. Interestingly, M(1), E(2) and K(2) had all been rejected by same sex peers despite there being no gender imbalance. All the more remarkably, M(1) climbed from rejected social status to popular social status after re-testing. This questions views expressed earlier in the literature by Petersen and Gannoni (1992) that rejected children experienced a negative labelling effect from other children, as well as themselves, and that even when they attempted to behave in a positive way, their peers might continue to respond negatively towards them and perceive them in a negative manner. Additionally, unlike L(1), M(1) still had a one-to-one helper during the period of re-testing which could have been, to a certain extent, an isolating factor because of more limited group interaction.

11:4 ADVANTAGES AND CONFLICTS OF MY ROLE

I am acutely aware that one of the most difficult demands for any therapist, researching an area of extreme vulnerability, would always be that I am expected to build and maintain a therapeutic relationship with young people who have difficulty accepting responsibility, managing emotions, making responsible choices, finding a purpose in life and believing adults can actually help them. In the literature, Richardson (2001) emphasised the importance of remembering that many socially isolated and challenging pre-adolescents may already have been seen by a variety of professionals whom they regarded as 'a waste of time' because their experiences were neither need-fulfilling nor gave them a sense of purpose. Renna (1991) had also questioned the practicalities of developing meaningful relationships with youth who had a history of abuse, neglect and rejection by caretakers. Wubbolding (2000) had expanded on this point by asking how purposive tasks could be achieved when certain individuals had been so damaged already by the course of life. However, I was interested in following Frankl's (1984) premise that change was always possible with the most damaged of individuals as long as a sense of trust and hope prevailed. Glasser (1968, 1992) emphasised the importance of a therapeutic climate which fostered a sense of connection for 'at risk' children. He

asserted that the relationship between therapist and participant was the 'soil' that enabled therapeutic work 'to take root' (Glasser, 1998).

In Groups 1 and 3, trust between the participants and I grew very quickly, resulting in all group members choosing to participate in a nurturing environment which was able to harness positive social behavioural change. Following guidelines provided in the literature by Ledley and colleagues (2005), I provided the type of therapeutic environment which allowed group members to come to terms with their difficulties and strengthen their inner resources, making them more self-aware, autonomous and open to the learning of social competence. For example, when working with G(1) and K(3) on their feelings and behaviours associated with stress in having to care for dependent adults, I was aware that both boys were trapped within a cycle of ineffective behaviours that kept them returning to their unresolved issues because they had not confronted their pain. By first working on building up trust and then bringing these issues into their awareness, I was able to help them confront their issues. The trust which became established between us allowed them to come to terms with their difficulties and strengthen their inner resources in order to become more self-aware, autonomous and open to learning. I constantly encouraged positive social behavioural change through providing a therapeutic alliance which allowed them to be in control or 'plant their own garden' (Glasser, 1998). Using this symbolism again, my aim was that positive change would not be short-lived (as in a garden with annuals) but long-term (as in a garden with perennials), cared for with respect for its own organic life.

Once I had built up trust in Groups 1 and 3, I could encourage all the children to have greater control over their own lives, whereby reducing or removing previous feelings of helplessness. This, in turn, could lead to greater positive social behavioural change as more participants became newly empowered and assertive. I had observed that generally Group 1 was more assertive through non-judgmental respect for each other's choices - even if they made mistakes - because the atmosphere was one of encouraging ambience. Group (3), likewise, appeared to gain a boost in confidence because of the therapeutic bond, which was still in place six months later at the end of year visit.

This did not happen at any level with Group 2. They were unable to trust me because they needed more time and were wary of the 'yet another professional' label probably

attached. This was evidenced in K(2)'s end of year evaluation (appendix xiv) which concluded:

> "...the stuff I've got inside isn't going to be repaired by a few weeks with some do-gooder who's never been in my world." (Statement 23)

I was so aware of the need to build genuine, long-term trust into our relationship, but it was not happening quickly enough because this was such an alien concept to Group 2. Sometimes I could see or sense advances but then we would come to a standstill again. It was, literally, two steps forward and one step backwards, as might be expected. But we were getting there. Crucially though, too slowly to meet my pre-set research criteria.

However, inability to develop trust in me was not the only obstacle I was faced with. Members of Group 2 were unable to engage in individual behavioural skills acquisition because of emotional disturbance. When I attempted to work on a skill such as assertiveness, there was always a primary emotional block, that of anxiety. Likewise, there were secondary emotional problems such as the emotional difficulties which arose as a result of their inability to tackle the primary problem. For example, E(2) had used fantasy to escape having to be assertive in the real world and had constantly hidden in his make-believe world. Both girls, on the other hand, had been over-assertive in their actions because of misconceptions about appropriate behaviour and there was not enough time to correct these misconceptions, remove their blocks and assist them to learn new, more positive behavioural skills, as highlighted (appendix xiv) by K(2):

> "Talking about the real personal stuff was awful, with you trying to get inside my head. I didn't know you well enough for all that." (Statement 14).

In order to know me on a more intimate level within the therapeutic alliance, I encouraged the children to view reality therapy as an unburdening process. In the literature, Larson (1999) had identified many lonely young people as needing to pour their hearts out. If positive social behavioural changes could be encouraged as unburdening took place, I reasoned that the children would feel valued in having made revelations and were more likely to build up further social trust. For example, it was difficult for G(1) and K(3) to 'betray' their dependent parent, so an intensely caring

therapeutic relationship was essential in order for them to offload. Having obtained a deep trust from both boys, the scene was set to explain that ordinary people survive the most extraordinary experiences. By discussing the basic premises of Frankl's (1984) writing, the examples of others' personal experiences were able to inspire the boys and give them licence to unburden, rather than making negative comparisons against someone's 'superior' coping skills.

L(2) was also able to pour her heart out, which started to have an impact upon her behaviour. However, she appeared to be too emotionally damaged and untrusting from witnessing domestic violence throughout her childhood and being a member of an older gang for this to make a lasting change and a reason for her temporary change could, perhaps, be interpreted as a mere fad. Whatever the reason might have been, being in control - usually more negatively than positively - was generally more important than forming a close therapeutic bond. Her notoriety at school (and resultant rise in self-esteem) was increased far more by bragging about associations from outside where there was no hint of authoritarianism or 'being manipulated' by professionals:

> "...I hang loose with kids who are really adults as they've packed in school and are doing their own thing." (8:6)

Another conflict and tension of my role was my awareness that never giving up on the participants was crucial for effective intervention. However, the children themselves had to show a measure of self-esteem for this to be successful and I had witnessed low self-esteem amongst all the children. Many of them had programmed themselves for failure by having selected or incorporated certain images into their mental picture albums in which they saw themselves as unworthy of being loved, unworthy of achieving and unworthy of having fun and freedom. However, by providing a warm and supportive therapeutic alliance, E(3) was able to make the following observation:

> "I would never admit to anyone in the class that I was lonely and felt left out. I would rather just cry where no-one can see me. But I can say those things here - because it matters here - and then I feel so much better." (10:6)

I was frustrated that children who were 'experts' in venting feelings and using excuses, were not very good at doing anything about their situations. Group 2 members chose behaviours of the underachiever, the unloved and the abused, as illustrated by L(2):

> "I can't help the way I am. No-one thinks I'm up to much anyway...and I know that too....so does it matter if I'm normal or outrageous? No point to any of it when you're nothing." (10:6)

Reasons for this type of attitude were explained in the literature by Hart and colleagues (1998), who warned that exceptionally damaged children tended to avoid intimate situations which they regarded as 'risky'. This appeared to be true with E(2). One explanation of why his therapy was not successful was because the barrier of gaining full trust was still viewed as a major obstacle and was replaced with denial and fantasy:

> "The way I behave isn't down to me....my brain takes over and operates all my switches. It's no good people saying I'm in charge, because I'm not. I'm just a boy robot looking for an earthling adventure." (10:6)

With Groups 1 and 3, as I was able to increase their trust in me, an advantage of my role was that I was able to empower participants to be confident in facing emotional issues and to stop fighting what they feared. I could also encourage all these group members to confront their feelings of social isolation, thereby being more in control over what they would do if their fears and anxieties reoccurred. In the literature, Leahy (2004) and Ledley *et al.* (2005) had highlighted that it was important for individuals to realise that fears did not change in themselves but, by observing them, a person had more control over these fears and therefore ultimately more control over the change they could personally make to become more socially competent. The trust which was present within the therapeutic alliance was a key factor in whether fears could be overcome.

Paradoxically, every child was frightened of social interaction to a greater or lesser degree and yet, by the same token, desperate to be noticed and well-liked. This meant that great sensitivity was needed in my role as practitioner-researcher. A typical example was K(3) who appeared to live in a perpetual state of emotional torment. On one occasion, he was observed dashing to the toilets to avoid being picked for a task

where he might have felt exposed. In the cloakroom he broke down, emotionally bereft, because he thought he had been excluded. With nurturing and encouragement, I was able to show him how to empower himself so that he was in control of his own therapy to alleviate his fears. I was aware that M(1) also needed 'the safety blanket' of my presence in a therapeutic role to help dispel her fears:

> "It gives me a nice warm feeling deep inside when I realise that there are people who care about me and want to help me feel less wobbly inside my head." (10:7)

However, fear was often too real and threatening for Group 2 members and our therapeutic alliance was not established enough to give sufficient reassurance to such damaged individuals. This was illustrated by the following extract from E(2):

> "There is a part of me that wants to run away each time a session is due because I'm scared to show my feelings in front of people who could use things I say to hurt me...." (10:7)

According to the literature, the role of every therapist from the cognitive-behavioural field should be to empower their client within the safety of the caring environment (Neenan *et al.*, 2000; Ledley *et al.*, 2005). Being in the uniquely advantageous position of being a therapist researching her own practice meant that I was able to empower the participants rather than merely observe them. Empowerment through the use of psychological 'tools' also provided a means for the children to project outcomes which they personally wanted and which could promote positive social behavioural change. By providing them with a set of 'craftsman's tools', a psychological kit of knowledge, skills, experience and expertise was amassed, giving them the information needed to build on skills they already had, and the confidence and understanding to try new ones. The safety of the 'therapy net' meant that I could encourage each group to explore whether they wished to progress with a particular relationship. I could also empower them to make self-evaluative decisions towards positive social development using their new set of 'tools', as recognised by M(1):

> "How do you get other kids to notice you? Maybe I need to make them see where I'm at; that it's something much deeper with me." (10:8)

However, Myers (1999) had recognised that these 'tools' were powerful in the hands of extremely vulnerable individuals, with every single step likely to have a potentially enormous impact on them and their relationship with others. Group 2 appeared not to be psychologically ready for use of such 'dangerous instruments'. I had observed that all three children were driven by an acute need for friends, but were unable to use their 'tools' in appropriate channels to achieve their goals. They appeared to view friendship only on their terms with no compromise and no trust, as highlighted by L(2):

> "....If they tell me to get lost, I usually work out a plan to get them because no-one rejects me and gets away with it. I'm the dealer, my rules." (10:8)

So was the lack of positive results with Group 2 due to personal or institutional factors? It would appear to be both. Although all members of all groups were psychologically impaired by their pasts, Group 2 was almost irretrievably damaged. Their damage was on a more profound level because every member of this group had experienced terrible loss and mistrust in their short lives. For example, none of them had fathers who were ideal role models and the children appeared to have lost faith in them. Likewise, none of them had mothers who were able to provide a guiding hand; these inabilities prompting doubt and mistrust. L(2) had no brothers or sisters, nor did K(2). Hence the children were involved in an abnormal adult world - totally alone - which must have been terrifying. They had probably learnt not to trust adults under any circumstances from a very young age. E(2) had lots of brothers - all older, all criminals. He too tried to live in this frightening world, trusting no-one because no-one was there for him. Surviving was, perhaps, all that could be expected from these children. Sometimes living in fantasy, getting the better of society and running wild was the only relief from their terrible afflictions. Of course these children did not trust me. Neither, despite my best efforts, did much sense of hope prevail, as Frankl (1984) had postulated was necessary for positive change. It would take a very long time - if ever. How did they know for sure that I too would not let them down?

I believe institutional factors also had a part to play. It seems that no-one had ever been prepared to look beneath the surface of Group 2's actions. Their schools, social workers and 'experts' who had been brought in to observe them only seemed interested in solutions for the effects of their behaviour (mainstream CBT), instead of investigating

the deep-rooted causes of their unmet needs (reality therapy). Their appalling pasts had not been adequately dealt with. Many professionals had even 'written them off', as evidenced by their own Headteacher (appendix xv):

> ".....Too late, too damaged - all of them I'm afraid." (Statement 48)

Another example of institutional influence was the practice of ability grouping and tracking at Group 2's school which, naturally, alienated group cohesion and created an 'in group / out group' mentality. Instead of achieving a sense of belonging, Group 2 members were socially isolated and sunk into a sub-culture which was hostile to the academic goals of the school as well as to each other. This was described by L(2):

> "My school is all about success and we have to go along with all that. But it's hard when you're crying inside but you don't know why. That feeling inside makes you stop and then you fall behind, so you become a dumb-bag because they don't want to take time to know you - the real you. It's easier to drop out from their cosy little fairy world where everything falls neatly into place and find something that is real and fight each other for it." (7:6)

11.5 SUCCESSFUL AND UNSUCCESSFUL OUTCOMES

A fundamental question to be asked when considering successful and unsuccessful outcomes is: did the planned programme actually work? I have already established during the analysis that the programme was successful with Groups 1 and 3, but not Group 2. So what exactly constitutes being successful or unsuccessful? In order to answer this, I perhaps need to return to the central research question and consider whether I was able to therapeutically engage on an effective level, bearing in mind that the very term 'effective' is highly subjective in itself. The close scrutiny of interventions, environments and interpersonal bonds with Group 2 would appear to answer my research question more than anything else. I hope that examination of these 'unsuccessful' outcomes will pave the way to greater understanding of how to engage *more effectively* next time around and identify the specific difficulties involved for future action practitioner-researchers. At the end of each of the following sections, a reflective and self-evaluative approach has been taken in looking at mistakes which were made and which need to be addressed in future study replication.

My fundamental role as therapist has already been considered. As well as being able to form a positive therapeutic alliance (perhaps the most essential of all criteria), seven other variables seemed to make a difference to overall success or failure: group bonding, impact of the physical environment, timescale, applicability, appropriateness of activities, support of parents and school staff and ability to self-evaluate. Each of these other factors will be considered in turn over the next few pages.

11:5:1 GROUP BONDING

An essential foundation for successful group therapy is that opportunities are provided to bring group members together as a united learning team, empowering each other and providing each other with a shared sense of belonging and fun. My aim was to foster social relationships within each group in order to drive their newly-found social confidence into the wider arena and thus promote positive social behavioural change. In the literature, Cohen (1993) had described these characteristics as 'the acid test' of positive mental health. It did not take long for this to happen with Group 1. They became completely cohesive as a group in Session 6 when worksheets were being filled in. As usual, G(1) finished his work quickly because of his advanced academic abilities. Instead of his usual tendency to daydream, he now felt ready to move closer to M(1), whom he knew had learning difficulties, and help her. L(1) joined in after a few minutes, something he had never done before, and soon the three children were working as a tightly integrated unit. Soon afterwards, it was noticeable that Group 3 had also tightly bonded as a group through a shared sense of loneliness and a gradual build-up of mutual regard and respect. On the other hand, members of Group 2 appeared to change very little, perhaps because anything which was not physically demanding or intellectually taxing was a welcome relief from their usual traumatic lives, as evidenced by E(2) who claimed to "love doing nothing" (9:4).

I was aware that we all needed to accept the existence of personal shortcomings within the confines of an intimate group so that self-limitations could be better understood. This would also allow participants to identify areas which they might wish to target in order to facilitate personal change. In encouraging the groups to write a rap song (appendix ix), I hoped closer social bonds would be formed because there was no leader

but equal partnerships. I was also mindful of the literature, which emphasised that the social interaction with others, the 'comfortableness' of equality within groups and the pleasure of just 'being together with others' had very positive effects on well-being without the need to compete (Bowlby, 1973b; Doll, 1996; Rotenburg and Hymel, 1999). This was indeed true for Group 1 and 3 members. Their joint group experiences helped to promote open communication about their needs without any form of dominance or power struggle and it was this openness which was a key factor in promoting positive social behavioural change. M(1) identified this in her questionnaire (appendix xiv):

> "I just liked being in the group with L and G. It made me realise that I can make a friend because now we're all friends....." (Statement 3)

As well as learning to be open with each other, I encouraged each group to abandon rigid demands in order for bonding to occur. In the literature, Galanaki (2004) had found that lonely children could be intensely self-focused. To overcome this, I urged all the children to ditch their rigid demands about how they, others and the world 'had' to be. By becoming irate about things not being the way they believed they *must* be, they were not immobilising their ability to move forward socially. L(1) and K(3) were good examples of this process. I was able to observe that the bonding process had impacted upon their lives and that they were not psychologically damaged beyond 'repair'. Both boys were responsive to all the reality therapy interventions and wanted to change their rigid behaviours which they could see were harming their chances of making friends and enjoying social opportunities. They gained insight into their lives through bonding with their respective groups and both were able to see how past withdrawal had negatively affected them on a social level. On the other hand, Group 2 members professed no interest in forming friendships or developing social skills. They preferred to maintain a rigid stance, putting up barriers to stop themselves being hurt. This took the form of escaping into unreality or sabotage and making themselves resistant to these barriers being broken down, as evidenced during clay work when E(2) proclaimed:

> "My sculpture boy is telling the other two monkeys in this room to get off my case. He is angry like I am." (6:2)

By exploring the logic behind irrational thinking within the group situation, alternative beliefs were considered which helped to reinforce positive social behavioural change for Groups 1 and 3. My goal in using reality therapy this way was to raise awareness of other possible beliefs which participants were overlooking or failing to identify for themselves. In the literature, Friedburg and McClure (2002) had emphasised the value of group bonding in letting participants compare their experiences with other group member's experiences. These researchers also felt that empathy could be learnt by most types of children but recognised that damaged individuals could make the process extremely difficult. My aim was to 'socially educate' M(1), L(1), L(2), E(3) and B(3), who vied with one another for the highest group status. In particular, it was important to work with L(2), who manipulated situations and made remarks so that the others were put down, whereby making herself feel good:

> "What is that painting supposed to be, K? I know it's supposed to be a patterned butterfly but it reminds me more of your mother's boyfriend's sick on the steps most Saturday nights when he comes home from the pub!" (9:5)

This example demonstrates that Group 2 members were unable to compare and exchange experiences in a positive way because they were not able to bond as a group. The teaching assistant rationalised that she considered it to be a mistake to have put the three children together in a group. She felt that K(2) and L(2) were too competitive to work alongside one another and should have been separated (appendix xv):

> "Difficult children need more the one-to-one touch so they don't feel threatened and are made to feel special." (Statement 60)

As Groups 1 and 3 evolved, I encouraged the children not to view emotions around social situations as static conditions but behaviours which were generated from within. As such, I wanted them to recognise that these behaviours were capable of positive change. The transition from external control thinking to internal control thinking was accomplished by using reframing activities within the two groups. Every time someone said "I can't", their words were reframed to "I won't" by the other group members. In the literature, Parish (1991) had advocated that participants should be taught the

language of inner control such as "I *choose* to do it" by assuming control of their own destinies through taking inner control and self-responsibility, instead of blaming external factors. Using collective analysis within Groups 1 and 3 allowed the group members to understand that it was their choice to make positive social behavioural change. An example of constructive group bonding was evidenced when members of Group 1 discussed the story of The Selfish Giant:

> G(1) "He knew he had a responsibility to help and that made him come through in the end...That couldn't have been easy for him when he spent so long just pleasing himself."
>
> M(1) "But he made the right decision in the end because he had a conscience."
>
> L(1) "Everyone benefited from his choice as no-one was lonely anymore." (10:4)

Members of Groups 1 and 3 accepted that their groups would not focus on negative scenarios from the past, understanding that what they did was the best they could have done at that moment. Instead, the therapeutic work centred around the misconceptions which they had held about fate and denial of personal responsibility. However, Group 2 were too far entrenched into the world of unreality, which they appeared to have created for themselves as defences, for this type of approach to make any constructive difference, as evidenced by E(2):

> "Aliens, dragons and gorgons don't worry about consequences and all that stuff, so why on earth should I? In my world, it's everyone for himself." (10:4)

I observed that Groups 1 and 3 were able to bond more effectively when they kept focused on the present moment and did not keep returning to past social behaviour. I therefore encouraged them to discuss changes which were possible within the present moment. In the literature, Stone (1993) had emphasised that when *they* were in control and enjoying the 'now', children would get back in touch with themselves and drive themselves towards change, as did indeed occur with Groups 1 and 3. However, although I watched L(2) becoming positively aroused when she did something worthwhile, her general demeanour suggested that she was acting as an individual

needing to make her own mark *outside* of the group process. K(2), similarly, viewed group bonding as a chance to be negatively competitive:

> "I'm motivated when I see a chance for me to be in there first, getting one over on the others, grabbing chances for me. There has to be a reason to do things." (10:5)

Therefore, together with E(2)'s lonely world of fantasy and self-isolation, the process of group bonding never happened for Group 2 and no successful outcome of positive social behavioural change was able to occur through this perspective.

Reflection and self-evaluation

Segrin's (2003) model for successful group therapy assumes that not only are the children benefiting from the brief individual time they each receive from the therapist in the group setting, but they also benefit from each other. I believe that Group 2 members *did* profit from the limited individual attention which I was able to give each of them. However, on the second count, my therapeutic approach badly failed. McLeod (2005) had always stressed that the ability to participate actively on some level was a benchmark of successful group therapy yet I did not heed this warning despite, instinctively, knowing that I had three 'difficult' children from the outset. Did I really believe that I was so competent that I did not need to worry? Segrin (2003) also recognised that children with low motivation (such as L), antisocial personalities (such as K) or those who chose to self-isolate (such as E) might not benefit from social skills training or therapy groups. He warned that those problems were better addressed first in individual therapy, at which point it could be determined if the child was ready for the group. Hence, I am guilty of putting my own agenda first and also fulfilling his prophecy, that if a child is integrated too soon, not only does that child not benefit, but also the other group members might be hindered (Segrin, 2003). I observed that Group 2 did significantly hinder one another on many occasions. In fact, they were a disastrous and destructive mix of personalities.

Stone (1993) had earlier been instrumental in warning therapists such as myself that group therapy was not possible with individuals with severe psychopathology or antisocial tendencies because their behaviour goals did not coincide with the mutual benefit of others. Furthermore, Mennuti and colleagues (2006) emphasised that such

children ought not to be included in group therapy unless the entire group comprised specifically of similar peers. Group 2, whilst all highly disturbed, were not similar. All three had specific and unique issues to overcome from their pasts. If I had undertaken more careful initial assessment, unexpected problems might not have arisen. I should have looked for a better 'fit' of group members, matching more selectively their individual needs and goals and taking into account more fully individual degrees of pathology, skill levels, maturation and social skills. Leahy (2004) had also stressed the importance of assessment when considering each group member's readiness for successful group participation and potential for contributing to the group process. Why did I not take the advice of Christner and colleagues (2006) who suggested that, where time was limited for this task, even a short individual session might pay off greatly in beginning a successful group? In hindsight, a small amount of individual time together might have completely altered the dynamics of my study. I was arrogant to think that everything would be all right simply because I - ex-teacher - was in command.

In my own defence, and not in any way an excuse, although more thorough initial screening would have helped me identify problematic situations which might have arisen in group treatment, many negative behaviours may not have made their appearance until the dynamics of the group had brought them forth, as identified in the literature by Yalom (2005). The personalities and characteristics of all three members of Group 2 challenged any goodwill one or more of them might have presented at any one time and immediately cancelled it out. If individual therapy had been an option before commencement of the main study, this goodwill could have been nurtured. Instead, I was left with a potential battlefield of sparring partners where I was often overwhelmed. Often their anger became mine and I had to check myself from exploding and mirroring the very behaviour I was trying so hard to quell, alone and often out of my depth. During the initial planning stages of the study, such a small group did not appear to warrant the presence of a second adult. In hindsight, would this have made a difference?

Freeman and colleagues (2004) had emphasised the importance of letting group members identify with each other's experiences. But how could that have been helpful when I had before me a fantasist, a young offender and a child who spoke of sexual abuse? Group 2 appears to fit Harrist and colleagues (1997) sub-type of the sad and depressed. The appropriate option should have been individual psychotherapy or a

group for depression. A group about making new friends seems, on reflection, almost trite under the severe circumstances presented by each group member. Group bonding was a pike dream which I could, and should, have spotted right at the very beginning.

11:5:2 THE PHYSICAL ENVIRONMENT

Before the study commenced, I emphasised to each Head that I needed to conduct my group therapy sessions in a physical environment which provided an atmosphere of calmness. This would give individuals 'breathing space' to self-evaluate choices about positive social behavioural change, and was therefore essential. In the literature, Leahy (2004) had emphasised that 'crowding' led to greater withdrawal, so I felt it was essential to provide a place of tranquillity within the given environment where children could peacefully reflect on positive social changes which they could make.

In reality, only Group 1's school was logistically able to supply this type of setting. I was allowed the exclusive use of the 'quiet room' - their special place where children experiencing emotional difficulties could self-refer to reflect and compose themselves. The school had sent two of its governors to study projects in Italian schools, which emphasised the importance of an environment containing natural materials in order to create a positive learning experience. The designated room was furnished with relaxing chairs in soft pastel shades and was carpeted and curtained in similar soft lilac tones to the walls to promote calmness. The lighting was naturally white rather than the usual yellow florescent type and beanbags were scattered in the corners for children to 'stress bust'. A large centre table had been made of natural beech and the surrounding chairs were cushioned for comfort. There was also a machine for chocolate and water, given not as a reward but to energise the brain. It was not abused. The children thrived in these surroundings, as evidenced by M(1)'s follow-up observations (appendix xiv):

> "...I loved the calm atmosphere of that room. I felt truly shut away from the rest of the world in there..." (Statement 30)

I had little choice about the physical environment at Group 3 school site. It was far from tranquil but, nonetheless, I felt it could work successfully as we had complete privacy in

a small library which was clean and cheerfully decorated. The walls were painted in bright vibrant colours which gave the atmosphere a 'happy feel.' The furniture was basic but there was carpet on the floor and pretty curtains which made the room feel like a cosy 'den'. In her post-therapy questionnaire, when asked about the best things in the reality therapy programme, E(3) had commented in Statement 8 that she loved all the things the group had done "in that lovely special room" (appendix xiv).

Personal reflection was not possible in the allocated setting at Group 2's school site because the environment was dirty, cluttered and cold which sub-consciously suggested to participants that they were not valued. The Head had offered a disused outbuilding, enthusing that it was the only place he had which would be entirely private. However, it had fallen into disrepair and had been badly vandalised. There was no heating as the radiator had been ripped from the wall and a broken window let in the biting autumn weather. Litter was strewn all over the floor and chairs had been overturned. None of the bins had been emptied and the tabletops were filthy, many having abusive language written over them. The large blackboard was full of crude messages each week and chalk was lying on windowsills and crunched underfoot. Unwashed coffee mugs were stacked in the sink and the cloakroom area was full of unclaimed mouldy clothes, which lay all over the floor. The toilets were neither clean nor hygienic and the whole ambiance of the place was, at best, depressing. Time was spent cleaning up this weekly 'war zone' and this unwelcoming environment naturally had a negative effect on the group participants, as evidenced by L(2)'s follow-up comments when asked what she did not like about the programme (appendix xiv):

> "I hated being in that filthy room. It made me feel that I didn't matter because no-one bothered to make it nice for me. Even when you came early each week to try to make it better for us, I still felt second-rate and that there was no point."
> (Statement 15)

Reflection and self-evaluation

Smith (1998), Long and Averill (2003) and McLeod (2005) all highlighted that effective group therapy rests upon three essential conditions: the participants who compose the group, the therapist responsible for conducting the group and the setting in which the group occurs. McLeod (2005) emphasised that close attention to each factor was

important in order to assume the most beneficial treatment possible, as each element enhanced or inhibited the others. Cohen (1993) and Albano and Barlow (1996) stressed that, in particular, the importance of the setting could not be minimised because it bore a close relationship to group outcome. They both warned that it must support the role of group treatment by commitment to the treatment goals and process. This should include practical considerations to accommodate the group, but especially the commitment of the organisation to support both therapy and therapist.

The Heads of the schools where therapy was given to Groups 1 and 3 were committed to the programme and fully supportive and encouraging. I sensed that they truly believed in me as an individual, wanting me to make a difference and wanting to know the principles of reality therapy, which I carefully explained to them. They ensured that our 'base' was nurturing by being either soothing or stimulating, and both types of environment seemed to work equally as well. I was happy to work in both the bright, stimulating library and in the cool 'time-out' room. Both environments sent out positive messages. I felt good there. The children wanted to be there. We all started our therapeutic journey together with hope and anticipation that this would be something special, something that was unique and we all felt privileged to share one another's company. Group cohesion and a solid therapeutic alliance were present almost from the start because of this supportive physical environment. It could be that the time spent in these two 'nice' environments was all it took for positive social behavioural change to occur naturally within these two groups. Indeed, I am convinced that the 'nicety' of their experience played a significant part. However, from feedback, I believe it was much more than just a good time away from the classroom. There was real learning within the brightly coloured walls and pastel decor *because of* the brightly coloured walls and pastel decor.

What can I say about the other environment at Group 2 school site? I must take on board my own therapy and not blame external factors for my failure. Certainly the conditions I was faced with were abominable, but I should have taken some inner control and self-responsibility from the outset. I should have said 'no'. So why didn't I? I have since asked myself that question a thousand times. I think I had possibly sensed that the Head was more sceptical about my chances of success; I certainly felt that I was being fobbed off and pushed out of the way where it did not really matter if I succeeded

or failed because he had given up hope a long time ago. I instinctively knew that if I tactfully complained, the response would be to just forget the whole thing. The Head did not want to know about reality therapy. He told me on our initial meeting that it would not work, whatever it was. He was tired of accommodating outside professionals who had all failed him. This was apparent without any spoken word. It was the Elliot hut or nothing. I made do. I felt I had no other choice but I was wrong and I see that now. I failed both the children and myself through my lack of assertion. Yet I did not want to be there so how could I expect others to feel any more enthusiastic? The extra pre-therapy time which I spent cleaning to make the room semi-habitable and fit for purpose would have been better spent bonding with the participants.

In the literature, Kopp (1989) warned that exposure to an unhealthy environment caused emotional distress and anxiety. I am convinced that the lack of respect shown to me by giving me such a poor working environment meant that I, unwittingly, passed that lack of respect onto the participants by expecting them to unquestioningly accept such conditions. The children from this group needed the pastel decor and the brightly coloured walls far more than the others. Such was the level of their emotional distress and anxiety, they were often out of control. Yet nothing in their physical environment supported or encouraged them. We were doomed for failure almost before we began.

11:5:3 TIMESCALE

The reality therapy intervention took place over the course of ten weeks. Had I been aware, at the outset of the study, of the severity of need which I would encounter with Group 2, I might have tried to extend or even double the timescale. I doubt this would have been possible, however, because I was limited by the availability of the children. The schools would not 'release them' until after their Standard Assessment Tests (SATs) in May and the summer holidays began in mid-July. This was the only time-slot I could negotiate. As well as my own concerns about time limitations, nine statements within the self-evaluative questionnaires (11, 12, 17, 22, 23, 24, 34), two statements from parental interviews (40, 41) and four statements from school staff (55, 58, 59, 60) identified lack of time as a major factor in why the therapy was perceived to be ineffective with Group 2 (appendices xiv, xv). For example, E(2) was beginning to

realise that he did have value "but then I didn't see you and life went back to normal" (Statement 22). K(2) took a harder line, recognising that "the stuff I've got inside my head isn't going to be repaired by a few weeks with some do-gooder who's never been in my world" (Statement 23). L(2) admitted that she did change for a while. The shoplifting had stopped and she was busy making clothes to sell to her peers. However, when "they started ripping me off" (Statement 24) she was unable to handle the betrayal on her own and returned to her old ways, where she could perhaps glean some security. Each time, the timescale of the intervention was insufficient in length to promote positive social behavioural change because of the severity of damage in all three individuals. More therapeutic time may have increased their chances.

Whilst recognising that Group 1 and 3 members had moderate emotional damage, I felt that my planned timescale was sufficient to enable positive social behavioural change to take place. I was right. I witnessed constructive change by studying their actions and scoring them on the Child Profile Format observation sheet (appendix vii), by heeding and recording their conversations and by interviewing parents / carers and school staff. After just one month, B(3)'s father observed that "we can both see changes already" (Statement 43), whilst K(3)'s mother stated that "I can really see a change in him, thanks to the reality therapy he's had" (Statement 45). By the end of the school year, these changes were even more noticeable (appendix xv). G(1)'s mother remarked that:

> "...he's a different boy - not isolated anymore...The therapy has been an outstanding success and has completely changed his personality because now he's always positive and outgoing" (Statement 46).

Likewise, M(1)'s father enthused in Statement 39:

> "...She's much happier now and her behaviour has greatly improved."

At follow-up interviews, Group 1 and 3 school staff also remarked that positive change had developed still further within the longer time span. The class teacher of Group 1 enthused that the three participants had "really emotionally grown and developed in the last six months" (Statement 65) and the Head of Group 3's school observed that "all three children have made significant social behavioural changes in these last six months..." (Statement 70).

Reflection and self-evaluation

So why did Group 2 need more time than the others, for whom the ten weeks produced a successful outcome? The literature seems to provide an answer and reaffirm that the process of group therapy possibly hindered therapeutic progress. Harrist and colleagues (1997) found that children who displayed signs of peer rejection demonstrated that their social problem solving skills were poor relative to their same-age peers. These deficits appeared to be closely linked to aggressive responses to hypothetical social situations (Harrist *et al.*, 1997). This might explain the angry behaviour which took place when asked to role play together or make clay models of their family. More time would have allowed a slower 'build-up' to such activities where, perhaps, difficult topics could have been first intimately discussed.

Friedburg and Crosby (2001) found that group therapy limited the amount of time each child received direct interaction with the therapist relative to individual therapy. Members of Group 2 responded well to individual attention. Maybe more time, whether in group or as an individual, would have allowed more possibilities to emerge. Vernon (2002) added that the therapist must possess adequate behaviour management skills and the ability to maintain structure if the group was to stay on track in the time allocated. So was I lacking in that department? As an experienced former teacher, I was not worried about handling difficult children but my own professional experience was based on 'naughtiness' rather than deep psychological issues. So was I too confident, too self-assured? On reflection, I think I possibly was.

Freeman and colleagues (2004) highlighted that if severe social anxiety incapacitated an individual, this also decreased the likelihood that the child would willingly attend therapy sessions. I knew instinctively that none of the three children really wanted to be there. I was, perhaps, unintuitive enough to think this was because they did not want to spend time with me. I did not reason that their unwillingness to attend and partake in activities - as well as their threats to run away - were something much more profound. If, at the outset of the study, I had more carefully conceptualised each child's background, as suggested by Freeman *et al.* (2004), I could have determined whether being in a group was the best intervention at that time. By failing to do this, I may well have wasted the time of the children, their parents, their school as well as my own.

11:5:4 APPLICABILITY

I was always deeply aware that it was essential to connect the content of the therapeutic sessions to the participant's own lives. Newby (1991) had called this personalisation, through which emotional learning could be enhanced. Muijs and Reynolds (2002) had emphasised that when a young person was able to make a connection between a learning task and the goal of becoming more socially competent, they would work harder and attempt more difficult emotional tasks to achieve their goal and therefore promote positive change. I felt that if participants understood some of the pictures in their Quality Worlds, they would articulate and promote reasons for learning to make positive social behavioural changes, as evidenced by the following comments in 10:3:

> "...It gives me a really warm feeling deep inside that I've saved shedloads of money and done what I wanted to achieve..." L(1)
>
> "...I can send myself off into a sort of trance so I can think deeply about what I don't know...but is staring me in the face." K(3)

Visualisation of social achievements also enabled Group 1 and 3 members to implement behavioural changes in order to make the 'pictures in their heads' a reality. By mental visualisation of what the participants did not have in the present, but wanted in the future, I could encourage positive social behavioural change to follow. In the literature, Pintrich and Schunk (2001) had advocated that when children were asked to visualise where they would have to go or what they would have to do to achieve change in a series of images, social competence could be achieved because the images had more significance than words.

However, whilst this had relevance to all members of Groups 1 and 3, it had an adverse effect on the participants from Group 2 because all three children came from dysfunctional backgrounds. Was it really fair of me to ask such children to visualise the future when it was bleak enough in the present and there was little hope of change? External complications seemed to be over-riding any internal motivation which they might have scraped together. When those you would normally look to for guidance and support were pre-occupied in dealing with domestic violence, mental health issues or sexual abuse, how can their offspring be expected to visualise a positive, rosy future?

From the outset, I had been aware of group division in terms of being able to apply the therapy to their own experience. When putting together the programme, I had not taken into account the severity of need with Group 2. One design certainly did not fit all.

Reflection and self-evaluation

The poignant question is, being aware of personal difficulties faced by Group 2 members, should I - morally - have modified the programme for them *despite* the fact that it was part of a research study? With hindsight, I am certain that I should have done so. However, at the time, I seemed to adopt tunnel-vision, adamant that I could not alter the structure because fair comparison between groups was essential. But at what price? I believed that giving Group 2 any sort of 'advantage' over the others would have made the project untenable. But would it? And by not doing so, was I not ultimately condemning certain aspects of the project to failure in any case? Undoubtedly, from the therapeutic point of view, it needed to be modified and geared specifically to Group 2's needs (to have any chance of being beneficial) because the damage was so intense. And surely the very premise of good action research is that we change our actions according to our intuition or professional judgment (Rolfe, 1998)? This paradoxical situation was a major conundrum and not resolved, I am sure, as most practising therapists would have wished. Unsurprisingly, the therapy was unsuccessful with Group 2 because both its content and approach often failed to be applicable to children living such fractured lives and it was not intense enough to meet their very specific needs. This was confirmed by Statements 41, 42, 51 from parental interviews and Statements 55, 58, 59, 60 from school staff (appendix xv).

As to group therapy itself, how applicable was it to such fragile children? I have already agonised over the appropriateness of group therapy (11:5:1), but maybe I need to consider the downside of individual therapy as well. I have long been aware that, over time, certain issues are easily evaded or not brought up in individual therapy and therefore not addressed, worked on and resolved (Galanaki, 2004). This can be particularly the case for children who struggle to take responsibility and relate meaningfully to others, as recognised by Rotenburg and Hymel (1999). With Groups 1 and 3, such issues were, indeed, dealt with quickly and effectively in group therapy.

There are also less obvious drawbacks to individual therapy which may have affected Group 2 if that route had been first taken. Crucially, they did not have previous experience of sensitive and receptive relationships. It would seem, this being the case, that if you have not been related to, then not only can you not relate to yourself but you cannot truly relate to others either. If the therapy experience is akin to a re-parenting, as suggested by Perry (1996), then a one-to-one relationship will not prove sufficient since the developing child learns and grows very much through the challenges of the various groups it encounters. If individuals, such as Group 1 and 3 members, have experienced 'good enough' parenting (Spiegel, 1989; Larson, 1997), then these challenges can be met. Without this foundation, it would seem logical that the therapy group could be of value. So why was the experience of group therapy not a positive one for Group 2?

Obviously, all groups vary and so do the problems and limitations which they present. As actions played out in groups can so closely mirror family dynamics and other real-life scenarios, group members can get upset or angry and act out, which can (and did) prove daunting. Group 2 also degenerated into following collusive and destructive patterns. For example, acting out an issue without being challenged by the other group members. Even when I brought the matter up, it often fell on deaf ears because the group had fallen into a group dynamic of not talking about certain subjects. Conversely, sometimes they became locked in certain patterns, where one member might play the role of 'rebel'. These patterns prevented anyone learning about their own issues. Such dynamics were subtle and complex and needed time to sort out.

Segrin (2003) recognised that group members could be scared of the group experience because they were being compelled to look at responsibility and maturity issues. I was aware that Group 2 wanted to have successful relationships but it was hard work and the participants had only been used to thinking about their own issues. The group experience compelled them to make space for others and their problems. Yet these group members were only interested in focusing on their own needs. Perhaps this was because they thought it would be the only chance they might ever have to be really 'heard'. Generally they appeared bored and disinterested in other members' problems, they failed to understand and they were not sensitive or quiet when appropriate. Often they gave unsolicited and unhelpful advice. If Group 2 could have struggled more with the relating process, rather than dismissing it almost as soon as it began, the ground

could have been laid for the sort of relationship where everyone was interested in, and capable of, relating to the other. If only I could have reached this point, I could have shaped and nurtured a strong, caring and meaningful relationship between group members which might, in turn, have made the content of their assigned therapeutic activities more applicable.

11:5:5 APPROPRIATENESS OF ACTIVITIES

A hard lesson which I have had to learn is that some of my 'exciting' practical activities did not have the desired effect. For example, I am now aware that use of powerful art therapy was inappropriate to use with the most psychologically vulnerable in such a short time span and caused distress instead of encouraging positive social behavioural change, as evidenced by E(2)'s questionnaire (appendix xiv):

> "I hated doing the clay. Couldn't bear to touch it. And I didn't like having to confront my behaviours and pull them apart - like the clay..." (Statement 13)

However, I observed that positive social behavioural change did occur when therapeutic activities *were* acceptable to the participants and viewed as 'cool' and 'street worthy'. An example of this was the music therapy in Session 9, where the children were asked to compose a rap song centred around their understanding of the basic needs (appendix ix). All groups enjoyed this activity and considered the task appealing. In the literature, Kendall (2000) and Leahy (2004) had emphasised the importance of using therapeutic activities which were powerful yet non-threatening in order to provoke a unique outcome, that of behaviour change in socially acceptable ways. Again, it should perhaps be emphasised that I did not realise at the planning stage of the therapeutic programme how damaged members of Group 2 actually were. Hence, although the advice of Kendall (2000) and Leahy (2004) was noted, the adverse effect of using certain activities considered 'safe' could not have been foreseen with members of this group.

For the less severely damaged children, I was able to promote positive social behavioural change by using reality therapy to enable them to 'step out of their own shoes.' By asking them to observe their own behaviour as a detached phenomenon, the

participants were able to analyse more appropriate responses. In the literature, Deblinger and Heflin (1996) had recognised that this needed careful handling with children in denial of their real issues but, by using guided self-discovery and reverse-role play, the children were able to become more self-aware. For example, K(3) was used to being in control at home as he was an adult carer, and often he made difficult decisions on his own. At first, the experience of group interaction overwhelmed him as he was not used to sharing ideas and having his contribution discussed by others. Threats were initially dealt with by hiding, daydreaming or refusing to talk. When encouraged to 'open up', he explained his emotional response as feeling vulnerable:

> "... as if the others will be able to look inside me and see I'm a load of rubbish...If I join in, I'm setting myself up to fail." (6:2)

I gave the children permission for mistakes to be made because, quite simply, they were human and human beings make mistakes. This approach was able to empower positive social behavioural change as 'emotional shackles' were undone. With Groups 1 and 3, by illustrating through psychodrama and other mediums that there were rarely absolute standards of right and wrong, I was able to break negative thought patterns, as shown in the following observation from K(3):

> "It is so lovely to be really listened to. The other two never make fun of me and I feel I can say what I like without worrying I'll be sneered at. That's worth a million pounds to me." (6:3)

Ledley and colleagues (2005) explained the importance of encouraging participants to acknowledge and agree that other people were entitled to live by different rules. However, Group 2 were unable to accept this. As already highlighted, they preferred to compete for attention, possibly to satisfy their low self-worth. All three children displayed a severe lack of co-operation, often manipulating the situation only to suit their own ends and trying to play mind games with me such as hiding materials which had been brought in for the session.

In the literature, Chodorow (1991) had suggested that using psychodrama as part of a therapeutic programme would empower an individual to deal with important issues and

feelings concerning their social behaviour, even when it was difficult for them to talk about these directly. For Groups 1 and 3, using reality therapy appropriately in psychodramatic form enabled scenes of positive social behavioural choice to be expressed in indirect, non-confrontational ways to encourage change. A strength of using reality therapy in this way was that it was possible to give the groups appropriate activities in which they were able to express fantasies and explore conflictual situations in indirect, non-confrontational ways. Another strength was that it also enabled them to deal with important issues and feelings, even when it was difficult for a member of a particular group to talk about these issues directly.

In the literature, Youngblade and colleagues (1999) had emphasised the usefulness of using devices such as puppets to explore social behaviours in safe and non-threatening ways. They were seen as one step away from actual social contact and therefore provided the perfect arena for behavioural exploratory work. Group 1 and 3 members had been able to embrace beliefs, behaviours and personalities which were different to their own when using puppets. Testing these personal attributes in safe ways through play had encouraged real-life positive social behavioural change to follow. By using puppets as a group activity to explore social behaviours, I had provided an opportunity for the participants to identify and discuss acceptable and unacceptable social behaviours as they occurred within the puppet work. This appeared to enable the identification of new behaviours as well as the expression and recognition of unconscious negative desires, as evidenced in 8:5:

> "You think you have got me just where you want me, don't you...you wicked pair! But one day I will turn the tables on you. I will get my revenge for all the suffering you have caused me." G(1)
>
> "I am going to push you overboard. Walk the plank! I need to free this ship from your presence. You have served our purpose but now...be gone!" K(3)

Although Group 2 members enjoyed the puppetry, their usage was entirely different to the two adult carers who appeared to have used the puppets in a healthy release of pent-up frustration. Group 2 used puppets in the same way to portray real people who had

caused them psychological distress in their lives but their 'play' rocked disturbingly back and forth from frenetic to sinister.

Reflection and self-evaluation

So what was the problem with Group 2? Was it simply that they were the most damaged? It would seem so. Certainly, their psychological damage was too intense for the puppetry, the psychodrama or the clay work to have had a positive effect. For example, when dealing with a group member such as E(2), who was unable to recognise reality in so many contexts, the intervention (in hindsight) had little chance of success as too much damage had already manifested itself. Predictably, when an activity was perceived as being too challenging, he would make an excuse and appear angry that his make-believe world was 'being invaded':

> "I'd like to melt into the computer and instead of being me I'd be Hercules."
>
> (8:4)

Yet the power of clay work had the effect of K(2) opening up to me about long-standing sexual abuse - so was this good or bad? As I reflected in the analysis (6:2), a weaker therapeutic intervention may not have had the ability to 'draw out' such an important revelation. The difference between groups was very pronounced too after puppet work. It brought Groups 1 and 3 to a new level of camaraderie, yet with Group 2 each member was unusually subdued. In my original reflection, I had observed that the content of their personal theatre had been so poignant that it had left them exhausted (8:5). Again, I ask the question: was this good or bad? Had time been better on my side, I would have liked to have helped all three children diminish their acting-out behaviours which left them so debilitated and learn more positive and productive ways to gain attention and approval. In other words, I could have helped them *unlearn* negative actions before beginning to *learn* that this behaviour (even in creative form) was intolerable, leaving all of us exhausted. I would hope that my positive expectations would help them assume responsibility for their acts and attitudes and allow them to take control of their lives.

Using such challenging activities highlighted that all Group 2 members were living in a self-imposed hell and choosing to remain there. I have worried that their disturbing 'play' may have reinforced negative emotions and added to psychological damage

already done. More time of intense therapy would maybe have allowed all of them to reflect upon this vital mantra:

> "I will never permit myself to return to the delusions and self-hatred of the past."

11:5:6 SUPPORT OF PARENTS AND SCHOOL STAFF

In the literature Allard and McNamara (2004) had recognised that shaming, sarcastic adult behaviour could cause insurmountable distress to children lacking in social awareness, resulting in wilful refusal to comply with reasonable adult requests and a resort to inappropriate behaviour. This had been demonstrated by Group 2 in rebellion against school staff attitudes. K(2) had spoken of feeling both embarrassed and angry that her class teacher had joked in front of others about why the group were leaving the room, saying it was time "to tell that poor lady their troubles" (9:6). However, L(1) and B(3) also reported feeling degraded by the attitudes of staff at their school, who used humour inappropriately at their expense, seemingly unaware of the psychological damage they were causing (9:6). Clearly, staff training into the principles of reality therapy at the outset of the programme would have been an advantage in overcoming this behaviour from 'responsible' adults. This was also recognised by the Head at Group1 school site:

> "...it would have been good if you could have trained my staff to further implement it (the therapy)." (Statement 55)

Lack of self-worth also appeared to occur in all nine individuals as a result of poor modelling by parents. The children from professional families were often left to their own devices and expected to be mature and independent. B(3), in particular, was resentful of the way his parents were lending their 'support'. The following example (5:4) illustrates that more emphasis should have been put on confidentiality and respecting personal boundaries at the onset of the therapeutic intervention:

> "I get quizzed about everything. They want me to repeat almost line by line what everyone said and then what you said. Firstly, I can't remember and secondly, even when I can, I don't want them to know anyway. But they make me feel like I *must* say, like they are still in the police and they have to know." B(3)

Group 2 children, in particular, had either poor role models or were ignored because of other family trauma. An especially poignant example was E(2) who was able to be 'real' for once when describing a reason for opting out of his stark reality:

> "You don't want to see my house! Man, it would stress out the Pope. Nobody does any clearing up so it's dirty, well filthy and I can write my name in the dust on our sideboard. I can feel my mood go down to my shoes when I get home from school. I tried to tidy up one day and got clobbered for it. Uggh! I prefer the company of my little friends from other planets than stay there." (5:7)

K(2) was also a child deeply damaged by parental trauma and only too aware of this situation:

> "My mum says my dad is evil and I must watch he doesn't snatch me. He says it's her and she's ruined me. I hate them both - best way. My gran used to say that actions spoke louder than words...so here's to you dear parents - wack, wack (shouts and punches desk with fist). Hope it bloody hurts." (6:6)

Reflection and self-evaluation

As a central part of the Every Child Matters agenda, improving support for parents and families is paramount because responding to a child's emotional needs has been shown to be the nub of parenting and the core issue from which all others flow (Gordon, 1991; Biddulph, 1993; Kurtz, 1996; Mental Health Foundation, 2002). However, recognition of this need came too late for the parents in this study who most needed it - especially the parents of Group 2 participants. The damage would appear to already have been done because support had not been forthcoming in the participants' early years or adequate in later years. I believe that I am also guilty of compounding the lack of support with this vulnerable group of parents. Apart from the initial parental interview, meetings were held one month after completion of the programme and then again at the end of the school year. This appeared to be sufficient input with parents of Groups 1 and 3. They appreciated the initial informal 'chat' and this first meeting allowed me to find out about the family structure and any special points which they wanted to emphasise about their child. Many parents were over-zealous in their enthusiasm, as if to overcompensate for past omissions of parenting care. I had not taken into account though that the parents of Group 2 children were markedly different at point of first contact. There were many points of resistance which I should have spotted in the initial

interview. I failed to appreciate that these parents needed me almost as much as their children. Although the programme could have been more 'parent-friendly', it would have been abound with inherent difficulties in working effectively because of issues of confidentiality. Even if, at the very outset, I had been totally aware that the parents would not, and could not, be supportive in the same way as the other two groups of parents, there would have been little I could have done because I was undertaking a piece of comparative research and not just straight therapy, where I might have been able to open up alternative ways of working according to need.

By the end of the programme, I felt that the parents of Group 1 and 3 participants were able to better understand their child's emotional needs (in generalised terms because of confidentiality limitations). This would help to reinforce the messages I was trying to instil, reiterating to their child the value of feeling good about oneself, the importance of managing the expression of feelings, respecting other people's emotions and the necessity of taking risks to reach for success. Yet did I really expect the parents of Group 2 children to be able to do this? None of them felt good about themselves as parents; they were unable to express their feelings and felt instead shame, guilt and depression; they were unaware / in denial of their children's emotional needs and the notion of taking a risk was, surely, too formidable to even contemplate. I should have seen the warning signs, so why was I so blinded from the reality of the situation? In the literature, Borland (1998) had emphasised that parental reinforcement of these abilities were crucial to a child's behaviour and to healthy development into adulthood, yet I had viewed parental involvement as a detached phenomenon and not connected to my eventual learning outcome, the overall well-being of the child.

I put my lack of foresight down to my inexperience as a researcher. From a researcher's point of view, having more contact with these parents would have given me the advantage of creating a more effective avenue to seek evidence of the efficacy of the therapeutic programme. But should I have worked with Group 1 and 3 parents and Group 2 parents on two different levels and, if I had, was I not making a subjective judgment about them, based on what others had told me and one brief meeting? Perhaps I already know the answer to this dilemma when I analyse the most telling of all post-therapy interview statements (appendix xv), made by the mother of E(2) when asked if she was aware of any significant positive social behavioural change in her son:

" He still has his computer friends, them space creatures and that. He don't even go for real people on the chatrooms. I can't understand it. But proper friends - no. We don't have room for people round our place anyhow and me other kids are always fighting so I don't want him to bring other buggers in. He can stay as he is, as far as I'm concerned." (Statement 49)

11:5:7 ABILITY TO SELF-EVALUATE

In the literature, Rotenburg and Hymel (1999) had highlighted that reality therapists should emphasise to children that they, through self-evaluation, had the personal ability to replace their own negative emotions which they used to fulfil unmet needs with feelings of contentment, ease and social competence. With this in mind, I wanted to provide a solid foundation for self-evaluation and appraisal of behavioural reactions to unmet needs in order to create positive social behavioural change. I felt that self-evaluative experiments would allow some children to adjust their thinking and embrace change more readily. Therefore, I encouraged all the participants to think deeply about how their behaviour to acquire new friends negatively affected their lives and how positive social behavioural change could occur in more appropriate ways. As recommended by Peplau and Perlman (1982), they were also urged to formulate predictions by deciding what they thought might happen if they tried out a new way of thinking or behaving in real life.

Members of Groups 1 and 3 were able to grasp this because they were able to talk rationally about their problems. Group 2, on the other hand, often resorted to fantasised or defensive behaviour when faced with any type of situation requiring self-evaluation. For example, when asked to self-evaluate his choices to prevent the bullying he encountered from escalating, E(2) chose to mask his uneasiness by making an excuse about why he could not immediately address the problem:

"I'm going to America for the weekend. My dad has got friends in Hollywood so we can go anytime and meet all the stars. We go once a month usually." (6:7)

Both E(2) and M(1) lived in isolated communities which may have added to their sense of social isolation. In the literature, Peplau and Perlman (1982) described loneliness as

an inherent aspect of society and not something which lay within the individual. They highlighted the increase of family mobility and a general increase in social mobility as important considerations. I felt that it was important to combat the false belief that others did not care about them by making the participants self-evaluate how factors such as their own physical location might be relevant factors which had an effect on their popularity status rather than some negative aspect of themselves. I also encouraged the children to look for 'evidence' that people did not care about them, thereby challenging these assumptions.

In the literature, Stallard (2002) had suggested that writing down challenges to unhelpful thoughts would raise social competence and self-worth. By generating alternatives for each unhelpful thought, attitude and belief, participants could be inspired to write down a flexible, non-extreme, realistic and helpful alternative. For L(1), G(1), E(3) and B(3), I observed that each had developed, in their own way, a multitude of defences against their unhelpful thoughts, attitudes and beliefs. However, when I was able to expose their negative thinking errors, positive social behavioural change could be promoted. I achieved this by boosting their self-confidence so that they were able to self-evaluate that only minor defences were needed and that the desperate defences they had displayed in the past were causing them near mental disorder.

For Group 2, change was not able to occur when intrusive thoughts were actually made worse because catastrophic thoughts had not passed through their minds but were instead challenged. All these participants seemed unable to live with doubt and unable to tolerate upsetting, intrusive thoughts. This may have been because they were already deeply disturbed or because when they tested the assumption that they were not cared for, they reached the conclusion that this was true. Glasser (2000, 2003) recognised that if social isolation was something which individuals had created for themselves through being deeply disturbed, they could self-evaluate making a positive behavioural change and reduce their loneliness. This behavioural change could occur through differentiation of thoughts, feelings, behaviours and the trigger event. The key was looking at personal meanings which were given to events in determining emotional responses. By emphasising meanings attached to events, specific problems could be broken down and new ways of thinking about those problems could be encouraged.

By encouraging the children to follow this premise, members of Groups 1 and 3 assumed responsibility for their own positive social behavioural change. I was able to encourage them to take effective life control by advocating choice as central to making that change happen. On the other hand, Rotenburg and Hymel (1999) had warned that, with emotionally damaged children (such as Group 2), learned hostility could further antagonise delicate situations. In the literature, Palmatier (1998) saw the role of an effective reality therapist as primarily to assist thought processes on the changes individuals might choose to make in their behaviour. By starting to develop a 'success' identity, participants had been able to self-evaluate their own capabilities for facilitating their own change towards greater social competence. This was not always easy. For example, G(1) said he felt compelled to be perfect because he had become used to being 'best'. However, he was sometimes unable to always live up to his own expectations and hence lived with an extreme fear of failure, stating that he never felt he was achieving much of any real significance (8:2). When school was not part of his mental picture album, he tried to select other pictures that would fulfil his needs. I encouraged him to self-evaluate ways in which he could develop his 'success' identity so that his own needs were met as well as the needs of his dependent adult.

Acquiring the ability to self-evaluate enabled the children to self-impose their own positive social behavioural change because they were able to recognise that all human beings were valued by others as well as themselves. By removing a self-rating label such as 'I'm a failure so I need to buy friends' or 'I'm worthless so it doesn't matter if I end up as a criminal', unconditional self-acceptance was promoted in its place. In the literature, Galanaki (2004) had emphasised that it was important to untangle self-worth from external measures of personal value. By achieving this, members of Groups 1 and 3 were able to consider themselves less defective, enabling a rise in social competence, as their sense of worth remained constant. A strength of working in this way was that I could help these participants to clearly recognise that everyone had extrinsic value to others and intrinsic value to themselves. When I told the participants that they, as humans, probably confused the two and classified themselves as 'worthy' or 'good' on the basis of assumed value to others, my therapeutic aim was to aid imagination into how much easier life would be, and how much more stable self-esteem would be, if there was a realisation that individuals had worth as people independently of how other people valued them. They could then self-evaluate that they were liked, admired or

respected without the fear of losing it or it being a dire necessity. By 'breaking the chain' of social isolation, my aim was to enable positive social behavioural change to occur naturally for Groups 1 and 3, as each psychological barrier was removed. By self-evaluating how they could effectively help themselves to get what they really wanted, I encouraged each group member to move forward and to be more socially aware. In the literature, Wubbolding (2000) stressed that the Quality World and a real world situation were likely to be opposed when a child was socially isolated, so reality therapy should concentrate on removing barriers. Another of my aims was therefore to show participants how to respond in ways that would make positive social outcomes more likely. This was achievable with Groups 1 and 3 because they were able to self-evaluate that their past behaviour had not always got them what they really wanted. For example, B(3) had spoken about not being able to understand why people avoided him and how he sometimes became so desperate that he brought sweets to school to buy friends:

> "I know I need to find a better way of making friends. Then at least there will be some point in me getting up in the morning...and they'll stop pretending I'm not there, just the Mars bars." (7:7)

In the literature, Knorr-Cetina (2001) had emphasised the importance of matching friendship to need and, once validated, developing the ability to keep emotional pace with another person as the relationship developed. By teaching the participants that they were free to set the pace, or follow the pace of the other person, I was able to foster social competence. G(1) recognised this when discussing happiness, observing that "..when it can be shared, and there's a bond of some kind, I guess it could be extra special" (10:9). Even E(2) was able to see that the feeling of inclusion promoted a special feeling of inner happiness:

> "This boy in the next class said good things about me to....because I helped him fix his computer. I was happy all day after that." (10:9)

By self-evaluating wins and losses in social situations, members of Groups 1 and 3 had been able to realise that changing hostile traits offered great possibilities for promoting positive social behavioural change. I felt that it was important for them to gain insight into their behaviour and recognise that the destructive aspects always had a negative

pay-off: social isolation. Whilst using energy inappropriately, no participant from these two groups intentionally aimed to cause anxiety to others but rather seemed consumed by self-interest. For example, B(3) had learnt to be excessively deceitful because he was so physically restricted at home. The therapeutic focus was on poor choice rather than the frenetic mind games which damaged children such as Group 2 played. In the literature, Richardson (2001) had warned that if consequences were imposed in a judgmental way, reality therapy would be directed on an individual's anger or feeling of being judged rather than their poor choice. It would seem that successful self-evaluation therefore depends upon new ideas to encourage a variety of choice, whilst it has to be recognised that making a choice is often a hard choice in itself.

However, overall, all three members of Group 2 were unable and unwilling to self-evaluate in the same way as the other two groups, who were all very successful at it. Instead Group 2 were highly defensive about their social isolation, succumbing to negative and self-defeating activities such as indulging in inappropriate monologues as displays of bravado. These acts appeared to be covering emotions which ran much deeper and were seen as masks which concealed their true feelings. An example of this was displayed by K(2):

> "I hate everyone at school so what do I care that they hate me back? Yeah, I don't like being on my own but it's too bad, it's their hard luck." (7:7)

Reflection and self evaluation

Little else needs to be said. As the linchpin of successful reality therapy is gaining the ability to self-evaluate (Glasser, 1980; 1998a; 2000; Wubbolding, 2000) I should perhaps congratulate myself on a mission accomplished with Groups 1 and 3. Yet I feel no sense of achievement because the other group had not even reached that hypothetical 'launch-pad'. I believe that Groups 1 and 3 had the personal mental capacity and appropriate support from others to be able to weigh up choices and choose appropriately from a number of options. Group 2 could not do this because they appeared to be weighed down with so many defence mechanisms that there were just too many 'shackles' to shake off in the time available. Maybe it was unfair of me to even begin a process which I, almost instinctively, knew would never have a successful outcome.

11:6 ENGAGING MORE EFFECTIVELY

In order to engage more effectively with pre-adolescent loners in group therapy, it is necessary to reflect upon the part I played in shaping the successful and unsuccessful outcomes of the study. Every time a needs-based intervention was undertaken, I learnt something about myself and how my own damage was seeping through into my present being. My reactions often surprised me. At other times, I unwittingly increased my professional knowledge-base by discovering something often very small which spread out into far-reaching dimensions. At each point of intervention I was learning - more about my own lifespan development, my parenting skills, the influence of my past on my present psyche and my ability as a therapist. However, the greatest shock was discovering that my mistakes were my biggest learning curve. I made so many of them, yet without them I would have learnt almost nothing. So I hold my mistakes up as examples for other action practitioner-researchers to learn from. I have realised how vital truth and honesty are in writing up my findings. Pretence at success would only result in failure; truth and honesty at admitting mistakes result in ultimate success.

I have learnt that I was scared of failure so I feigned confidence. This confidence led to arrogance and my arrogance meant that I thought I could skim over vital initial assessments. I 'got away with this' with Groups 1 and 3 because they were just ordinary children who had socially lost their way through difficult external circumstances. My luck ran out with Group 2. There was nothing ordinary about them. They were extremely disturbed, traumatised children and I was thrusting them into a situation which made them highly resistant. My therapeutic skills, as good as they might have been, would make no difference because they should never, ever have been placed in a group. Compounding that, they were then asked to sit in a cold, filthy room for a whole hour at a time. They were given challenging activities to do which took them out of their comfort zones. They were so disturbed that the short time-scale of ten sessions did not even break the surface. They had no responsible or caring adult at home with whom they could voice their concerns and even the school staff were not interested anymore. They could not self-evaluate change because their upbringings had made them self-focused and entrenched in their own inner worlds in order to survive. To them, change was threatening. Like caged birds suddenly discovering the door has been accidentally left open, they would always be too scared to fly away and would choose to remain 'on their perch, in the safety of their self-imposed prison.'

In many other moments of self-reflection, I have deliberated about whether reality therapy, or indeed any form of CBT, was the correct approach with Group 2. Could they handle such a confrontational approach? Although I often waivered towards a more integrative method of dealing with such profound damage, it is necessary to analyse my very direct way of working in order to establish whether the actual confrontative style had any part to play in the unsuccessful outcome of therapy with Group 2 and my inability to engage more effectively.

Were my interventions too harrowing with Groups 1 and 3 and maybe too weak with Group 2? This introspection is partially correct; confrontation *is* painful. My personal logic is that for any treatment population which engages in anti-social and often self-destructive behaviour, confrontational reality therapy has to be viewed as a responsible and caring therapeutic approach. Indeed, confrontation exists in every human transaction. It would seem that any question, no matter how benign, is also a confrontation by virtue of the process of reflection and reaction. Confrontation is thus synonymous with awareness and disturbs homeostasis. To use a metaphor from nature: without wind, leaves do not move; more intense winds are required to stir leaves weighted down by rain or snow. I accept that reality therapy can appear more extreme than other forms of therapy, and is an extreme form of CBT but, properly used, it would seem to be vastly more effective. I was aware that Group 2 had insulated themselves in protective and self-righteous cocoons, often aided inadvertently by the other well-meaning conventional mental health practitioners from the past who had armed them with excuses for previous behaviour. Therefore, in communicating with reticent and self-destructive members of Group 2, I considered reality therapy more able to pierce formidable defence systems that produce massive resistance to change.

When individuals from Groups 1 and 3 were put together, they related to each other in the group situation and this input provided the catalytic conditions necessary for self-exploration and change. Rather than receiving sympathy and comfort - which could inadvertently prolong homeostasis and paradoxically result in a child feeling misunderstood and even more alone and depressed - confrontation successfully forced these groups to face reality. However, reality therapy was unsuccessful with Group 2 because the participants did not have the ego strength and desire to improve. Can you really blame their cynicism when their futures looked so bleak? Hence the reality

therapy confrontative approach did not work for all, but my belief is that it had the best chance of succeeding if anything at all which I could have used would have made a difference. Again, I make the point that better initial screening would have provided a more effective check against their acting out and countertransference.

Perhaps I have been too hard on myself in thinking that I could and should have engaged more effectively with Group 2. However, there were times when I failed to understand the clinical challenges involved in treating such profoundly damaged children. I was demanding the termination of life-defying behaviours and also refusing to accept anything less than the best. I'm sure this must have been difficult to hear at the beginning of the programme - when self-esteem was at its nadir - but I felt the message "you can do much better" was both therapeutic and prima-facie evidence of genuine care. My aim was that when the intent was positive, caring confrontation would become the ultimate expression of what Johnstone (2000) termed 'empathic love.'

In the literature, Papageorgiou and Wells (2003) warned that abuses of power were a potential risk with all treatment procedures. If my intention had been humiliation, pain and intimidation, this would have been a perversion of reality therapy. Instead, I try to compare the confrontational aspects of reality therapy to laser surgery which, when skilfully and judiciously used, attacks and eradicates malignant cells. Confrontation, I have come to understand, is necessary to pierce the armour of denial, even with difficult groups such as Group 2. Facing the truth still seems to me to be the first step in effective therapy towards long-lasting change. As Leahy (2004) recognised, our society abounds in methods for avoiding reality.

Despite all former doubts and angst about my choice of therapeutic method, I have to conclude that using confrontation *was* the correct procedure because it attacked avoidance. Sadly, other forms of therapy are often unwittingly twisted into the service of this avoidance. Reality therapy enabled all members of Groups 1 and 3 to make positive social behavioural changes for themselves, yet none of Group 2 made any progress towards more positive change. However, it would seem that it was not the confrontative style of reality therapy at fault but a conglomeration of the other factors, already described, which contributed to an unsuccessful outcome for the latter group.

And my role as therapist? It was pivotal. It had been my responsibility to set up the goalposts and put out the props. Often I misjudged it, mishandled it, misinterpreted it. I will only engage more effectively with future groups when I accept this and use my newly-acquired knowledge to go forward to the next AEU cycle:

> "..we do what feels to be the right thing at the time and then attempt to understand our action by evaluating its effects."
>
> (Rolfe, 1998, p. 184).

11:7 SUMMARY

According to McLeod (2005), the ending of a special counselling relationship often raises issues such as loss, grandiosity at how important the therapy has been for the participant or self-doubt over how little use the therapy actually was. I felt all these emotions. The bond with Groups 1 and 3 was strong because of their enthusiasm and affection, which I was able - within professional boundaries - to return. The feeling of self-doubt was heightened because it was necessary to retain everyone's personal contributions to the programme (11:2), and I felt guilt that the children had inadvertently but surreptitiously been used, as discussed by Josselson (1996). Groups 1 and 3 also appeared sad that the therapy was ending, as evidenced by E(3), which likewise gave way to mixed feelings of satisfaction in a 'job well done' and of loss:

> "....and we all respected each other's contribution. It was so nice; I'll miss that most of all." (Statement 8)

However, the greatest feelings of self-doubt were those around the negative outcome with Group 2 participants, as highlighted by K(2):

> "...I would have got more out of it if it had just been you and me, instead of having to defend myself and fight my corner." (Statement 5)

The reasons why the therapy was only a partial success have been documented. As an experienced therapist, they appear so obvious now upon reflection. As an inexperienced researcher, they were not duly considered when beginning the programme because enthusiasm overshadowed common sense to a certain degree. Perhaps that is the lesson which, above all others, highlights the difference of wearing two (often) conflicting 'professional hats.'

CHAPTER 12

CONCLUSIONS

Now this is not the end. It is not even the beginning of the end.
But it is, perhaps, the end of the beginning
- Winston Churchill 1874-1965

12:1 FUTURE RESEARCH FOCUS

All travellers who experience amazing journeys want to do more. Not revisiting the same place, but using that experience to delve deeper into contrasting territories. To promote further reality therapy research in this country, I would like to return to the very beginning - the prison in Wales - where the first ideas were formulated. A similar intervention could be devised for socially isolated individuals within the prison system, using small purposive samples of prisoners and comparing three groups of adults in therapy. A study of prisoners in rehabilitative therapy for social behavioural difficulties could then be described, analysed and interpreted alongside this study of vulnerable children at the preventative stage.

12:2 MULTI - CULTURAL FOCUS

Always, when undergoing child-centred therapeutic research, the utility of the intervention with young people from diverse backgrounds should be considered. Cornwall was chosen as a good representation of social division within Great Britain, a county rich in tourism yet one of the most socially deprived regions in Europe. However, all participants in the study were of the same colour and creed, so perhaps some reflection should be given to how reality therapy could be used with children from ethnic minorities. The therapeutic programme was emotionally challenging by the very nature of it being a qualitative enterprise. As a first exploration with reality therapy in Britain, this would appear to be justifiable and, I believe, it should continue to be so.

It would be short-sighted of practitioner-researchers to automatically assume that further reality therapy studies should use a quantitative methodology in order to enhance acceptability within a wider multi-cultural community. Reality therapy is a method inherently designed for the exigencies of today. Our planet, continually growing in awareness of cultural differences coupled with instant communication and a desire for both speedy and demonstrable results, is a very different place from even five years ago. Certainly, it would be good to use larger samples from more ethnically diverse populations, but it would be even better to extend reality therapy to a wider field within an action research design because of their unique compatibility. This previously untapped combination would seem to be an important contribution to knowledge.

Most importantly, however, is that all professionals working with socially isolated children and adults, whatever the ethnicity of the cultural group or personal methodological preference, should emphasise the importance of effective early intervention in order to eradicate internal negativity, fear and anger which can fester and grow as life develops. By creating a therapeutic environment which promotes positive social behavioural change, reality therapy can be used to confront disaffection, disengagement and disillusionment.

12:3 BEYOND NOW

I make no further recommendations, for fear that many enthusiastic ideas could be deemed too grandiose for the scope of this study which was, basically, about my own micro-learning. Instead, I would like to share a few thoughts to sum up this highly personal research experience. I cannot deny that undertaking such a project was of value to me personally because I find great satisfaction in passing something of myself into the future, some idea of mine, something that provides guidance and comfort. It is my hope that a caring act or constructive way of dealing with loners will persist and spread out in wavelets in unpredictable ways among people I can never know. This is because ideas have power. The insights of many great thinkers and writers through the centuries have helped me quell roiling thoughts about my own being in the world and have enabled me to discover meaningful paths through life. Each of us creates concentric circles of influence that may affect others for years, even for generations. That is, the effect we have on other people is - in turn - passed on to others, much as the ripples in a pond go on and on until they are no longer visible but continuing at a nano level.

The idea that I can leave something of myself, even beyond my knowing, offers me a potent answer to those who claim that meaninglessness inevitably flows from one's finiteness and transiency. This statement is aimed directly at my critics, the many who voiced much concern that this study, at my age, was a waste of my valuable time when I should have been chasing status and material rewards instead. Attempts to preserve personal identity are always futile. Transiency, on the other hand, is forever. I refer to leaving behind something from my life experience; some trait, some piece of wisdom, guidance or comfort that passes on to others, known or unknown. Who has not

experienced a glow upon learning that one has been, directly or indirectly, important to another? My desire to be of value to others is largely what has kept me pecking away at my keyboard long past the standard time for student scholarship.

Through introspection and self-reflection, I have endeavoured to record for posterity my own personal truth. My final paradox is that, as Freud (1955) recognised, a time may indeed come when the pictures and statues which we admire today will crumble to dust, or a race of men may follow me who no longer understand the works of our poets and thinkers. A geological epoch might even arrive when all animate life upon the earth ceases; but since the value of all this beauty and perfection is determined only by its significance for our own emotional lives, it has no need to survive us and is therefore independent of absolute duration. Yet, by the same token, the aim of every artist is to arrest motion - which is life - by artificial means and hold it fixed so that a hundred years later, when a stranger looks at it, it moves again. As Wolcott (2001) enthused, the art of writing itself feels like renewal.

I personally loved the act of creation, from the first glimmering of an idea to this, my final manuscript. I have found the sheer mechanics to be a source of pleasure. I have loved the carpentry of the writing process: finding the perfect word, sanding and burnishing rough sentences, tinkering with the tick-tocks of phrase and sentence cadence. Undoubtedly, facing my own personal demon as I have wrestled with the printed page has helped to dispel sadness and the consequent revelations have enabled me to become a more effective therapist. Indeed, the writing of this thesis has been a journey, a poignant journey backward as well as forward. In my reflective head, I have revisited my own child when he was young as well as my own childhood. Events from long ago have pulled at me. I have been the wounded healer (Guggenbuhl-Craig, 1971; Rippere and Williams, 1985).

I am astonished to see that self-doubt has shadowed my entire life and amazed too by the persistence and clarity of so many associated memories. As I became more and more immersed in the research programme, I found the past ever more with me - as Dickens first described in 1859 in the following extract from *A Tale of Two Cities*, whereby inadvertently reinforcing the tenets of action research as we know it today:

> "For, as I draw closer and closer to the end, I travel in a circle nearer and nearer to the beginning. It seems to be one of the kind of smoothings and preparings of the way. My heart is touched now by many remembrances that have long fallen asleep."
>
> (1987, p.295)

Perhaps I should finally reflect that, by now completing the last methodological circle, I am doing as Dickens suggested, smoothing out rough spots of my story, embracing all that has made me and all that I have become.

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APPENDIX 1
JOURNALS USED IN REVIEW OF LITERATURE

From USA
Aggressive Behavior
American Psychologist
Annals of Psychotherapy
Applied Developmental Psychology
Atlantic Monthly
Behavioral Disorders
Cognitive Behavior Therapy
Clinical Child and Family Psychology Review
Developmental Neuropsychology
Developmental Psychology
Development and Psychopathology
Dissertation Abstracts
Dissertation Abstracts International
Educational Psychologist
Group Ethics and Behavior
Journal of Counseling Psychology
Journal of Educational Psychology
Journal of Emotional and Behavioral Disorders
Journal of Clinical Child Psychology
Journal of Genetic Psychology
Journal of Personality and Social Psychology
Journal of Reality Therapy
Infants and Young Children
International Journal of Behavioral Development
International Journal of Choice Theory
International Journal of Group Psychology
International Journal of Reality Therapy
Personality and Social Psychology Bulletin
Psychological Bulletin
Psychotherapy: Theory, Research and Practice
Review of Educational Research
Scholastic Parent and Child
School Psychology Review
The School Counselor

From UK
Action Research
British Journal of Guidance and Counselling
Child Development
Childhood Education
Clinical Child Psychology and Psychiatry
Counselling
Educational Review
Emotional and Behavioural Difficulties
Journal of Child Psychology and Psychiatry
Journal of Educational Psychology
Journal of Family Psychology
Journal of Research in Personality
Journal of the Theory of Social Behaviour
Nursing and Health Care
Psychiatry
Qualitative Sociology
Special Education
Theory and Psychology

SUMMARY DESCRIPTION OF THE "CYCLE OF MANAGING, SUPERVISING, COUNSELING AND COACHING"

(The Cycle is explained in detail in books by Robert E. Wubbolding:
Understanding Reality Therapy, Harper Collins, 1991; *Employee Motivation*, SPC Press, 1996)
NEW BOOK: *Reality Therapy for the 21st Century, Accelerated Development, 2000*

Introduction:

The Cycle consists of two general concepts: Environment conducive to change and Procedures more explicitly designed to facilitate change. This chart is intended to be a **brief** summary. The ideas are designed to be used with employees, students, clients as well as in other human relationships.

Relationship between Environment & Procedures:

1. As indicated in the chart, the Environment is the foundation upon which the effective use of Procedures is based.
2. Though it is **usually** necessary to establish a safe, friendly Environment before change can occur, the "Cycle" can be entered at any point. Thus, the use of the cycle does **not** occur in lock step fashion.
3. Building a relationship implies establishing and maintaining a professional relationship. Methods for accomplishing this comprise some efforts on the part of the helper that are Environmental and others that are Procedural.

ENVIRONMENT:

DO: Build Relationship: a close relationship is built on TRUST through friendliness, firmness and fairness.

A. Using Attending Behaviors: Eye contact, posture, effective listening skills.
B. AB = "Always **Be** . . ." **C**onsistent, **C**ourteous & **C**alm, **D**etermined that there is hope for improvement, **E**nthusiastic (Think Positively).
C. Suspend Judgment: View behaviors from a low level of perception, i.e., acceptance is crucial.
D. Do the Unexpected: Use paradoxical techniques as appropriate; Reframing and Prescribing.
E. Use Humor: Help them fulfill need for fun within reasonable boundaries.
F. Establish boundaries: the relationship is professional.
G. Share Self: Self-disclosure within limits is helpful; adapt to own personal style.
H. Listen for Metaphors: Use their figures of speech and provide other ones.
I. Listen to Themes: Listen for behaviors that have helped, value judgements, etc.
J. Summarize & Focus: Tie together what they say and focus on them rather than on "Real World."
K. Allow or Impose Consequences: Within reason, they should be responsible for their own behavior.
L. Allow Silence: This allows them to think, as well as to take responsibility.
M. Show Empathy: Perceive as does the person being helped.
N. Be Ethical: Study Codes of Ethics and their applications, e.g., how to handle suicide threats or violent tendencies.
O. Create anticipation and communicate hope. People should be taught that something good will happen if they are willing to work.
P. **Practice lead management, e.g., democracy in determining rules.**
Q. **Discuss quality.**
R. **Increase choices.**
S. Discuss problems in the past tense, solutions in present and future tenses.

DON'T:

Argue, **Boss Manage,** or Blame, Criticize or Coerce, Demean, Encourage Excuses, Instill Fear, or Give up easily.

Rather, stress what they **can** control, accept them as they are, and keep the confidence that they can develop more effective behaviors. Also, continue to use "WDEP" system without giving up.

Follow Up, Consult, and Continue Education:

Determine a way for them to report back, talk to another professional person when necessary, and maintain ongoing program of professional growth.

PROCEDURES: **WDEP**

Build Relationships:

A. Explore **W**ants, Needs & Perceptions: Discuss picture album or quality world, i.e., set goals, fulfilled & unfulfilled pictures, needs, viewpoints and "focus of control."
B. Share Wants & Perceptions: Tell what you want from them and how you view their situations, behaviors, wants, etc. This procedure is secondary to A above.
C. Get a Commitment: Help them solidify their desire to find more effective behaviors.

Explore Total Behavior:

Help them examine the **D**irection of their lives, as well as specifics of how they spend their time. Discuss ineffective & effective self talk.

Evaluation – The Cornerstone of Procedures:

Help them evaluate their behavioral direction, specific behaviors as well as wants, perceptions and commitments. Evaluate own behavior through follow-up, consultation and continued education.

Make **P**lans: Help them change direction of their lives.

Effective plans are **S**imple, **A**ttainable, **M**easurable, **I**mmediate, **C**onsistent, **C**ontrolled by the planner, and **C**ommitted to. The helper is **P**ersistent. Plans can be linear or paradoxical.

Note: The "Cycle" describes specific guidelines & skills. Effective implementation requires the artful integration of the guidelines & skills contained under Environment & Procedures in a spontaneous & natural manner geared to the personality of the helper. This requires training, practice & supervision. Also, the word "client" is used for anyone receiving help: student, employee, family member, etc.

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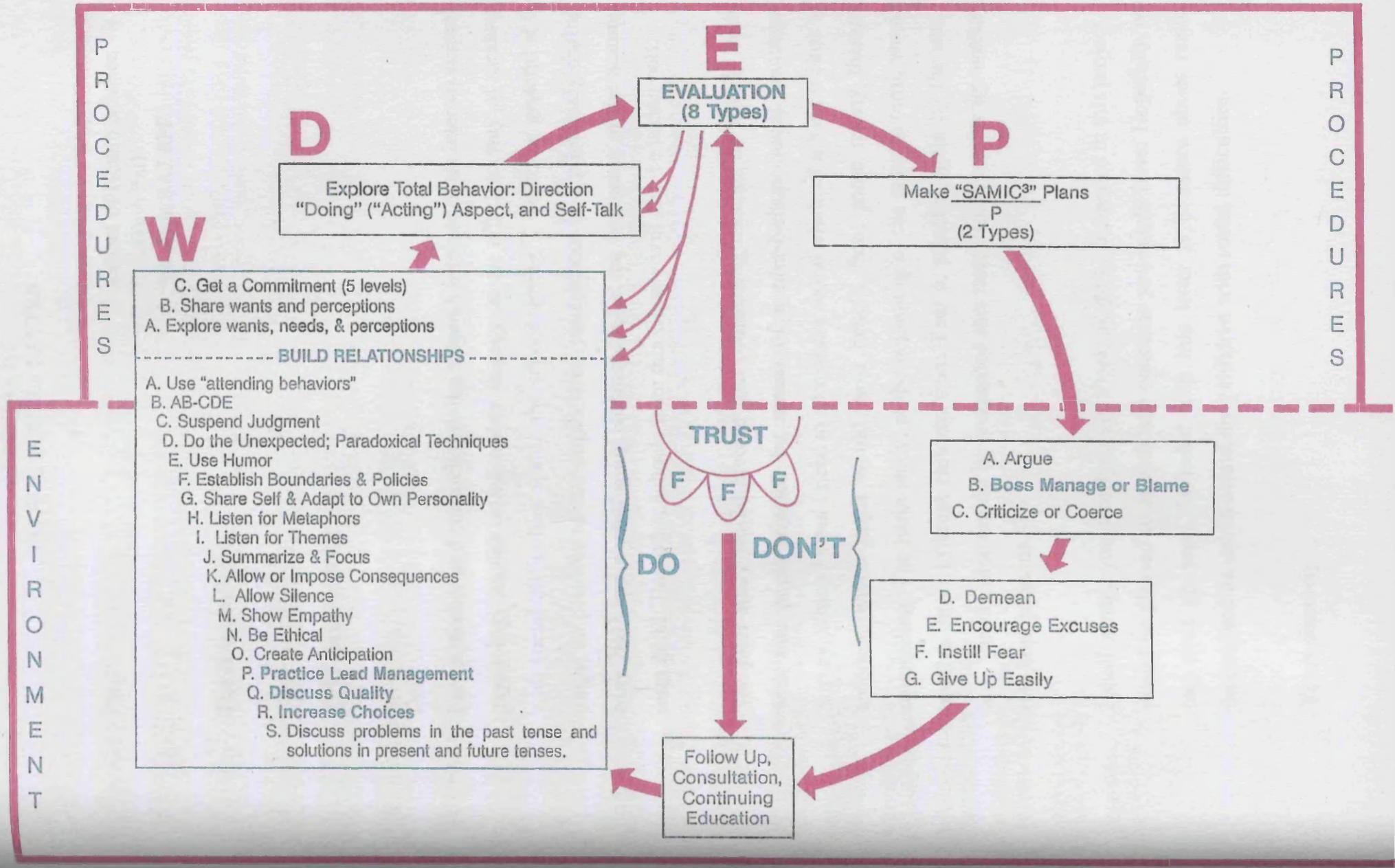
The Center for Reality Therapy provides counseling, consultation, training and supervision including applications to schools, agencies, hospitals, companies and other institutions. The Center is a provider for many organizations which award continuing education units.



APPENDIX III
INTRODUCTORY LETTER

University of Wales Swansea
School of Health Science
Singleton Park
Swansea SA2 8PP

The Headteacher
.....
.....

25th February, 2002

Dear.....

I am a teacher and counsellor doing research into use of an internal control psychology model called reality therapy as an effective way of dealing with social difficulties within the school setting. I would be grateful if it might be possible to use pupils from your school in a pilot study during May 2002 and a main study commencing at the beginning of the autumn term 2002. Two other schools from this County will also be taking part.

The pilot study would involve five counselling sessions on a daily basis with one pupil selected by means of a nfer-Nelson Social Inclusion Survey, which I would need to administer to the whole of a Year 6 class to ascertain which pupil would most benefit from some reality therapy counselling. The main study, at the beginning of the autumn term, would involve three different children from Year 6, selected again by the same test. The children would be counselled this time as a group for ten weekly one-hour sessions.

I shall contact you shortly to see if you might be interested in this project. I would be pleased to answer any concerns you might have. Hopefully we can meet up soon. Included with this letter is literature about reality therapy and its use in counselling children with social difficulties.

Yours sincerely

APPENDIX IV
LETTER SEEKING CONSENT AND CONSENT FORMS

University of Wales, Swansea
School of Health Science
Singleton Park
Swansea SA2 8PP

19th September, 2002

Dear Mr and Mrs.....

I am a post-graduate research student at the above address, now living and working in Cornwall. Recently I became a part-time teacher, employed by the County Council, which I do to support my studies. I also have my own counselling practice and I specialise in confidence building, relationship problems and depressive illness.

I am currently researching the use of reality therapy with children experiencing social difficulties. Recently I conducted two tests at.....'s school. When the results were analysed, ...was identified as a child who might benefit from some therapeutic work. Reality therapy is both safe and fun. It helps pupils think and talk about their individual needs and wants in order to make constructive choices to plan for a better future. A shorter pilot scheme has already been successfully completed at your child's school last term.

With your permission, I would be happy to see.....for ten sessions every Thursday morning from 26th September, with one follow-up session approximately one month after that and one at the end of the school year. I intend to use worksheets and creative resources and tape record the sessions. These tapes are for the purpose of my research only. The whole process is highly confidential.....'s real name would not be used in any part of my thesis and the only staff involved in this 'time out' would be the class teacher, the teaching assistant and of course the Head. The other children would not be made deliberately aware of the nature of our time together although, if.....enjoys it, ...may wish to tell them.

If you are willing to give your permission for me to work with ....., would both you and your child kindly sign the enclosed consent forms. Full information has already been given to..... I will then phone you to arrange a time at your convenience when we can meet to discuss fully any concerns you might have. It would also be helpful if you would agree to a short informal interview so that I have as much relevant information as possible before therapy commences. The pilot study highlighted that parental involvement was a key factor to the success of the project.

Yours sincerely

PARENTAL CONSENT FORM

I give my consent for .....to participate in the forthcoming reality therapy project at.....school.

I clearly understand that I have the right to withdraw consent at any time if I feel the therapeutic process is damaging my child in any way at all.

Signed.....

Date.....

PUPIL CONSENT FORM

I would like to take part in the reality therapy project at my school. There has been no pressure put upon me to do this by school or my parents and I understand that I may withdraw from the project if I am unhappy. If this happens, I also understand that I will not be blamed or punished in any way.

Signed.....

Date.....

APPENDIX V

SOCIAL INCLUSION SURVEY (SIS)

NFER-NELSON

How much do you like to .... with each person at school?

	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
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	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹
	?	☺	😐	☹

SOCIAL INCLUSION SURVEY (SIS)

THE 'LIKE TO WORK' (LITOW) AND 'LIKE TO PLAY' (LITOP) QUESTIONNAIRES

SCORING SHEET

NFER-NELSON

School .... Class ....

Administered by .... Date ....

			Number of faces ticked: Number happy	Number neutral	Number sad	Total number of faces ticked	Social acceptance descriptor
Name of target pupil	LITOP	Same sex					
		Other sex					
		Whole group					
	LITOW	Same sex					
		Other sex					
		Whole group					
Name of target pupil	LITOP	Same sex					
		Other sex					
		Whole group					
	LITOW	Same sex					
		Other sex					
		Whole group					
Name of target pupil	LITOP	Same sex					
		Other sex					
		Whole group					
	LITOW	Same sex					
		Other sex					
		Whole group					
Name of target pupil	LITOP	Same sex					
		Other sex					
		Whole group					
	LITOW	Same sex					
		Other sex					
		Whole group					

Directions: Separate questionnaires completed by boys and girls. Record the numbers of faces ticked for each of the targets pupils by same sex, other sex and whole group classmates.

APPENDIX VI
THE RESEARCH PARTICIPANTS

GROUP 1
G(1)
G was a boy who kept his own company, although the Head was uncertain whether this was out of choice. He did not have any friends although children would speak to him, but the relationship was usually because other children 'used' him rather than having him as a friend. G was an extremely intelligent, gifted boy but he was reticent to push himself forward - never asking, only responding. He was on the register of special needs at Level 1 for emotional reasons, so the school could keep an eye on him. He had a sister who was eight years older - with whom he shared a bedroom - and he came from a working-class single parent family. G lived with his mother, although his dad did attend school functions and took an interest in him. His mother suffered from depression and had huge emotional problems. This meant that usually G had to get himself to school, feed himself and put himself to bed whilst his mother spent the majority of her time in bed feeling depressed. Her rented house, which was owned by the local authority, was damp and prone to regular flooding. She desperately wanted housing relocation to a coastal resort to give her family a fresh start, but had been thwarted on many occasions, which compounded the depression.

G was always tired because his sister played music until the early hours, resulting in him often being late for school. He also ran errands before and after school, assuming the role of carer to his mother, and kept the house as clean and tidy as he was able. His natural intelligence was almost stifled because of these problems and the responsibility on his young shoulders made it difficult for him to 'lighten up' and play. He appeared not to know how to play and, naturally, this isolated him from his peers. G had no outward behavioural problems but would retreat into an inner shell when feeling threatened emotionally. He had not had any counselling although the school worried about his home situation and had questioned him. However, G had great integrity and was intensely loyal to his mother although he knew there were major problems at home. The Head was of the opinion that he had a huge fear of being removed from his mother if he were to say anything.

L(1)
When L was younger, he was increasingly in trouble for responding inappropriately to his friends and being 'over the top'. If a child asked him to go and hit someone he would, in order to be popular with that person for a short period of time, without thinking about the longer-term consequences of the bullying. He was very pliable as he appeared to have such a need to be part of a group or gang. Now L was older, those tendencies had grown less obvious, although he still had a basic lack of understanding about his and other people's behaviour and how to assimilate that and respond in an appropriate way. He was a tall handsome boy and had used his size, on a number of occasions, to intimidate others. L came from a two-parent professional middle-class background and was an only-child. The parents were described as fully supportive of the school and, likewise, offered the research project their full co-operation. The Head reported that he frequently had interviews with Mum, who would typically agonise that she just did not know what to do with L or how to discipline him. The Head ascertained that the school had worked hard on his bullying problem and that behaviour was slowly improving, although there was still a long way to go.

L was on the special needs register at Level 5 for behaviour problems, thereby having a learning support assistant for behaviour management. The behaviour adviser for the local authority had worked with L for a number of years setting short-term targets with rewards. L had also undergone psychodynamic counselling to enable him to try and talk about the way he felt and

the way he behaved with his peer groups. Rewards and sanctions had, with limited success, been used as being the way to change his internal perceptions.

M(1)

M was a very 'bubbly' girl who appeared, at first glance, to always have other girls around her. Her easy ability to overpower seemed to be a major factor in her social rejection as the other girls struggled to keep her 'out of their faces'. M was on the special needs register at Level 5 as she had been diagnosed as having the medical condition of semantic pragmatic, which could be described as often communicating inappropriately socially and behaviourally with her peers. Her condition meant that her understanding and communication skills were also inappropriate. M tended to respond in an 'over the top' fashion to anything that was said to her which, ultimately, had an isolating effect. Some classmates would regard her as a bully. M entered Case 1 a year before the research project began. She had a learning support assistant who was trained to communicate with her.

M was an only-child and came from a two-parent professional middle-class background. Both parents were fully supportive of any initiatives to help their daughter. She travelled a relatively long distance to the school from a major tourist resort because her parents felt that the small, friendly atmosphere helped to 'contain' her. The Head hoped that reality therapy would enable M to acquire more coping strategies.

GROUP 2

E(2)

E had not been identified as a child with particular social behavioural difficulties by the school although he was a very quiet, withdrawn boy who lived in a total fantasy world. The family was well-known to Social Services as his parents had severe mental health problems. Both parents had bipolar disorder and took medication, often adversely making them unable to cope. They were unable to live together because of the effect that their illness had on one another so they lived in separate houses, although both shared the responsibility of care for their children and they had no intention of divorcing. Social Services kept a tight check on this family as E had three older brothers and a younger sister, all with behaviour problems. The parents attended parenting classes and the other children in the family had been taught behaviour skills. However, E tended to be ignored and forgotten at home and spent all his free time 'lost' in computer games which he could play on his own.

E maintained an individuality which his class mates found rather odd. His hair was styled effeminately and he was affected in his mannerisms. He told lies continuously and bragged about being rich, having seen the world and many other preposterous claims. E was unable to cope with stress when pressure built up at home. His loneliness was apparent through the total world of fantasy he had built around himself.

K(2)

K had been a pupil at the school for only a few months when the test was carried out. Despite this, she had gained a reputation amongst her peers because of her outlandish behaviour. All previous records of this girl had disappeared, much to the frustration of the Head. He had discovered she had been in a special school and had not spoken until she was eight years old but he had no records or further information. The Head was aware that K did not speak as if she were deaf, so he was not sure if the problem was language delay or whether it was physical or mental. All that could be established with certainty was that she had a persecution complex. Everything she wrote and talked about was how much everyone hated her. This inevitably

became a self-fulfilling prophecy. K came from a family perceived to be working-class. She lived in run-down council flat accommodation with a reputation for its drug addict population who regularly would 'shoot up on the landings'. K had one sister by a different father and she lived with her mother, her mother's boyfriend and her sister. The boyfriend accompanied the mother to the parental interview and was preoccupied with confidentiality aspects. Usual assurances were given and exceptions to this explained at length. During the course of the research, these exceptions had to be put into place.

K was not allowed out to play after school in case she was 'snatched back' by her father and the family lived in an atmosphere polluted by fear. The Head described K as a horrible nightmare, having rock-bottom self-esteem, being totally isolated with not one person liking her. She had already begun sessions with the county Head Educational Psychologist, due to the severity of her problems and the impact her behaviour was having on the rest of the school population. K would sit in the class and stare blankly at the class teacher for long periods of time. She did not communicate at all, other than sending malicious notes around the class using insulting foul language about the parents of her classmates, or more directed notes such as "I know you hate me and I hate you back." Exactly like her mother and sister, K would only speak when staring directly at the floor. She used this technique as a way of distancing herself, so as not to get involved unless totally on her terms. Her class teacher described her as a manipulative bully.

L(2)

L had attended the school since she was four and had been immediately diagnosed as a difficult child. Social Services were involved with both her and her mother, a single parent who had experienced domestic violence over a long period. She had attended a social skills class run by Social Services when she was younger and this had improved her behaviour. However, L had not only slipped back to her old ways but, in recent months, had become worse. She was an only-child who had a history of being violent, stealing and bullying other children. Impulsive and unpredictable behaviour became the norm after witnessing physical abuse to her mother. Nowadays, it was not unusual to lash out at her mother herself. As a consequence, L had major emotional behavioural difficulties and was deliberately nasty to her peers causing social isolation which, in turn, compounded the matter even further. She would tell people that she was suffering from depression. The Head confirmed that there was certainly something very wrong going on inside her head. L had been put on the school Action Plus Register, which meant an advisory teacher came into the school to work with her. Her mother was unemployed, having a flat in the same block as K's family and was considered working-class by definition. She was supportive of any measures to help L and appeared almost frightened of her daughter, who continuously lied to her and regularly stole from her.

L spent a lot of time out on the streets after school and hence was very streetwise for her age. She had caused havoc in the neighbourhood and would lash out unexpectedly and unpredicably. She was willing to attend counselling sessions but refused to wait, imposing the terms that if people did not follow her rules she would simply disappear. The Head acknowledged she had run out of school on many, many occasions. He felt behaviour plans were a waste of time with her. Having witnessed violence at home, as well as being on the receiving end of it, he felt L had no respect for females and that it was okay, in her philosophy, to knock women around. The key problem, as he saw it, was that L needed nurturing.

GROUP 3

B(3)

B was a big lad physically, towering over his contemporaries. The staff described him as extremely immature, choosing younger children to play with in the yard, which was especially

noticeable because of the size difference. He was the eldest of three children and his parents had both retired early from the police force in London with physical injuries. The family had recently moved to Cornwall to seek a better lifestyle, so both parents were highly involved in the rearing of the children and they could be described as middle-class. B was very involved with his siblings, which could explain his penchant for younger children. His father, conversely, believed his son was very mature and attributed that as the reason for his social rejection. Both parents were very serious, formidable characters and B gave the impression of being slightly afraid of them. However, they were very anxious to contribute to the research programme in any way they could. They were worried that the school had put their son on the special needs register and simply could not understand it. B was identified at the lowest level, so the school could keep an eye on him. A major concern of the school was that he was never allowed out to play at home on his own. His parents were adamant that we lived in a dangerous world and that they had seen it all as police officers. This meant that, at school, B indulged in complete attention seeking - always acting the silly class buffoon, disrupting games and inappropriately interrupting. He did not have the social skills to interact with other children of the same age and was therefore totally rejected by his more worldly and mature classmates.

E(3)

E was a loud, talkative girl whom her classmates found overpowering. She lived permanently with her grandmother, being taken away from her mother and an abusive stepfather by Social Services. After her parents' divorce, E remained in the care of her mother until she was emotionally and physically abused as a toddler by her mother's new partner. E had a deep hatred of her mother but was in regular contact with her real father, whose mother she now resided with. Her grandmother and her partner could be described as caring and wealthy pillars of the community and subsequently E was afforded every luxury, such as her own pony. E's new family would be considered upper middle-class; her grandmother, the partner and her father all worked professionally. E appreciated the care her grandmother had given to her but still seemed haunted by her terrible past. She exuded a lot of love and affection and was so desperate to be liked by adults that she regularly told tales. This, of course, made her unpopular with her peers. E was not statemented or on the register of special needs. Her unpopularity with classmates appeared to be solely her over-enthusiasm to be liked, which ultimately had a habit of backfiring on her.

K(3)

K was an intensely shy, quiet boy. He could not bear to have attention drawn to himself and was the sort of boy who liked to always 'sit in the shadows', just getting on with his work. He was not on the special needs register and had never had any form of counselling. In fact, K was a highly intelligent boy who enjoyed all his schoolwork and was one of the cleverest members of the class. However, he was a complete scatterbrain, disorganised and untidy, a bit of an 'absent-minded professor'.

K appeared to have no friends at all, playing only with his younger brother. His father had a disability and was unable to work and his mother was a dinner lady. K was expected to care for his father as and when it was needed. The family would be described as working-class. Mum was an overpowering character, very involved with everything and very jovial. In her company, she was the one who did all the talking on her son's behalf. K was often seen standing in the playground watching other children's games. When encouraged to join in, he would go bright red and look as if he were about to cry.

APPENDIX V11 CHILD PROFILE FORMAT OBSERVATION SHEET

Section A: Evidence of anxiety / ability to cope	**not clear yet**	**seldom**	**sometimes**	**very often**	**usually**
Restless and unsettled					
Moves about the room inappropriately					
Appears worried, miserable					
Is tight and held-in					
Dominates group situations					
Fights with other children					
Bullies other children					
Is a victim of bullying / verbal abuse					
Can be assertive					
Responds to provocation from peers without over-reacting					
Able to share valued resources					
Able to share attention					
Respects other children's privacy					
Respects other people's property					
Values / takes care of own belongings					
Can tolerate unexpected events / changes in routine					
Can accept adult authority					
Able to relate with physical contact					
Considers the feelings of others					
Liked by other children					
Can make and keep friends					
Can independently negotiate with peers and take responsibility for the consequences					
Can cope with difficulties on a task without becoming unduly upset					
Values / takes care of own work					
Shows pleasure in own success					
Appreciates other children's achievements					

Section B: Evidence of capacity to acknowledge / work on difficulty					
Able to acknowledge own feelings of sadness / anger					
Able to acknowledge difficulties					
Accepts responsibility for own behaviour					
Able to use worksheets and discuss them					
Can accept adult intervention					
Can **engage** in discussion about an area of difficulty					
Can **initiate** discussion with an adult about an area of difficulty					

Section C: Evidence of ability to work on tasks					
Has adequate concentration span					
Can accept help with a task when necessary					
Sustains interest in an activity until completion					
Uses own initiative when planning and carrying through a task					
Can aim for quality of achievement					
Can be co-operative with peers in group situations					
Can be co-operative with peers in unstructured situations					
Is able to use art-form(s) to express creativity					
Is able to use the written word creatively and imaginatively					
Is able to use guided meditation purposefully					

APPENDIX VIII

REALITY THERAPY DREAM EVALUATION QUESTIONNAIRE

- Does this dream scene remind you of anything you have done in the past few days? If so, please describe it for us.

- Does this dream scene remind you of recurring or ongoing conflict/s you may be experiencing in your life? If so, please explain.

- Is this dream scene describing something you may want to have or may want to do? If you think so, please explain.

- Is this dream scene showing you how you are currently trying to get what you want?

- Is your dream suggesting that you are successful?

- Is it suggesting that perhaps your behaviours are not as effective as possible?

- Could your dreams be encouraging you to continue using your new behaviours to get what you want?

- Is your dream possibly offering you a new and creative way of getting what you want? Explain.

- What might you learn from this dream for use in the present and future?

APPENDIX IX GROUP 1 RAP SONG (ORIGINAL - 2002)

RAP LYRICS	MY VERIFIED INTERPRETATION	BASIC NEED
Gonna fly free Free-fallings where I'll be Looking for a path to tread Take me to where it's good It's good when there's a point Born free, roam free	We're all born free spirits But we fall Into life's different avenues So there has to be A point Of our existence	All
We gotta make a change It's time for us as a people To start makin' changes Let's change the way we eat Let's change the way we live And the way We treat each other	It is time for Cornish kids To come together as one Let us change our lives For the better	Freedom
If you can make it Through the night There's a brighter day Everything will be alright If ya hold on It's a struggle everyday Gotta roll on	This means that even When adversity strikes One should never look down But attempt to look up Because at the end Of the darkest tunnel Is a little light	Power
To this group I'm eternal Sittin' here super snooky Please take care of Model men-love them-love them And dogs and two fine fish	I'm established in this group Sitting here happy My new family is special And pets and interests Which mean a lot	Love and Belonging
Let me serenade The streets of Penzance From Ludgvan to Trenance Mounts Bay area And back down Cornwall's where they put The mack down	Enjoy yourself Party An anthem for Cornwall	Fun
Still I rise Please give me To the sky And there I die I don't want you to cry	We all die, and when it is one's Time to go we should accept it Rather than fight it because death is Something which will come to us all It is part of life	Survival

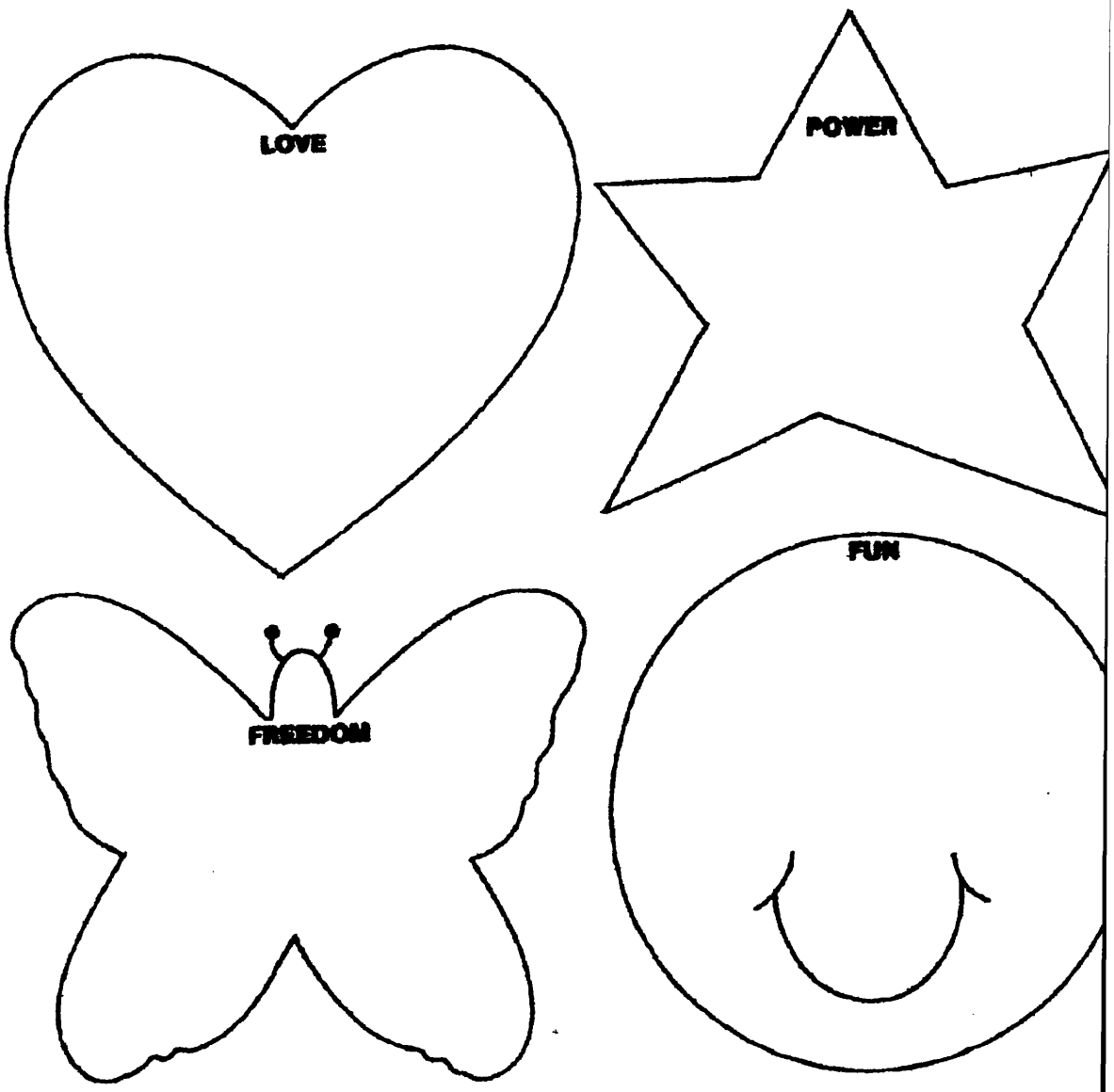
APPENDIX X

REALITY THERAPY WORKSHEETS

How are we all alike and how are we different?

All people, the world over, have basic needs: * the need for love and belonging * the need for personal power which means we all want to compete, achieve, be recognised and be listened to * the need for freedom or independence * and the need for fun. For every basic need there are special wants that you have for getting that need met. What you want and what somebody else wants may be different, but your needs and that person's needs are the same.

Directions: Talk about each need and give examples of what is meant by each need. Write your examples in the need shapes below.

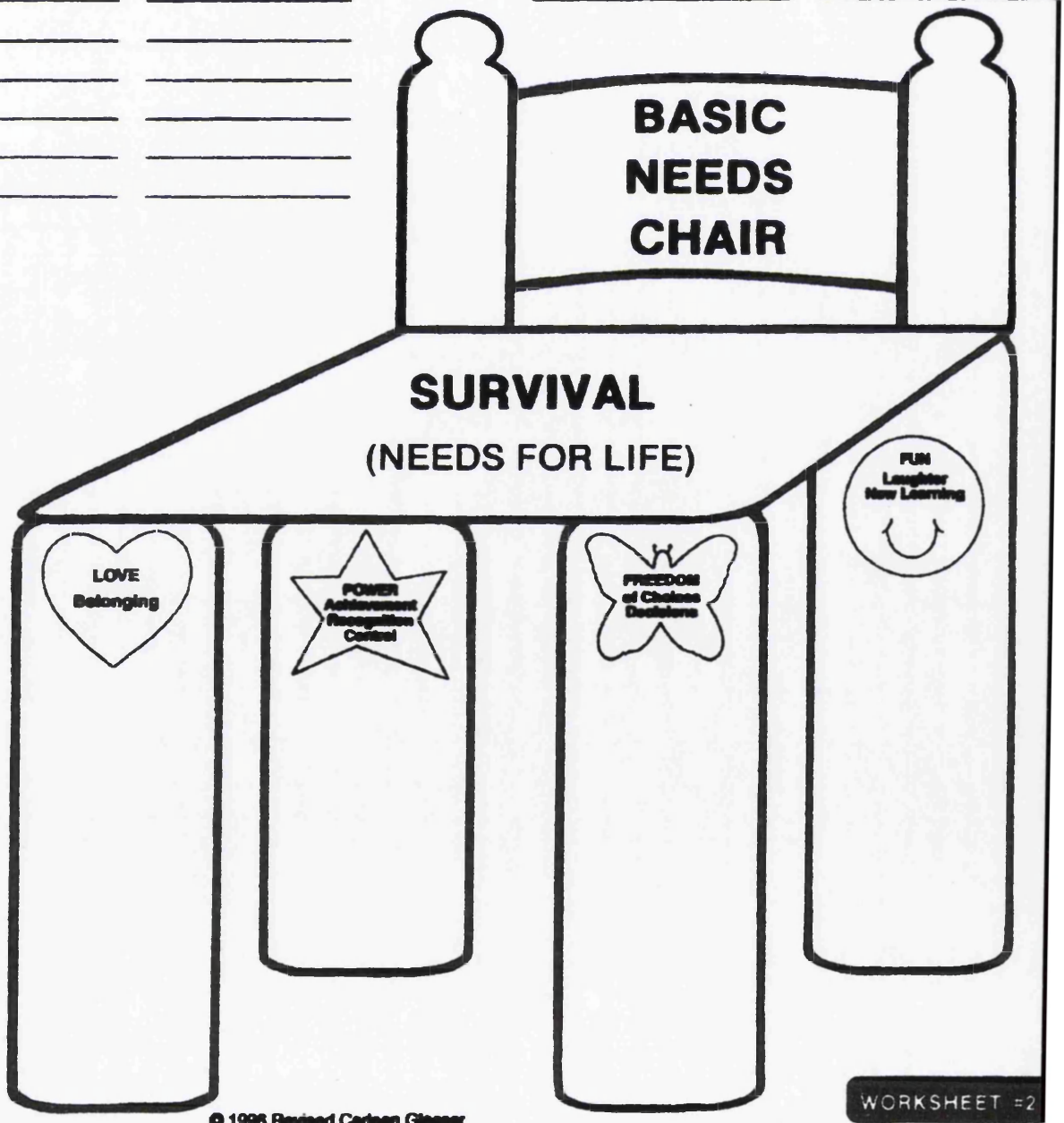


How much of what you need do you already have?

We all have the need for love and belonging, power, freedom and fun, and of course, th need to survive. Survival is like the seat of a chair. Without a seat there would be no chai The needs of love, power, freedom and fun are like the legs of a chair. If any of them weak or missing, the chair wouldn't work very well. Your life is like that too.

DIRECTIONS: List the people, activities or groups you are involved with now i your life. Go over the lists. Put the items in the legs of the chair below if the fulfill that need. Put an * by any item that makes it into all four legs.

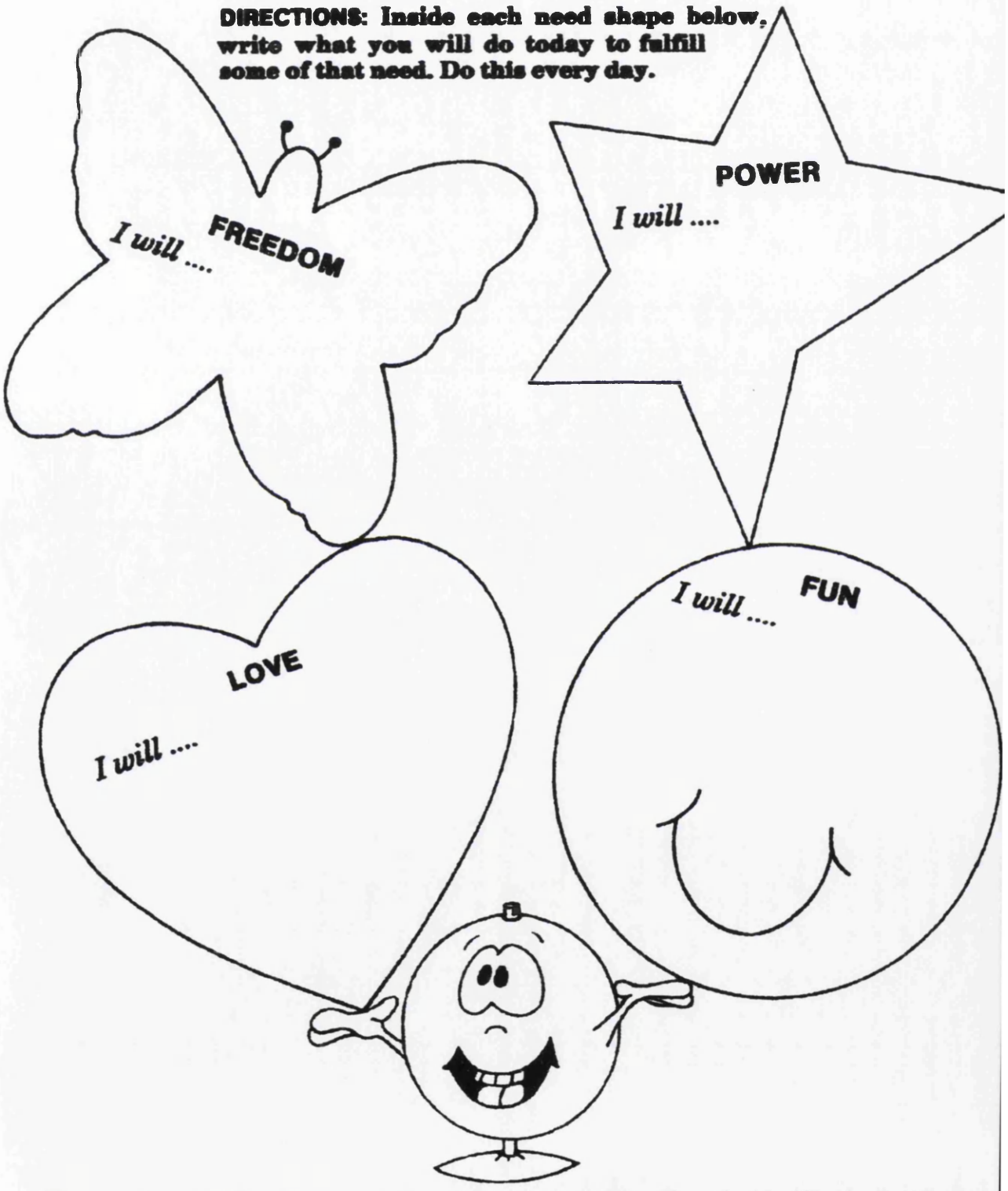
PEOPLE	ACTIVITIES	and	GROUPS . . .	that satisfy my need



How can you help yourself get what you really need?

Develop the Balance-Your-Needs-Daily-Habit!

DIRECTIONS: Inside each need shape below, write what you will do today to fulfill some of that need. Do this every day.



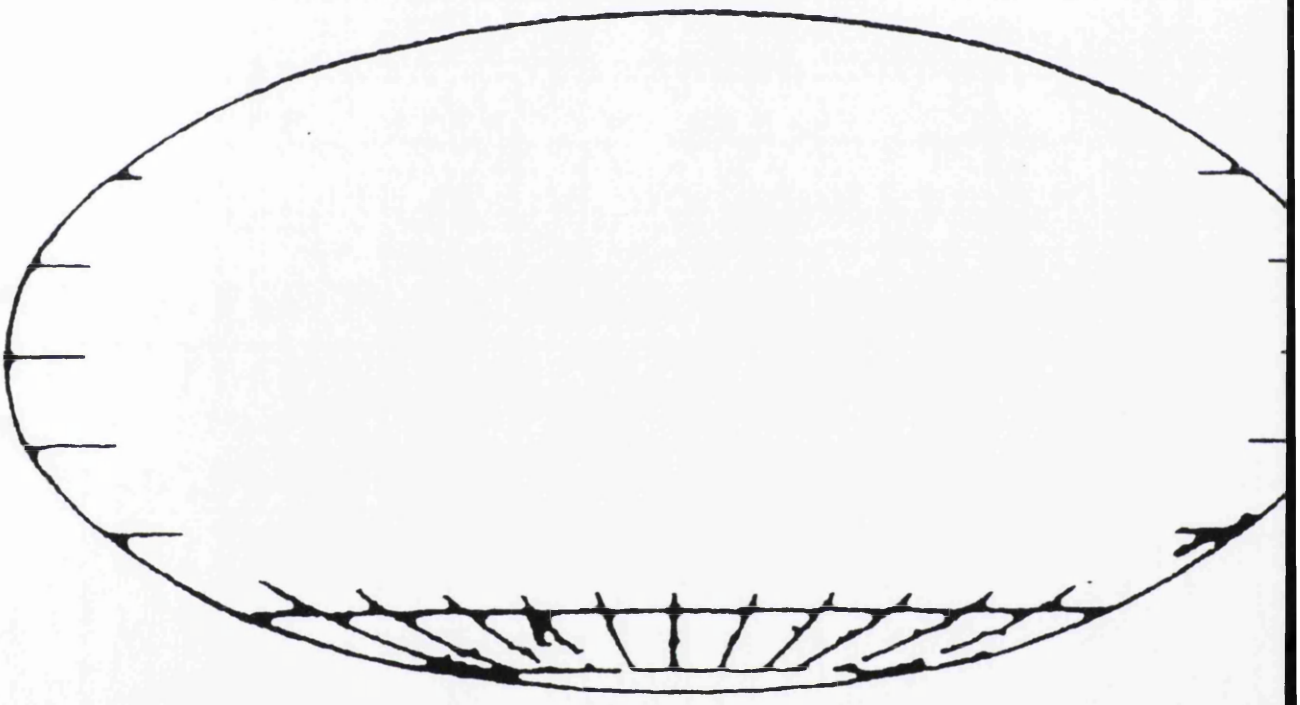
The more your needs are met everyday, the better your life will work. Just like the four legs on the chair, if one or more of the legs is missing, your life, like the chair, will be out of balance.

WORKSHEET #3

What's it like when you don't get what you want?

There's the **Real World** and there's your **Quality World** picture of what you want inside yo head. Your **Quality World** contains pictures of the people, things, and beliefs that satisfy yo needs. Sometimes what's happening in the **Real World** and the ideal way you want life to be your **Quality World** are two different pictures! When these pictures don't match, you get frustration signal in your brain. That frustration signal is like the spark that starts the engi in your **Car of Life**. When you're very frustrated, your **Car of Life** reves up its engine a your behavior wheels start to spin so fast they squeal as you peel out. You behave in ways to t to make the **Real World** more like the **Quality World** in your mind. Sometimes you a successful, sometimes you are not.

DIRECTIONS: In the space below describe a REAL WORLD situation in your life th definitely does not match the picture of what you want in your QUALITY WORL State exactly what you want in your QUALITY WORLD.



You've just described a picture that doesn't match what you want. Your behavior wheels ar spinning!

What are your feelings when the pictures don't match? _____

_____

Do you have any physical symptoms? What's your body talk? _____

_____

What are you thinking about when your pictures don't match? _____

_____

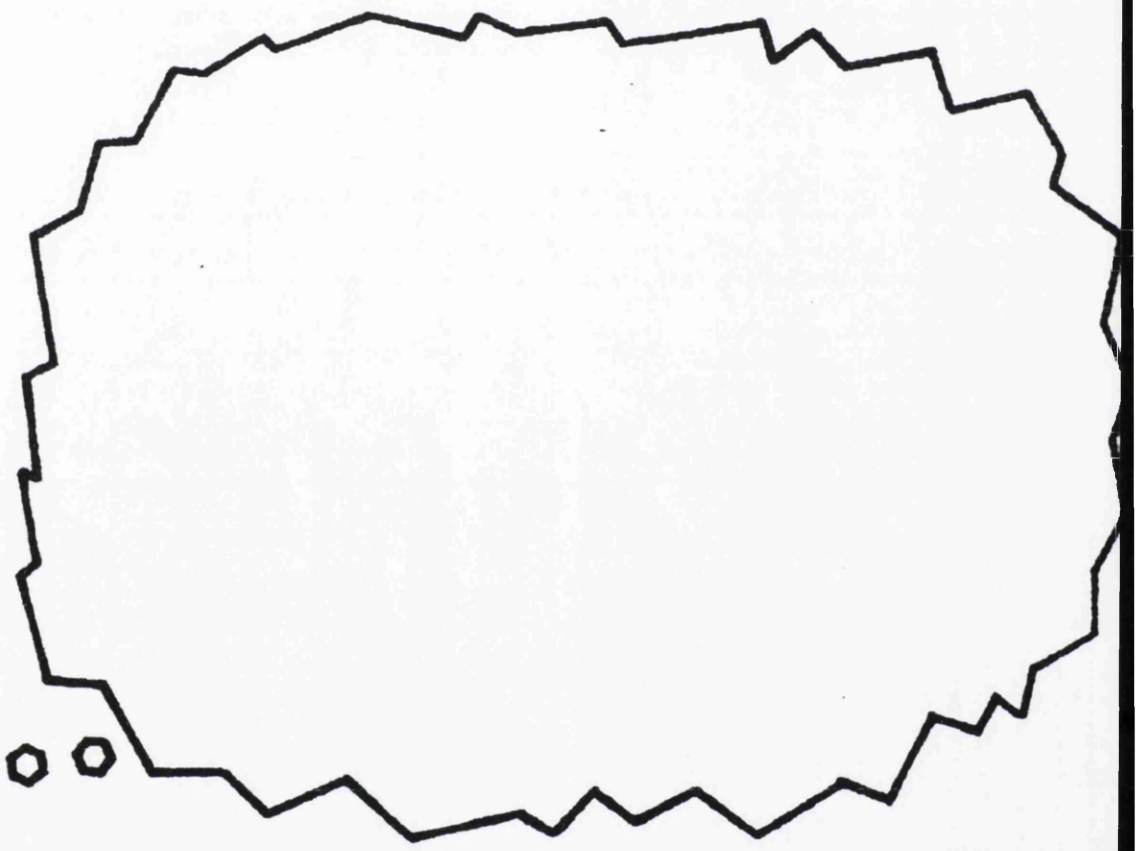
What are your actions? What are you doing? _____

_____

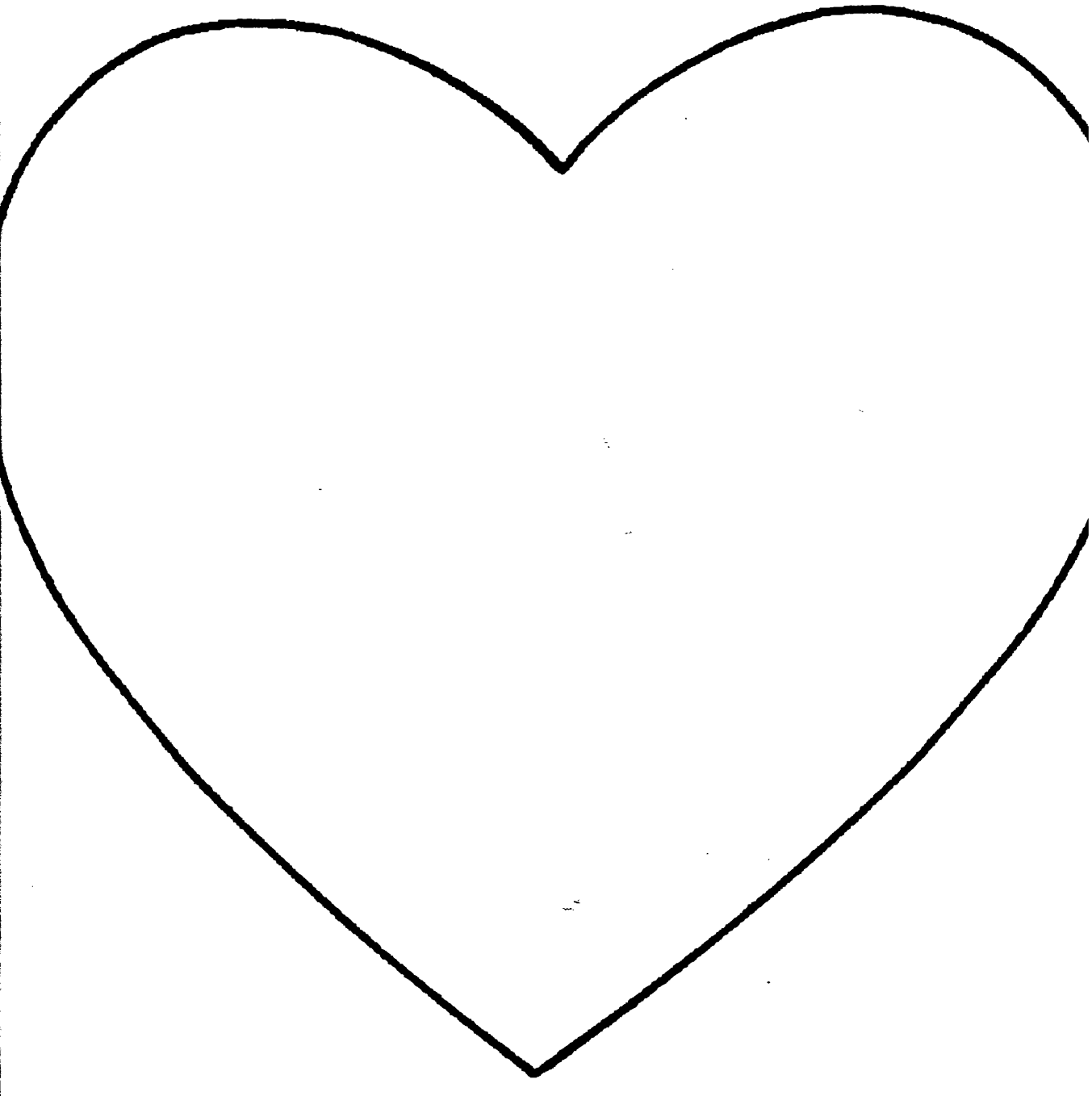
NOW DECIDE: IS WHAT YOU'RE DOING ABOVE HELPING YOU?

My Own Red Light Picture

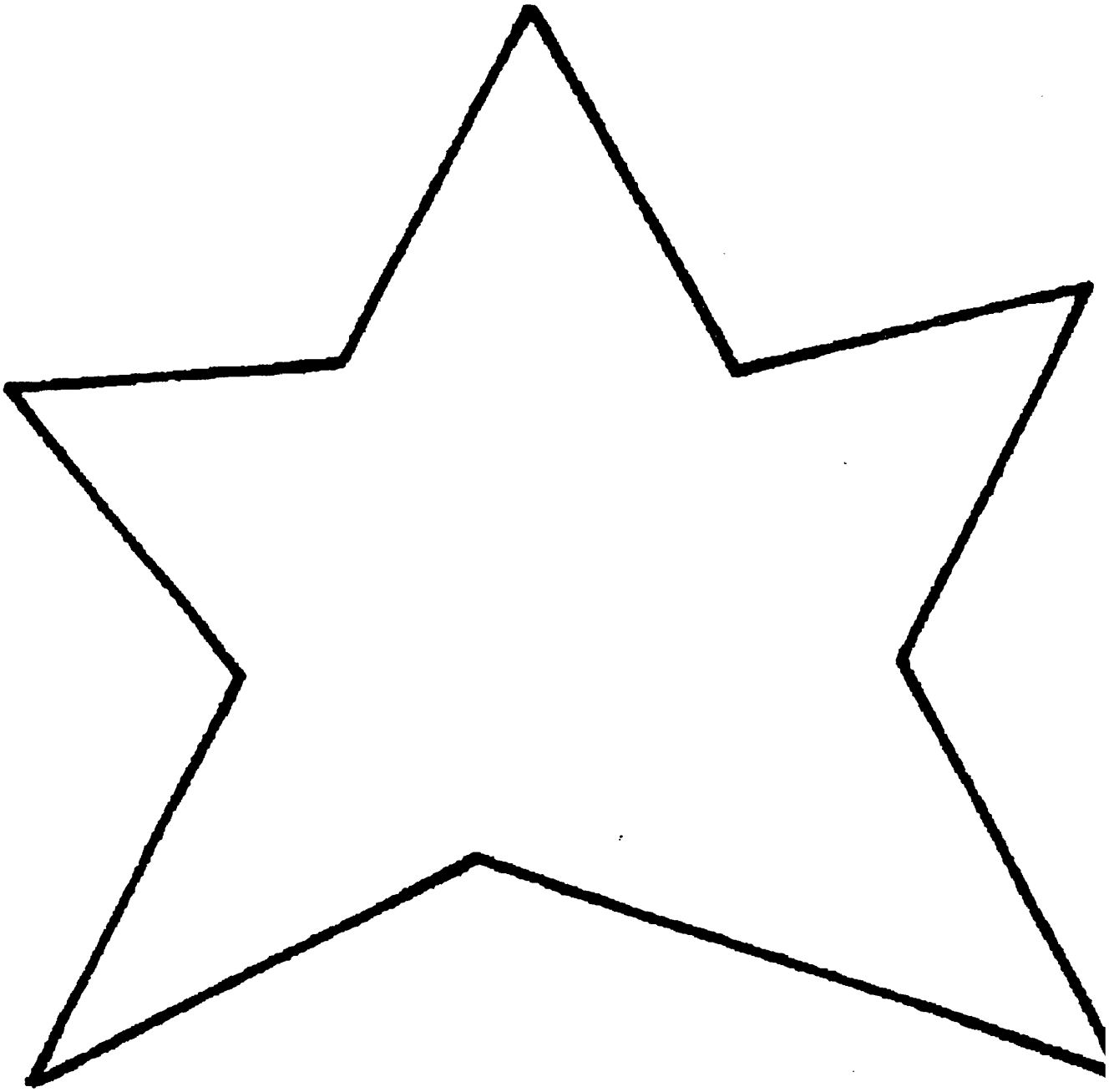
Draw a picture of a time when your red light would be flashing. You are not happy when the picture you see in the Real World does not match the picture you have in your Quality World. This is a time when you didn't get what you want. Tell the story below.



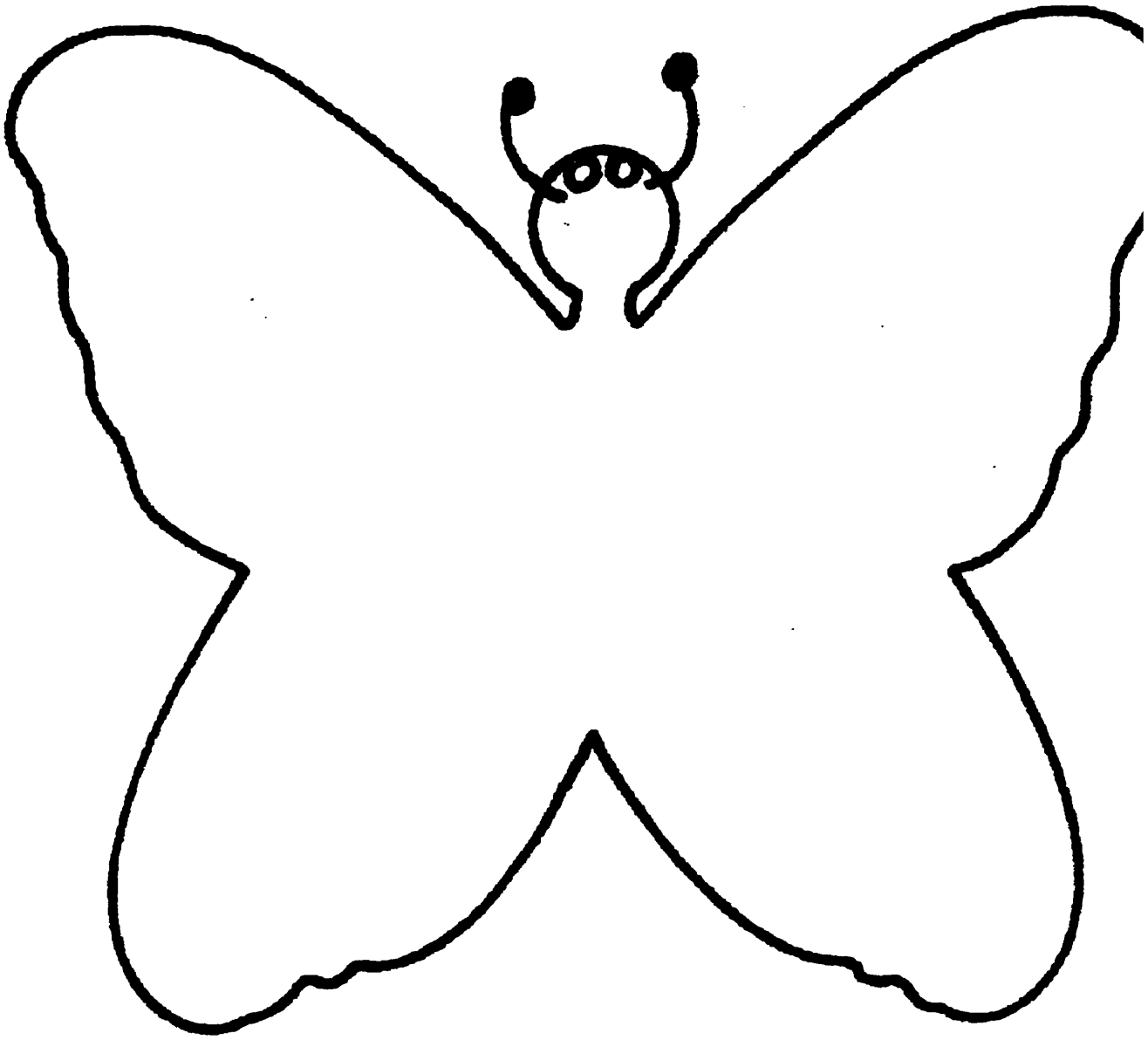
The Story of This Picture



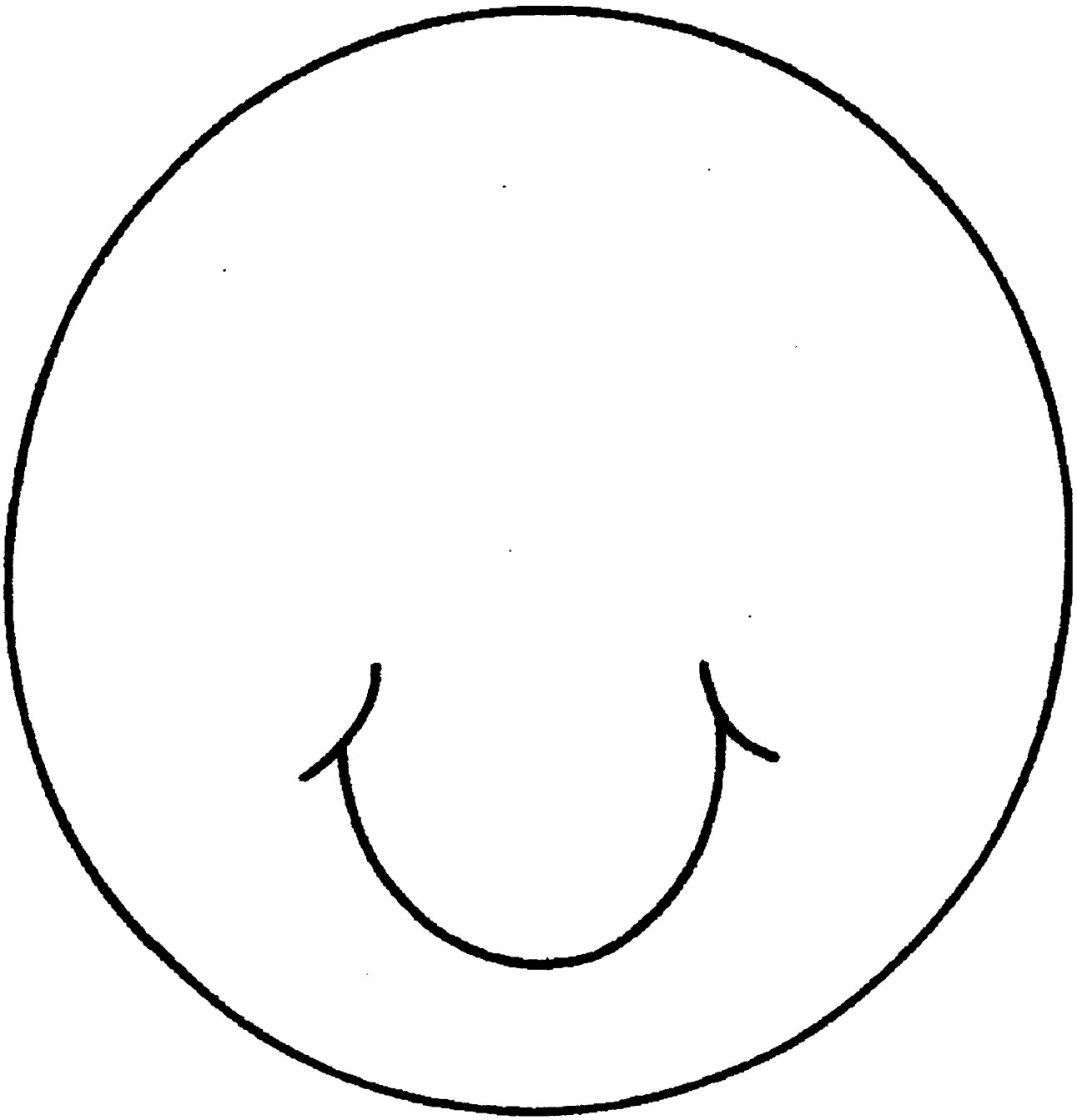
I love and belong.



I'm proud of me.



I have a mind of my own.



What I enjoy

Is your road taking you where you want to go?

When you decide which behaviors to use to get what you want, you make a choice. Choices are the roads you can take in your **Car of Life**. There are always consequences at the end of every road or choice you make. A Consequence is something that results because of the choice you make. A Consequence can help you or hurt you.

DIRECTIONS: Write three possible choices or roads you could take in a situation you are worried about in your life. Next, write what might happen or the consequences of taking each road. Can you decide which road to take based on the possible consequences?

CHOICES

CONSEQUENCES

CONSEQUENCES

CONSEQUENCES

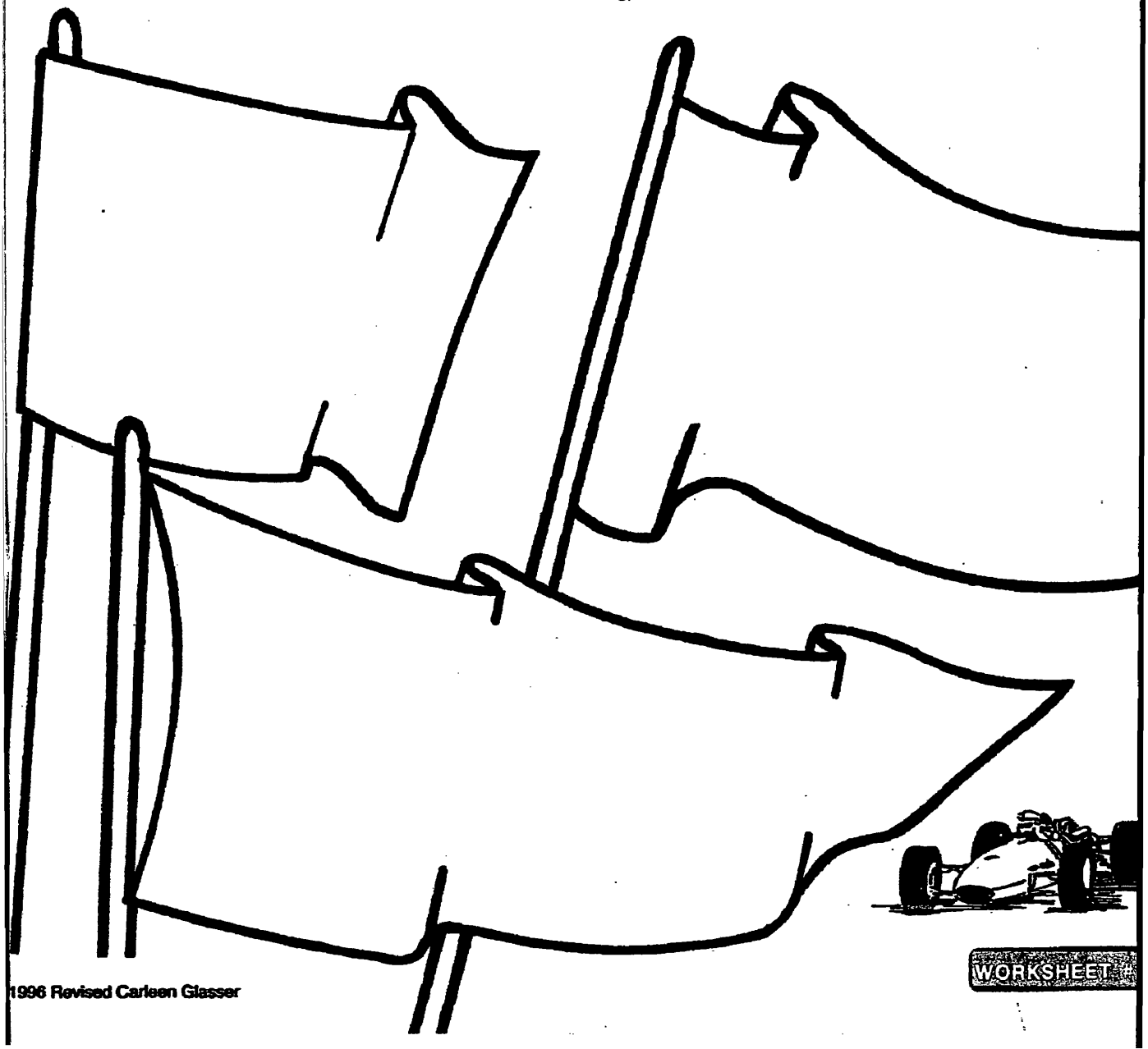
How do you know if you're happy or not?

When you're not happy, a red flag goes up in your brain, like a signal that lets you know you don't have what you want. A red flag is the painful knowledge that the picture of what you want is not matching what you have in the Real World. You have a strong urge to do something to change this situation!

When you're happy and satisfied with what you have, it's like a sunny yellow flag that waves in your brain. A yellow flag is the pleasant knowledge that you have what you want. Your picture inside your mind matches the picture of what you have in the Real World. You don't have as strong an urge to change what you have when you're happy with it.

There are lots of things you see in the world that are just "there." Neither red flags nor yellow flags go up in your brain when you become aware of them. These are the green flag pictures that are neutral to you. That means they are neither painful nor pleasurable. Your car keeps rolling along!

DIRECTIONS: In the flags below, describe some red flag, yellow flag, and green flag situations in your life right now. Label the flags red, yellow, or green, or outline them in the color that matches what you've described.

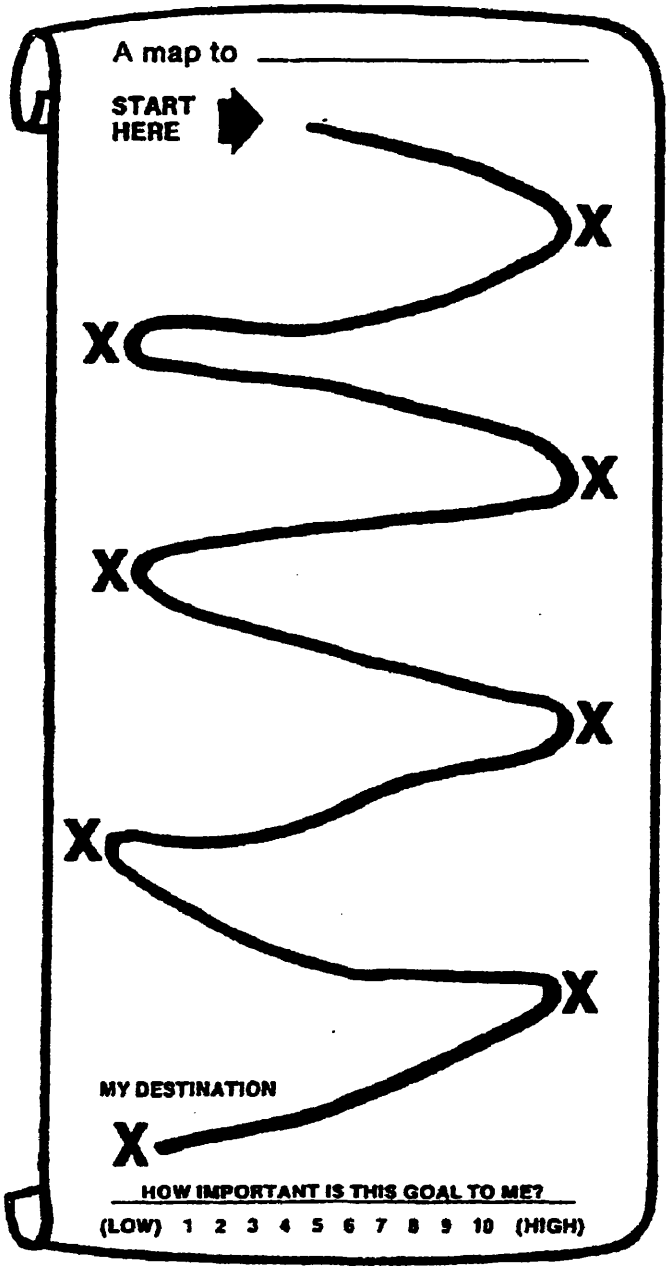


What do you want that you don't have?

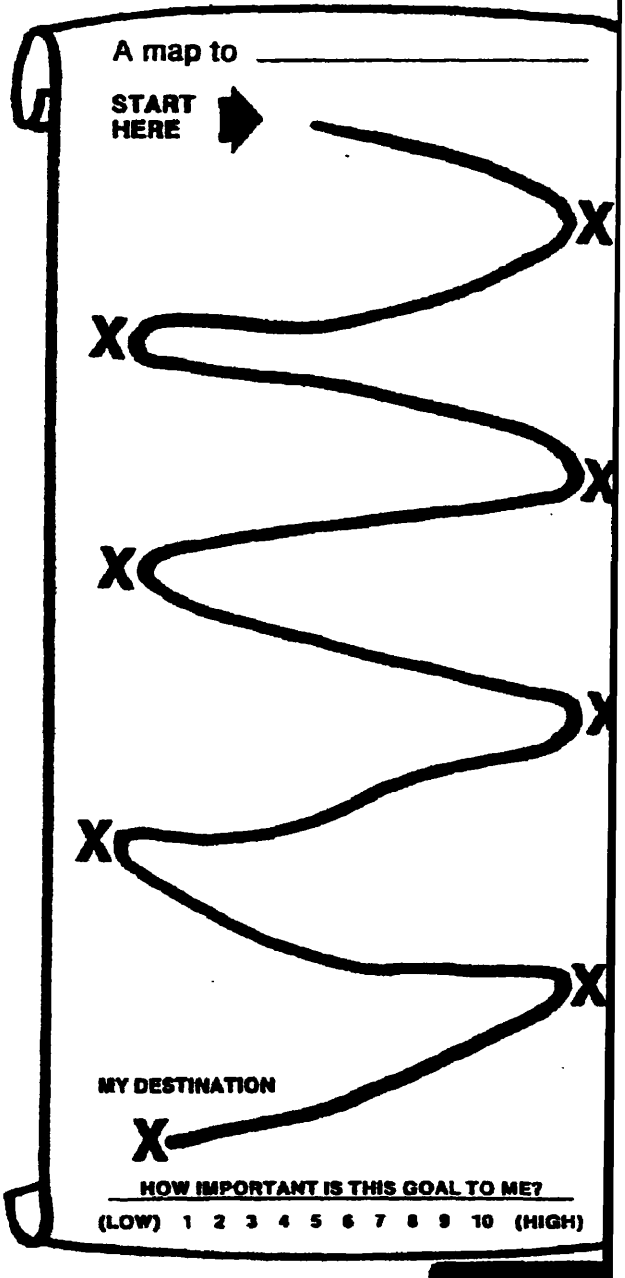
You might have a goal that you would like to achieve. That goal might be something y would like to be able to do right now or something you think you would like to be la One goal of a race car driver might be to finish the race. Another might be to win race! In your Car of Life, do you have a destination? What are some of your goals?

DIRECTIONS: On the scrolls below, draw a map to one of your immediate go and one to a future goal. Write in where you would have to go or what y would have to do to get to your destination. After the last X at the bottom of t map, write in what you actually would have if you got your goal. Decide h important it is to you to reach your goal. On a scale of one to ten at the bott of each map, rate your goal. One is low importance. Ten is high importance.

MY IMMEDIATE GOAL

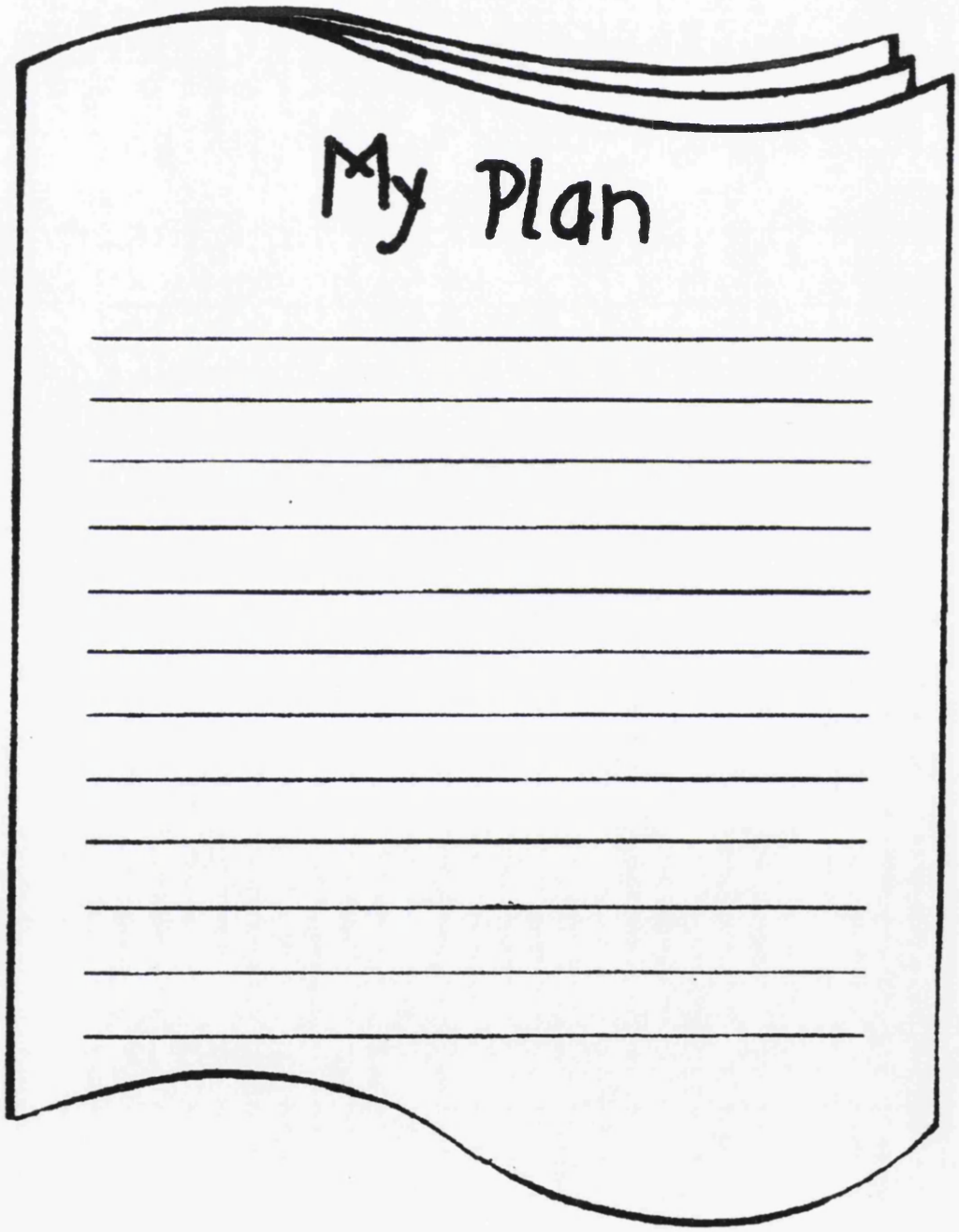


MY FUTURE GOAL



WORKSHEET

If what you are doing now is not getting you what you want, you need a plan. Check back on your completed worksheets to remind yourself what you have been doing. In the space below, write what else you could do instead.



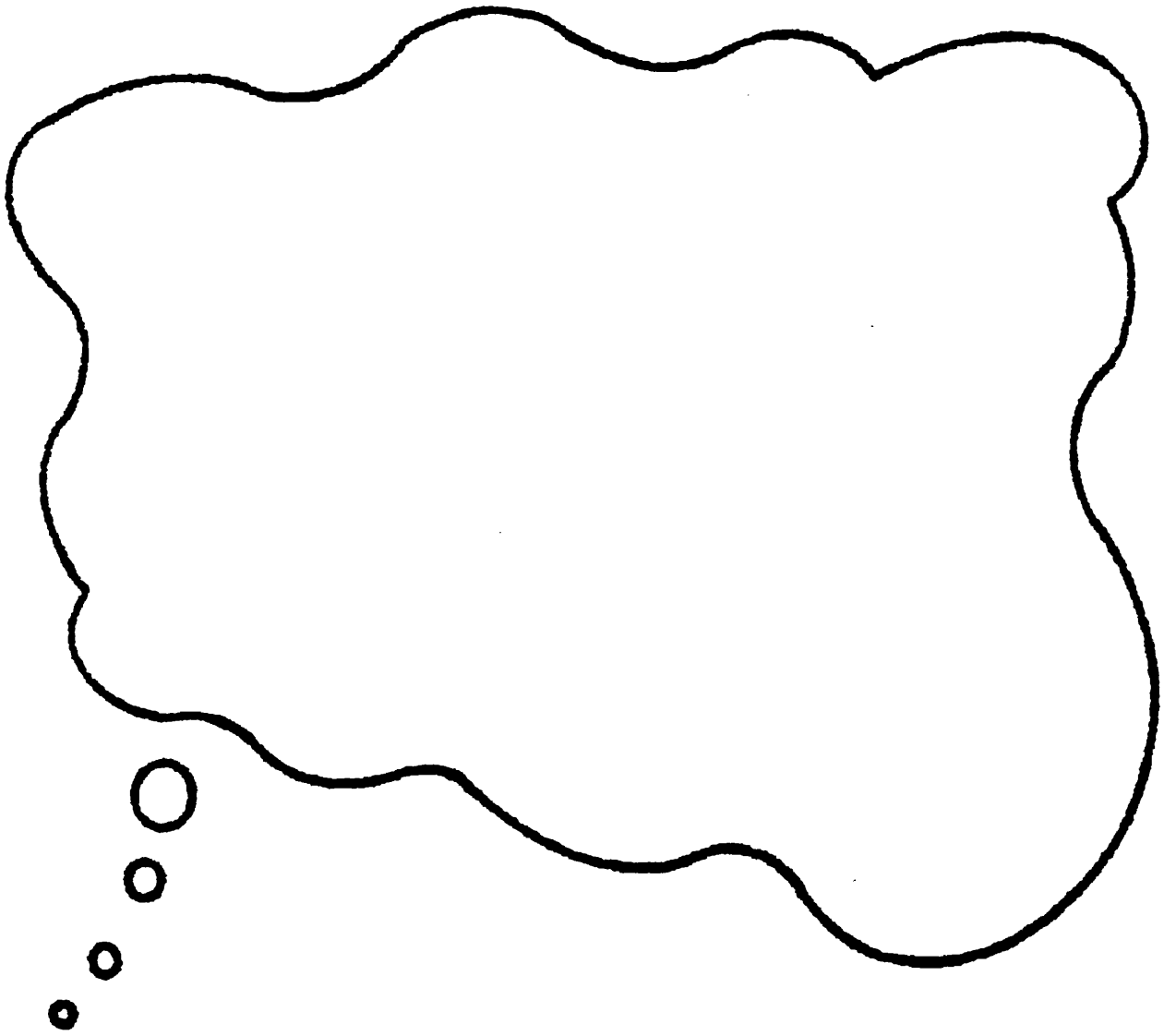
CHECK IT OUT

Now that you have a plan, you need to look again to see if it has a reasonable chance of working.

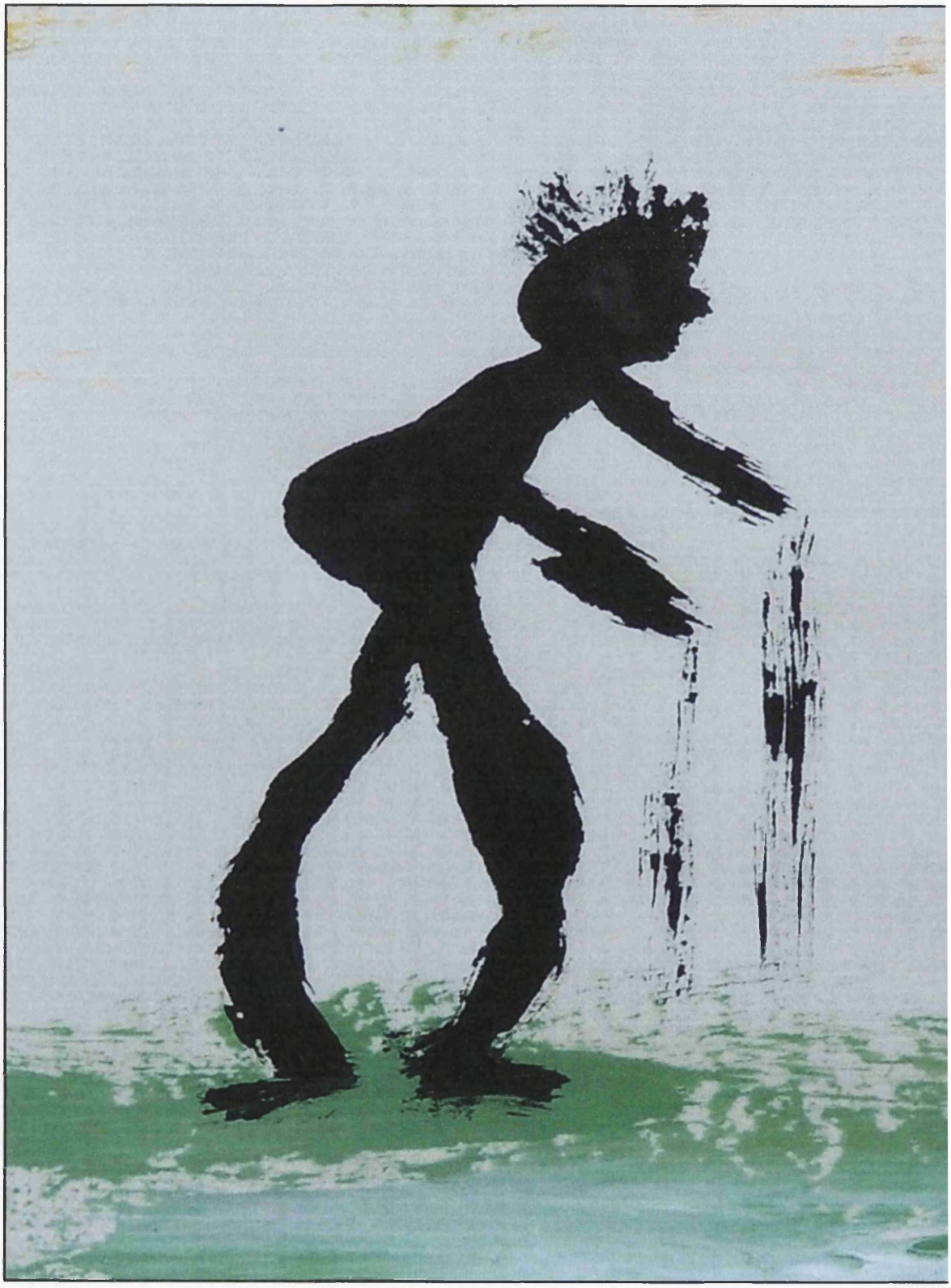
Ask yourself:	**Check YES or NO**
Is my plan simple?	**___ YES ___ NO**
Does my plan depend on me, not on somebody else's action?	**___ YES ___ NO**
Is it something to do, not something to stop doing?	**___ YES ___ NO**
Does my plan tell What? When? Where? How? How Many? and With whom I will do it?	**___ YES ___ NO**
Is my plan something I can do everyday or often?	**___ YES ___ NO**
Can my plan be done right now or very soon?	**___ YES ___ NO**
Have I promised someone or made a contract to do my plan?	**___ YES ___ NO**
Will I avoid doing anything that might wreck my plan before I even get started?	**___ YES ___ NO**

If most of your answers are Yes, your plan has a good chance for success.

How do you feel now?



APPENDIX X1
PAINTING OF BOY WITH SENSE OF PURPOSE
BY B(3)



APPENDIX X11 GROUP 2 PUPPET THEATRE

APPENDIX XII1 CLAY MODELS - FAMILY GROUP - L (1)

APPENDIX XIV
QUESTIONNAIRE ANSWERS

SELF-EVALUATIONS AFTER ONE MONTH

What do you think were the best things about the reality therapy programme?

Group 1

1. "I liked doing my action plan as it helped me to really focus on what was important to me – like making an effort to find new friends and stop hiding behind excuses. By writing it all down, I could take it in better and I hung my plan in my bedroom to remind myself that it was important to me." G(1)

2. "I know I've always had trouble with my behaviour, but doing this stuff has given me a guide to keep the lid on things and think about what I'm doing before I go and cause a mass catastrophe, like I always used to." L(1)

3. "I just liked being in the group with L and G. It made me realise that I can make a friend because now we're all friends, and that means a hell of a lot." M(1)

Group 2

4. "I liked the fact you didn't treat me like a freak, which other people like you have done before, but I would have liked to have seen you on my own - to have more special time. You accepted me for who I was and I liked that." E(2)

5. "I didn't like anything about the programme because I had to sit in the same room as L and E. I would have got more out of it if it had just been you and me, instead of having to defend myself and fight my corner." K(2)

6. "I've started the action plan - making me own things to wear -and I'm designing a few things. I love it because I can choose what colours and shapes I want, draw them out and fit them exactly. I'm actually quite good at it. Haven't stolen anything since you last came here; been too busy doing this stuff. Mum bought me some remnants and gave me a sewing machine that she saw going cheap – really nice - so things are better between us two as well." L(2)

Group 3

7. "I loved being able to really think about how the way I was behaving wasn't helping me, without being laughed at or judged. It seems obvious now that what I was doing wasn't working but when you're there, somehow it isn't." B(3)

8. "All the things we did as a group were terrific, in that lovely special room. We thought things through together and looked for ways in which we could try out new ideas. Everyone had their say and we all respected each other's contribution. It was so nice; I'll miss that most of all." E(3)

9. "Learning how to make friends was the best thing I got from it. I am actually putting into place some of the stuff I learnt in the group. For example, I asked.....to walk home with me and he said no. So I didn't push it and the next day he approached me and explained that he had to go to the dentist yesterday. Then we got talking. Before, I would have cried thinking that I'd been rejected and there was no other explanation." K(3)

What did you not like about the reality therapy programme?

Group 1

10. "I didn't like it at the beginning because I hadn't thought about trust before. But I learnt that to have a friend you do need to trust, and I really trust L now. I had so many things I was frightened about saying – that was the worst part – yes, feeling okay about being able to let go." G(1)

11. "I would have liked more time on the programme. I can feel I've started to really change already but I'm afraid that, now I'm back to my own resources, things will slip back because I know what I'm like." L(1)

12. "We seemed to rush along too fast. I loved the puppet theatre, the clay models and composing the song – but as soon as we'd done one thing it was on to something else. It would have been nice to have had time to wallow in our glory a bit and maybe to have done the puppets for the class, which would have earned us 'brownie points'. It was great, but too much to take in sometimes. I would have liked the programme to have been longer." M(1)

Group 2

13. "I hated doing the clay. Couldn't bear to touch it. And I didn't like having to confront my behaviours and pull them apart – like the clay. It made me feel uncomfortable because I realised that sometimes I wasn't handling things too well. I feel better now because I can go back to my old ways." E(2)

14. Talking about the real personal stuff was awful, with you trying to get inside my head. I didn't know you well enough for all that." K(2)

15. "I hated being in that filthy room. It made me feel that I didn't matter because no-one had bothered to make it nice for me. Even when you came early each week to try to make it better for us, I still felt second-rate and that there was no point." L(2)

Group 3

16. "I didn't like the times we weren't doing the reality therapy. It became part of my life because it made me realise that things didn't have to stay the same and that I did have choices." B(3)

17. "There was nothing which I didn't like about the programme. I thought it was really brilliant, except perhaps that...just as I was really getting to understand it, it seemed to be all over. Perhaps the only real drawback was that it didn't last long enough. I feel so much better already, so just imagine how fantastic I would have felt if I could have had more of the same!" E(3)

18. "It was embarrassing for me to begin with because the emphasis was so much on behaviour. I knew I was behaving in all sorts of weird ways, but you pretend it isn't happening or that it doesn't matter. Then someone like you comes along and makes you take stock of what it's all really about - and it's scary. It did me good to confront my demons, but boy was it scary!" K(3)

SELF-EVALUATIONS AT END OF SCHOOL YEAR

Do you now feel your life has changed for the better since you participated in the reality therapy programme?

Group 1

19. "I've really changed. Because I've learnt to confide, something I've never done before, I've found that it's made life so much easier for me. L and two other boys come back to my house after school sometimes and actually help me to do my jobs, so I have more time to enjoy myself afterwards. By learning to let other people in, I've learnt that I can be happier and less lonely." G(1)

20. "Me and G are really good mates now. I go and give him a hand with his mum and he comes fishing with me now on Saturdays. It's much less lonely sitting on the riverbank. Dad is okay, but he doesn't laugh at my jokes like G does. I don't go around pushing my way into crowds anymore. I've changed a lot in that way. I'd rather sit and draw with G and plan our next fishing trip." L(1)

21. "I'm happier than I've ever been before. The girls at school have started to include me and I got three invites to parties last month. Before I came to you, I hadn't had three invites since I started at the school! The girls tell me I've changed because I'm not so bossy. I do think about the way I behave now and work out if it's getting me what I want. I always remember that!" M(1)

Group 2

22. "I haven't changed. Still me and the Martians fighting lost causes. I *had* started to value myself a bit more because you made me feel that I wasn't a lost cause, but then I didn't see you and life went back to normal." E(2)

23. "No-one can change me. I'm beyond help, I reckon. I have been seeing a lady about the stuff I told you about. My step-dad doesn't live with us anymore and it's better. But the stuff I've got inside isn't going to be repaired by a few weeks with some do-gooder who's never been in my world." K(2)

24. "I did completely change for a while. Stopped all the thieving and that. I told you about the sewing stuff, didn't I? I got really busy making stuff for other people, partly to encourage them to be my mates. I charged them though and had loads of dosh, but then they started ripping me off. Taking the clothes and then refusing to pay for them. So I thought 'sod this' and you weren't around anymore, so I gave it all up. Back to me old ways, you might say." L(2)

Group 3

25. " I've made a couple of really nice friends - apart from K - because I didn't push myself onto them and took slow steps to build up a trusting relationship, like we talked about. I'm also allowed to go out on my own now. I think my parents can see I've changed and that I can now think for myself." B(3)

26. "I decided to start being myself instead of what I imagined others wanted me to be. I followed through with my action plan, which was to take responsibility for my own behaviour. It worked really quickly. I have a little picture of 'the behavioural suitcase' in my purse. When I start being pushy again, I get it out and remember the reality therapy stuff. Everyone has noticed how I've changed." E(3)

27. "Do you remember I told you about the boy I had made an acquaintance with, when you showed us that picture with the bridge? He is now a good friend because I came to realise that there was nothing to stop me approaching him. There was no mountain blocking my path or gorgon chasing me away. My fear was my enemy. Fear deep within. It was down to me to change that and make things different. I did. I'm not feeling empty anymore." K(3)

What would have made the experience more meaningful for you?

Group 1

28. "It would have been nice to have had maybe a couple of sessions where we all just got to know each other first, before all the heavy stuff." G(1)

29. "We talked an awful lot about choice, but perhaps we could have had more choice in people we worked with. However, having said that, I was really nervous about the group and it turned out to be great. If I'd had more choice, I would probably have missed the opportunity to really know G and M." L(1)

30. "I would have liked more background music because it relaxes me. I loved the calm atmosphere of that room. I felt truly shut away from the rest of the world in there. If we'd had a relaxing CD on in the background, it would have completed the experience for me." M(1)

Group 2

31. "There was not much meaning in my life then, and there is certainly none now, because life is not real. I enjoyed doing the reality therapy but it seemed unreal. My life is a bad dream most of the time - a struggle - and all I can do is try to blot it out. The time with you was a pleasant blip in space, which would have been nicer if I hadn't had to endure those awful girls." E(2)

32. "I don't understand the question. People like me don't talk about value, worth or all those other words you used in the therapy we had. Those words are for normal people, people with some chance. And don't tell me we make our own chances in life and have choices– which you did – yes, I took it all in - because when you're way down in the black survival pit, you don't have choices." K(2)

33. "I couldn't stand being in the same room as K. She wanted all the attention and acted up when she didn't get it, which made me behave badly. Although E was just about bearable, I would have preferred to have worked alone with you, especially with my problems. In the group, I didn't confide as much as I could have because I couldn't trust K not to put about what she'd heard." L(2)

Group 3

34. "It was hard trying to put my action plan into practice, trying to persuade my parents that I had made changes and was now more responsible. I could have done with some back-up, although I got there in the end. Another visit to school or even my home, midway between January and July, would have been good as the two follow-up interviews seemed a long way apart and the extra support would have been useful." B(3)

35. "Nothing. I loved the experience just as it was because I was made to feel like a special person. I like to think about the time we spent together. It was really meaningful because it was so intense and intimate. I needed that because I was agitated; I see that now. Yes, slipping into depression at being so alone and thinking about why I was even alive. Now things are different because *I* am different and those thoughts aren't so scary." E(3)

36. "I would have liked to have come for longer, like a little club or something. It's hard to give up something which was so good and made such a difference. It made me look at things in different ways and look for different solutions to solving problems. It's a shame more children couldn't have done it. Maybe there wouldn't be so many problems in school if everyone could learn about choices, inner control and self-responsibility. I think the whole school should have the chance to do this therapy and our group would have been the pioneers. That would truly have made the experience more meaningful to me." K(3)

APPENDIX V11 CHILD PROFILE FORMAT OBSERVATION SHEET

SectionA: Evidence of the Child's Anxiety / Ability to Cope	**not clear yet**	**hardly ever**	**sometimes**	**very often**	**usually**
Restless and unsettled					
Moves about the room inappropriately					
Appears worried, miserable					
Is tight and held-in					
Dominates group situations					
Fights with other children					
Bullies other children					
Is a victim of bullying/verbal abuse					
Can be assertive					
Responds to provocation from peers without over-reacting					
Able to share valued resources					
Able to share attention					
Respects other children's privacy					
Respects other people's property					
Values/takes care of own belongings					
Can tolerate unexpected events/changes in routine					
Can accept adult authority					
Able to relate with physical contact					
Considers the feelings of others					
Liked by other children					
Can make and keep friends					
Can independently negotiate with peers and take responsibility for the consequences					
Can cope with difficulties on a task without becoming unduly upset					
Values/takes care of own work					
Shows pleasure in own success					
Appreciates other children's achievements					

Section B: The Capacity to Acknowledge and Work on Difficulty					
Able to acknowledge own feelings of sadness, anger					
Able to acknowledge difficulties					
Accepts responsibility for own behaviour					
Able to use worksheets to discuss					
Can accept adult intervention					
Can **engage** in discussion about an area of difficulty					
Can **initiate** discussion with an adult about an area of difficulty					

Section C: The Child's Ability to Work on Tasks					
Has adequate concentration span					
Can accept help with a task when necessary					
Sustains interest in an activity until completion					
Uses own initiative when planning and carrying through a task					
Can aim for quality of achievement					
Can be co-operative with peers in group situations					
Can be co-operative with peers in unstructured situations					
Is able to use art-form(s) to express creativity					
Is able to use the written word creatively and imaginatively					
Is able to use guided meditation purposefully					

APPENDIX XV
POST-THERAPY INTERVIEWS

PARENT / CARER EVALUATIONS AFTER ONE MONTH

What would you consider have been the strengths and weaknesses of using reality therapy with your child?

Group 1

37. "G is such a good boy that I can't say his behaviour has really changed. What I have noticed is that he seems less worried about things. Poor lad carries the world on his shoulders because of me. I get very depressed and tired and spend long periods in bed, so G has to look after me. He never complains, mind you, but now he seems to have more of a spring in his step as if he is dealing with it all better. The programme definitely has made a difference in that way. I don't have any negative feelings about it at all. It has rescued G because he no longer has the attitude that life is a bit of a drudge." G(1)'s mother.

38. "A key strength, from my understanding of the therapy, was that it was not concerned about looking for a single root cause of L's behaviour, which all his other counselling has always focused on. This therapy was effective because it concentrated on how his problems were managed. That has been a turning point for my husband and I, just understanding how to deal with what we were presented with, rather than soul-searching for some mystical cause. Nothing derogatory to say about reality therapy. It's a shame so many other children couldn't benefit from it. God knows, some of them need it." L(1)'s mother.

39. "M has been enormously enthusiastic about being in her little group. She tells us everything is confidential and then spends all night rabbiting on about all the exciting things she's done. She's much happier now and we've noticed that her behaviour has greatly improved. She isn't so impulsive. She stops and thinks now before plunging straight in and, because of this, she appears to be starting up some new friendships, which is great for her. It's as shame the group has finished now. She'll be lost for something to talk about!" M(1)'s father.

Group 2

40. "E seems exactly the same to me. I don't think the therapy helped or hindered him. It would take a bomb to get a response from him – he's a nutter like me and it'll take more than a few meetings with you to change that." E(2)'s mother.

41. "I would say that K is possibly worse than when she began the therapy. It was really traumatic for her, especially revealing the abuse and that. The impact has been hard on us all and we're still seeing the police. It's ironic that just as you were gaining her trust, you had no option but to sort of

break it again, because of what she told you. That therapy gave her the confidence to shed this emotional burden she's had round her neck, but then it finished and she's left high and dry and having to start again with another person from the social worker, who has never heard of reality therapy. That's the way it always seems to have been. Just as you are getting somewhere, the help stops and something else takes its place. My feelings are that she's now too damaged to ever heal up – gone too deep – damaged goods I'm afraid, beyond hope of mending." K(2)'s mother.

42. "L is far more settled. I bought her a sewing machine and some bits of fabric because she said she was going to try to change. So far it's working and it's bringing us closer as she doesn't swear at me so much and isn't thieving. The programme seems to have made her more aware of her behaviour and I can see her pulling herself up sometimes when she's about to kick off. I don't have any complaints about it at all. Shame it's over. I just hope L can keep up the impetus herself without professional back-up. I don't have the expertise." L(2)'s mother.

Group 3

43. "The programme worked really well for B and we can both see changes already in behaviour. He's learned lots of techniques to regulate himself when his behaviour starts to slip. I don't need to dish out the discipline so much because he's almost self-disciplining. It's a brilliant therapy in that it teaches self-responsibility. We like that, coming from our police backgrounds. What a shame these techniques aren't better known in this country. It would have be good if parents had been able to do a course as well, so we could really reinforce the techniques at home. That would be our only criticism." B(3)'s father.

44. "E is a much happier young lady and is starting to socialise, which is so lovely for her. As her carer, I do worry that she mixes with us oldies all the time – so yes, the therapy has really taught her how to interact and assess her own behaviour. My only criticism is that she could have done with longer. Sometimes it takes a while to get into these things and then - hey presto - it's finished." E(3)'s grandmother.

45. "K has an almost permanent smile on his face these days. It's a joy to see because he is starting to make friends and overcome all that terrible embarrassment he used to have. He has more confidence and just seems more at ease with himself and the rest of the world. I haven't had a cross word for him in several weeks and I can really see a change in him, thanks to the reality therapy he's had. Fantastic. Pity it's over, but I'm sure he's over the hill - and he's done it for himself." K(3)'s mother.

PARENT / CARER EVALUATIONS AT END OF SCHOOL YEAR

Have you noticed any significant social behavioural change in your child in the last six months?

Group 1

46. "G has three good friends now, who regularly come to the house and help him to help me. It's good all round because it makes him happy, so it makes me happy. This depression pulls me down so much that the last thing I need is G mopping about and looking worn out. Yes, he's a different boy – not isolated anymore. His eyes light up when his friends come round. The therapy has been an outstanding success and has completely changed his personality because now he's always positive and outgoing. I wish I could be the same." G(1)'s mother.

47. "All that pent-up aggression seems to have disappeared. G is his best friend now and they go fishing together. L isn't lost anymore and needing to take out his frustration on the world. He's learn to regulate his own behaviour and keep it in check. When he changes school in two months, I don't think he'll need further behavioural support. That seems to be a thing of the past." L(1)'s mother.

48. "She's so much happier; the difference is unbelievable. She has a little band of friends now and is getting invites to parties. Last year, she said she didn't want a party of her own. It was, I think, because she knew that no-one would go and she couldn't face the rejection. It's a different kettle of fish this year though. She's already planning it and, at weekends, making little personalised gifts for her party bags. I feel I have got my daughter back again after several years in the wilderness." M(1)'s father.

Group 2

49. "He still has his computer friends, them space creatures and that. He don't even go for real people on the chatrooms. I can't understand it. But proper friends - no. We don't have room for people round our place anyhow and me other kids are always fighting so I don't want him to bring other buggers in. He can stay as he is, as far as I'm concerned." E(2)'s mother.

50. "K is better than she was, although she still has a huge uphill struggle. She doesn't have any friends still because her behaviour is still pushing them away. Her other lady she's been seeing say's she's deliberately isolating herself, but we knew that. She can't or won't let anyone in – not even me. I'm not sure whether she'll ever be properly right in the head." K(2)'s mother.

51. "L was doing so well and I was really proud of her. But now – it's exactly as it used to be; as if the therapy course never happened. I feel powerless. She thought she had some friends she could trust but they ended up making a fool of her. She couldn't handle it and without you, didn't have

the coping mechanism to overcome it. So she's back stealing and giving me grief. Because of everything in her past, maybe a girl like her will never change." L(2)'s mother.

Group 3

52. "Both my wife and I can see a big change. We all discussed the reality therapy together and B really seems to have taken all the theory about taking responsibility for his own actions on board. As a result, we have started to back down and trust him more. He's allowed out on his own now, which was always a big issue for him. Because he's out and about, he's found a couple of friends -although we do insist on vetting them. K, who was in his group, is a particular friend. We approve of him. Yes, all good changes for the better we are pleased to report." B(3)'s father.

53. "E has this little picture of a suitcase in her purse and she keeps consulting it. She tells me she's doing self-evaluation of her behaviour. Sounds very impressive! But she has changed in lots of ways in these last six months. Less pushy and aggressive. Calmer, more at peace with herself. Yes, big changes. She regularly has girlfriends around now and she doesn't dominate them anymore or show-off, which used to put them off." E(3)'s grandmother.

54. "The fairies have come and given us a different son! His attitude has completely changed in the last six months. Things don't seem to get on top of him like they used to. He can actually laugh off problems now and look for some 'scientific' explanation. He always was a little professor, mind you. He has a friend who walks with him when he takes his dad to the club and he sees a couple of others. No more hiding in the corner when the doorbell rings." K(3)'s mother.

SCHOOL STAFF EVALUATIONS AFTER ONE MONTH.

What would you consider have been the strengths and weaknesses of using reality therapy with your pupils?

Group 1

55. "I am not so worried about G as I was before the therapy commenced. He is looking less drained and seems to be joining in more, without waiting to be asked. I think undertaking the therapy made him feel special and, of course, he has struck up a friendship with L, which is good for both of them. L needs the stability which G can give him and he seems to have calmed down because he doesn't have to prove himself anymore. The therapy worked in much the same way on M. She used to be highly neurotic but she's calmer now and less compulsive. Both L and M could have done with more therapy, considering the length of time they've had problems. L had a whole course of psychodynamic counselling which did little good. This therapy has worked a treat for him though. No real

weaknesses except it needed to be longer - over more weeks I mean - and it would have been good if you could have trained my staff to further implement it." Head.

56. "G is the same old fella he always was, helpful and unassuming, but he seems happier now and his work this last couple of weeks has been outstanding because I've noticed that his concentration has improved. L is such a changed soul that I've redeployed his teaching assistant to other duties as he hasn't acted up at all this term. M is still noisy. I think that's just her though, but she is noisy happy instead of noisy frustrated. Big difference. The strength of this therapy appears to be that it works on different personality types. G is very different to the other two and yet it worked equally well with all of them. Nothing bad to say about it, except it's not well known enough. I'd have liked my own kids to get some of it, but no-one's ever heard of reality therapy!" Class teacher.

57. "I am M's one-to-one helper for her semantic pragmatic condition. It means she can't always communicate in an appropriate way either behaviourally or socially. I haven't got any criticism of the therapy at all. It seems to have improved her condition, although I realise it's early days. She is more socially aware now and thinks before jumping in and pushing herself onto others. By backing off, other children are coming to her instead; it's really interesting to see. Her behaviour is better too. Still over-the-top but in more acceptable ways now. I shouldn't say this, but the therapy seems to have been so effective that I'm worried I might not have a job for such longer!" Teaching assistant.

Group 2

58. "The reality therapy didn't work as well as I had hoped. I haven't noticed a significant change in either K or E, although we've had less trouble with L and she does seem to have settled down a bit. K, on the other hand, is a wild-cat at the moment since the abuse allegations. It's a difficult time for her. I truly believe that these three individuals are beyond help, other than that provided by some sort of psychiatric institution. It seems that K has been living in an abusive household for years, not allowed out because of mother's neurosis - so trapped and forgotten. E has mental health problems of his own, reinforced by cuckoo parents. What sort of upbringing is that? L's mum does try, but she's weak and worn-down by her own demons. L is trying to change, but there is only so much we can do here and mum isn't in a position mentally to back us up. The therapy was too short and didn't even get to the core of the damage. There maybe wasn't time to build up the necessary amount of trust between you, although K did feel safe enough to disclose. I'm sure children with less emotional turbulence would benefit from reality therapy but these kids need *intense* therapy – constant daily reinforcement. They also need parental back-up, which none of them really have, and time to heal from past wounds before any sort of motivational process could ever take effect. As a school, we do our best but our 'counsellors' aren't trained to a high enough standard to deal with such profound disturbance and we, as a school, can't give them the amount of time they really need." Head.

59. "I don't think the therapy was concentrated enough. K, E and L all needed to address issues from the past before they could sort out their present lives and ways they behaved in social situations. From my understanding of what they did, the focus was more about setting the past aside and analysing present behaviour. I'm not sure that philosophy works with children who have been utterly mentally destroyed. I think they should have come to terms with the past first to enable them to move to the stage you were at. L is the only one of the three to have improved slightly. However, her mother isn't always emotionally available for her and without that, I fear she'll slip back again." Class teacher.

60. "I'm a general teaching assistant assigned to the class. The majority of my time is spent with K and L because of their behaviour. I don't really have much to do with E at all, because he just sits and dreams all day, so I don't need to 'keep the lid' on him. I think the therapy has helped L because she doesn't appear to be so angry anymore and has settled down to her work. I have noticed a definite change there. As for K, what can I say? She's the most disturbed and difficult pupil I have ever worked with in my thirty years experience. She is such a nasty piece of work that it is difficult to have either sympathy or empathy. I haven't seen any improvement in her at all since she did the reality therapy. We do humanistic counselling at this school, which had no effect either. L had some too, but to no avail– at least your therapy seems to have 'cut through' a lot of stuff with her. One observation I did make was that it didn't seem the best of ideas to put the three of them together in a group. Kids like K and L are too competitive to work together. I always separate them or it's warfare in the classroom. Difficult children need more the one-to-one touch so they don't feel threatened and are made to feel special." Teaching assistant.

Group 3

61. "No weaknesses. I liked this therapy very much and would like to use it more in the future on other pupils who have emotional difficulties of some kind or another. One of its key strengths appeared to be the idea that the meaning you attach to any sort of event influences the emotional responses you have to that event. I talked a lot about that to B and K when we were sitting outside one day. They found that very helpful. I also like the fact that this therapy was about normalising your emotions, physical sensations and thoughts rather than persuading you that they're clues to 'hidden' problems. I think we can look too deep within ourselves sometimes. I know that's necessary with psychiatric problems, but E, K and B aren't in that category. They're all just normal kids who, for whatever reason, have lost their way socially. This therapy gave them a roadmap, if you like, to find their way back. And it's worked. They're all happier and seem better adjusted on a social and emotional level." Head.

62. "One thing I thought was fascinating about reality therapy was that it made the kids understand that you can develop emotional problems *about* your emotional problems. K was, before, a typical example of that in that he seemed ashamed about being depressed. As he's an intelligent lad, he's digested all that and has already started to change his behaviour. B

has stopped being the prize goof and is starting to gain acceptance from the rest of the class as a result. E is really into the learning techniques you've shown her and is always quoting some behavioural suitcase. The therapy seems particularly effective because it emphasises self-help. E was too reliant on her grandmother before. Now she's becoming more independent. I don't think reality therapy had any detrimental effect on these three children at all." Class teacher.

63. "All three of your therapy group were very different little people. They were all lonely but their ways of coping with this were very different. Reality therapy worked across the board, so I've no criticisms at all." Teaching assistant.

SCHOOL STAFF EVALUATIONS AT END OF SCHOOL YEAR

Have you noticed any significant social behavioural change in your pupils in the last six months?

Group 1

64. "I am pleased to say that the social behavioural change in all three pupils over the last six months has been significant. M had no friends at all when she started your programme. She was a rejected little girl whose only social contact all day was her teaching assistant. I noticed a change back in January, but now she has had time to blossom into this delightful creature who is popular and behaves ninety per cent of the time very appropriately. L, likewise, is a changed character. The violence and aggression is under control - his control - because he can now self-evaluate his own behaviour. He gets on like a house on fire with G and they are amazingly good for one another. L brings out the reticence in G and G has a calming effect on L. A great team. Both also have other friends too, not many - but that doesn't matter. The important thing is that behaviourally, there have been very positive changes. G looks much more refreshed too these days because a lot of his home pressure has disappeared, thanks to some accommodating mates. An excellent result." Head.

65. "It's unbelievable to think that only a few months ago, all three of these children had zero friends, were behaving inappropriately and were dead unhappy. All of them are now looking forward to going to their new school and have the confidence to socially make a success of it. I dread to think how it would have been if they had not undertaken the project. The change in their social behaviour can be seen by just watching them. G no longer hides away, waiting to be approached. He now has the confidence to assert himself. L is no longer a bully and is considerate towards the needs of others – unheard of before you came along. M is now able to express her needs in ways which do not automatically put others on the defensive, henceforth rejecting her. These three have really emotionally grown and developed in the last six months." Class teacher.

66. "M was a girl who was sad and lonely – and this came across in everything that she did. Even in January, she was still on an uphill struggle. But now she has changed beyond recognition. I was supposed to be going up to her next school with her to assist continuity, but now she will probably be going it alone. She doesn't want or need a one-to-one anymore. Her condition is being reassessed and I shall tell them that her improvement has been down to her course of reality therapy. I know exactly what they'll say: 'What's that?!'" Teaching assistant.

Group 2

67. "There was a glimmer of hope with L. When I last spoke to you, I mentioned that there had been a slight improvement and mum had told me that things were much better at home. That, I'm afraid, has been annihilated. L is back to her old ways, stealing and running out of class again. She is exactly back to square one because we were not able to give her the intense support she obviously needed to keep her strategies up. Mother did her best but they don't have a mother and daughter relationship because mother can act like the dependent child and often comforts herself with a drink too many. It's very sad, because out of the three of them, L was probably the one who could have fought against the odds. She started to mix and interact well but then there was a fight over non-payment of some garment which L had made for a friend. I think L felt betrayed and gave up after that. K was 'out of her tree' for several weeks whilst the police were interviewing her. But there has been no social behavioural change for the better since then. She is still friendless and despised by the class. E has not made a change for the better either. He has severe mental problems. His fantasies are taking over his life and he is fast losing his grip on reality. He's a disaster waiting to happen. Too late, too damaged - all of them I'm afraid." Head.

68. "I'm leaving teaching at the end of the year, changing career completely and a lot of it has been down to those three kids. They have made my life a living nightmare in the last six months. K is still an awful child, worse every day....yes, I'd say she's actually got worse. God knows I've tried, but I'm not a shrink and I can't handle her. L improved, then got into a fight where she tried to strangle another girl whom she thought was her friend. It's terribly sad because L *was* becoming socially competent, but then the girl let her down badly and L couldn't find it within herself to handle the rejection or build up trust again. E still displays scary behaviour. He has no new friends, although he'd disagree, but they're all in his mind - imaginary ones. I worry what will become of them all, even though they've driven me crazy." Class teacher.

69. "The goodwill which L was showing last time you were here has completely disappeared and she is now as difficult as ever. If the therapy had been longer, maybe you could have kept her on track. We certainly haven't been able to. Since she's stopped her fashion designing, she seems to have no sense of purpose anymore. K will try to pick a fight with her at every opportunity and neither of them have any friends. They certainly can't stand the sight of one another. E is also friendless. He's much the same as six months ago, still in a world of his own. I wonder how you can change children like that." Teaching assistant.

Group 3

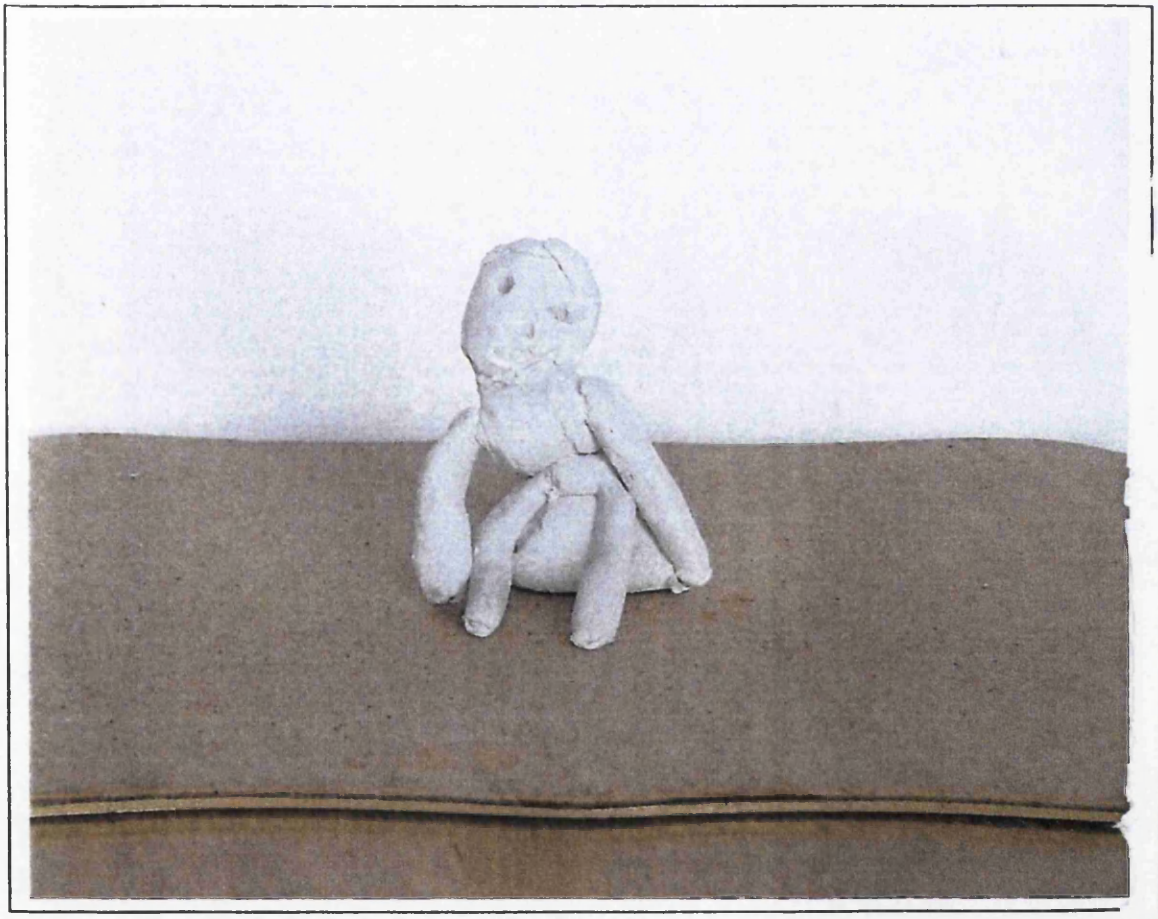
70. "There has been an enormous change in the social habits of all three children. B seemed to grow up almost overnight and is now responsible and sensible. He has a good friendship with K, who now exudes confidence and has far more mature emotional responses. Both boys can now rationalise their social behaviour and self-evaluate the changes they need to make. They love analysing the psychological explanations of their own behaviour. Neither has a wide circle of friends, but that's just fine with them. I think they like the closeness of intimate relationships far more. E has been accepted into her peer group again because she has normalised her emotions and doesn't push herself forward in unacceptable ways. Yes, all three children have made significant social behavioural changes in these last six months. I am so pleased for them." Head.

71. "Yes I really have noticed a marked improvement in behavioural relationships within the last six months. A while back, we decided to update our 'buddy' scheme in the playground for children who had no-one to play with or who felt overwhelmed out there. Guess who are the main daily players in this scheme now? K and B! Not as lonely children, mind you, but as leaders in organising games and approaching others who look a little lost. I would never have believed it six months ago! They do it together as a joint effort and spend hours huddled together developing further ideas and plans. It gives them a real purpose in life. I suppose E is doing a similar thing. I understand that the famous pony, which once caused so much jealousy, is now coming to the school fair for E to give pony rides to others. It's wonderful to see all three of them radiating confidence at last and finally having a future to look forward to." Class teacher.

72. "`All three children are much more at ease in the company of others. I'm often outside with them and they are all able to play properly now. It used to upset me to see K standing on the perimeter of the field looking lost and dejected. Now, not only does he join in, but he actually organises activities. He's had a real boost of confidence. I used to watch B too, getting on everyone's nerves as he bombarded his way into the games of others and then got mad when they told him to get lost. He's far more sensitive and socially aware these days. E doesn't show-off either and is happy just to be one of the crowd." Teaching assistant.

APPENDIX XVI

"NEEDING A FRIEND"



FROM FAMILY GROUP BY L(1)