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FOCUS ON EXCEPTIONAL CHILDREN

Therapeutic Discussion Groups in Public School Classes for Emotionally Disturbed Children

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The Montgomery County, Pennsylvania, Intermediate Unit Learning and Adjustment (L & A) Program has operated quality programs for emotionally disturbed children for 15 years. Beginning with one class located at a mental health clinic facility in 1964, the program has grown to over 100 classes from kindergarten through high school, located in regular elementary and secondary schools throughout the county. These programs provide a cascade of services ranging from itinerant support to children in the mainstream, to resource rooms, to part-time classes, to self-contained classes, to five classes located at a state hospital facility.

After the first year of operation at a clinic, we noted the many drawbacks to working with those children in an isolated setting and subsequently chose to house new classes within the regular public schools (Anderson & Marrone, Book One, 1978). This major decision in the direction of programming in the least restrictive environment (LRE) at a time when many programs were being started in centers was an important one. It helps us understand the day-to-day difficulties of emotionally disturbed children in being accepted by and coping with those in the regular school milieu — thus, pointing to the need for specific program components designed to deal with the children's emotional problems. Programs for the physically handicapped incorporated physical and occupational therapy, and programs for the sensory impaired incorporated specialized equipment and techniques for helping students compensate for their handicaps. It was equally important to build in the L & A Program methods and techniques for dealing with children's emotional handicaps.

Initially, we had attempted to meet this need by requiring each student accepted into the program to be in psychotherapeutic treatment either privately or through mental health clinics. Several problems developed, however, in regard to this requirement. First, many parents of the candidate children could not sustain the

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treatment either economically or emotionally. Second, the students referred for placement frequently came from families whose problems made it difficult for them to seek outside help. Third, hours of time each week were required for communication between the children's teacher and the therapist. Fourth, the special education teachers thought that the therapists' suggestions were impractical and not pertinent to the teachers' work with groups of children in public schools. Fifth, the therapists believed that the teachers were mishandling some of their patients because the teachers lacked understanding of the psychodynamics of their patients

Provisions had to be made for mental health services for all the emotionally disturbed children in the special education classes, regardless of parental resources and commitment. Such provisions would have to be economically feasible within the public schools' funding capabilities and, in addition, the gulf between the teachers who were working with the children 35 hours per week and the therapists who were seeing the children one to three hours per week had to be resolved if the children were to progress.

Therefore, we decided to employ mental health professionals to work directly with the students and their teachers in the classrooms. A controlled trial of individual versus group versus no therapeutic treatment for one year yielded results that clearly pointed to advantages of the group therapeutic approach with these children. The greatest benefit of conducting therapeutic discussion groups in the classroom was the opportunity for the therapists to train the teachers and teacher aides in psychotherapeutic techniques and understandings and for the teachers to train the therapists in group educational methods and procedures. With these professionals working together on a weekly basis, communications were enhanced and the children benefited.

In working within this group therapy model, we noted several additional benefits:

1. The groups became an effective vehicle for providing support to teachers, since the teachers were a part of the team working with the child. This was corroborated by continued teacher enthusiasm for their work.
2. The groups provided set times for teachers to listen to children and for children to listen to children.
3. The groups provided time in the curriculum for dealing with the children's affective needs in the areas of understanding self and others.
4. The groups enabled the mental health professionals to identify ongoing changes that would permit early intervention in cases of potentially severe pathology.
5. The groups provided encouragement for improvement in the students' behaviors.
6. The groups showed a ripple effect of empathy, concern, and caring for others through training children as therapeutic change agents and through modeling this behavior by the adults.
7. The training in psychodynamic understandings that occurred through the therapeutic discussion groups assisted teachers in choosing appropriate methods and techniques for dealing differentially with the students' behaviors — thus, diminishing classroom management difficulties.

PROGRAM APPROACHES/CASE STUDIES

The therapeutic element of the L & A Program focuses on the individual and group, in attempting to ameliorate symptoms and change behaviors. The following discussion relates to observed behavior disorders of the emotionally disturbed children most frequently in the L & A program, and uses case descriptions to demonstrate situations representative of the whole.

For Psychosis

The initial therapeutic goal for psychotic children is to have them *attain observed appropriate behavior.* The

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superficiality of this goal is obvious, but to allow bizarre activity to continue would further alienate the child from others. The program seeks to accomplish this initial goal through several methods: (1) a behavioral modification system rewarding appropriate responses; (2) a clear verbalization to the child, with group support, stating that the child's behavior (or verbalization) is out-of-line (taking a strong position of nonacceptance); and (3) acceptance of compulsive activities temporarily, if they approximate appropriate activity (recognizing that constant repetition represents the individual's attempts to control the psychosis).

For example, Dennis, a childhood schizophrenic), perseverated on reading library cards on the backs of books. Since the behavior was not overtly offensive, he was allowed to use this defense and hopefully modify it toward compulsive reading of the books themselves! This allowed the group and individual work to be directed toward more significant goals than eliminating Dennis' compulsive but inoffensive behavior.

The goal that is most therapeutic but harder to obtain is to *improve interaction with others.* In the program, this process is initiated by encouraging interaction with one other person (child or adult). When the involvement is between the psychotic child and a second child, the teacher must praise and reinforce both children. In this situation, identification with the teacher and/or therapist is essential for the second child to persevere in trying to relate with a child thought of as "weird." As time goes on, this "circle of two" is expanded through group process to include more youngsters and adults. The hope is that the psychotic child will increase his or her contact with reality through increased interaction with other people who reinforce this reality — a goal that is possible only if the child's overt behavior is appropriate enough to prevent rejection and interruption of those necessary relationships. The following example illustrates this discussion.

Don had been unable to function in nursery school or kindergarten. His parents had taken him to several hospital clinics for evaluation, and the diagnosis was childhood schizophrenia. At six years of age, Don was admitted to the L & A Program. In our classes, he was constantly engaging in bizarre behaviors. For example, he ran to hide in the coat closet when strangers entered the room. When one of the students in the class said, "Don, you're a pumpkin," Don grasped his head in his hands and screamed, "I'm a pumpkin! I'm a pumpkin!"

Don could read words and perform simple arithmetic computations. At age eight when he was to go with the class to the Museum of Natural History, Don asked his teacher, "Is a brontosaurus carnivorous or herbivorous?" Yet, during that same period of time, when another student said, "Don, you're a chocolate bar," he gradually sank to the pavement and lay as if melted from the heat of the sun.

Initially, Don had to be supported in the group by his teacher's presence in the chair next to him and protected from one child in the group who constantly tried to upset him by whispering, "Don, your lunch is poisoned," or "Don, the ball is a bomb that will explode in your face." This tormenting child who verbally attacked Don was a source of concern to the teachers of the class. They thought that Don was going to be pushed even further over the edge by these behaviors and, as a result, were increasingly angry toward Don's tormentor.

The therapist was instrumental in two areas of this concern. First, in the therapist's opinion, Don's psychosis functioned in itself to frighten him more than any words from another child. In fact, Don's responsiveness to the other children (albeit inappropriate) was evidence that he had not completely withdrawn from human contact. Also, the ability of Don's ego to use adult support in these situations was a good prognostic sign — which provided reassurance to the teachers. The second insight that assisted the teachers and the group to function positively for Don and the other children was the therapist's explanation of *why* the other children overtly tormented Don: His aberrant behavior was terrifying to them. The only defense that seemed to stand between Don's "craziness" and their own natural but frightening impulses was a total rejection (manifested by ridicule) of Don and, therefore, of their own fear of loss of control leading to insanity.

The adults in the group sessions repeatedly interpreted to the children the awareness of these fears with reassurance that, first, Don's problem was not a "catching illness" and there need be no fear of it spreading and, second, the youngsters' fears were understandable (this was coupled with reinforcement of their growing ability to handle themselves). The wisdom of this approach was manifested by the children's increasing success in achieving their behavioral goals. The teachers' attitude that "we are not afraid of your thoughts and feelings; we can accept them and we will assure you that no one will be abandoned in a state of non-control" helped the children begin to be comfortable with Don. As this comfort increased, the group's assistance in reinforcing reality and supporting Don began to have a profound and gratifying effect.

Gradually, Don was able to hear some of the other students' concerns about how he embarrassed them when he talked "crazy talk" or when he ran in fear from a rubber ball. After seven years in the groups, Don cried real tears when some of the students said they were disappointed in the way he had behaved at an assembly. This was the first time he had ever cried because his feelings were hurt, not out of fear. He had formed a meaningful relationship with the other students in the group, based upon caring and trust.

The group had helped the other students understand Don's retreat from reality and its basis in fear. Thus, group members in addition to the teachers and therapist were able to assist in his treatment. They reminded Don when his behavior was not appropriate, and they protected him from regular junior high students who cruelly attacked Don by snapping towels at him in the boys' locker room. While the group was helping him with practical suggestions for dealing with the symptoms of his illness, they also were working to understand the basis for the fears and terror that were real to him. This understanding and support, coupled with practical suggestions for dealing with his symptoms, helped Don improve. Many psychotic children are like diabetics — we may not have found a cure, but we can help them cope and thus minimize their symptoms.

After nine years in the program, Don was finally mainstreamed into regular classes and subsequently graduated from high school.

For Passive Aggression

Gary was referred to the program when he was ten years old and in the fifth grade. Although Gary's father had high expectations for his son, he was not able to give to him emotionally. Gary's mother had been chronically depressed, having had an unhappy childhood. She received little in the way of love and affection from her husband, who traveled a great deal in his job. When Gary was seven, his mother placed his nine-year-old brother in a residential school for disturbed children, where he has remained to date.

Although Gary's IQ was 150, he had a great deal of difficulty organizing his work and achieving in school. Far more significant was his capacity to evoke anger in adults within minutes and children within seconds. Unlike many of the passive aggressive students in the L & A Program who have difficulty doing their assigned work because their "pencil broke and they have to sharpen it . . . they have to go to the bathroom . . . they can't find their book . . . they did their homework but a dog jumped on them and tore it up . . . they're trying but the boy behind them keeps bothering them," Gary's intelligence allowed him the ability to be much more subtle.

For example, after being out ill for three weeks in seventh grade, he returned with a note from his physician requesting a special limited physical education program for Gary. He showed the note to his teacher and said that he'd take it to the gym instructor. One month later his parents and special education teacher were upset to hear that Gary was failing physical education. When the special education teacher began pursuing the cause, the physical education teacher said he'd never seen the note and because Gary did not participate in the activities, he was failing. His parents said he'd taken the note to school, and the special education teacher verified this statement. When questioned about the note, Gary just smiled and shrugged.

Gary had an infuriating manner of looking, smiling, and shrugging. He also had a great knack for selecting aggressive students with short tempers whom he could inevitably provoke. For example, at a track meet, a boy from another school was ready to take on Gary in a fight without a word being exchanged between the two, for no apparent observed reason — they didn't even know each other. On another occasion, a regular education student knocked Gary's two front teeth loose while Gary was walking in the hallway to one of his mainstreamed classes. At home, Gary volunteered to help his father mow their lawn several times, but the mower uncannily broke each time. Gary was not able to admit any feelings and always appeared unconcerned.

Passive aggressive children present a unique problem to teachers because they differ so greatly from the overt openly hostile child. Overt children present clearly observed behaviors, and strategies exist for dealing with them. Teachers frequently feel more comfortable and hold genuine warmth for a tough little guy who lets people know loud and clear where he's coming from; they might be angry at the behaviors but can rejoice at the gains as they see both the child's *and* their successes.

Passive aggressive children are different. People find themselves furious at these children but feel guilty about it because "Tom is so sweet to adults." He may whisper in an ear, "You're the best teacher I ever had," just when that teacher is about to blow up because Tom has forgotten his homework for the thirteenth time in 14 days. He is so helpful and fawning that the teacher secretly wishes "Butch" would cream him. We believe this intense feeling of exasperated anger in situations in which no clear behavior exists is diagnostic of a passive aggressive behavioral disorder.

We look upon children like Gary as "sockets." They are always available to set off someone else but never seem to have been the source of the spark. The group therapeutic discussion approach is most helpful in dealing with this deeply entrenched disorder.

After initially supporting Gary in his dealings with others, the therapist began to point out in the group how Gary's behaviors were angering others. During this time, the therapist cautioned the other children to stay out of it by saying, "He's fishing with some powerful bait. Don't let him sucker you in. Don't let him hook you." Too, it has been helpful to praise group members whenever they do not respond to the provocations.

After a number of such group sessions, it was sufficient to say to Gary, "You're doing it again. Sad try." Following Gary's recognition of what he was doing to make others angry, the therapist began to help him understand that he was evoking anger in others because he had not been able to deal openly with his own anger. Although Gary's mother appeared to give to him on a superficial level, she had been undercutting and rejecting him since birth. The father had overly high expectations for his two sons, which neither could attain, and Gary did not have an opportunity to express anger at being rejected. As he learned to openly express his anger, he had less need to provoke others. The group was supporting his attempts to handle his feelings more directly.

Someday Gary should be able to find a mate who will love and care for him — feelings he probably will never be able to obtain from his parents. His eventual success or failure in meeting his own basic needs will depend upon his ability to sublimate his own aggressive feelings in achievements at work, along with his ability to make himself a more lovable, caring person. Without the therapeutic discussion groups to help the others in his class understand and deal with Gary more effectively, he would not have been able to survive in school. More important, unless such insight and change occur in passive aggressive children, they will continue this self-destructive behavior through the rest of their lives. The result may not be violent, but nonetheless devastating. Employers, fellow workers, and the community will simply fire them or reject them.

For Depression

Jane was referred to the L & A Program at age thirteen and in the seventh grade. Her family consisted of an alcoholic father who had been in and out of the hospital, a narcissistic mother who used her children to satisfy her own emotional needs but was unable to give anything to them, a nineteen-year-old brother who had withdrawn from social contacts and spent most of his time in his room reading about the Civil War or staring at the walls, and a ten-year-old brother who was in trouble for stealing, vandalizing, and being disruptive in school. This younger brother also was referred to our program.

Jane had always been hyperactive. Her behavior early in life was seen by her mother as "bad" and "disobedient." Of greater significance, her mother saw Jane as being in the way and causing trouble that interfered with the mother's life. When the father was sober, he was loving and giving, but these periods were few and far between. At home, Jane had been expected to wait on her brothers, prepare meals, and clean up after her father. At school, she had been disruptive and had thrown temper tantrums. She consistently had placed herself in dangerous situations, such as the time she hitched a ride with three young men who had been drinking. Luckily, the police stopped the car before they had an opportunity to harm her.

Jane's mother's response to this and Jane's other behaviors was to call Child Welfare and tell them that she could no longer deal with Jane because she was incorrigible. Child Welfare placed Jane in a foster home for eight months, during which time Jane continued to be disruptive. She was returned to her parents in November of her sixth grade year. The first three months after her return, she managed to avoid the overt behavior that had gotten her into trouble initially, but had started to smoke marijuana on a regular basis and began to experiment with other drugs. She was referred to the L & A Program in March and entered the class in April.

When it was clear that Jane was going to be a member of the class, the therapist began to prepare the group for her entry. As might be expected, Jane's melding into the group was a difficult process. Jane's need to test her new situation, classmates, and teachers was verbally provocative and negative. The group, on the other hand, was fiercely defensive of its teachers and other group members. The situation remained rather stormy until mid-May when, in a group discussion, Jane opened up her concern about her father's health. She said, "My father has been told that he's going to die if he doesn't stop drinking, and he won't stop. I've tried to keep him from drinking. I took the bottles and poured the booze down the drain, but he just goes out and buys more." This opening of her feelings resulted in a supportive response from the group. Bill said, "Why don't you pour out half the booze and fill the rest with iced tea?" Al-

though this suggestion did not represent a practical solution, it was the first indication to Jane of a supportive response from the group. This was a significant breakthrough leading to Jane's acceptance by the other students.

Summer, unfortunately, was a difficult time for Jane, with continuing drug abuse and problems at home, but throughout the next school year the therapist and teachers worked with Jane in group along the following lines: "You may feel pretty crummy about yourself, but we know you're a valuable human being. We care about you. We care what happens to you. We wish you wouldn't do things that hurt you. We know you feel you are 'bad' and 'no good', but we like you. We feel sorry that you are behaving in a way to get other people to reject you." Eventually, as Jane began to feel supported by the group, the therapist began to introduce the thoughts that: "Just because your folks have had difficulties in their lives is no reason for you to mess up your life. From this point on, what are you going to do about *you*? You have a choice to make. You can go down the tube or you can decide to do what's best for you."

This process provided the caring and love Jane needed to support a change in her self-image, which in turn led to less anger and frustration. It eventually resulted in improved behavior toward others, which produced more positive feedback. The therapeutic process was supported by all members of the group. As Jane began to feel better about herself, she demonstrated less need to abuse drugs, place herself in dangerous situations, and engage in behavior that evoked rejection from others.

Unlike adults, who have greater ability to identify and verbalize their depression feelings, young children are harder pressed to express the agony they feel. We have found in our years of working with emotionally disturbed youngsters that depression has a course which, although more readily identified in late adolescence and adulthood, is often disguised in childhood. We believe that the dynamics occurring in depressed children are as follows: The child is born with deep and strong needs for love, care, and acceptance from a love object — usually parents. When circumstances block this need from being fulfilled, for any number of reasons, the result is frustration and anger in the child. In Jane's case, the unfulfillment was caused in part by her mother's narcissistic inability to give. In other cases, the reason for the deficiency in the love object could be emotional withdrawal, physical illness, or separation. Even death is perceived by children as a block and frustration of their emotional needs.

The observable behavior seen in young elementary-aged children is not only the sad withdrawal of a rejected child, but more frequently approximates the angry howl of a frustrated and furious infant in pain. This manifests itself in outbursts of aggression toward people, destructive and frequently self-dangerous attacks upon the environment. Observation of a child named George may help to illustrate.

George's mother had been ill during her pregnancy with George. She had developed toxemia with persistent hypertension, which caused her to be hospitalized after his birth and frequently bedfast during his first two years. George had been told by his visiting grandparents that he had "almost killed your mother" and that he shouldn't ask her for so much.

George came to school as a frustrated and angry child. He was considered by his kindergarten and first grade teachers to be terribly disruptive, and he spent most of his first two years of school sitting in the principal's office. George's behavior problems continued after enrollment in the L & A Program. He was seen laughing almost hysterically while destroying other children's papers and his own work.

One day George bolted from the room and ran up a flight of stairs leading to the school's attic. Normally the door to this area was padlocked, but it had been left open by the custodian, who was bringing down Christmas decorations. With his teacher close behind, George began to walk across the attic joists. Still giggling, he tried to turn, slipped, and his leg broke through the ceiling of the main office, where it dangled above the room. Although somewhat humorous now, this act typified George's past, which indicated his lack of concern (and possibly suicidal intention) for himself. In an individual life space interview after this event, George climbed into a long, horizontal cabinet, closed the doors, and stated: "This is where I belong — dead in a coffin." From his "coffin," he spoke of his worthlessness and the reasons why he should be dead.

In group sessions, George began to talk about his activities out of school. Although the stories may have seemed adventurous, they usually involved danger. In one group session, George mentioned that he liked to swing across a certain gully on an old rope. One of the other boys in the group knew of the spot and said that the rope was rotten and George could get killed. Eight-year-old George responded quietly that he wouldn't mind: "It's so peaceful there — I wouldn't mind dying there."

This type of revelation of a child's real feelings and motivation has been observed many times, to the point

where we have concluded that these angry, disruptive actions often are expressions of the depression and self-loathing that exist in too many children.

ADMINISTRATIVE CONSIDERATIONS

During our own observations of the therapeutic programs, we have become aware of several pitfalls that can cause difficulty for others in initiating similar programming. People who have visited our program and enthusiastically returned to their own areas have frequently experienced vague and frustrating resistances in implementation. We believe that these difficulties can be dealt with and resolved if all parties can first agree upon the validity of the concept that providing treatment to emotionally disturbed children is an imperative part of an effective program for the emotionally handicapped. Although this statement may appear to be a verbalization of the obvious, we unfortunately have observed many SED programs that focus primarily on *containment*. The major function of these programs seems to be to provide comfort for the rest of the school and community.

Although behavioral systems can be effective (we make use of behavioral modification in our own program), we are convinced that true change occurs with the process of insight leading to conscious change of behavior with the eventual result of unconscious improvement in one's mental functioning and well-being. Accomplishment of this process must have the commitment of all parties concerned. For example, the administrator of a program must show visible and strong support of the therapeutic component. Again, this seems to be an expression of what appears obvious; however, the therapeutic component has been put into a low priority position by the simple omission of vigorous support.

Initiating a therapeutic discussion group program in classes for emotionally disturbed children requires employing either a psychiatrist or a clinical psychologist two hours per week per class, and one social case worker or guidance counselor one day per week per class during the first year of the program. The therapist responsible for each group should conduct the intake evaluations of children being considered for that class and should work at least 46 weeks of the 52-week year. Preferably, the social case worker should be employed full-time on a 12-month basis with a maximum of five classes or the equivalent for the first year, increasing to a maximum of eight classes after the third year of employment.

The interview evaluation of these professionals must be a part of the administrator's function, and his or her enthusiasm for the program can be demonstrated at the outset by obvious interest in the very acquisition of the personnel. In like fashion, the interviewing and hiring of teachers and teacher aides for the program allow the administrator to express his or her interest and personal investment in the therapeutic component, as well as the necessary educational concerns. In other words, the administrator should make all personnel working in the program fully aware that they have been hired as members of a therapeutic team whose job is to assist youngsters to overcome their emotionally handicapping conditions.

The administrator should set up procedures for the evaluation and intake of children referred to the program. This task includes instructions to referring school district personnel regarding the need to clearly explain the reason for referral and the evaluation. Failure to do this in the past has caused a number of unusual episodes. On one occasion, a parent arrived for evaluation with the assumption that the "evaluation" was a dental examination — with resulting hostility. Apparently, the actual reasons for and explanation of the process of evaluation had not been set forth clearly to the parent.

In practice today, our L & A Program social workers are responsible for contacting parents before the evaluation to confirm the appointment and remind the parent to be sure to bring the child. Previously, concerned parents often would meet the appointment without the child, to "scout the ground" and be assured that their handicapped youngster was going to be evaluated fairly and appropriately. The outreach by social work staff alleviates this anxiety and assures efficient service to the children and their families. The social worker also is responsible for obtaining the family history form, which the parents usually complete before the intake evaluation; or, the social worker may assist the parent in completing the form at the time of intake.

With those initial contacts established, the social worker becomes the primary facilitator of communications between the parent and the school. These communications include the monthly completion of parent and teacher observation forms (see Figures 1 and 2), frequent telephone contacts, parent evening group meetings held once each month, and a minimum of three face-to-face meetings with the teacher during the school year.

The administrator should give the parents a complete explanation of the parameters of the therapeutic discussion group process and obtain parents' written approval

OBSERVATIONS OF: _____ TEACHER: _____
(child's name)

BY: _____ SCHOOL: _____

DATE: _____

List *ANY medication* child is taking and dosage if known:

1. Health
   a. Illnesses, visits to doctors, injuries, anticipated hospitalizations for diagnosis or treatment
   b. Child's reaction to any of the above
   c. Any changes in eating, sleeping, personal habits
2. Changes in family
   a. Additions or losses of members of family or household
   b. Illnesses of parents — anticipated hospitalizations
   c. Family stresses (please share with us any strains that may be affecting the child)
3. Mood and general attitude
4. Self-management in dressing, eating, bathing, getting ready for school, etc.
5. Relationship with adults — parents, neighbors, friends, etc.
6. Relationships with brothers and sisters
7. Relationships with other children
8. Play — what child does for fun
9. Work — attitude toward school, homework assignments, and household chores
10. Your own comments that you would like us to consider regarding your child and the school program

Figure 1. PARENT OBSERVATION FORM

TEACHER: _____ SCHOOL: _____

OBSERVATIONS OF: _____ DATE: _____
(child's name)

MEDICATION: _____

1. Health

2. Self-image

3. Mood and general attitude

4. Self-management

5. Relationships with adults in school

6. Relationships with classmates

7. Approach to schoolwork

8. Comments or anecdotal illustrations

Figure 2. TEACHER OBSERVATION FORM

for their child's participation. Before the advent of the Individualized Education Program, our L & A Program had a form that stated, "I, _____, request placement of my child, _____, in the Learning and Adjustment Program. I understand that my child will be seen by a psychiatrist/clinical psychologist on a weekly basis for therapeutic discussion groups." With IEPs in use, we now include this under "Related Services" on the face sheet.

The program administrator's or supervisor's responsibilities also include meeting with the school district administrators, particularly the building principal, prior to placing a class program in a school — at which time he or she should provide a thorough discussion of the therapeutic discussion groups. Videotapes of typical groups in action have been helpful in illustrating our own groups.

THE TEAM IN THERAPY

Strong administrative components are essential, but implementation of the program delivery system depends upon the team. For the group therapy sessions to be effective, team members must have realistic ideas about what the groups can accomplish. They also must have a basic understanding of their own roles in the group, and the roles of the other group members.

The Therapist

Most therapists have been trained to function autonomously. Functioning in the role of a team member may cause the therapist a great deal of anxiety. Therapists commonly use one of two defensive postures in dealing with this anxiety:

— *The Great Sage.* The therapist adopts a pseudo-psychoanalytic approach. He or she sits back quietly, sees all, knows all, but says nothing. This approach is safe for the therapist but devastating for the children and teachers, who often see the therapist already as a mysterious, mindreading, vaguely threatening being. By playing the Great Sage, the therapist adds to these perceptions, and anxiety levels can rise to such a high pitch that effective interaction is impossible. The children, with unconscious encouragement from the teachers, probably will destroy the group process for this group.

— *The Brilliant Analyst.* The therapist attempts to demonstrate his or her prowess in brilliant interpretations and esoteric understandings. The therapist hopes that these demonstrations will impress both teacher and aide, maintain his or her status as a highly endowed individual with great power, and prevent the terrible truth from ever becoming known — i.e., "I do not know the answer to every psychodynamic problem." This is an error made by these authors in our earlier years. In a certain group we had been making brilliant interpretations — albeit too deep, too esoteric, and too early in the therapeutic process, before a bond of trust was developed between ourselves and the teachers and children. The children's reaction took the form of a behavioral outburst at our arrival, coupled with an attempt to lock us out of their room. We immediately reevaluated our approach. When we allowed the group to proceed at its own pace, we were delighted to find how well the group process worked. The youngsters brought out meaningful material, and effective changes began taking place.

The Teacher and Aide

As mentioned above, teachers sometimes perceive therapists as being surrounded by a certain aura, and psychotherapy as a mysterious intellectual process that occurs only in the sanctity of an office. Unfortunately, this is a myth commonly propagated by the profession. The result, in any event, is that teachers' participation in groups often is restrained and fraught with anxiety. In initial stages of group therapy, the teachers may say nothing — only to state in post group discussions that they were afraid they might say something that would ruin what the therapist was trying to achieve. As team members come to respect one another and communicate freely, this anxiety diminishes; both teachers and therapist cease being overly concerned about any mysticism and are able to pay attention to the verbalizations and feelings of the children with whom they are working.

The Children

The children also come into the group discussions with preconceived notions. They usually meet the therapist with a great deal of anxiety and resistance — especially, but not only, when the therapist acts as Great Sage or Brilliant Analyst. As a result, these children react by withdrawing or failing to participate. The more active, aggressive youngsters might act out; the passive-aggressive youngsters might instigate negative behaviors from the other youngsters in the group and the teachers; and the more psychotic and withdrawn children might withdraw further into their psychotic and withdrawn state of nonparticipation.

Adolescents are particularly vulnerable to this fear, since they are going through a period of great concern about their integrity as whole beings. Consequently, anyone who would seem to have the ability to read their thoughts, minds, and impulses is, of course, dangerous to them, and the best defense against that person is to reject everything he or she says and even his or her physical presence within the room. When a trusting relationship is finally established, and when they are convinced that what they say is going to be respected and listened to, adolescents are able to move into "heavy" material and deal positively with information about their feelings in a manner that is rather astounding and gratifying.

In the beginning, younger children usually understand very little about the nature of the therapy session. They receive an explanation at the beginning of therapy that this is a talking session wherein problems are discussed with confidentiality, that the adults' job is to help them understand how they feel when they feel bad and how to handle themselves when things are tough.

Interestingly, the younger children generally grasp these concepts quickly, and children in the young groups frequently form relationships with the therapist more quickly; however, their ability to identify and express their feelings in language is limited. For that reason, therapy sessions with younger children consist largely of "show and tell" — talking about TV and TV characters,

adventure fantasies, and so forth. But such sessions are important. Over a period of time, themes begin to emerge, and these themes are the keys to problems that bother the children.

Modeling and identification, we have found, are also effective techniques in the therapeutic groups in our program. The therapist facilitates identification by allowing himself or herself to be known by the youngsters as a person with interests, likes and dislikes. Thus, the therapist sets an example of how they might handle their feelings appropriately.

When the therapist, teacher, and children all understand and are comfortable with their roles in the group process, group discussions can be successful. The teachers and therapist, however, must have realistic ideas about what to expect from "successful" groups. Teachers, aides, and therapists must all remember that every session on a weekly basis is not going to evolve into a deep, meaningful, emotional experience with radical change in behaviors of the group members. In fact, we pragmatically believe that if in one of every eight discussions a major change occurs, we are doing well with the entire group. The therapist also must recognize that the group may linger for a long period, seeming to make no advance, and then suddenly spurt forward with no known cause. Therapists have found success by allowing themselves the freedom to admit that some situations are not clear to them and that many of the problems that the children represent are longstanding and will present difficulties for years to come.

COMPOSITION OF THE GROUP

Teachers' and aides' understandings of students have reached high levels through participation in therapy groups. In addition, students see teachers and aides as helping adults in light of these experiences. Therefore, it is essential that both teachers and aides be included in groups.

In the weekly group sessions operated by the psychiatrist or clinical psychologist, our L & A Program includes the social worker as frequently as possible. The children often bring problems to them and request their assistance in resolving these various difficulties.

Because no attempt is made to separate students in our classes by diagnostic categories, our program has students whose problems are expressed through aggressive, acting-out behaviors in groups along with students who withdraw or have difficulty staying in contact with reality. This mixing of students with various behaviors has presented no problem. In fact, psychotic students benefit from the support and reality "rub-in" by the more aggressive students, and the more aggressive student's self-concept is improved through the process of helping others with possibly more severe problems.

Contrary to popular opinion, maintaining the same members in the group throughout the year may be neither practical nor desirable. We have found that in classes with no change in child membership, an unspoken acceptance of each other's pathology has developed so that there is no felt anxiety to change those behaviors that need to be changed. On the other hand, when a new group member has been introduced to the class and thus to the therapy group, members have found it necessary to refocus on the purposes of the therapeutic discussions and to test roles and interactions — which in many instnces have had a positive effect on the progress of the group. An extreme of too many or too frequent changes in membership, however, does not allow sufficient time for developing group cohesiveness and, thus, the members maintain their defensive strategies rather than feeling supported and safe in trying new directions and changes.

The ratio of referral in our program is nine boys to one girl, and female presence in the group is generally helpful — either students or adult members. The three-year age range in our classes is satisfactory.

At a time when our classes were at maximum, there was concern that 12 students, the teacher, aide, and therapist constituted too large and unwieldy a group, with little opportunity for meaningful interactions. One of the therapists proposed and effected a solution to the perceived dilemma: She divided the group in two; the teacher and therapist met with half the class, followed by the aide and therapist with the other half of the class. Problems involving sibling rivalry and suspicion arose which were not alleviated by having the teacher and therapist meet with each group. As time went on, negative effects of the divided group intensified, leading to a decision to again keep the group together in one body meeting with the teacher and aide at one time.

Although some classes in our program have relatively large numbers of youngsters, certain factors are operating that allow those groups to be effective. For example, some youngsters do not have the ability to verbalize their feelings as easily as others, and a quiet listener in a group frequently is gaining as much insight as a verbalizing child who does not listen as actively. We had this pointed out to us rather pleasantly by a youngster who for many years appeared to be nonverbal and relatively uninvolved with the group conversation. Several years later, he

stated that he understood why a youngster was laughing at which seemed to be a serious matter, because he used to do the same thing, and he remembered a group discussion about it some time ago.

TIME AND SCHEDULE OF GROUPS

The therapeutic discussion group model of the L & A Program consists of the therapist and social worker going to each class once a week, at the same time every week. When possible, the master itinerant teacher and/or supervisor join these professionals. The therapist and social worker meet with the teacher and, whenever they can, the teacher aide prior to the group discussion, to find out what has been happening with the students since the previous week's session. This meeting usually involves 10 to 20 minutes but may be lengthened or shortened depending upon the needs of that particular teacher and group of students. If more than one L & A class is housed in the school, the aide from another class may cover the class whose adult members are involved in the pre-group discussion, enabling both adults to participate. Another alternative is to have the master itinerant teacher take over the class, freeing both teacher and aide for the pre-group conference.

After this pre-group meeting, the therapist and either the social worker or master itinerant teacher go into the classroom, greeting the children individually as they move toward those students identified by the teacher and aide as having the most difficult time that day. They support these youngsters through the transitional period while the teacher is directing the students in the class to move their chairs into a circle for the group discussion.

After approximately 30 minutes for primary age children and 45 to 60 minutes for older children, the teacher dismisses the group to return to their regular class arrangement and proceeds to the next activity, frequently a math lesson or some other highly structured, individualized activity. A good therapeutic group may raise a rather high level of anxiety, and, although ideally each session might be a self-contained beginning, middle, and closure situation, this is not usually the case. Subjects frequently must be left for further resolution and discussion. Thus, structured activity helps to denote closure and aids the transition to other curricular areas. In addition, the therapist may assist the students in beginning their work by moving from desk to desk praising them for starting their work; then the therapist quietly leaves the room.

In a few minutes when the teacher feels comfortable about leaving the room, the class is covered, like the pre-group session, by an aide from another class in the same building, by the master itinerant teacher, or by the regular class aide. A post-group discussion is held to analyze the group psychodynamics that occurred during the session and to review each child's progress toward the affective goals and objectives established by the team in conjunction with the parents. A sample post-group analysis form is given as Figure 3. This serves as both a general outline for the post-group discussion and as a written record documenting the session.

Finally, team members indicate what responsibilities they will be assuming during the coming week, prior to the next session. Examples of some of these responsibilities might include contacting the parents about medication the child is taking, providing the teacher some specialized instructional materials, or talking with a regular class teacher about a student's behavior during his or her mainstreamed courses. The teacher receives instructions, as specific as possible, concerning how to conduct daily therapeutic discussion groups during the remainder of the week.

The actual time set for groups is a crucial factor. In our experience, the most productive group therapy time, for younger children especially, has been the first period in the morning. On the secondary level and in resource rooms, group time is determined by the schedule and nature of the students' mainstreamed classes. The therapist must keep the time frame in mind to allow for an appropriate stopping point before the bell interrupts.

The group session should be an integral part of each student's schedule. Groups are maintained on a daily basis for students in self-contained and part-time classes and less frequently for students in resource rooms. By conducting the groups on a regular schedule, the youngsters become acclimated to this experience as a part of their total school schedule. In fact, they often look forward to the groups and are distressed when a session is not held because of special assemblies, illnesses of adult members, and such reasons. The entire staff of the L & A Program makes every attempt to remain consistent, and to give the youngsters full warning in advance if an absence of an adult member is anticipated, along with the opportunity to verbalize their feelings about that absence both before and after its occurrence.

One last aspect of time and schedule has to do with specific behavior incidents or events. Although the group can accommodate specific negative behaviors as they happen, in general it is preferable to have the teacher try to settle immediate problems as they occur. This

DISCUSSION LEADER: _____ PSYCHIATRIST: _____

TEACHER: _____ DATE: _____

Identify the following:

1. Tone of the group at start of session

2. Main theme of the group

3. Level of group interaction (narcissistic, problem-solving oriented, cathectic, insightful, supportive, hostile, etc.)

4. Any individual serious problem handled

5. Name of child most dominant in group discussion

6. Tone of group at conclusion of session

7. Things to come back to

NOTE: Report form is to be filed in folder, in locked file in teacher's classroom.

Figure 3. GROUP DISCUSSION REPORT FORM

practice keeps the group from becoming a "chew out" session that hinders attempts to effect long-range changes in how the students handle their feelings. Avoiding that kind of group session at the time of the therapist's weekly group is particularly pertinent — otherwise, the therapist may become a "wait until your father gets home" figure.

PHYSICAL STRUCTURE

After conducting groups in a number of different settings and configurations over the years, we have concluded that a circle of chairs within the classroom is the most beneficial physical setting. The ease and comfort of familiar surroundings surpass the benefits of an unfamiliar room with all the amenities. Regular chairs are better than the desk armchairs common in secondary schools; these armchairs make the circle too large, preventing easy interpersonal communication.

Also, outdoor sessions, while they may seem idyllic, are hampered rather than enhanced by the open space and multitude of stimuli. Likewise, groups having the students seated on the floor cause disruptions because young children tend to move around and become involved in private conversations while overly dependent pupils swarm around the adults present. Students with minimal cerebral dysfunction especially seem to need the space limitation that a circle of chairs offers.

Another point of concern is surface management within the group. The types and depth of controls needed are fully dependent on the students involved. Hyperactive, aggressive children may have to be seated next to an adult for control; withdrawn students sometimes need quiet reminders or gentle touching to stay in touch with reality and focus on the group's conversation. Teachers and aides generally learn the needs of individual children quickly and respond accordingly.

In probably only one case will seating need to be changed during the middle of a group session: If two adjacent students are having problems with each other while the group is intensively working, one of the adults may quietly, with no fuss, change seats with one of those students.

GUIDELINES FOR THE GROUP PROCESS

In beginning and progressing through the group process, certain guidelines must be followed to assure success:

1. The children are told that they may speak on any topic. Physical aggression and unnecessary obscenities are inappropriate. Certain expletives are ignored if the child is truly expressing feeling; however, language that expresses feelings without being offensive is encouraged.
2. Confidentiality is stressed; what is said in group stays in group — the only exception being one's duty to protect the child from himself or herself and to act accordingly. For example, a student who states that he or she is doing or going to do any illegal or dangerous act must know that we, as responsible adults, will act to prevent it.
3. To assist the group in getting started, a discussion centering on specific interests of the students, or praising one of the youngsters for something he or she did well is frequently initiated by the therapist. This emotional feeding is a necessary first step and is the first goal in the therapeutic process of developing a trusting, warm relationship. Students likewise are encouraged to talk about their interests, hobbies, likes, dislikes, and other nonthreatening topics.
4. After several weeks, certain clear pictures of the individual children become apparent to the team. At this point, a number of items are pertinent, the understanding of which forms the basis for the child's eventually improved functioning. The step-by-step progression, from the child's perspective, is as follows:
   a. *Recognition of behavior.* Many times, youngsters are completely unaware of their actual behaviors that are detrimental to themselves and others.
   b. *Exploration and recognition of the feelings behind the behaviors.* For example, a youngster may not be aware that chronically kicking the back of another student's chair is, in fact, an angry activity.
   c. *Correct identification of the real source of the feeling.* For example, the passively angry youngster mentioned in b., above, may be expressing frustration at not having his or her needs met.
   d. *Connecting the feelings and the consequences of the actions.* For example, the passive-aggressive behavior of kicking the chair results in angry response from the other student and alienation between the two.
   e. *Making a decision to change.* The therapist may note that the child appears to be unhappy and that he or she may wish to change to avoid the painful feelings.
   f. *Having alternatives.* At this point, the adults and the group are involved in suggesting alternative behaviors that may help to alleviate the pressure of the feeling.
   g. *Receiving support for the change.* The group can effectively support changes in a positive direction through verbal and emotional warmth.
   h. *Recognition by the child that the new, changed behavior accompanied by a better feeling about himself or herself in the environment, results in a better functioning, happier life for the child and those in his or her environment.*

ADDENDUM

One aspect of the training in psychodynamic understandings that occurs through groups as its assistance to teachers in choosing appropriate methods and techniques for dealing differentially with students' behaviors. Thus, classroom management difficulties are diminished. Of even greater significance is the students' development of interpersonal problem-solving skills that they will use throughout their lives.

In sum, after our experience with over 6,000 groups during the past 12 years, we cannot imagine a program for emotionally handicapped students that would not fit the proven, cost effective methodology of therapeutic discussion groups in the classroom.

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ALERT

October 5-7, 1979
National Conference on Learning Disabilities
The Galt House Hotel
Louisville, Kentucky

October 18-20, 1979
American Association for Education of the Severely/Profoundly Handicapped
Chicago Marriott Hotel
Chicago, Illinois

October 18-20, 1979
National Association for Gifted Children
BWI Airport Holiday Inn
Baltimore, Maryland

CLASSROOM FORUM

Beverly Dexter
Lynchburg College

Everyone seems to think teachers should ALWAYS be kind, cheerful, and considerate, but there are days when I just don't feel up to these ideals. I realize that my profession demands this behavior of me, yet I know that I have human feelings and frustrations, too. Should I forget about being a teacher just because I don't always feel like the ideal person in the classroom? Is there any way to overcome these frustrations and still maintain my sanity?

We all have our "days." Some scratch them off as "lows" based on biorhythm feedback. Others refer to them as "down in the dumps" or "dog" days. No matter what they are termed, everyone experiences them. To be "up" all of the time is next to impossible, especially with so many outside factors acting upon us. When we hit a low, it is hard to face the fact that this is a "factism of lifeism" — that such drops in general attitude and self-esteem are a part of life.

There are no sure-fire tricks for getting out of a low that work all the time for all people, even though there are hundreds of books currently on the market that claim to have the answers to life's mysteries. The themes center on one's inner feelings. Some say meditation is good for the soul — but when chaos erupts in the classroom, the last thing teachers are able to think about is the calming effect of meditation — they realize that even a minute's peace would be nice, but in the meantime, they must figure out a way to calm the din.

During my first year of teaching, I had a compassionate principal who realized that no human being could possibly wake up every day ready to face children in the classroom for six hours at a stretch. In private conferences, he told each of us that he didn't want to see us in school if we didn't feel ready to meet the demands of the day. "Face it," he said, "there are days when you are going to do more harm than good to the children. I want you to call in sick on those days. Take the day off to

compose yourself. Just don't get caught shopping or having a three-martini lunch in public!"

The general public, as well as the administration, might have fainted had they heard this man expound his "theory of relativity" to his faculty. However unethical it sounds, though, that theory made the most sense of any I have heard from numerous administrators since I began teaching in 1965. At the time, I was an itinerant speech therapist in five schools, and the overall morale was higher in that principal's school than in the other four put together. There was also *less* teacher absenteeism in that school. The teachers didn't abuse the privilege of taking a "sanity day" because they knew the principal was right — there *are* days when you will do more harm than good.

The following is excerpted from a "typical day" of a few months ago.

7:00 a.m. — The alarm didn't go off, and we were abruptly awakened by the plumber's knocking at the front door. (We had gutted the bathroom, and renovations were in progress.) The dog and cat left claw prints on us as they scurried off the bed to hide from the plumber.

7:10 a.m. — The plumber flushed the commode, only to find that it wasn't working properly. No bathroom privileges for us now!

7:15 a.m. — Breakfast — but as a result of being late in getting up and dressed, cold cereal was the best I could muster up, despite the 15-degree temperature outside. Incredibly, the milk was sour, we discovered as we attempted the cereal. Now there wasn't time to fix even toast. Scratch breakfast.

7:20 — Al dropped his contact lens on the floor. Before he could react, the dog had rushed to the scene and devoured it in a gleeful gulp.

7:25 — My car was snowed in, and the cat was inspecting the winter world from under it, refusing to leave. When I eventually did scare her into moving, she leapt onto the windshield, leaving behind paw prints of ice and mud.

7:45 — Driving to work, I realized that the keys to my office were still in my lunch sack . . . the one in the refrigerator.

7:50 — My class notes were on my desk . . . in the locked office . . . and no one was around to open the door. I remembered that I was to show a film, so I tracked down the projector. Since the self-threading one was still out for repair, I had to settle for the other one (with Tom Edison's original autograph," I muttered).

8:20 — My room was unlocked and I attempted to thread the machine — and actually succeeded! A bright spot.

8:30 — Most of the students had arrived, so I introduced the film, turned off the lights, and started the film.

8:31 — The light bulb on the projector decided to go out. There were no spares.

8:45 — Visibly shaken, I dismissed the class.

8:46 — On the way out, one of the students glibly commented, "They sure don't practice what they preach about being 'in control,' do they?"

8:47 — I seriously contemplated changing professions.

9:00 — Another faculty member walked in exclaiming, "Isn't this a glorious day!"

9:01 — I composed a letter of resignation in my mind.

9:05 — The plumber called. "If you thought you had a mess in here when you left, you should see it now" (chuckles). . . .

. . . *Face it — There are days when you are going to do more harm than good.*