

SOCIAL GROUP WORK: A DIAGNOSTIC TOOL IN CHILD GUIDANCE*

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Poor peer relationships constitute one of the most frequent symptoms in referral to child guidance clinics. Traditional interdisciplinary diagnosis fails to evaluate the child's social relationships to peers. A social group worker, using a structured, small, short-term group, can provide data regarding a child's patterns of interacting with peers in terms of his actions and interactions and other children's reactions to him.

THE TREATMENT PLAN for each patient at the Pittsburgh Child Guidance Center is based on an interdisciplinary diagnostic evaluation. Traditionally such an evaluation includes a social history and a psychiatric and psychological evaluation of the child. Two additional methods, a social group work evaluation of the child and a family observation,¹ now are being used selectively. This paper will discuss how diagnostic groups began at the clinic, the types of such groups, preparation of children for the group, plans for group meetings and observations made in the group. Examples from clinical practice will be used.

Social group work as a diagnostic tool emerged to meet a clinical need. Group work is a treatment method frequently used with school-age patients diagnosed as having neurotic, transient situational and/or minor character disorders. Caseworkers, psychologists and psychiatrists needed diagnostic information about such children and knew that this information was available in the data from the treatment groups.

Disturbed peer relationships are among the most frequent symptoms for which children are referred. Diagnosis of the problems of the child should include adequate data about peer difficulties. The traditional model often fails to

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provide these. Our reporters, parents, teachers and children themselves rarely give a clear picture. Often they give conflicting reports. The individual evaluations clarify why such problems arise in terms of intrapsychic stress but frequently fail to clarify how they are manifested socially and how they create secondary social problems.

The group worker can provide additional information. For example, the group report may show that a child behaves in a grossly different manner with children, or with children and an adult, than he did when he was seen individually. The group report can confirm or may deepen other staff observations. It does complete the diagnostic picture regarding peer relationships.

Though diagnostic groups seem an answer to an existing clinical need, the introduction of a new method is not always easy or welcome. Resistance to change by some staff members, trainee difficulties in sharing patient responsibility, parental concern about missed school time and parental fear of group contagion occasionally can prevent placement of a child in a diagnostic group. If group work diagnosis is to be used with a child, the need for such an evaluation must be recognized by one of the professional workers and must be accepted by other staff members and trainees.

DIAGNOSTIC AND TREATMENT GROUPS IN DIAGNOSIS

The goal of the diagnostic group is to evaluate the problems of each member. The group serves as the milieu in which observations are made. The group process is the vehicle which provides observable experiences. The primary

concern of the group worker is the individuals within the group rather than the group itself.

One social group worker selected a small, short-term group including no more than six members and meeting for no more than four sessions. A small group provides the greatest opportunity for the children to be involved in an interacting system, too few members for the children to assume such formal roles as team members and assurance to the child that he will not be overlooked in the crowd. To observe the process of group behavior a series of meetings is necessary, but there must be few enough to prevent the children from investing too much in the group experience itself.

Since observation of individual functioning within the group process is the primary task of the group worker in a diagnostic group, a carefully balanced group is not so necessary as in a treatment group, where the primary task is manipulating the group process. Children can be included in the same diagnostic group if there are no contraindications regarding specific children being together. Severely bizarre, physically handicapped and retarded children are not accepted in diagnostic groups.

Two types of age groupings have been useful: (1) children within a two-year age range and (2) children who range in age over several years on a fairly continuous basis, provided that there is no more than one year's difference between any child and the child closest to him in age. The choice of grouping is based on the patient population.

Groups of one sex usually are best. Several diagnostic groups with both boys and girls have been tried. In general such groups split into two per-

manent subgroups with the boys in one and the girls in the other. This split seems to cut down the freedom of the children to interact in the group and to place marked limits on the behavior manifested.

As the demand for group work evaluation of children has increased, temporary placement of children in ongoing treatment groups has been used for diagnosis. Placing a child in an ongoing treatment group requires careful evaluation of both the child and the existing group. Not all treatment groups can tolerate a new child nor can they tolerate the loss of a member without damage to the treatment process. It may not be possible to admit specific children to specific groups. For some children temporary membership in a treatment group is emotionally harmful, but they can benefit from being part of a group in which all members begin and end at the same time. In deciding to place a child in an ongoing treatment group, the primary concern of the group worker is with the welfare of the treatment group regardless of the need or readiness of the child to be diagnosed.

PREPARATION OF THE CHILD FOR THE DIAGNOSTIC GROUP

The child who has had trouble with other children usually finds a diagnostic group an easily comprehensible procedure. Peer relationship problems generally are painful to the disturbed child himself as contrasted to many other referral problems which cause pain to the school personnel or to his parents. A byproduct of the group diagnostic procedure has been to help a resistant child accept the interest of the clinic in helping him.

Both the parents and the clinic should prepare the child for the group experience. The caseworker interprets the group to the parents in the hope that they will explain the group to the child (but often they do not). The clinic preparation of the child varies according to the needs of the child, the preference of staff members, the point in the diagnostic procedure at which the group is introduced and the type of group being used.

When a diagnostic group is the initial clinic experience for all members, the preparation for the group is the responsibility of the group worker and can be done in the first meeting. He informally meets each child in the waiting room prior to the first meeting, introduces himself and then introduces the children to each other. Together all walk to the meeting room where the group as a whole is told the reasons for its existence and the basic rules. During the first session the worker explores with the children why they are coming to the clinic, including "what their parents have told them," and their concerns and fantasies about the clinic and group experience.

Since the group sessions may fall at any place in the diagnostic process, some children may have had previous clinical appointments. The total diagnostic procedure, including the group, should be discussed in the first interview with the child. Some staff members feel that this introduction should include an introduction to the group worker and/or a brief tour of the meeting room.

Many children show anxiety about entering a new group. The child's therapist or the group worker should explain to an anxious child the nature of the

clinic group: a protected group with a worker who knows that the child has had trouble getting along with other children. The child who has had almost continuously disappointing experiences in peer relationships may frankly fear another unprotected group situation. It is necessary to help him see that group experience at the clinic will differ from group experiences he previously has had. Some therapists hesitate to use the group experience when a child expresses anxiety about it; they assume that his expressed anxiety is the problem without exploring the possibility that the child is expressing fear of something else, the nature of which he does not understand. When a child expresses extreme anxiety and reasonable efforts to clarify the nature of the protected group experience fail to reduce this anxiety, it is important to work out these feelings with the child. The group experience for this child may be temporarily dropped.

When a child is assigned to an ongoing treatment group, the group worker must have some direct contact with him individually before he is admitted. He must meet the group worker and see the meeting room. He should not be faced with a totally new situation in which all the other children are familiar not only with the room and the worker but with each other. The group members too need to be prepared for the new member. Generally they watch for the new child in the waiting room and initiate social intercourse before the group session begins. The group worker should observe this premeeting activity and be prepared to offer the new member support should it be necessary.

GROUP PLANNING

The diagnostic meetings are planned

so that each child is exposed to specific emotional and social tasks and stresses. The series of four meetings permits an evaluation of the pattern of the child's behavior, his ability to maintain certain behavior and his adaptive ability. The functioning of each child in each group session is measured against expectations for children of his own age, sex and cultural group.

The following broad outline for the four sessions provides similar experiences for each group. The specific activities vary with age, sex and even the seasons of the year. In the first meeting the worker uses crafts, games and activities which are potentially highly interesting, provide opportunities for both individual and group activity and offer safe ways for constructive isolation. In the second session the worker increases the demand for peer interaction and the need for social skills, such as participation in group games or sharing of equipment. The degree of change and the pressure exerted by the program will be based upon an evaluation of individuals in the first meeting. Differential demands can be made upon each member within a small group and different demands are made upon different groups. In the third meeting the social behavior of the members is tested in the community outside the safety of the meeting room by a trip to the store, to the museum or to the ball park. On this trip the worker will gain information about the ability of each child to handle such social tasks as crossing the street, watching out for pedestrians and the like. After the third session the group worker reviews his impression of each child with the rest of the diagnostic team. Together team members determine what the group worker needs to investi-

gate further. The final session is planned so that the observations needed for each child can be made. During all four sessions the group discusses the purpose of the group, how the group is related to the total clinic procedure, how the members feel about coming to the clinic, how they view their own problems and what help they themselves want.

When a child is seen in an ongoing treatment group, the group worker has less freedom to adjust the content of group sessions to a standard pattern. Evaluation of the child is based on the child's ability to manage his experience within the existing group. In some ways the provocative behavior of the child may stand out more clearly. The breadth of specific experiences will be limited for a treatment group will have more cohesiveness and self-direction than a newly formed diagnostic group. In addition, the treatment group is likely to use group pressures to force the new member to adjust to its behavior.

In all diagnostic group sessions the social group worker plans to take an active role as a helping adult, supporting, interpreting, limiting and giving information as well as equipment. The role remains consistent throughout the four sessions and is made explicit to all members initially. The worker uses program to manipulate and to influence the group process, to produce demands for social skills and to reduce tension.

COLLECTION OF DATA

Group diagnostic data are gathered clinically rather than in a standard research procedure. The group worker is a direct worker; that is, the intervener, limiter, enabler and the like. He is the planner and the provider. He selects the group members. He also is the diagnostic

observer. Planning a specific milieu and program provides structure for the group sessions and permits a general range of observations similar from diagnostic group to diagnostic group but the actual activities in each meeting always are subject to limits and changes which are deemed clinically necessary. Within the group meeting the worker must be flexible with reference to the individual needs of each member.

The social group work report on a child provides clinical information. It is presented on a descriptive, impressionistic and interpretive level. The data are subjective. The group worker has been involved in the process which he is evaluating. He is observing emotions, reactions and interactions on both a quantitative and qualitative level. The data presented are selected by the group worker and related by him to what he perceived as the treatment needs of the patient. Often he predicts from the group sample of behavior to other social situations. For example, he reports how he believes a child will behave in other group situations.

OBSERVATIONS

What does a social group worker report? Primarily, his report is an evaluation of the pattern of behavior of a child in three areas: (1) relationship to other children, (2) relationship to an adult in the presence of other children and (3) the child's knowledge and use of social skills, for example, physical and developmental tasks and expected peer roles. These patterns of behavior are reviewed in several contexts: (1) initial approach to the group situation, (2) ability to change over a period of four sessions (3) stresses which precipitate regression, (4) behavior which provokes unhappy

or unpleasant reactions from others and (5) the child's reaction to group pressure. It is as important to observe the impact of a child's behavior on other children as to observe the child's behavior.

The group worker is trained to understand unconscious motivation determining behavior, but this is not the area of his diagnostic responsibility. His responsibility is to evaluate social functioning and to differentially assess the adaptability of the disturbed behavior, the clarity of reality-based reactions, the social hunger and the motivation for change. The group worker attempts to learn the nature of the social situations which cause a child to become less anxious or more symptomatic. Finally he tries to identify how the behavior of a child unknowingly provokes negative reactions to the child.

Specific examples of the observations the group worker makes can be enumerated, and two examples of diagnostic group work reports on two children seen in diagnostic groups can illustrate some of the points made.

The specific evaluation is made in terms of such patterns as interaction, reaction, provocation, modification and intensification. For example, in regard to the child's relationship to other children at the initial group meeting: (1) Can he show that he wants a relationship? (2) Can he accept friendly overtures? (3) Does he provoke feelings of protectiveness? (4) Under what situations can he relate and to whom? (5) Can he maintain relationships when tension is high? Or in his relationship to an adult in the presence of other children over the period of four meetings: (1) What is the pattern of relating to the

group worker? (2) How does a child use the preferred relationship? (3) Is this a child whom adults like in a one-to-one situation yet who shows gross problems in the group when he must compete with other children for the attention of the adult? (4) Do his feelings toward the worker shift when the worker gives to, compliments or supports another child? (5) Do his dependency demands vary with the reality of the situation? In his knowledge of and use of social skills in the context of stress: (1) Can he accept appropriate roles in basic games? (2) Does he quit a game if another child gets a favorite role? (3) Will he disrupt activity when he doesn't want to play? (4) Are his social handicaps caused by lack of knowledge which can be remedied? (5) Do confused moral attitudes cause emotional rejection of activities?

Parts of group work diagnostic reports on two children seen in diagnostic groups illustrate how this theoretical analysis of observations into areas of relationship, contexts and behavioral patterns blends into an integrated whole when the behavior in the group of an actual child is described.

Sylvia is an eight-year-old Jewish girl referred to the clinic for sibling rivalry and conflict with parents. The caseworker requested a group diagnostic because Sylvia was in trouble whenever she was with other children.

As Sylvia entered the group, she acknowledged that there were difficulties with children, but did not admit to any part in any of these difficulties. She stated, "I don't have trouble with children; they have trouble liking me. If they tried harder, they could like me."

The most outstanding aspect of Sylvia's adjustment to a peer group was her tremendous use of denial. She lied with regularity. This was neither a protective measure nor one of confusion of reality. It seemed to be more a manipulating technique. Sylvia was constantly aggressively defensive. She immediately denied having done something whether she

had done it or not; she instantly projected the blame to another child in the group. This was not a fearful denial of a child who anticipated she was at fault. Rather it seemed to be her major way of managing children.

Sylvia was an accurate observer of all that went on in the group. In any situation where it was possible she tattled. She was an astute observer of all rules regarding the other children. Whenever arguing a subject she would go back to the previous week, selecting distorted incidents to document her stand. Whether she was right or wrong, she attempted to out-argue each child on any issue which she created.

Sylvia was tremendously intrusive. She was jealous of any worker-child interaction or child-to-child interaction. She would intrude by joining, interrupting or distracting the worker or one of the interacting children. She had very few play skills and could only play if she were boss. The only "satisfactory" play experience she had was when she would offer to play with one child in a defiant effort to show an active rejection of another child. Although she showed phobic reactions to the elevator in her contacts with both her psychiatrist and her psychologist, the elevator caused no sign of fear in the group meeting, when she was competitive to see who got on first, who got off first or who pushed the most buttons.

Sylvia definitely wanted to be liked by the worker but she did not know how to go about it. She could not believe that an adult could be consistent. She never gave up the chance to win an argument, which she started, continued and then usually ended by having a temper tantrum.

In group discussion there was competition with the other children for the worker's attention. She gained this attention mostly by breaking group-room rules or doing something she knew the worker had specifically asked her not to do. If the worker ignored these infractions, Sylvia would bring them to the worker's attention, loudly stating she had not done it.

Sylvia found it impossible to share with the children. She never had enough. She could not share tasks, food, activities or attention. She ate a phenomenal amount of food. She had very few craft skills or activity skills. She was constantly verbally aggressive. She was extremely intelligent and could assess how to annoy people with tremendous skill.

The other children initially attempted to find a way to play with Sylvia. At first they seemed to want to be accepted by this bright little girl. Gradually they began to withdraw

and allow her to isolate herself. By the fourth session they were complaining to the worker when they found themselves deprived of cookies, equipment or attention from the worker.

SECOND CASE

Leon is a ten-year-old boy who was referred to the clinic for school behavior problems, immaturity and sibling rivalry. He was referred to the group for diagnosis by the psychiatrist who could not see the problems which the school and the parents complained about in his individual sessions. Leon's behavior was markedly different over the four-week period. In his initial approach to the group he seemed to reach out to play with the other children with a high level of social graces. He attempted to relate to the healthiest boy in the group. This lasted only half of the meeting. He challenged Mike to a game of chess which he played with great skill and craftiness. When he found that Mike was an equal competitor, he became disinterested and lost on purpose. He was aloof from the other boys and looked disdainfully at them in their participation in the active games of tag and dodge-ball. He refused to participate in refreshments because the food was not kosher, yet he "stole" cookies several times.

In the second and third meeting Leon seemed to be tense and anxious. He was asked to play games by the other boys but would participate only in table games. Whenever intelligence played a factor, he could beat the boys easily. When forced to play a game of luck or physical skill, he became impatient and usually quit. He began to tell the boys that their games were stupid and he didn't want any part of their crazy games. He began to try and test the boys' intellectual knowledge by asking questions regarding math, chemistry and history. By the fourth session he could make no attempt to play with the other boys. He was no longer asked to play, yet he could not stand the isolation and tried to keep contact with the other boys by poking fun at them. He ate an enormous amount of cookies. He refused to sit down and eat with the boys because they "hated him."

With the worker Leon kept his distance. Any direct interaction with the worker seemed impossible for him. His only direct approach to the boys was when he wanted them to communicate with the worker for him. This included such obvious behavior as asking one of the boys to ask the worker if Leon could go to the men's room.

SUMMARY

This paper reports on social group work as a method used to diagnose disturbed children at the Pittsburgh Child Guidance Center. It shows how the need to understand the social behavior of children led to the use of diagnostic groups. The kind of groups used, the preparation of the children, and the planning for these groups are described. Finally data made available through group work diagnosis are discussed and illustrated.

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