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The Role of Leader's Social Competence in Children's Social Skills Training

by
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Dissertation presented to the School of Graduate Studies of the University of Ottawa in partial fulfilment of the requirements for the degree of Doctor of Philosophy.

Abstract

The purpose of the present study was to investigate whether certain leader variables contribute to the efficacy of children's social skills training (SST). Trainees were 59 grades 3, 4, and 5 boys chosen from a sample of 944 children who were identified as high on aggression using the Revised Class Play. Twelve male social skills leaders participated in the study. Leaders were third- and fourth-year undergraduate students (2 in criminology and 10 in psychology) who were selected from 39 volunteers based on sociability and hostility scores. Twelve groups of trainees (4 to 6 trainees per group) participated in 10 sessions of SST. Outcome measures included post-treatment scores from the Social Skills Training Mastery Test, pre- and post-treatment scores of aggression and sociability from the Revised Class Play, and pre- and post-treatment scores of self-control from the Social Skills Rating System-Student Form. Leaders completed the Interpersonal Behavior Survey, the Interpersonal Style Inventory, and the Symptom Checklist-90-Revised to obtain scores on various leader variables including empathy, sociability, hostility, and self-confidence. Leader in-session variables (including warmth, enthusiasm, and quality of feedback) were coded from video-taped SST sessions using the Modified McDaniel Observer Rating System. Children in groups led by leaders high and low on hostility, sociability, and quality of feedback did not differ significantly on outcome measures. While these results may suggest that therapist variables are less important in structured interventions such as children's SST, it is also possible that a more powerful study using more groups and investigating only a few therapist variables might have produced significant results. Implications of the results were discussed with reference to the limitations of the design of this study, and suggestions for future research were noted.

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This thesis is dedicated to my two great kids, Michael (6) and Hillary (almost 2). Thanks for the joy you've brought into my life and for helping put this thesis into perspective. I hope that you are as lucky as I was to discover a vocation that makes you happy to go to work each day. And if you both decide to become psychologists like your mom and dad, we won't complain!

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Substantial evidence has accumulated to suggest that several types of therapist variables are associated with therapy outcome (for example see reviews by Beutler, Machadeo, & Allstetter-Neufeldt, 1994; Lambert, 1989; Parloff, Waskow & Wolf, 1978). While the role of therapist variables has been investigated in reference to most different types of adult psychotherapy, very little research has investigated its role in child psychotherapy (Morris & Nicholson, 1993) and it has yet to be studied in relation to children's social skills training (SST), an intervention modality which is becoming increasingly prevalent with youngsters at risk for psychological maladjustment. The purpose of the proposed study was to examine whether certain leader variables contribute to the efficacy of children's SST. A brief overview of the research on therapist variables in relation to adult and child psychotherapy outcome appears next. This is followed by a description of children's SST, and the evidence concerning its effectiveness with aggressive children. A social learning model of SST is presented to explain skill acquisition. This is followed by a discussion of the relevance of the adult therapist variable literature to child therapy. Finally, a rationale for the study of leader variables in relation to children's SST is presented along with the hypotheses of the present study.

Therapist personality and relationship variables

The study of therapist variables is important for several reasons. The identification of therapist characteristics that affect outcome could be used by training institutions as a basis for the selection of candidates (Matarazzo, 1978). This type of information could also be used to match patients and therapists in order to maximize the outcome of therapy (Lambert & Bergin, 1983).

Therapist variables can be conceptualized either as enduring personality traits of as patterns of behavior evident during the process of therapy sessions. According to Lambert and Bergin (1983), the study of therapy process variables linked to the behavior of the therapist is essential because it comes closer to investigating a cause-and-effect relationship between more global and more distal therapist characteristics and outcome. Several authors suggest that, since process variables may involve therapist characteristics that can be modified with training (Beutler et al., 1986; Lambert & Bergin, 1983), information of this kind could be useful in the development of training procedures designed to increase the effectiveness of therapists. Unfortunately, there has been little effort to extend this research to therapeutic interventions with children.

Research indicates that clinicians strongly believe that therapist characteristics play a key role in treatment outcome (Kazdin, Siegel, & Bass, 1990). This belief is supported by findings indicating that psychotherapy outcome is more strongly related to therapist characteristics than to specific types of interventions (Crits-Christoph, & Mintz, 1991; Luborsky, Crits-Christoph, McLellan, Woody, Piper, Liberman, Imber, & Pilkonis, 1986). Furthermore, within various

therapeutic approaches, some therapists consistently produce positive effects, while others consistently produce negative effects (Beutler, Machadeo, & Allstetter-Neufeldt, 1994).

When examining the therapist variable literature it is evident that research has focused almost exclusively on adult psychotherapy rather than child psychotherapy (Morris & Nicholson, 1993). According to these authors, this is likely due to a longer history of psychotherapy research with adults. In addition, they note that researchers have only recently begun to investigate child psychotherapy as a separate entity. Consequently, the following review of the literature on therapist variables is based largely on research with an adult population and its implications for child psychotherapy may only be marginal.

A wide variety of therapist characteristics have been found to be related to psychotherapy outcome, including therapist experience, personal adjustment, attitude similarity, personality, therapist style, intervention style, and relationship variables (Beutler et al., 1994; Lambert & Bergin, 1983). The present review will focus exclusively on research dealing with therapist personality and/or interpersonal style variables (e.g. hostility, sociability, self-confidence, empathy, and warmth). For more comprehensive reviews of the therapist variable literature, the reader is referred to several excellent review articles (Beutler, et al., 1994; Beutler, Crago, & Arizmendi, 1986; Lambert, 1989; and Lambert & Bergin, 1983).

All schools of psychotherapy support the notion that the therapeutic relationship plays a significant role in the formation of a working alliance and, ultimately, the success of the therapeutic outcome (Lambert & Bergin, 1983). Substantial evidence is accumulating which

supports the notion that therapist relationship skills are the most powerful predictors of outcome across many orientations of therapy (Greenberg & Pinsof, 1986; Orlinsky & Howard, 1986). Therapist relationship variables identified by the client-centered school as "necessary and sufficient conditions" for therapeutic change, including empathy, warmth, and genuineness, have been widely researched (Patterson, 1984; Lambert, De Julio, & Stein, 1978). In his review of reviews, Patterson (1984) concluded that the role of these relationship variables in psychotherapy outcome is incontrovertible. For example, in a study of 40 outpatients receiving individual psychotherapy, patients treated by therapists who were judged as high on empathy, warmth, and genuineness showed significantly greater improvement than those whose therapists were judged as low on these traits (Truax, Wargo, Frank, Imber, Battle, Hoehn-Saric, Nash, & Stone, 1966). Studies investigating the roles of therapist empathy, warmth, hostility, sociability, self-confidence, and enthusiasm in adult and child therapy will now be reviewed.

Empathy

Rogers (1957) defined empathy as the ability of the therapist to experience accurately and understand empathically the client's feelings and private experience. Lafferty, Beutler and Crago (1989) examined the differences between more and less effective trainee therapists on several therapist relationship variables and therapist theoretical orientation. Thirty trainee therapists (psychiatric residents, clinical psychology interns, clinical social work trainees and psychiatric nursing trainees) were labelled as more or less effective based on their clients' pre- to post-

treatment change scores on levels of symptomatic distress. Patients' perceptions of their therapists were measured across four dimensions: empathic understanding, positive regard, unconditional acceptance and congruence. Results demonstrated that therapist relationship variables, including empathy, patient involvement, and directiveness, significantly discriminated between more- and less-effective therapists. Patients of more effective therapists felt more understood by their therapists compared to patients of less effective therapists. Theoretical orientation did not discriminate between more and less effective therapists.

Lorr (1965) had 523 patients complete an inventory of 65 statements about therapist behaviors. Each patient had participated a minimum of 3 months in individual therapy. Factor analysis isolated 5 factors: Understanding, Accepting, Authoritarian, Independence-Encouraging, and Critical-Hostile. Patient ratings of therapist understanding were positively correlated with client and therapist improvement ratings (r=.31 and r=.19, respectively). These results support the importance of clients' perception of the therapist's level of empathic understanding to positive therapeutic change.

In a replication of Lorr's (1965) study, Cooley and Lajoy (1980) investigated both the client's and therapist's perception of the therapeutic relationship in relation to client- and therapist-rated treatment outcome. Clients were 54 adults seen in individual therapy at a community mental health clinic by 8 therapists (2 psychologists, 3 MSWs, 2 psychiatric nurses, and one Master's level intern). Consistent with Lorr's findings, clients' ratings of therapist understanding correlated moderately with client-rated improvement (r=.49). Therapist self-ratings of understanding

correlated significantly with various therapist ratings of improvement (correlations ranging from .35 to .44), but were uncorrelated with client-rated improvement.

The importance of therapist empathy in brief focal dynamic therapy was investigated by Free, Green, Grace, Chernus, and Whitman (1985). Clients were 59 patients who received individual therapy at a university psychiatric clinic. Patients were randomly assigned to 13 therapists who were all 2nd or 3rd year psychiatric residents. Results indicated a significant relation between patient-rated therapist empathy and a reduction in the patient's hostility level (r=.35). A greater increase in quality of interpersonal relationships was also found in patients whose therapists were viewed by their patients as more empathic (r=.28).

Najavits and Strupp (1994) compared more and less effective psychodynamic therapists on various therapist behaviors. Sixteen therapists (8 psychologists ans 8 psychiatrists) each treated 5 outpatients as part of the Vanderbilt II Study, a study designed to examine the effect of therapist training on psychotherapy outcome. Three therapists who ranked at the top in outcome (i.e. who had no negative outcome cases and had no patients leave before session 16) were identified as more effective. Three therapists who were in the lower half on outcome were identified as less effective. These researchers reported that more effective therapists scored significantly higher on patient- and self-ratings of understanding compared to less effective therapists.

Burns and Nolen-Hoeksema (1992) studied the role of therapeutic empathy in recovery from depression for 185 adult patients who participated in cognitive behavioral therapy. As noted by these authors, the role of empathy in cognitive behavioral therapy has been controversial. Ellis

(1962) has downplayed the importance of therapeutic rapport, while Beck has argued that the therapeutic relationship is a key factor in effective cognitive behavioral therapy (Beck, Rush, Shaw, & Emery, 1979). Therapy outcome was measured by pre- to post-treatment change scores on the Beck Depression Inventory. Patient ratings of therapist empathy were collected post-treatment using the Empathy Scale. Therapists included psychologists, clinical psychology graduate students, one physician, and one pastoral counsellor. Controlling for homework compliance and initial severity of depression, results indicated a moderate to large association between therapist empathy and reduction in depression scores. These authors concluded that therapist empathy is a major factor in the degree of clinical recovery even in highly technical forms of therapy such as cognitive behavioral therapy.

Rabavilas and colleagues conducted a retrospective evaluation of the importance of therapist characteristics in a flooding treatment for phobic and obsessive-compulsive patients (Rabavilas, Boulougouris, & Perisaki, 1979). Five therapists provided 36 patients with a mean of 12 sessions of in vivo exposure treatment. Patients were identified as improved (N=23) or unimproved (N=13) based on follow-up ratings of therapeutic change. Patients' ratings of therapist qualities were collected retrospectively during follow-up after completion of the treatment (average time of follow-up was 1.4 years after the completion of therapy). Significantly more improved than unimproved patients rated their therapists as understanding (87% versus 39%, respectively). While these results do lend some support to the important role of therapist empathy in treatment outcome, the authors suggest caution in interpreting these findings because

of the retrospective approach to measuring patients' opinions. More specifically, patients who improve in therapy may tend to rate their therapists more favourably compared to unimproved patients. The generality of these findings may also be called into question because of the small number of therapists.

Esse and Wilkins (1978) attempted to assess the relative contributions of therapist empathy and imagery instructions in reducing clients' fear of snakes. Thirty undergraduate female students who were fearful of snakes were assigned to one of three conditions: imagery instructions delivered in a mechanical, non-empathic manner, imagery instructions delivered in an empathic manner, and empathic conversation without imagery instructions. Subjects participated in one 45-minute treatment session. No differences in outcome were found between the imagery instruction/no empathy and imagery instruction/empathy conditions. However, the unempathic imagery instruction group produced greater reduction in snake avoidance compared to the empathic conversation/no imagery instruction group. The researchers concluded that relationship factors are relatively unimportant in the success of behavioral procedures. However, there are several limitations to this study. Subjects received only one 45-minute treatment session with the therapist. It is questionable whether any relationship variable would be powerful enough to affect therapeutic outcome in one single session. In addition, as noted by Morris and Nicholson (1993), the results may have limited generalizability since the study did not utilize a clinical population.

Miller, Taylor and West (1980) compared the relative effectiveness of focused and broad-spectrum behavioral approaches in treating problem drinkers. The nine undergraduate and graduate psychology students who served as therapists participated in 3 months of intensive training in basic listening and counselling skills and in either the focused or broad-spectrum behavioral treatment. No significant differences in effectiveness were found between the treatment conditions. However, a strong relationship emerged between therapist empathy and therapist success rates at six- to eight-month follow-up (r=.82). Therapist levels of empathy thus accounted for 67% of the variance in therapist successfulness. Furthermore, when success rates of individual therapists were compared to the 60% success rate of a bibliotherapy condition, five therapists surpassed the mean bibliotherapy improvement rate, while four did not. The four therapists who did not surpass the 60% improvement rate were rank ordered 5th, 7th, 8th and 9th in empathy. These results provide strong evidence for the importance of therapist empathic skills in behavioral interventions.

While a substantial amount of research has accumulated to indicate that therapist empathy is related to outcome in adult therapy, very little research has investigated this variable in child psychotherapy (Morris & Nicholson, 1993). The present literature search identified one study which investigated the role of therapist empathy in outcome of child psychotherapy. Kendall and Wilcox (1980) compared two different cognitive behavioral treatments designed to help chronically delinquent children develop self-control and decrease impulsive behavior. Therapists were 12 upper-level undergraduates and one advanced graduate student, all with experience

working with this population. Therapist self-ratings of empathy correlated significantly with pre- to post-treatment change scores on two performance measures of self-control (errors on the Matching Familiar Figures Test, r=-.36; errors on the Porteus Mazes, r=-.29), Hyperactivity ratings on the Conners Teacher Rating Scale (r=-.45) and teacher ratings of impulsivity (r=-.32). These results indicate a positive, moderate association between therapist empathy and improvements in self-control as well as decreases in impulsivity and hyperactivity. These authors stress the need for additional research on the role of therapist variables in child psychotherapy. In summary although their study provides support for the role of therapist empathy in cognitive behavioral therapy with delinquent children, additional research is required before conclusions can be made regarding the general contribution of empathy to outcome in child therapy.

Warmth

According to Rogers (1957), warmth or unconditional positive regard refers to the therapist communicating care, concern and a sincere interest in the well-being of the client. Najavits and Strupp (1994) compared the warmth of more and less effective psychodynamic therapists. Sixteen experienced therapists (8 psychologists and 8 psychiatrists) treated 5 patients each in 25 sessions of time-limited dynamic psychotherapy. Three therapists were identified as most effective based on highest ranking in global ratings of outcome, no negative cases, and having no patients drop out of therapy before session 16. Three less effective therapists ranked below the 50th percentile on outcome, had at least one negative outcome case, and had 2 or more

patients discontinue treatment before session 16. More effective therapists were rated significantly higher on warmth compared to less effective therapists.

Various therapist variables, including warmth, were examined in relation to therapeutic success by Bent and his colleagues (Bent, Putnam, Kiesler, & Nowicki, 1976). Subjects were 93 clients seen in individual therapy at a large mental health facility. Therapists were psychology interns, psychiatric residents, and social work trainees. Clients who were very satisfied with therapy (top 25%) were compared to clients who were very dissatisfied (bottom 17%) on their perceptions of therapy and their therapist. Results indicated that satisfied clients characterized their therapists as significantly warmer, more likeable, more active, and more involved compared to dissatisfied clients.

Antonuccio and colleagues investigated the relation between therapist warmth and group cohesiveness in a psychoeducational group treatment for depression (Antonuccio, Davis, Lewinsohn & Breckenridge, 1987). Group cohesiveness has previously been shown to be related to treatment outcome in group therapy (Schaffer, 1982). Eight leaders each conducted two treatment groups for clinically depressed adults. Clients were assessed at pre-treatment, post-treatment, and 1-month follow-up on various outcome measures. Group cohesiveness was rated by the group leader at the end of each session. Leader behavior during group sessions was rated by trained undergraduate observers using the McDaniel Observer Rating Scales. Results indicated a high degree of association between leader warmth and group cohesiveness (r=.72). Groups were more cohesive if their leaders were rated as warmer by independent observers. However, no

significant relationship was found between leader behavior and treatment outcome. These researchers suggest that this may have been due to a restricted range of outcomes resulting from very effective leaders and a highly structured treatment program.

Green and Herget (1991) investigated the extent to which therapist warmth predicted family therapy outcomes. Eleven therapists were rated by a team leader on degree of warmth after various sessions of family therapy. One month after the end of sessions, both clients and therapists rated the overall degree of client progress towards goals in a global rating. At 1 month and 3 year follow-ups, clients assessed the degree to which they had attained their main goal in therapy. Significant and positive correlations were obtained between therapist warmth and 1-month therapist global rating of outcome ($r = .63$, $p < .05$), 1-month client global ratings of improvement ($r = .63$, $p < .05$), 1-month client ratings of main goal ($r = .58$, $p < .05$) and 3-year client ratings of main goal ($r = .79$, $p < .01$). These results indicate a strong relationship between therapist warmth and client improvement in family therapy.

Williams and Chambless (1990) utilized a prospective design to assess the relationship between outcome following in vivo exposure treatment for agoraphobia and clients' perceptions of their therapists. Subjects were 33 agoraphobic clients who completed 10 sessions of in vivo exposure treatment at a university mental health clinic. Therapists were 23 graduate psychology students and volunteer mental health professionals. Outcome was measured using pre- and post-treatment scores on the Behavioral Avoidance Test. Clients rated their therapists on the Therapist Rating Scale following the fourth treatment session. The investigators reasoned that this allowed

the client sufficient time to form an opinion about the therapist while being early enough in the course of treatment to minimize the confounding effect of treatment progress on the client's view of the therapist. A correlation of .30 was reported between treatment outcome and client's perceptions of the therapist's level of caring and involvement. Clients who rated their therapists as more caring and involved thus showed greater improvement compared to clients who treated their therapists as less caring and involved. These investigators speculated that clients may be more willing to enter feared situations with a therapist whom they perceive as genuinely caring about their feelings.

Morris and Suckerman (1974a) investigated the role of therapist warmth in outcomes following systematic desensitization. Twenty-three female undergraduate students identified as snake phobics were assigned to one of three conditions: warm therapist, cold therapist, or a no-treatment control. Subjects participated in 2 sessions of relaxation exercises and 4 sessions of systematic desensitization. The warm therapist group showed significantly greater improvement compared to both the cold-therapist and no-treatment control groups. No difference in outcome was found between the cold therapist and no-treatment control conditions. These results suggest that therapist warmth plays an important role in positive treatment outcome in systematic desensitization.

In an extension of the Morris and Suckerman (1974a) study, the same investigators varied therapist warmth using an automated desensitization procedure (Morris & Suckerman, 1974b). Twenty-three female undergraduates identified as snake phobic were randomly assigned to one of

three groups: warm automated therapist group, cold automated therapist group, or a no-treatment control group. Treatment consisted of listening to 2 audiotaped sessions of relaxation training and four 20-minute audiotaped sessions of systematic desensitization. In the warm automated therapist condition the taped therapist spoke in a soft, melodic, and pleasant voice, while in the cold automated therapist condition the taped therapist was harsh, impersonal, and businesslike. Greater improvement was found in the warm automated therapist condition compared to both the cold automated therapist and the no-treatment control condition.

Some researchers have suggested that a cold therapist may be equally effective as a warm therapist with specific types of therapeutic procedures (e.g. Morris & Magrath, 1979). Using a similar design to that used in his earlier studies (Morris & Suckerman, 1974a, 1974b), Morris investigated the role of therapist warmth in contact desensitization treatment for adults with a fear of heights (Morris & McGrath, 1979). Nineteen height-fearful subjects were randomly assigned to one of three conditions: warm therapist, cold therapist, or no treatment control. Pre- and post-treatment measures were the Height Avoidance Test and the Fear Survey Schedule. Subjects in the warm and cold therapist conditions received the same contact desensitization procedure over 3 sessions. The warm therapists maintained eye contact and expressed friendliness and support while the cold therapists avoided eye contact and expressed a feeling of indifference. Subjects completed the Therapist Warmth Questionnaire after each session. Both subjects and independent judges rated the two types of therapists as significantly different in warmth. No difference was found between the warm- and cold-therapist conditions using the Height Avoidance Test as the

outcome measure. However, the cold therapist group reported significantly less fear at post-testing compared to the warm therapist group. Morris and McGrath concluded that therapist warmth was not a necessary condition for successful outcome in contact desensitization. This conclusion is questionable on several grounds. First, since subjects received only 3 sessions of therapy, it is likely that there was not sufficient time to develop a therapeutic relationship and for the relationship to have an impact on the subject. Second, failure to find a difference between the warm and cold therapist groups using the Height Avoidance Test as the outcome measure may suggest that the procedure was so effective or ineffective that it overshadowed the contribution of therapist warmth. Finally, no attempt was made to show that the warm and cold therapist groups were equal on pre-treatment levels of fear of heights. Perhaps lower post-test fear levels for the cold therapist were due to less fearful pre-treatment scores.

In summary, psychotherapy outcome research with an adult population has consistently indicated a positive relationship between therapist warmth and treatment success (Patterson, 1984). However, little research has investigated this association in child therapy (Morris & Nicholson, 1992).

Hostility

While few studies of the effects of hostility on therapeutic outcome were found, the research as it exists overwhelmingly supports its negative effect on outcome. According to Strupp (1973), patients prefer therapists who possess the attributes of good parents and decent human

beings. Such therapists are described as warm and empathic and low in hostility.

Lorr (1965) factor analysed 523 patients' responses to a behavioral checklist describing therapists behaviors. Five factors were isolated including one defined as Critical-Hostile. Items loading on this factor included: "Becomes impatient when I make mistakes", "Acts smug and superior as though he knew all the answers", "Gives the impression he doesn't like me", "Talks down to me as if I were a child", and "Is critical and not easily impressed". Clients perceived this type of therapist as critical, cold, impatient, competitive, and disapproving. The Critical-Hostile factor was negatively correlated with patients' perceptions of how understanding and accepting their therapists were. Patients' ratings of how critical and hostile their therapists were found to correlate negatively with patient ratings of improvement ($r=-.19$). Thus, patients who viewed their therapists as critical and hostile felt they improved less compared to patients who did not view their therapists in this way.

A striking example of the harmful effects of a hostile therapist was reported by Yalom and Lieberman (1971), who investigated a possible relation between client ratings of leader behavior in encounter groups and group casualties. Eighteen leaders conducted encounter groups involving a total of 209 university undergraduates. Sixteen group casualties were identified. A casualty was defined as an individual who as a direct result of his experience with the encounter group became more psychologically distressed and this negative change was an enduring one, as judged eight months after the group experience. Leaders were rated by encounter group members and were grouped into seven leader styles: Aggressive Stimulators, Love Leaders, Social Engineers,

Laissez-Faire, Cool/Aggressive Stimulators, High Structure, and Tape Leaders. Aggressive Stimulators were intrusive, confrontative, challenging, authoritarian, asserted firm control, took over from participants, were impatient, and insisted on immediate self-disclosure, emotional expression, and attitude change. Cool/Aggressive Stimulators were aggressive stimulators, but not to the extent of Aggressive Stimulators. These leaders were non-authoritarian, and rarely structured the meetings, and offered little positive support. Results indicated that, of the 16 casualties, seven had group leaders who were identified as Aggressive Stimulators, and 2 had group leaders who were Cool/Aggressive Stimulators. The five Aggressive Stimulator leaders thus produced 44% of the group casualties. Moreover, not only did they produce more casualties, but these casualties reported more severe psychological decompensation. The Cool/Aggressive Stimulators had casualty rates which were comparable to the other non aggressive leader types. These results provide compelling evidence for the harmful effects of a hostile leader.

In a study reviewed earlier, Najavits and Strupp (1994) investigated the different qualities of more and less effective psychodynamic therapists. Less effective therapists were rated as significantly more hostile than more effective therapists. Hostile behaviors included belittling, blaming, ignoring, neglecting, attacking, and rejecting. These researchers concluded that the basic qualities of effective human relationships, including warmth, affirmation, and a minimum of hostility, may be central to effective psychotherapy.

Jones and his colleagues studied clients' perceptions of the therapeutic relationship and therapist intervention techniques in crisis intervention and long-term psychodynamically oriented therapy (Jones, Wynne, & Watson, 1986). Forty patients were seen in dynamically oriented crisis intervention and 40 received long-term psychodynamic therapy. Sixty-one therapists, including psychologists, psychiatrists, and social workers, participated in the study. Clients' perceptions of their therapists were collected using the Client Post-Therapy Questionnaire. Clients' ratings on a factor termed Negative Experience was negatively related to various outcome variables rated by therapists and clients. The Negative Experience factor measures the degree to which the therapist was perceived as critical or sometimes making remarks that decreased clients' self-respect, and as creating some uncertainty as to whether the therapist considered them worthwhile people. These results indicate that clients who improved less in therapy had therapists who were more critical and hostile than clients who had more successful outcomes.

Enthusiasm

Several authors have identified enthusiasm as an important quality in effective therapists (e.g. Kottler, 1991; McConnaughy, 1987). According to Kottler (1991), great therapists have strong personalities and powerful personas. They radiate positive energy, they are witty, upbeat, enthusiastic, and are good communicators. Successful therapists are interesting and fun to be around. McConnaughy (1987) stresses the importance of the therapist's enthusiasm for personal growth:

> Therapists' interest in their personal development is critical to their ability to assist clients to change. A vital, creative therapist is going to bring this vitality to his or her clinical work, and the clinical work can in turn enhance the therapist's process of self-discovery. The therapist's enthusiasm for personal growth will be conveyed to the client, and this quality can serve to influence the client's movement toward positive change. (p. 305)

A measure of therapist enthusiasm is the degree to which the therapist is interested in helping his patients. In addition to comparing the efficacy of different treatments for drug abuse, Luborsky and his colleagues investigated the role of enthusiasm in treating drug-dependent male veterans (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985). Therapist levels of interest in helping their clients correlated moderately, but not significantly, with various outcomes at seven-month follow-up. The investigators reasoned that the .05 significance level was not reached primarily due to the small sample of nine therapists.

Bennum and his colleagues reported results from two studies, one based on a German population and one on a English population, which involved the development of a questionnaire to measure clients' perceptions of therapists (Bennum, Hahlweg, Schindler, & Langlotz, 1986). Factor analysis of the measure yielded three factors: Positive regard/Interest, Competency/Experience, and Activity/Direct Guidance. The Positive Regard/Interest factor included items which rated the therapist as sympathetic, friendly, cooperative and interested. This factor appears to measure two variables, namely warmth (or unconditional positive regard) and

interest in helping patients. In the German study, client ratings of therapist Positive Regard/Interest correlated moderately with client and therapist ratings of outcome (correlations ranging from .23 to .38). In the English sample, moderate to high correlations were reported between these same variables (correlations ranging from .37 to .65). These results highlight the important role of therapist warmth and interest in helping patients on therapeutic outcome.

Self-Confidence

Several authors suggest that therapist self-confidence contributes to therapeutic effectiveness. McConnaughy (1987) has argued that the therapist's belief in the individual's capacity for change and his/her belief in the efficacy of psychotherapy helps the client feel safe enough to risk the pain and confusion inherent in undergoing personality change. He believes that through formal training and personal development, the therapist learns to believe in him/herself enough to become an effective model of identification for their patients. Kottler (1991) suggests that therapists perceived as confident and credible by their clients are more effective. These therapists are:

> ...people at ease with themselves, natural in their gestures and movements, as if every part of them is an expression of an inner core that is satisfied and self-assured. They are comfortable in their bodies; with their words and nonverbal cues, they communicate that they know who they are, where they have been and where they are going. (p.88)

Clients in two marriage and family training clinics rated their therapists on various therapist variables including experience, confidence, concern, fit of treatment, and whether the therapist knew how to deal with their concerns (Crane, Griffin & Hill, 1986). Therapists were masters- and Ph.D.-level graduate students. Results indicated that client ratings of concern, fit of treatment, and knowing how to deal with concerns accounted for 36% of the variance in overall client ratings of the therapist. Therapist confidence was not a significant predictor. However, as Crane and his colleagues point out, retrospective client ratings of therapists six to eighteen months following therapy termination are subject to various forms of subject bias and should be interpreted cautiously. In addition, beginner therapists may be likely to show less confidence in their skills. Consequently, variability in confidence ratings across therapists had a small range likely and may have been responsible for the non-significant finding.

In a study reviewed earlier, William and Chambless (1990) studied the relationship between therapist characteristics and outcome following in vivo exposure treatment for agoraphobia. Thirty-three clients participated in 10 sessions of treatment. Therapists were 23 graduate psychology students and volunteer mental health professionals. These authors reported a moderate correlation between client ratings of therapist self-confidence and treatment outcome (r=.39). Clients who perceived their therapists as more self-confident demonstrated greater treatment gains on the Behavioral Avoidance Test. In vivo exposure treatment for agoraphobic clients is stressful, requiring them to directly confront and enter situations which they find fearful. William and Chambless argue that the therapist's skill in handling difficult situations in a confident

manner may reassure clients that they too can deal successfully with stressful situations.

Sociability

Sociability refers to an individual's tendency to seek out and enjoy the company of others (Lorr, 1986). Like extraverts, sociable people are more involved in the outer world of people and things; they prefer to focus on the outside environment (Brigg-Myers, 1980). There is little research on this variable. However, in a recent study, Nelson and Stake (1994) investigated the association between quality of the therapeutic relationship and therapist scores on the Myers-Briggs Type Indicator. Thirty-five experienced therapists (average of 9.3 years of experience) conducted therapy with one or two clients for a median of 45 sessions. Fifty-three adult clients participated in the study. Results indicated that clients' and therapists' ratings of the quality of the therapeutic relationship were more positive when therapists rated themselves as more extraverted (r=.30 and r=.34, respectively). The authors suggest that, since extraverts focus more strongly on people in their environment, they may express themselves and convey understanding and caring to their clients more successfully. These results may indicate that high expressiveness and level of interaction between extraverted therapists and their clients may lead to a more positive relationship.

Summary

A substantial amount of research has accumulated to indicate that therapist relationship variables including empathy and warmth are positively related to outcome in adult psychotherapy (Patterson, 1984). Only one study investigated the role of empathy in a cognitive behavioral treatment to increase self-control in chronically delinquent children (Kendall & Wilcox, 1980). While results in this study supported a positive relation between therapist empathy and outcome, additional research is required before conclusions can be made regarding the contribution of this variable to child cognitive-behavioral therapy. While only four studies were found that investigated therapist hostility in adult therapy, the results have provided overwhelming support for the negative effects of this variable (e.g. Lorr, 1965). No research was located on the effect of therapist hostility in child therapy. Little research has investigated therapist enthusiasm, self-confidence, and sociability in relation to outcome in either child or adult therapy. However, one study reported a significant relationship between therapist interest in helping his adult patients and therapeutic outcome (Bennum, et al., 1986), providing some evidence for the role of therapist enthusiasm. Therapist self-confidence was found to be a factor in vivo exposure treatment for agoraphobia (William & Chumbles, 1990), but was not a factor when rated retrospectively 6 to 18 months after therapy (Crane, et al., 1986). One study reported a positive association between therapist extraversion and client and therapist ratings of the quality of the therapeutic relationship (Nelson & Stake, 1994). Since extraversion refers to the degree to which an individual seeks out the outer world of people and things, this study provides indirect support of the role of therapist

sociability in adult therapy.

The research on therapist variables to date has focused largely on adult therapy (Morris & Nicholson, 1993), and on the role of relationship variables (Beutler, et al., 1994). Research on therapist variables such as enthusiasm, hostility, self-confidence, and sociability are lacking. Furthermore, very little research has investigated therapist variables in relation to child therapy.

Children's Social Skills Training

Extensive research suggests that poor peer relationships in childhood are associated with high risk for later maladjustment and social difficulties (Parker & Asher, 1987; Kupersmidt, Coie, & Dodge, 1990; Ladd & Asher, 1985). Studies have reported that early peer rejection is associated with poor self-esteem (Percell, Berwick, & Beigel, 1974), delinquency (Roff, Sells, & Golden, 1972), depression (Wolpe, 1973), poor academic achievement (Hartup, 1970), adult alcoholism, antisocial behavior, and other adult psychiatric disturbances (Parker & Asher, 1987). In addition, social adjustment difficulties frequently represent an important component of several types of childhood emotional disorders, including conduct disorder, depression, anxiety disorders, and Attention Deficit Hyperactivity Disorder (Matson, Sevin, & Box, 1995). French and Tyne (1982) reported that 5 to 15% of elementary school aged children experience difficulties with interpersonal relationships. Strain and his colleagues have reported that 14 to 30% of children referred for clinical services demonstrated peer relationship problems (Strain, Cooke, & Apolloni,

1976). Evidence linking childhood problems with peers to lack of psychological well-being and poor outcomes later in life has led investigators to develop intervention programs designed to foster positive peer interaction and promote peer acceptance (Bierman, 1986).

In the following section social skills and social skills training will be defined, along with purported causes of deficient social skills functioning. A summary of the major training techniques utilized in social skills training is provided. This is followed by a review of the effectiveness of SST interventions with aggressive children.

Children's social skills training: Definition

La Greca (1993) defines children's social skills as " positive social behaviors that contribute to the initiation and maintenance of positive social interaction" (p.288). Cartledge and Milburn (1986) suggest that social skills are, "socially acceptable learned behaviors that enable a person to interact with others in ways that elicit positive responses and assist in avoiding negative responses from them" (p.7). Gresham and Elliot (1990) have identified five general response classes of social skills including cooperation, assertion, responsibility, empathy, and self-control. It is important to make the distinction between skills, performance, and competence (O'Donohue & Krasner, 1995). Skills refer to whether or not a behavioral response is in an individual's repertoire, while performance is the degree to which the person displays a behavioral response which is already in his/her repertoire. Thus, an individual may have a response in his/her repertoire, but may not perform this behavior perhaps due to some competing state such as

anxiety or anger arousal. Competence refers to how the individual's performance of the skill affects the environment. Hops (1983) defines social competence as a summary term which reflects social judgement about the quality of a person's performance of a particular social skill.

Elliott and Gresham (1993) have proposed several reasons why children may be deficient in social skills, including lack of knowledge, insufficient practice or feedback, lack of cues or opportunities to learn skilled behaviors, lack of reinforcement, and the presence of interfering problem behaviors. As these authors note, a social skills deficit in a particular child may be a result of one or more of these factors. Some children may be deficient in a given social skill because they simply lack the social knowledge pertaining to that skill. The deficiency may be in one or more of the following areas: lack of knowledge of appropriate goals, lack of knowledge of behavioral strategies to attain these social goals, or difficulty recognizing appropriate contexts for the use of the skill. Some children fail to exhibit a newly learned social skill because they have not had sufficient opportunity to practice using the skill. This is referred to as a performance deficit rather than a knowledge deficit because the child has the requisite knowledge but performs this skill in an incompetent manner due to insufficient practice. Moreover, fewer opportunities to practice the newly acquired skill result in less feedback on how to alter social behavior and further refine the performance of the skill. A third potential reason for social skills problems is the lack of cues in the child's environment that would prompt the use of a newly learned skill. As noted by Elliott and Gresham (1993), social skills interventions should ensure that skills are taught under many different social cue conditions to facilitate generalization. Some children may fail to perform a

skill due to lack of reinforcement of that skill from peers or significant others in the child's environment. Finally, children may fail to perform or acquire a given social skill due to the presence of interfering problem behaviors. This is referred to as the competing states model. Examples of competing problem behaviors include distractibility and impulsivity associated with Attention Deficit Hyperactivity Disorder. An important assumption concerning social skills is that they are primarily acquired through learning which involves observation, modeling, rehearsal, and feedback (Michelson, Sugai, Wood, & Kazdin, 1983). Consequently, social skills intervention efforts should focus on providing learning experiences to introduce new skills into a child's repertoire.

Goldstein (1982) defines psychological skills training as, "the planned, systematic teaching of the specific behaviors needed and consciously desired by the individual in order to function in an effective and satisfactory manner, over an extended period of time, in a broad array of positive, negative, and neutral interpersonal contexts. The specific teaching methods which constitute social skills training directly and jointly reflect psychology's modern social learning theory and education's contemporary pedagogic principles and procedures"(p.3). Social skills training is thus a psychoeducational intervention designed to teach or facilitate positive social skills in children who demonstrate peer relationship difficulties (La Greca, 1993). The major purpose may include teaching new skills not in a child's repertoire, strengthening the use of existing skills, or eliminating barriers to skill performance (Ladd, 1984). Teaching social skills is similar to teaching academic concepts. Both effective school teachers and SST trainers model appropriate or expert

skill performance, give the children opportunities to practice the newly acquired skill, and provide corrective feedback (Cartledge & Milburn, 1986). The following section provides a description of the various major intervention techniques used in children's social skills training.

Social Skills Training Techniques

Four major social skills training techniques have been identified by several investigators (Schneider, 1992; Matson et al., 1995; Gresham, 1985). These include operant procedures, modeling, coaching, and social cognitive techniques.

Operant procedures refer to the use of social or material reinforcement of specific social skills in either a natural or analog setting (Schneider & Byrne, 1985). These methods, which were derived from the applied behavior analysis literature, typically include reinforcement, punishment, shaping, and chaining (Matson et al., 1995). Behaviors targeted for intervention are operationally defined and may include behaviors such as eye contact, sharing, or disruptiveness in the classroom. The use of operant procedures assumes that the child is displaying a knowledge or performance deficit (Elliott & Gresham, 1993). This intervention technique is typical of earlier studies which focused on increasing low-accepted children's frequency of interaction with peers (Coie & Koeppl, 1990).

Modeling involves the presentation of filmed or live demonstrations of a target social skill (Schneider & Byrne, 1985). This procedure is based on the social learning principle of observational learning (Bandura, 1977), which suggests that a child may add a new behavior to

his/her repertoire simply by seeing or hearing someone else perform this behavior. In other words, children seek to reproduce what they observe. Children are more likely to learn a behavior when they observe it being reinforced (Bandura, 1977). In most SST packages which include modeling, modeling is typically combined with other techniques including coaching, roleplaying, behavioral rehearsal, corrective feedback, and operant procedures (Matson et al., 1995).

Coaching refers to the use of direct verbal instruction and discussion in the teaching of the target skill (Schneider & Byrne, 1985). Coaching involves three steps (Elliott & Gresham, 1993). First, the trainer uses verbal instruction to define, explain, and prompt the child in the use of the target skill. Next, the trainee rehearses the skill with the coach. The coach then provides feedback and offers suggestions on how to improve future performance of the skill. As noted by Elliott and Gresham (1993), coaching involves telling the child how to perform the given skill, while in modeling the trainer instructs the child by showing or demonstrating the skill.

Schneider and Byrne (1985) identified a fourth category of SST intervention techniques, social-cognitive, which refer to intervention techniques that focus on the cognitive processes associated with social competence. These cognitive-behavioral techniques emphasize training children in problem solving skills and in regulating their behavior. Both these cognitive approaches are based on the assumption that cognitions play a major role in affecting behavior and consequently that a socially unskilled child's behavior may be a result of inadequate thinking styles (Cartledge & Milburn, 1986). The finding that children with good problem solving abilities demonstrate better social adjustment than poor problem solvers (Richard & Dodge, 1982) has

provided support for formal training of socially deficient children in problem solving skills. Social problem solving steps include identifying the problem, generating several alternative solutions to the problem, evaluating each solution, choosing a solution and trying it, and evaluating the effectiveness of the applied strategy (Cartledge & Milburn, 1986). The second major cognitive-behavioral technique is training in altering a child's self-statements. This technique is exemplified by Meichenbaum's (1985) stress-inoculation training which emphasizes the development of thinking skills and verbal mediators to be used in stressful situations. First the child is engaged in a discussion designed to help him/her understand and conceptualize the problem. The child is then given training in four types of coping self-statements designed to help the child prepare for the stressor, confront and handle the stressor, deal with feeling overwhelmed, and produce reinforcing self-statements. The child then practices using these skills in roleplaying situations.

Most social skills training packages utilize a combination of several SST techniques (Gresham, 1985; Schneider, 1992). For example, in Schneider's (1992) meta-analysis of SST studies, 25 of 79 studies utilized combined techniques including modeling and coaching (12 studies), modeling and social cognitive techniques (8 studies) and coaching and social cognitive techniques (5 studies). An example of a treatment package which uses a combination of techniques is Goldstein's (1988) structured learning method. A social skill is first broken down into specific skill steps. For example, skill steps for making a friend are planning what you want to say, walking over, introducing yourself and asking the person his/her name, and talking or asking if he/she would like to do something. The importance of learning the skill is discussed, along with

presentation of the skill steps (coaching). Next, the leader models the use of the skill through a roleplay. Each trainee then practises using the steps through roleplays and receives feedback from the leader and group concerning the adequacy of the roleplay.

Effectiveness of SST with Aggressive Children

The purpose of this section is to provide a summary of the research investigating the effectiveness of SST interventions with aggressive children. The review is selective in that it focuses exclusively on published studies whose subjects were aggressive latency-aged children between the ages of 6 and 12.

Studies using operant or coaching techniques. In a well designed study, Bierman and her colleagues compared the effects of a program using coaching and positive reinforcement to a program using prohibitions and response cost for negative behaviors with 6 to 10 year-old peer-rejected boys (Bierman, Miller, & Stabb, 1987). Thirty-two 6 to 10 year-old rejected boys were randomly assigned to one of four conditions: coaching/positive reinforcement condition, prohibition/response cost condition, combined treatment condition, or a no-treatment control condition. In the coaching/positive reinforcement condition, coaches began each session by describing and eliciting examples of the target prosocial skill. As the children participated in various play activities, the coach positively reinforced each use of a target behavior through social praise and token reinforcement. The prohibition/response cost condition involved the coach setting various rules targeting negative behaviors during a play period (e.g. no fighting, no

whining, etc.). While the children played cooperatively without violating any rules, tokens were rewarded on a random schedule. Violation of a rule resulted in removal of a token. In the combined condition, the coach both instructed and reinforced pro-social target skills and set prohibitive rules and removed tokens for negative behaviors. Boys in the prohibition/response cost condition evidenced significantly fewer negative behaviors and received more positive behavior from their peers during play sessions at post-treatment compared to no treatment controls. Boys in the coaching/positive reinforcement condition initiated and received fewer negative behaviors and more positive behaviors compared to no-treatment controls at 1-year follow-up. Bierman notes that as predicted, these results indicate less immediate but more stable behavioral improvements for the coaching/positive reinforcement group. As predicted by the investigators, the combined treatment group demonstrated immediate post-treatment decreases in initiations of negative behaviors, and decreases in negative peer responses and stable positive peer interactions at 1-year follow-up. In addition, boys in the combined treatment program received significantly fewer negative peer nominations at post-treatment and at 1-year follow-up. Bierman notes that, the failure to observe changes in peer acceptance due to treatment is consistent with previous studies. This may be due to trainees failing to generalize new skills to the natural setting or failure to maintain the use of these new behaviors long enough to affect peer reports. In addition, children may be utilizing newly learned skills, however, peers may be rigid in their expectations and stereotypes.

Studies using multi-treatment SST packages. Coie and Krehbiel (1984) compared the effectiveness of academic tutoring and social skills training with low achieving, socially rejected children. For the purposes of this study only the results of the SST intervention will be discussed. Forty 9-year old children were randomly assigned to an academic tutoring group, an SST group, a combined group, or a control group. The SST intervention consisted of 6 individual sessions where children were paired with another child from the classroom and were coached on four prosocial skills (participation, cooperation, communication, and support) both before and after the play session. This was the same intervention developed by Oden and Asher (1977). Each subject then participated in 6 group sessions of social problem solving designed to enhance problem solving skills through discussion, practice roleplay, and feedback. Social skill sessions were conducted by advanced undergraduate students. Results indicated no significant differences between the social skills and control groups in classroom behavior. Minimal improvement was evidenced on peer-ratings on a 5-point play preference scale. This improvement at post-treatment disappeared at 1-year follow-up. The investigators note that, given the severity of behavior problems in the subject sample, positive effects might have been obtained if the intervention program had been longer in duration. In addition, the SST program may have had a minimal effect because it failed to tailor the program to the observed skill deficits in the target group.

Schneider (1991) compared the relative effectiveness of a cognitive-behavioral SST package to a desensitization/guided imagery condition with aggressive institutionalized latency-aged children. He speculated that cognitive-behavioral interventions have achieved only minor

success with aggressive children because they rely too heavily on cognitive mediation of aggressive behavior. Schneider argued that children's aggressive behavior may be more impulsive and consequently less subject to cognitive control. Instead he argued, intervention should focus on increasing aggressive children's levels of self-control in situations of arousal. Subjects were randomly assigned to the cognitive-behavioral skill building condition or the desensitization/imagery condition. The skill building condition consisted of problem solving, perspective taking exercises, videotaped modeling, roleplay practice, and feedback. In the desensitization condition, children were trained to achieve a relaxed state and this was paired with visualization of a troublesome social stimulus. Both conditions showed a similar decrease in observed aggressive behavior (from 3 incidents of aggression per 40 minute period to an average of approximately 1 incident per period). Cooperative behavior increased significantly in both groups. No changes were observed in either condition on teacher ratings of self-control.

Schneider and Byrne (1987) compared individualized and non-individualized SST with emotionally and behaviorally disturbed latency aged institutionalized boys and girls. Twenty-eight subjects were randomly assigned to the individualized treatment, the non-individualized treatment, or wait-list control groups. Each child in the individualized treatment group received training on predetermined skill deficit areas. Children in the non-individualized treatment group received randomly chosen sessions from 24 possible modules in 4 skill clusters: social perception, social cognition, coping with conflict, and forming friendships. Both treatment groups indicated mastery of the behavior training objectives as measured by role play tests. The individualized treatment

group showed significant gains in cooperation observed on the play ground, whereas no changes were found for the other two groups. No significant decreases in physical aggression were found for any of the groups. The authors suggest that these results fail to provide support for the use of individualized training over non-individualized training. However, given the lack of significant treatment effects in both treatment conditions, additional inquiry into this issue is warranted.

Lochman and his colleagues investigated the relative effectiveness of a treatment package of different cognitive-behavioral techniques with aggressive and non aggressive rejected children (Lochman, Coie, Underwood, & Terry, 1993). The package consisted of 7 individual sessions of social problem solving, nine individual sessions of SST designed to enhance playing and friendship skills, 14 group sessions on group entry skills, and 4 individual sessions of self-instructional training to learn to cope with angry feelings. Leaders were psychology graduate students and a doctoral level psychologist. Eighty-six children were randomly assigned to treatment or control groups based on their aggression and rejection scores: aggressive-rejected intervention group (N=13), aggressive-rejected control group (N=11), non aggressive-rejected intervention group (N=33), and non aggressive-rejected control group (N=29). Results indicated that the aggressive-rejected intervention group had significant reductions in teacher ratings of aggression and rejection at post-treatment, and a significant decrease in teacher rated aggression and increase in teacher rated pro-social behavior at 1-year follow-up compared to the control group. A significant increase in peer-nominated acceptance at post-treatment was found in the aggressive-rejected treatment but not in the control group. No significant findings were reported for the non

aggressive-rejected groups. As these investigators suggest, these results provide strong documentation for the effectiveness of a cognitive-behavioral/social skills training treatment package for aggressive-rejected children, suggesting that intervention strategies and goals should be designed to meet the identified deficits of subgroups of behaviorally homogeneous children. These findings are consistent with previous promising findings (e.g. Kazdin, 1987).

Middleton and Cartledge (1995) investigated the effectiveness of a social skills training package with five 6 to 9 year-old aggressive boys. The training package consisted of modeling, roleplaying, corrective feedback, differential reinforcement of incompatible behaviors, parental involvement, and maintenance programming. The training was completed through several phases. First, observations of aggressive behavior were conducted in the classroom, gym, and playground to determine pre-treatment baseline levels. Efforts were made to review observational data carefully to ensure that the SST program specifically addressed the children's skills deficits. The second phase consisted of 12 sessions of SST conducted in small groups with one target aggressive child and two competent peers. Parent involvement at this phase included "home sessions" where the parent asked the child to demonstrate the skill learned that day and praised the child for a correct portrayal of the skill. This was followed by a second baseline phase during which treatment was stopped for 10 weeks. The fourth phase involved additional SST sessions, parental involvement, and classroom coaching. In the classroom, observers and teachers looked for opportunities to provide instruction and reinforce the use of skills taught in the SST program. The final phase involved follow-up observations of aggressive behavior in the classroom and on

the playground. Significant reductions in observed aggressive behavior were recorded for 4 of the 5 children and for the group as a whole. A 38% reduction in aggressive behavior was recorded after the first treatment phase. With removal of the program, aggressive behavior increased 15% from the post-first treatment phase. Following the second treatment phase, a 79% reduction of aggressive behavior was observed. These results provide strong evidence of the effectiveness of a multi-component SST package in reducing observed aggression at school. While the impact of these components was not assessed separately, procedures such as parental involvement, training directly to observed skill deficits, and the use of competent peers as models were likely important contributing factors. Noteworthy is the marked decrease in aggressive behavior (79%) following the use of coaching and the differential reinforcement of target skills in the regular classroom. The investigators argue that these findings suggest that, in order for behavioral maintenance of decreases in negative behavior to occur, repetitive, extensive SST instruction, combined with incidental teaching and reinforcement by teachers, parents, and peers is likely necessary. Middleton and Cartledge (1995) emphasize that, for aggressive children, concerted instruction should be extended over a period of many weeks or possibly years. The authors note that limitations of this study included the failure to measure changes in peer acceptance, that observations of the occurrence of newly learned behaviors were not assessed, and that a longer follow-up period was not included to determine the maintenance of newly learned skills.

Studies using problem solving intervention programs. In an early investigation of the effect of problem solving on aggressive children, Pitkanen (1974) compared observations of aggressive and prosocial behavior during a contrived task in a laboratory classroom for 12 children who received problem solving and a no-treatment control group. The social problem solving program was delivered by trained teachers and consisted of problem solving following the presentation of slides of conflict situations. In the second phase of the training, strategies developed in problem solving sessions were practised through roleplaying. Results indicated a significant decrease in aggressive behavior for the problem solving group compared to the no-treatment control group. However, these results have questionable social validity given that observations of aggressive behavior were conducted during contrived tasks in a laboratory classroom setting.

Camp and her colleagues investigated the effectiveness of the Think Aloud Program in teaching self-control to aggressive boys (Camp, Blom, Hebert, van Doorninck, 1977). Twenty-three aggressive second grade boys were randomly assigned to the 'Think Aloud' condition or to the control group. The 'Think Aloud' condition children received thirty 30 minute sessions of problem solving training led by teachers over a 6 week period. Children were trained to develop several alternative solutions to interpersonal situations, to anticipate consequences, and to evaluate outcomes. Results indicated that the 'Think Aloud' group showed significantly greater decreases in impulsivity compared to the control group. These investigators noted that emotionally and behaviorally disturbed children have difficulty generating solutions to problems compared to normal children. After training, the 'Think Aloud' group were able to generate more

solutions compared to the control group. However, a high proportion of these solutions involved the use of aggression. The 'Think Aloud' condition showed significantly greater gains in teacher rated prosocial behavior compared to the control group, but evidenced no change in teacher rated aggression. These results demonstrate successful use of problem solving in improving problem solving skills and prosocial classroom behavior in aggressive children.

Lochman and his colleagues compared the effectiveness of problem solving and operant procedures in reducing aggression and disruptiveness in aggressive 9 to 12 year old boys (Lochman, Burch, Curry, & Lampron, 1984). Seventy-six subjects were assigned on a rotating basis to one of four conditions: operant, problem solving, problem solving and operant, and no treatment. The operant treatment lasted 5 weeks and involved setting behavioral goals which were monitored and reinforced by a teacher. The problem solving condition consisted of 12 weekly sessions designed to increase social problem solving skills. Results indicated significant decreases in observed aggressive and disruptive behavior and parent ratings of aggression for problem solving and combined problem solving and operant conditions. No significant changes in peer nominated acceptance or aggression were found. The authors reported that addition of the operant procedures to the problem solving condition tended to augment the treatment effects. This suggests that external reinforcement and monitoring of behavior in the classroom is a useful adjunct to cognitive-behavioral treatment.

Lochman and Curry (1986) compared the relative effectiveness of two cognitive-behavioral interventions with twenty 9 to 11 year old aggressive boys. The subjects were assigned using a comparison group design to one of two conditions, the problem solving/operant condition or the problem solving/self-instructional/operant condition. Children in the first condition received 12 sessions of problems solving training as described in Lochman et al. (1984) and an additional 6 sessions of problem solving. In addition, the children set weekly classroom goals which were monitored and reinforced by the teacher (operant procedure). Children in the second condition received the same 12 session of problem solving, the operant procedure, and 6 sessions of self-instructional training to decrease off-task classroom behavior. Both conditions showed significant decreases in parent ratings of aggression and increases in self-rated self-esteem and observed classroom on-task behavior. In addition, the children in the problem solving/operant condition had significant decreases in observed disruptive and aggressive classroom behavior. While these results support the usefulness of cognitive-behavioral techniques with aggressive children, several caveats are noteworthy. Conclusions concerning the effectiveness of these interventions are tenuous given the lack of a control group. However, as the authors point out, the effectiveness of the problem solving program was established by Lochman et al. (1984) and the purpose of the current study was to compare the two treatment conditions. In addition, both conditions used an operant procedure designed to enhance on-task classroom behavior. Consequently, as Lochman et al. (1984) noted, it is difficult to discern the relative contribution of the cognitive-behavioral and operant techniques to treatment outcome.

Lochman (1992) conducted a 3-year follow-up of children who had completed Lochman's problem solving program in several previous investigations. Results indicated that aggressive children displayed lower levels of substance abuse problems compared to the no-treatment aggressive control group. Furthermore, they had rates of drug involvement comparable to the non aggressive low-risk group. No differences were found between the treatment and control group on rates of delinquent behavior. The aggressive treatment group displayed higher levels of self-esteem and showed greater gains in problem solving skills relative to the control group. Children who received booster sessions showed lower levels of passive off-task behavior in the classroom. Lochman indicated that these results are consistent with the findings of other researchers (e.g. Kazdin, 1987) who support the use of intensive interventions that extend over long periods of time. Overall, these results indicate that cognitive behavioral interventions with aggressive boys can produce long-term effects in specific areas of functioning.

Kazdin (1985) has noted that few studies investigating the effectiveness of cognitive-behavioral treatments with aggressive youth have utilized clinic samples. Consequently, Kazdin and his colleagues evaluated the effectiveness of problem solving skills training and nondirective relationship therapy with seriously disturbed antisocial children (Kazdin, Esveldt-Dawson, French, & Unis, 1987). Fifty-six children who were referred for inpatient treatment for antisocial behavior at a psychiatric facility were randomly assigned to problem solving skills training, relationship therapy, or a treatment-contact control group. The problem solving condition met for 20 sessions of individual training with a clinician. Sessions utilized modeling, roleplay, corrective feedback,

and social reinforcement to develop problem-solving skills. Children in the relationship therapy condition received 20 sessions of individual nondirective relationship therapy. Children in the control condition met with a therapist for 20 sessions and engaged in discussions concerning routine activities. Results indicated significant decreases in parent ratings of Internalizing, Externalizing and Total Behavior Problem scores on the Child Behavior Checklist both at post-treatment and at 1-year follow-up for the problem solving condition. Children who received problem solving training also showed significant decreases in aggression and increases in school adjustment compared to the control group. Children in the relationship therapy condition evidenced significant decreases in parent ratings of Externalizing Problems and teacher-rated aggression compared to the control group. These results are tempered by the finding that while significant effects were demonstrated predominantly for the problem solving condition, most of these children's scores still remained in the clinical range. Consequently, while significant changes occurred in these children's behaviors both at home and at school, clinically significant behavioral problems still remained. A second important consideration when interpreting these findings is the confounding role of the effect of other interventions which these children received during their hospitalization.

Guevremont and Foster (1993) investigated the impact of a problem solving intervention followed by a generalization programming procedure for five aggressive 11 to 12 year old boys. Each child received 18 sessions of individual problem solving training. This consisted of modeling, roleplay, and feedback sessions of problem solving to vignettes identified as problematic for the

child. The generalization program involved completing a brief daily problem solving log. Each child showed significant increases in problem solving skills including number of solutions, quality of solutions, and quality of means for achieving the best solution. Observational data indicated minimal short-term changes in classroom disruptiveness and aggression only after the generalization program. The authors suggest that these changes are as likely a function of the generalization program as of the problem solving intervention. These results suggest that cognitive-behavioral interventions with aggressive boys may result in limited treatment outcomes.

Summary. Investigations of the use of SST interventions for aggressive children have produced mixed findings. The usefulness of operant techniques in decreasing observable aggressive behavior and increasing observable pro-social behavior is well documented (e.g. Bierman et al., 1987). Moreover, operant procedures may be especially effective as an adjunct technique in multi-treatment packages (e.g. Middleton & Cartledge, 1995). It is generally difficult to ascertain the specific contribution of coaching as an effective technique because it is combined with other treatment techniques. Regardless of this, several of the studies using coaching techniques reported positive findings. Five studies utilizing multi-treatment packages with aggressive children were reviewed. Four of these studies utilized packages including cognitive-behavioral techniques. Three studies provided strong support for the effectiveness of multi-treatment packages demonstrating significant decreases in observed aggression (Schneider, 1991; Middleton & Cartledge, 1995) and decreases in teacher ratings of aggression and increases in

teacher ratings of prosocial behavior in one study (Lochman et al., 1993). Two studies provided only minimal support for the usefulness of multi-treatment packages with aggressive children (Coie & Krehbiel, 1984; Schneider & Byrne, 1987). Studies investigating the effectiveness of cognitive-behavioral techniques alone with aggressive children have produced mixed findings (Lochman, 1992; Guevremont & Foster, 1993). Studies have replicated improvements in problem solving ability, classroom behavior, self-esteem, and parent ratings of aggression. Lochman (1992) has demonstrated long-term effects of these techniques at 3-year follow-up for a limited set of outcomes. Other studies have produced only limited effects (e.g. Camp et al., 1977). Guevremont and Foster (1993) have noted several problems with research on social problem solving with aggressive children. First, as noted previously, while positive effects have been found, some studies have failed to demonstrate a significant treatment effect. Some studies have demonstrated improvements in problem solving abilities; however, these changes have not translated into changes in behavioral adjustment. Except for a few studies, many have failed to utilize behavioral observations as an outcome measure, making it difficult to determine if changes in problem solving lead to changes in behavior. Many studies included additional treatment components, making it difficult to evaluate the specific contribution of problem solving skills to treatment outcome. Finally, most studies did not include generalization procedures.

Schneider (1992; 1987) has reported lower effect sizes of SST for aggressive children than for withdrawn children. He (Schneider, 1991) suggested that these lower effects may be due to several factors. First, given the complex etiology of aggressive behavior in children (causes may

include improper modeling, harsh parenting, hormonal and neural mechanisms, and frustrating environmental conditions), no single intervention can be expected to address all causes. In addition, Schneider suggested that SST interventions with aggressive children rely too heavily on cognitive mediation of aggressive behavior. He proposed that children's aggression in natural settings may be more impulsive in nature and consequently not subject to the degree of cognitive control expected by investigators. Schneider (1991) proposed that interventions should focus more on training for self-control in situations of arousal. In addition, cognitive-behavioral and social skills programs should develop interventions that match the identified deficits of subgroups of homogeneous children (Lochman, et al., 1993; Middleton & Cartledge, 1995; Coie & Krehbiel, 1984). Many studies have failed to train specifically for these deficits and this may have been a factor in the negative findings reported. As noted by Guevremmont and Foster (1993) and others (e.g. Schneider, 1992), scant attention has been payed to developing generalization programming procedures to encourage the use of newly learned skills in various settings. Finally, several investigators strongly stress the importance of intervening with aggressive youth in a concerted and intensive manner over a period of weeks or possibly years (Middleton & Cartledge, 1995; Kazdin, 1987; Lochman, 1992).

The Role of Therapist Characteristics in Children's SST

While research indicates a moderate overall effect for children's SST, there is wide variability in the effectiveness of SST interventions across different studies (Schneider, 1988; Weissberg, 1985; also see review of SST with aggressive children above). The variables explored to date cannot fully explain these fluctuations in outcome. One moderating factor which has recently been suggested as a key one is the role of leader characteristics (Schneider, 1989; Weissberg, 1985). Unfortunately, little is currently known about the impact of this variable on SST outcome or in child therapy in general (Morris & Nicholson, 1993). This is probably due to the fact that SST research is relatively recent compared to the therapist variable literature, which was mostly compiled before 1980. Furthermore, SST research has focused predominantly on determining the effectiveness of different training strategies and investigating which populations of children they work best with (O'Donohue & Krasner, 1995). The purpose of this section is to present the main thesis of this study, that various leader variables should be related to outcome in children's social skills training. First, a model of SST based on social learning theory will be presented to account for how therapist variables affect outcome in SST. Several issues need to be addressed in determining which therapist variables might play a role in children's SST. Given that therapist variables have been shown to be a factor in adult psychotherapy, how does this information help us in choosing which variables might impact on psychoeducationally-based skills training with children? The relationship between adult and child therapy will be discussed in order to determine the applicability of the adult therapist variable literature to child therapy. The role of

therapist variables in structured cognitive behavioral therapy is then presented. Finally, the hypotheses for the study are presented.

Social Learning Model. Ladd and Mize (1983) proposed a cognitive-social learning model of social skills training to explain skill acquisition occurring as a result of SST. According to social learning theory, children form cognitive concepts of behaviors from learning experiences such as listening to verbal instructions or observing an individual model a specific behavior (Bandura, 1971). These concepts are stored by the learner as guides for future performance. Learners may be motivated to perform the behavior if they observe others being reinforced for this behavior or if they are directly reinforced for performing the behavior. Ladd and Mize's model of social skills training includes three training components. The first is instruction, which is defined as providing the trainee with information about salient features of a social behavior (eg., description of the behavior, breaking the behavior down into skill steps) or providing information about standards or performance goals. There are two types of instruction, modeled and verbal. Modeled instruction involves demonstrating how to perform the skill through live acting or filmed enactments of the skill. On the other hand, verbal instruction entails using language to communicate descriptions and other information about the skill. The second major training technique is behavioral rehearsal (Ladd & Mize, 1983). Here, the child is required to act or rehearse the skill in a manner that matches the performance standard set by the expert modeling the skill. According to social learning theory, behavioral rehearsal facilitates encoding, retention, and retrieval of cognitive representations of learned behaviors (Ladd & Mize, 1983). In addition,

overt rehearsal helps establish motoric equivalents of behaviors previously coded and stored in memory. The third and final step is feedback, which is defined as providing the trainee with information concerning the degree to which his/her skill performance matched the standard provided by the expert model. Feedback allows the child to gain important information to improve performance of a given skill.

An example of a training package which is based on these social learning principles is Goldstein's (1988) structured learning program. This training approach was used in the present study. Goldstein's structured learning method teaches skills through four steps. First, skills are broken down into skill steps and these steps are introduced and discussed with the trainees. For example, the skill 'Making a Friend' would be broken down into the following means: 1) decide what you are going to say, 2) walk over to the person, 3) introduce yourself, 4) ask the person his/her name, 4) strike up a conversation or do something together. After the skill steps have been introduced, the leaders will model appropriate use of the skill by conducting a demonstration roleplay, in an expert fashion. Next, the trainees imitate the trainer's performance of the skill through a practice roleplay. The trainee then receives feedback from the leaders and other trainees concerning the correctness of their depiction of the skill. Consequently, the ability of the trainer to model appropriate and skilful behavior in formalized training of skills is an important factor in the success of this method of social skills training. Modeling of appropriate social behavior is not limited to the formal skills taught during the SST session, but also occurs outside of these skills. More specifically, all of the leader's behaviors prior to, during, and following the session, which

may be observed by the trainee, are behaviors that the trainee may choose to imitate.

To summarize, according to Ladd and Mize's (1993) social learning model of social skills training, children may learn appropriate social behaviors through verbal and modeled instruction, by being given an opportunity to translate this information into skilled performance through rehearsal, and by receiving feedback concerning how closely these performances match a standard or criterion. This model then has implications for the types of leader variables which may facilitate successful learning of social behaviors in SST. First, the leader must be socially competent to the extent that he/she can model or enact the skill in an appropriate and expert manner. This was demonstrated by Rotherman (1982) in a study of assertiveness training with children. Rotheram (1982) evaluated the effectiveness of the trainer as a model in the acquisition of assertive behavior. Nine undergraduate and graduate students served as trainers for the assertiveness training groups. Each therapist was rated in assertiveness based on behavioral data from roleplays, self-ratings, and ratings by project supervisors. Seventy-four 4th and 5th grade students from four classrooms served as trainees. Groups of six subjects were randomly assigned to each of the nine leaders. Twenty-four one-hour assertiveness training sessions were conducted over a twelve week period. Results indicated that trainer's assertiveness levels were significantly related to the children's reports of the group experience. Children taught by more assertive leaders reported feeling more trusting and liked the group more. As well, these children perceived greater change in their own levels of assertiveness, and scored significantly higher on an Assertion Quiz at post-treatment, and maintained these changes at one-year follow-up. However, children with less

assertive leaders generated more assertive alternatives on an interpersonal problem solving task compared to children who received the training from more assertive leaders. Rotheram (1982) suggests that these results are a function of different styles of teaching. More specifically, highly assertive leaders may be teaching by bombarding the children with behavior to model. Supervisors reported that they were clearer, quicker and more directive in controlling group activity. Less assertive trainers may be creating more of a problem solving field where children took more initiative in the group, acquiring assertiveness for themselves. These results suggest that, for assertiveness training, the degree of assertiveness of the leader facilitated certain outcomes and limited others (such as problem solving ability). A limitation of this study was its failure to investigate whether the children differed on observed assertiveness in a natural setting. Despite this limitation, these results provide some support for the modeling effects of leader characteristics on outcome in children's assertiveness training. Clearly, further research is required to investigate the role of modeling therapist behavior on outcome in children's SST.

From a social learning perspective, Bandura (1971) has stressed the ability of the therapist to model target behaviors as a critical issue in successful therapy. Some authors have suggested that the therapist's role as change agent might best be conceptualized in terms of modeling and instructing the client to imitate (D'Zurilla & Goldfried, 1971). Implicit in this model is the ability of the therapist to model the skill or behavior to be acquired by the client. Modeling of social behavior not only occurs during formal enactments of skill steps during the SST session proper, but also during less structured times both before and after the session. Therefore, while the

children are with the leader, all of the leader's behavior serves as behavior that the child trainee may later choose to imitate. Consequently, the leader's level of social competence may be a factor in the success of SST given that the child may choose to imitate behaviors that the leader displays while with the child. Both Goldstein (1986) and O'Donohue and Krasner (1995) have also speculated that trainer relationship such as empathy, warmth, respect, genuineness, directiveness, oral communication, listening skills, and interpersonal sensitivity may be important attributes of a successful trainer. O'Donohue and Krasner (1995) suggest that the skills that clients may need to manage their lives may be similar to the skills that helping professional require to help their clients. For example, both groups need to communicate, be assertive, function successfully interpersonally, manage stress, and control their anger.

The relevance of the adult therapist variable literature. In this introduction, the adult therapist variable literature was reviewed in order to develop hypotheses concerning which therapist variables may be factors in children's SST outcome. The relevance of this literature to therapist variables in children's SST is questionable given the many differences between adult individual psychotherapy and cognitive-social learning skills based interventions with children. However, the adult therapist variable literature was reviewed because little or no research has examined the role of therapist variables in child therapy (Morris & Nicholson, 1993). In the following section, the differences between child and adult therapy are outlined. This is followed by a comparison of the social skills training approach with individual psychotherapy. Despite the differences between these approaches, an argument is offered for using the adult therapist variable

literature as a starting point for hypotheses about which therapist variables may be important in children's SST.

Kazdin (1995) has outlined several differences between adult and child therapy. First, child psychotherapy is conceptualized from a developmental perspective. This approach emphasizes that children pass through various stages during which biological, affective, cognitive, behavioral development, and experience with the environment influence each other. This dynamic development poses challenges for assessment and treatment. Unlike adult psychotherapy, behaviors are only identified as dysfunctional in relation to the child's developmental age (Kazdin, 1995). For example, a behavior such as bed wetting would be viewed as a significant problem at age 10, but not at age 2. An additional difference between adult and child psychotherapy is the greater effect of contextual factors in a child's life. Children are dependent on the significant adults in their lives, and as a result are vulnerable to influences over which they have little control (Kazdin, 1995). These factors include parent mental health, marital functioning, socioeconomic disadvantage, physical and sexual abuse, and neglect. Adults in psychotherapy typically initiate and refer themselves for treatment. Furthermore, they retain and exercise the decision to remain in or terminate treatment. Conversely, adults initiate treatment for children usually because they find a child's behavior disturbing (Kazdin, 1995). Therefore, in many instances, children are relatively powerless in treatment decisions. As Kazdin (1995) suggests, this may affect the child's level of motivation to engage in the work required for psychotherapy. In adult therapy, the client is usually the primary source of information concerning his/her functioning. Conversely, in child

therapy, significant others including parents and teachers typically provide much of the information about the child's behavior. Finally, more options exist in terms of the medium of treatment, who the therapeutic agent is, and what the treatment setting is like for child versus adult therapy (Kazdin, 1995). As Kazdin notes, the medium in child therapy can include talk or play, and the same treatment approach may appear quite different depending on which modality is used. While the therapist is often the primary therapeutic agent, family, parents, teachers, siblings, and peers can play significant roles in administering treatment. Treatment settings can also vary, including a clinic, the home, or the child's school. To summarize, child and adult therapy differ significantly in areas including the greater utilization of a developmental perspective and how dysfunction is identified, children's dependence on adults, who initiates and controls whether the child remains in treatment, how the child's behavior is assessed, and the number of options for intervention.

As discussed in the previous section, many differences exist between adult and child therapy. Similarly, differences exist between the skills training and more traditional individual psychotherapy approaches to intervention (O'Donohue & Krasner, 1995). The major approaches to individual adult psychotherapy differ in their conceptualization of psychological problems, the role of the therapist, and the conditions that produce change (Corsini & Wedding, 1989). Briefly, psychodynamically oriented therapy helps the client gain cathartic insight with the help of the therapist's interpretations and clarifications. In Rogerian client-centered therapy, the therapist helps the client towards personal growth or self-actualization. This is accomplished through

exploration of the client's phenomenal world and personal meanings using techniques of reflection and providing the necessary and sufficient conditions for therapeutic change, which include therapist genuineness, unconditional positive regard, and empathic understanding. In rational-emotive therapy, the goal is for the client to think and emote more rationally. The therapist accomplishes this through instruction in logic and challenging irrational ideas and cognitive errors. Skills training differs radically from these examples of models of adult psychotherapy (O'Donohue & Krasner, 1995). It provides an educational experience where skill and performance deficits are addressed in a direct manner (O'Donohue & Krasner, 1995). This approach utilizes social learning theory and modern pedagogic procedures to systematically teach specific behaviors which the individual desires to acquire (Goldstein, 1982). Individuals are not viewed as patients who have mental disease, and are cured through medical and therapeutic means. Instead, clients are seen as learners who have difficulty in learning or performing various skills and are taught various skills (O'Donohue & Krasner, 1995). Maladaptive behavior is viewed as the absence of specific skills (McFall & Twentyman, 1973). The intervention objective is to provide direct training in those skills lacking in the individual's repertoire.

Child therapy and skills training are clearly very different from adult psychotherapy. Given that the majority of studies which investigated therapist variables in adult psychotherapy focused on individual psychotherapy, the relevance of this literature to child psychological skills training is questionable. However, two arguments are offered in support of utilizing this literature as a starting point. First, the major hypothesis of this thesis is that leader social competence is related

to outcome in children's social skills training. Social competence is defined as a global term reflecting social judgement about the quality of the manner in which an individual relates with others (Hops, 1983). Socially competent behavior consists of specific, identifiable skills. All major forms of therapy, including cognitive-behavioral therapy, support the role of therapist relationship skills in successful therapeutic outcome (Patterson, 1984). Moreover, a great deal of the adult therapist variable literature has indicated the role of relationship variables (Beutler, et al., 1994). Several authors have also suggested that relationship building skills may be important factors in skills training (e.g. Goldstein, 1982; O'Donohue & Krasner, 1995). While no research exists that has investigated these variables in children's social skills training, or child therapy, and despite the differences between children's SST and adult psychotherapy, the wealth of research in the adult psychotherapy literature appears a good place to begin developing hypotheses. Kazdin (1995) argues that research on child therapy is at an early stage compared to adult psychotherapy research, and it has focused primarily on the individual and on the relative effectiveness of different treatment techniques (Kazdin, Bass, Ayers, & Rodgers, 1990). Kazdin (1995) suggests that child therapy research should focus on additional areas including the search for moderator variables such as therapist variables. In this effort, Kazdin (1995) argues that child therapy research should capitalize on the advances of adult therapy research in developing leads pointing to new areas of research. This thesis presents the adult therapist variable literature in an effort to provide leads in the development of hypotheses pertaining to the role of therapist variables in children's social skills training.

Hypotheses. The central role of the leader in SST is to engage the children in a fundamental reappraisal of their manner of interacting with others. Through a social learning theory model of SST, this is accomplished through verbal and modeled instruction, rehearsal, and feedback from the leader. It is unlikely that all leaders are equally able to accomplish teaching the concepts and engaging the children in this manner. This study proposes that various leader variables play a role in the effectiveness of SST.

The goal of the SST program utilized in this study was to decrease aggressive behavior and increase prosocial behavior in aggressive elementary-school aged boys. The program is divided into sections which are designed to achieve this goal. Five sessions are designed to help children deal with conflict situations such a teasing, dealing with another person's anger, and coping with failure and rejection. The second half of the program focuses on prosocial skill alternatives to aggressive behavior, such as how to make a friend, playing a game, and perspective taking. Given the dual focus of the SST program on decreasing aggression and increasing prosocial behavior, it is proposed that leaders who are able to model these skills may be more effective leaders. Consequently, it was hypothesized that leaders who were low on aggression and high on sociability would be more successful leaders.

While no research was found that investigated the role of therapist sociability in child therapy, Nelson and Stake (1994) concluded that therapists who demonstrated high levels of interaction and expressiveness were more able to create a positive relationship with their adult clients, possibly affecting outcome. O'Donohue and Krasner (1995) have speculated that the

ability to function successfully interpersonally may be a factor in successful skills training. Leaders high in sociability are individuals who enjoy socializing with others and prefer to spend time with others versus spending time alone. These individuals are likely to be more socially competent and may be more expert and effective modelers of socially skilled behavior. This modeling of skilled behavior may effect change not only when these leaders model skills being taught, but also in the manner in which they interact with the children before, during, and after the sessions. Moreover, socially competent leaders will likely have more successful interactions with the children in the SST group. Consequently, the child may be more motivated to perform these behaviors because the child observes the leader being socially reinforced for these behaviors by the other children. In addition, socially competent individuals may simply be more fun and interesting to be around compared to less socially skilled individuals. Children may be more engaged to learn when spending 45 minutes with such an individual. It was hypothesized that leaders high on sociability would have more positive outcomes in children's SST compared to leaders low on sociability.

As reviewed earlier, the few studies investigating the effect of hostility on adult therapeutic outcome have produced overwhelming support for its negative effects. Therapist hostility has been found to be related to client's perceptions of therapist understanding and acceptance, patient and therapist ratings of improvement (Lorr, 1965; Jones et al., 1986), and negative outcomes (Yalom & Lieberman, 1971). Hostile therapists are perceived as critical, cold, impatient, competitive, and disapproving (Lorr, 1965). It is hypothesized that leader hostility will be associated with more negative outcomes in children's SST. According to social learning

theory, this may be occurring through several pathways. First, hostile leaders may be modeling more aggressive behavior and children who are already predisposed to behave aggressively may choose to imitate this behavior. This is tantamount to the blind leading the blind. In addition, hostile leaders may model less prosocial behavior, decreasing opportunities to provide role-modeling of appropriate behavior during the sessions. Hostile leaders may be less socially skilled and consequently less competent at conducting formal modeling of session skills. Because the hostile leader's behavior is described as cold, impatient, disapproving, and critical, these individuals may be less pleasant to be around. They may also provide less positive reinforcement to the children, resulting in a decreased likelihood that the children will be motivated to attempt any of the skills learned. Hostile leaders may be more challenging and commanding in their tone. This could possibly lead to power struggles with the children and an escalation in behavior problems. If much time is spent disciplining and dealing with behavior problems, then perhaps the children have less opportunity to learn. Again, a hostile style in dealing with behavioral problems provides inappropriate behavior for the children to imitate. Finally, hostile leaders may be more negative, critical, and less sensitive when giving the children feedback on their roleplay rehearsals of the skill steps. This may result in a decrease in the child's self-esteem and the likelihood that the child will be less willing to risk attempting the skills in future roleplays or in a natural setting. It was hypothesized that leaders who were low on hostility would have more positive outcomes in children's SST compared to leaders high on hostility.

Although considerable evidence has accumulated to suggest that variables such as empathy, warmth, enthusiasm, and self-confidence may be important therapist characteristics for client outcome, it was beyond the scope of the present study to evaluate their significance. Such a study would have required a very large group of both trainers and trainees. Nevertheless, the present study set out to examine the relationships of each of these variables to each other and to sociability and hostility. Personality theorists differ on the number of dimensions that are necessary to describe personality, but it may be the case that empathy, warmth, enthusiasm, and self-confidence are not completely independent of sociability and hostility. The present study evaluated the relationship among these constructs.

One variable which has not received a great deal of attention as a therapist variable but which seems particularly important for a behaviorally-based technique such as SST is the quality of feedback provided. Previous research has demonstrated that observer ratings of quality of therapist feedback was related to the degree of cohesiveness in a group treatment for depression (Antonuccio, et al., 1987). Goldstein (1986) has suggested that the ability to provide feedback in a sensitive manner may be an important therapist characteristic in children's SST. Ladd and Mize (1983) define feedback as providing the trainee with information concerning the degree to which his/her skill performance matches a standard or criterion level of performance. Feedback may be either evaluative or informative (Ladd & Mize, 1983). Evaluative feedback simply informs the child that there is or is not a mismatch between the learner's performance and the criterion. No reason is specified with regards to the nature of this mismatch. Evaluative feedback from the

trainer would take the form of approval, praise, or a positively toned description of the behavior. Conversely, when providing informative feedback, the leader indicates a mismatch and specifies how the behavior should be adjusted. Informative feedback may involve redefining important features of the skill, stating rules and conditions for enacting the skill, or describing consequences of the behavior. Trainers that provide effective informative feedback are able to specifically communicate which aspects of the skill the child has done well and what he/she has to improve on. This provides the child with useful information to correct his/her attempt at using the skill. Certainly some individuals are more skillful at giving feedback than others. When feedback is given in a sensitive and caring manner, the trainer provides a safe environment for the child to attempt newly learned behaviors and risk making mistakes in order to learn. In addition, the leader who is proficient at giving feedback to others is modeling an important skill for the children to learn. It was hypothesized that leaders who were more skilful at providing quality feedback would be more effective leaders compared to leaders whose feedback was of lesser quality.

To summarize, the goal of this study was to investigate the impact of different trainer variables on the effectiveness of children's social skills training. It was hypothesized that leaders who were high on sociability, and provided higher quality feedback would have more successful outcomes compared to leaders low in these variables. In addition, it was hypothesized that leaders who were low in hostility compared to high hostility leaders would demonstrate more positive outcomes.

Method

Subjects

Leaders

Twelve male social skills leaders participated in the study. Male leaders were chosen for several reasons. First, male leaders and trainees were chosen to elliminate gender as a possible interaction effect. Including gender as an additional independent variable would have required a significantly greater sample of potential trainees and leaders. Conducting additional SST groups would have been out of the scope of a doctoral thesis which did not receive any funding. Finally, male leaders were chosen in order to provide same-sex models for the trainees. Leaders were third- and fourth-year undergraduate students at the University of Ottawa (2 in criminology and 10 in psychology). Leaders ranged in age from 20 to 29 years, with a mean of 22 years.

Screening of leaders. Third- and fourth-year undergraduate psychology and criminology classes at the University of Ottawa were canvassed to solicit volunteers to conduct social skills training groups. Thirty-nine male volunteers consented to participate in the screening phase of the study (see appendix A for the informed consent form). Volunteers completed four paper-and-pencil questionnaires: the Interpersonal Behavior Survey (IBS), the Interpersonal Style Inventory (ISI), the Eysenck Personality Questionnaire (EPQ), and the Symptom Checklist - 90 - Revised (SCL-90-R; see Measures below). These questionnaires were completed in a single sitting requiring approximately 3 hours.

Volunteers with SCL-90-R Global Symptom Index scores in the clinical range (a T-score at or above 70) were not considered for positions as social skills leaders in order to avoid exposing children to extreme personalities. Of the 39 volunteers, four were excluded on this basis. The remaining 35 volunteers were rank ordered according to their scores on the IBS General Aggressiveness-Rational scale and the ISI Sociable scale. General Aggressiveness scores ranged from 2 to 15, with a mean score of 8.09 (SD = 3.34). Sociability scores ranged from 16 to 96, with a mean score of 67.86 (SD = 23.91). Six leaders were chosen on the basis of their General Aggressiveness scores: the three highest and lowest ranked candidates. Six additional leaders were selected based on their Sociability scores: the three highest and lowest ranked candidates. The purpose of this selection procedure was to ensure variability among the leaders on two variables of primary importance, namely sociability and aggressiveness. Selecting leaders according to extreme groups on these two primary variables resulted in a good distribution of scores on these two variables for the selected leaders (see Tables 1 and 2). Table 3 summarizes each leader's scores on the variables used for selection.

Trainees

Trainees were 59 grade 3, 4, and 5 boys who were identified as high on aggression using the Revised Class Play. Trainees ranged in age from 7 years and 11 months to 11 years and 7 months, with a mean of 9 years and 7 months. Since the focus of the intervention was to decrease aggressiveness in elementary school-aged children, only boys were selected because of the

relatively higher incidence of childhood aggression in boys compared to girls (Grusec & Lytton, 1988). In addition, as mentioned earlier, male trainees and leaders were chosen to elliminate gender as an independent variable, in order to limit the design to an affordable size.

Initially sixty boys participated in the treatment phase. One boy dropped out of the study after six sessions because he moved to another city, and therefore was excluded from the analyses. This resulted in a final sample of 59 boys who took part in the SST groups. To be included in the study, trainees had to be registered in a regular class and school, and could not have been participating in any other SST program at the time of the study.

Screening Trainees. Trainees were drawn from grade 3, 4, and 5 classrooms in 8 schools in the Protestant Regional School Board of Western Quebec and the Carleton Roman Catholic School Board. Only regular classes were invited to take part in the screening phase. Social adjustment classes and programs for the handicapped were excluded.

A total of 1321 children of both sexes were asked to participate in the screening phase of the study (see appendices B and C for a copy of the letter sent to the parents and the informed consent form, respectively). Of these 1321 children, 944 received parental permission (72%).

The Revised Class Play (RCP) was group administered to all 944 children participating in the screening phase. RCP Aggressive-Disruptive factor scores were calculated for the boys only ($N = 450$; Table 4 summarizes the descriptive statistics for the RCP Aggressive-Disruptive scores by school). The 67 boys whose Aggressive-Disruptive scores ranked in the top quintile in their school were identified as aggressive for the purposes of this study and were invited to participate

in the treatment phase. Of these 67 boys, 60 received parental permission to participate (See Appendices D and E for a copy of the letter sent to the parents and the informed consent form for the treatment phase).

Measures

Leader Variables

Interpersonal Behavior Survey. The Interpersonal Behavior Survey (IBS) is a paper-and-pencil, self-rating measure of adult assertive, aggressive, and social behavior (Mauger & Adkinson, 1987). Two of the IBS scales were relevant to the present study: the General Aggressiveness-Rational scale and the Self-Confidence scale. The General Aggressiveness-Rational scale is a measure of general aggressiveness which is composed of 38 items. Example items include: "I usually tell people off when they disagree with me", and "I rarely lose my temper". The Self-Confidence scale is a 16 item measure of self-confidence in one's interpersonal relationship skills. Sample items include: "Rather than ask for a favour, I will do without", and "I often avoid members of the opposite sex because I fear doing or saying the wrong thing". Mauger and Adkinson (1987) reported internal consistency reliability (coefficient alpha) values of .88, and .79 for General Aggressiveness-Rational and Self-Confidence scales, respectively. Test-retest reliability coefficients for a 10-week interval were .92 for the General Aggressiveness-Rational scale and .89 for the Self-Confidence scale (Mauger & Adkinson, 1987).

Studies have reported moderate associations between General Aggressiveness-Rational scale scores and other measures of aggression, including .57 with the Aggression scale of the Edwards Personal Preference Schedule (Adkinson, 1979), .65 with the Total Hostility score of the Buss-Durkee Hostility Inventory (Adkinson, 1979), and .47 with the Hostility Factor of the Interpersonal Checklist (Newsom, 1978). The Self-Confidence scale has been found to correlate .34 with the Self-Acceptance scale of the California Psychological Inventory (Adkinson, 1979). As well, Moverman (1977) reported correlations of .46, .35 and .40 with the Total Positive, Family Self-Esteem and Self-Satisfaction scales of the Tennessee Self-Concept Scale, respectively.

The IBS required 45 minutes to complete for each volunteer. General Aggressiveness-Rational and Self-Confidence scores were calculated by summing the values on each of the items comprising the factors. General Aggressiveness-Rational and Self-Confidence scores can range from 0 to 38, and 0 to 16, respectively. In the current study, General Aggressiveness-Rational and Self-Confidence scales were utilized as measures of Hostility and Self-Confidence, respectively.

Interpersonal Style Inventory. The Interpersonal Style Inventory (ISI) is a self-report inventory which measures an individual's characteristic ways of relating to other people (Lorr, 1986). The Nurturant and Sociable scales were utilized in the present study. The Nurturant scale is a twenty item measure of a person's tendency to offer or give emotional support and help to others. Example items include: "I like jobs where I can help people", and "I am not the kind of person who rushes in to help when he/she hears a hard luck story". The Sociable scale is a 20 item

measure of an individual's disposition to seek out and enjoy the company of others. Sample items include: "I enjoy social gatherings where there are a lot of people present", and "I would just as soon spend a quiet evening watching TV as going out to a party".

Lorr (1986) reported coefficient alpha values of .78 to .81 and .86 to .87 for the Nurturant and Sociable scales, respectively. Two-week test-retest reliability coefficients of .81 for the Nurturant and .95 for the Sociable scales were also reported. Nurturant scale scores were found to correlate .81 and .52 with Altruistic and Person Oriented scores, respectively (Lorr, Youniss, & Stefic, 1984). Furthermore, Nurturant scores correlated .41 with global peer ratings of nurturance (Lorr, 1986). Sociable scores were found to correlate .67 with Person Oriented scores (Lorr, Youniss & Stefic, 1984), and .57 with global peer ratings of sociability (Lorr, 1986).

The ISI was completed by each leader and required about 1 hour to complete. The ISI was computer scored and interpreted by the Western Psychological Services Test Centre. Scores for both the Nurturant and Sociable scales are reported as percentiles based on a normative sample. In this study, Nurturant and Sociable scales were used as measures of leader Empathy and Sociability.

Symptom Checklist-90-Revised. The Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1977) is a self-report symptom inventory designed to measure the psychological symptom patterns of psychiatric and medical patients. The SCL-90-R consists of 90 symptoms that are rated on a 5-point Likert scale of distress from 0 ("not-at-all") to 4 ("extremely"). The SCL-90-R produces 9 primary symptom dimension scores and 3 global indices of distress. Only

the Global Severity Index was utilized in this study. The Global Severity Index provides an indication of the current level or depth of an individual's psychopathology. A split-half reliability of .94 was reported for the Global Severity Index (Brophy, Norvell, & Kiluk, 1988). Although there is no information on test-retest stability of the Global Severity Index, test-retest reliability coefficients ranging from .78 to .90 have been reported over a 1 week interval for the nine symptom dimension scales (Derogatis, Rickels, & Rock, 1976). The SCL-90-R's ability to discriminate between various clinical and non-clinical populations has been demonstrated in numerous studies (Derogatis, 1977; Prather, & Williamson, 1988; and Derogatis, Meyer, & King, 1981). Global Severity Index scores correlate .92 with a comparative global symptom index on the Middlesex Hospital Questionnaire (Bolelоucky & Horvath, 1974).

The Global Severity Index was calculated by summing the 90 item scores and dividing by 90. These Global Severity Index scores had a range of 0 to 4.00. Tables of norms for a non-patient population were utilized to convert Global Severity Index scores to standardized T-scores. In the current study standardized Global Severity Index T-scores were utilized to screen out volunteers who exhibited extreme personalities or psychopathology. Volunteers who scored at or above a T-score of 70 were not chosen to lead a SST group.

Modified McDaniel Observer Rating Scales. The McDaniel Observer Rating Scales is an observation rating system designed to record teaching behavior on nine different dimensions (McDaniel, 1974). Of these nine dimensions or scales, only three were scored in the present study, namely: Warmth, Enthusiasm, and Feedback. Descriptions and operational definitions of each of

these three scales were modified somewhat for the present study to apply more closely to leader behavior in SST groups instead of to teacher classroom behavior. This modified observer rating system was called the Modified McDaniel Observer Rating Scales (MMORS). The Warmth scale measured the degree to which the leader is positive, friendly, and sensitive in his/her interactions with the trainees. The Enthusiasm scale tapped the sense of commitment, excitement, and involvement the leader conveys while teaching. Finally, the Quality of Feedback scale was a measure of the quality of communication to the trainee concerning the adequacy, acceptability, completeness, and correctness of his/her responses.

The scales of the MMORS are termed high inference scales; after observing a training session for several minutes, the observer summarizes the "major thrust and intent" behind the many leader behaviors observed (McDaniel, 1974). For each scale the observer rates the leader's behavior on a six-point scale. For example, for the Enthusiasm scale, ratings range from (1) dull to (6) enthusiastic. Each point on each scale is operationally defined in the MMORS manual (see Appendix F).

McDaniel (1974) reported interrater reliability coefficients of .95, .83, and .94 for the Warmth, Enthusiasm, and Feedback scales of the MORS, respectively. Scores on these scales were found to be significantly related to group cohesiveness in treatment groups for depression (Antonuccio, Davis, Lewinsohn, & Breckenridge, 1987). In the present study, the MMORS was used to code leader behavior from videotapes of the SST sessions.

Average scores on each leader dimension were calculated by summing the ratings received by each leader in each of the 45 two-minute videotaped segments coded and dividing by 45. Scores on each dimension had a potential range from 0 to 6.

Child Outcome Variables

Revised Class Play. The Revised Class Play (RCP; Masten, Morison & Pellegrini, 1985) is a peer report measure of children's positive and negative social behaviors. Children are asked to nominate up to three peers in their class who best fit the behavioral descriptions in the 30 items comprising the test. Factor analysis of the RCP has isolated three factors: Sociability-Leadership, Aggressive-Disruptive, and Sensitive-Isolated (Masten et al., 1985). Only the Aggressive-Disruptive and Sociability-Leadership factor scores were utilized in this study. The Aggressive-Disruptive factor consists of 7 items which include "Picks on other kids", and "Gets into a lot of fights". The Sociability-Leadership factor consists of 15 items which include, "Plays fair" and "Has many friends".

Coefficient alpha values of .90 to .93 and .93 to .95 were reported for the Aggressive-Disruptive and Sociability-Leadership factors, respectively (Masten, et al, 1985). Six-month test-retest coefficients were .87 and .77, and 17-month test-retest coefficients were .63 and .64 for the Sociability-Leadership and Aggressive-Disruptive factors, respectively (Masten, et al., 1985). Aggressive-Disruptive scores have been found to correlate .57 with teacher ratings of Disruptive-Oppositional behavior (Masten et al., 1985). Ledingham, Schneider and Byrne (1991, unpublished

manuscript) reported a correlation of .85 between the RCP Aggressive-Disruptive factor and the Aggression factor on the Pupil Evaluation Inventory. Sociability-Leadership scores have been found to correlate .32 with teacher-rated Cooperation-Initiation (Masten, et al., 1985), and .82 with Pupil Evaluation Inventory Likeability scores (Ledingham, et al., 1991, unpublished manuscript).

The RCP was group administered in individual classrooms and required 15 to 30 minutes to complete. Instructions for administration and a copy of the RCP are provided in Appendix G. The Aggressive-Disruptive and Sociability-Leadership factors were scored by summing the number of votes received by each child from all peers on the relevant items. Nominations from both boys and girls in the class were utilized. Total scores were standardized within each classroom by dividing by the number of raters minus one. Aggressive-Disruptive and Sociability-Leadership scores had a potential range of 0 to 7, and 0 to 15, respectively.

Social Skills Rating System - Student Form. The Social Skills Rating System - Student Form (SSRS-S) is a self-report measure of childhood social skills (Gresham & Elliott, 1990). Subjects rate themselves on the frequency of behaviors (from 0-never to 3-very often) described by items that load on four subscales; Cooperation, Assertion, Empathy, and Self-Control. The Cooperation subscale consists of 10 items which measure behaviors such as helping others, sharing materials, and complying to rules and direction. Example items include: 'I finish classroom work on time', and 'I keep my desk clean and neat'. The Assertion subscale includes initiating behaviors such as asking others for information, introducing oneself, and responding to the

actions of others. Example items include: 'I start talks with class members', and 'I make friends easily'. The Empathy subscale includes behaviors that show concern and respect for others. Example items include: 'I feel sorry for others when bad things happen to them', and 'I listen to my friends when they talk about problems they are having'. The Self-Control subscale consists of 10 items and measures behaviors that emerge in situations of conflict (e.g., responding to teasing) and non-conflict situations requiring compromise and taking turns. Examples are: " I control my temper when people are angry at me" and " I ask adults for help when other children try to hit me or push me around".

A coefficient alpha values of .68, .53, .74, and .65 were obtained for a sample of elementary school aged boys on the Cooperation, Assertion, Empathy, and Self-control subscales, respectively (Gresham & Elliott, 1990). These authors also reported a four-week test-retest reliability of .54, .52, .66, and .52 for Cooperation, Assertion, Empathy, and Self-control, respectively. Gresham and Elliott (1990) reported correlations between the Youth Self-Report Form and the SSRS-S subscales. Cooperation correlated -.48 with Externalizing Problems, and .36 with Total Social Competence. Assertion correlated -.48 with Externalizing Problems, and .27 with Total School Functioning. Empathy correlated -.26 with Externalizing Problems, and .07 with Total Social Competence. Self-control correlated -.21 with Externalizing Problems.

To calculate the Cooperation, Assertion, Empathy, and Self-Control subscale scores, frequency ratings for each of the 10 items on each subscale were summed. Subscale scores had a potential range of 0 to 20.

Social Skills Training Mastery Test. The Social Skills Training Mastery Test was developed for the current study to measure the degree to which trainees had learned the contents of the SST program (see Appendix H for a copy). The Social Skills Training Mastery Test consisted of 9 items which were administered to the trainee in an interview format after the conclusion of treatment and required approximately 5 to 10 minutes to complete. Test administrations were tape recorded and scored using the Mastery Test Scoring Sheet (see Appendix I). The Mastery Test scoring key is provided in Appendix J. Total scores with a potential range of 0 to 22 were obtained by summing the individual item scores (note: some items had scores greater than one). Randomly chosen reliability checks were conducted on 12 of the 59 trainees (20%). Kappa values ranged from .59 to 1.00 across the 9 questions in the Mastery Test ($M = .86$, $SD = .14$).

Procedure

Pre- and Post-Treatment Testing

Leaders. Each leader completed a number of self-report questionnaires during the screening phase. These were the Interpersonal Behavior Survey (IBS), the Interpersonal Style Inventory (ISI), and the Symptom Checklist-90-Revised. Volunteers were tested individually or in small groups. The average time required to complete the questionnaires was approximately 3 hours. No instructions were given concerning the order in which the questionnaires were to be completed. Volunteers were told that questionnaire results would be used to select individuals who would be invited to conduct SST groups. Volunteers were not informed of the selection criteria.

Trainees. Results from the administration of the RCP during the screening phase provided pre-treatment peer reports of aggression and sociability for the 59 trainees. Following the end of the SST groups, the RCP was re-administered in those classes which contained trainees. Prior to both pre- and post-treatment assessment, children were told that they would be participating in a study being conducted in their school by the University of Ottawa. Children were informed that the purpose of the study was to learn more about children's friendships. Specific instructions for the administration of the RCP are provided in Appendix G. Care was taken to avoid making a connection between the SST groups and the questionnaire administrations, in order that the children would be blind to the true purpose of the testing sessions (i.e. to select aggressive boys

for the SST groups and to provide pre- and post-treatment assessments of each trainee's level of aggression and sociability). The RCP was group administered in one 30-minute sitting.

All 59 trainees completed the SSRS-S pre- and post-treatment to obtain self-ratings of self-control. Trainees were tested individually or in small groups. Trainees were told that the purpose of the testing was to "find out what they knew about friendships and how to get along with others."

Following completion of the SST groups, trainees were individually administered the Mastery Test by the principle investigator. Trainees were told the following," I'm going to ask you some questions about what you learned in your social skills training group. Your answers will be recorded on this tape recorder so I'll remember them later. Okay, let's get started."

Treatment

Social skills training groups. Twelve groups of trainees (4 to 6 trainees per group) participated in 10 sessions of SST over approximately a 10-week period (1 session per week). Sessions were conducted at school, during school hours, and lasted about 30 minutes each. These sessions provided training in various skills, including joining others, dealing with teasing, understanding another's feelings, giving compliments, dealing with another's anger, making suggestions, playing a game, and coping with failure and rejection. Five sessions dealt with issues surrounding dealing with conflict (e.g. dealing with teasing), while prosocial skills (e.g. giving compliments) were taught in the remaining 5 sessions. Although the program was developed

specifically for this study, eight of the sessions were based on material from the Individualized Intervention for Social Competence Program (Schneider, Raycraft, Poirier, & Oliver, 1986). These sessions were developed, refined, and tested with several SST groups conducted by the principal investigator over a period of 3 years. The two remaining sessions were developed based on material from the Prepare Curriculum (Goldstein, 1988). These two sessions were pilot tested during a SST group conducted by a graduate student in clinical psychology at a local elementary school. The average score on the Mastery Test was 16.52 (75%). This indicated that trainees learned the contents of the SST program to high degree. For a more detailed description of the SST program see Appendix K.

Assignment of leaders and trainees to SST groups. Logistic reasons precluded random assignment of both leaders and trainees to SST groups. The eight elementary schools at which the training took place were scattered across the Ottawa-Hull region. Several of the schools were not accessible by public transportation, and consequently were assigned to leaders who had their own vehicles. The remaining schools were assigned on the basis of proximity to leaders' homes and compatibility of timetables. Similarly, since children could not be transported from school to school, random assignment of the 59 trainees to the 12 SST groups was not possible. In small schools, where only enough trainees were identified to fill one group, all trainees were assigned to that group. In larger schools, where 2 or more groups were conducted, trainees and leaders were randomly assigned to these groups.

Training and supervision of leaders. Leaders participated in two 3-hour group workshops to learn how to deliver SST in accordance with the program manual. In the first workshop, leaders were provided with a general introduction to SST (definitions of social skills, concurrent and longterm correlates of poor peer acceptance, models of SST, SST with aggressive children), and SST training techniques, (including contingent reinforcement, modeling, roleplay, feedback, social problem solving, and anger management), followed by information about the study (nature of the target group, basic information about the groups, how to prepare a lesson, ethical issues, and when to call for help). The second workshop included a review of major SST techniques, practice in the use of these techniques through role-playing, and a review of when to call for help. Prior to the first lesson, each leader prepared his first lesson and met individually with the principal investigator for feedback and clarification.

While leaders conducted their SST groups, they met individually with the principal investigator or Dr. Barry Schneider for supervision. Supervision involved reviewing the videotapes, commenting on compliance to the manual, and answering questions. Supervisors avoided commenting on and attempting to change the leaders' style of delivering SST, since the goal of the study was to determine how differences in leader variables would affect outcome in children's SST. Leaders received supervision on lessons 1 to 3, 5, 7, and 9. Session 1 or 2 was supervised by Dr. Barry Schneider, while the remaining 5 sessions were supervised by the principal investigator. Both supervisors were blind to each leader's scores on the various personality measures used to select leaders during the screening phase.

Compliance with the program manual. Twenty percent of each leader's sessions were randomly selected and coded by a registered clinical psychologist for compliance to the manual. Appendix F contains the Manual of Instruction for use of the Compliance Coding Scheme, and a copy of the Compliance Coding Scheme. Reliability checks were conducted by the principle investigator on all sessions coded. Kappa values were 1.00 when coding for the presence of prescribed components for each session and 0.94 when coding for the presence of any significant departures from the stated intervention protocol. Coding for compliance to the manual indicated a 92% adherence to the prescribed components for each session. Coding did not detect any treatment aspects that represented significant departures from the intervention protocol.

Observations of Leader Behavior

All treatment sessions were recorded on videotape. The Modified McDaniel Observer Rating Scales (MMORS) were used to code leader behaviors of warmth, enthusiasm, and feedback.

Observer training. Leader session tapes were coded by an undergraduate psychology student. A graduate psychology student also participated in the observer training and provided reliability checks during the coding of the leader sessions. Observer training was carried out over a period of 15 days. Observers utilized previously recorded SST sessions (these tapes had been accumulated as part of the Afterschool Social Skills Program at the University of Ottawa) to practice using the MMORS to code leader behaviors. The criterion for ending training was a

Kappa of .75 for two consecutive training periods in each category. The additional coding of leaders tapes for the nature of feedback was completed by a Masters level and a Ph.D. level Psychologist.

Coding leader tapes. Selected excerpts of 9 of the 10 SST sessions conducted by each leader were coded (lesson #4: Understanding another's feelings was excluded because most of the session involved showing a filmstrip). Randomly selected 2-minute segments were viewed by the observer and then coded for warmth, enthusiasm, and feedback (see Appendix F for the MMORS Coding Sheet). Five 2-minute segments were coded from each of the leader's nine sessions. This yielded a total of 90 minutes of coded training per leader. Reliability checks were completed on all nine sessions and were randomly distributed across all 12 leaders. A total of 270 minutes or 25% of the coded SST sessions were coded for reliability.

Results

Descriptive Analyses

Table 5 summarizes the descriptive statistics for the leader variables for each leader group (i.e. high hostile, low hostile, high sociable and low sociable). High and low sociable groups had large differencesoin sociability, but had fairly low differences on hostility. Consequently, hostility appears to be held constant in these two groups. The high and low sociability groups did not appear to differ that greatly on the remaining leader variables including empathy, self-confidence, warmth, enthusiasm, and quality of feedback.

High and low hostile groups differed significantly on hostility scores ($t(4)=7.28$, $p<.01$). However, while the low hostile group did in fact score low (3rd percentile) compared to a general population norm group of 400 males (Mauger & Adkinson, 1980), the high hostile group scored only in the average range (42nd percentile). This suggests that labelling this group as "high hostile" may be a misnomer. Furthermore, while the difference was not significant ($t(4)=-1.33$, $p>.05$), there appeared to be a fairly large difference between the high and low hostile groups on sociability (59th and 82nd percentiles, respectively). This suggests that these two groups may differ not only on hostility but also on sociability. The high and low hostile groups did not differ significantly on the remaining leader variables including empathy, self-confidence, warmth, enthusiasm, and quality of feedback.

Internal Consistency. Cronbach alpha values were calculated to obtain an estimate of internal consistency for the measures utilized in the present study. Internal consistency provides a measure of the degree to which all items in a subscale measure the same trait or characteristic (Brown, 1983). The Cronbach alpha for trainee aggression was .85, which is comparable to values reported in the literature (.90 to .93; Masten et al., 1985). A value of .63 was obtained for trainee sociability, which is somewhat lower than previous estimates of .93 to .95 (Masten et al., 1985). A Cronbach alpha value of .80 was obtained for trainee self-reported self-control, which is higher than the .65 value reported by Gresham and Elliot (1990). Finally, a Cronbach alpha value of .56 was obtained for the Social Skills Training Mastery Test.

Estimates of internal consistency could not be calculated for several leader variables for the following reasons. Sociability and empathy scores were obtained from the Interpersonal Style Inventory, which can only be computer scored by Western Psychological Services. Since the items that constitute the Sociable and Nurturant scales are not identified by the publishers, Cronbach alpha estimates could not be calculated. An attempt was made to calculate Cronbach alpha values for leader hostility, and self-confidence using the sample of 39 potential leaders. However for this sample, there was insufficient variability on many items from each of these scales to calculate Cronbach alpha values.

Interrater Reliability Estimates for Observational Measures. Kappa values were calculated for the Modified McDaniel Observer Rating System and for the additional coding of leader feedback (Cohen, 1968). According to Fleiss (1981), Kappa values below .40 represent poor interrater agreement, values from .40 to .75 represent fair to good agreement, and values above .75 represent excellent agreement. Kappa values for the Modified McDaniel Observer Rating System variables were acceptable. Kappa values were .62 for warmth, .61 for enthusiasm, and .70 for quality of feedback. Kappa values were excellent for additional coding of leader feedback. More specifically, Kappa values were .78 for type of feedback, and .76 for tone of feedback.

Effects of Treatment

Trainees' scores on the Mastery test ranged from 10 to 20.5 out of a possible 22 points. The average score was 16.5 (75% correct responses), indicating that the children, as a group, were successful in learning the content of the SST program.

Table 6 summarizes descriptive statistics for pre- and post-treatment trainee outcome variables. T-tests indicated that trainee scores on Aggression, Sociability, and Self-control did not change significantly from pre- to post-treatment ($t(58) = .05$, $p>.05$; $t(58) = -1.68$, $p>.05$; and $t(58) = 1.54$, $p>.05$, respectively).

In order to test for a possible interaction between therapist type and SST outcome difference scores, eighteen separate one-way ANOVAs were conducted in which high and low hostile leaders, high and low sociability leaders, and high and low quality of feedback leaders were compared on the six dependent variables, namely pre-post difference scores for trainee Self-control, Empathy, Cooperation, Assertion, Aggression, and Sociability. Results indicated that high and low scoring leader groups did not differ significantly on any of the outcome variables (using a per analysis alpha level of .01).

Differences Among Leaders' Groups on Pre-Treatment Outcome Variables

Between-group ANOVAs were performed to determine if leaders' groups differed on pre-treatment outcome variables. This information was important in determining whether to utilize pre- to post-treatment difference scores or only post-treatment scores as the dependent variables in subsequent analyses. Since difference scores contain the error variance of both pre-test and post-test, it is possible that the error variance may make it impossible to detect small differences between means. Utilizing post-treatment scores only should decrease the error variance relative to the size of the differences between the means.

Three separate one-way between-group ANOVAs were conducted to determine whether the twelve leader groups' trainees differed on pre-treatment scores of Aggression, Sociability, and Self-control. Results indicated no significant effect of group on pre-treatment trainee Aggression scores ($F(11,47)=1.58$, $p>.05$), pre-treatment trainee Sociability scores ($F(11,47)=1.55$, $p>.05$),

or pre-treatment Self-control scores ($F(11,47)=0.41$, $p>.05$). Consequently, only post-treatment trainee outcome scores were utilized as dependent variables in all subsequent analyses.

Effects of Leader Characteristics on SST Outcome

Leader data were treated as extreme groups for the following analyses. Extreme groups were utilized because leaders were selected from a pool of potential leaders based on the highest and lowest ranking scores on hostility and sociability. In addition, an extreme group design may indicate differences that would not be evident if the normal central portion of the distribution were included. More specifically, perhaps only extreme personalities may be related to differences in outcome.

Testing of Assumptions. Two assumptions of ANOVA were tested for all the One-way ANOVAs conducted. The first assumption tested was that the distribution of the dependent variable within each group followed the normal distribution. This was accomplished using the Chi-square test of normality (Statistica, 1995). In addition, the assumption of homogeneity of variance, which states that the variances in the different groups of the designs should be equal, was tested. This was done using Levene's test of homogeneity of variance (Statistica, 1995). Eighteen one-way ANOVAs were conducted in which high and low Hostile leaders, high and low Sociability leaders, and high and low Quality of Feedback leaders were compared on the six dependent variables, namely post-test scores for trainee Self-control, Empathy, Cooperation, Assertion, Aggression, and Sociability. The decision was made to conduct separate ANOVAs

instead of a MANOVA because the main question of interest was whether specific therapist variables were related to specific outcome variables (Huberty & Morris, 1989). A modified Bonferroni correction was performed to correct for the increased likelihood of making a Type I error given the large number of statistical tests performed (Keppel, 1982). As suggested by Keppel (1982), the experimentwise alpha level was set at .20. This value was divided by the number of ANOVAS performed (18) to arrive at a per analysis alpha level of .01. Consequently, the alpha level utilized to determine significance of differences between groups in each ANOVA was .01.

Tests of homogeneity of variance for each of these ANOVAs suggested that variances were not different in the comparison groups, except for the comparison of high and low feedback groups on trainee Aggression. However, according to Keppel (1982), Monte Carlo studies have demonstrated that sizable differences in variances do not distort the F distribution seriously. Due to the robustness of ANOVAs to departure from the assumption of homogeneity of variance, ANOVAs were performed on this variable. Tests of the assumption of normality indicated normal distributions for most of the dependent variables within the groups, with the following exceptions. The Low Sociable leader group had positively skewed distributions for trainee Aggression and Sociability. This would be expected since it was hypothesized that trainees in these groups would demonstrate less change in post-treatment scores. The positively skewed distribution indicates that only some trainees improved (the positive end of the tail), while the rest of the group lagged behind. Similarly, the Low Hostility leader group had a positively skewed distribution for trainee

Sociability. Finally, the High Feedback leader group had a negatively skewed distribution for trainee Aggression. This would be expected given the hypothesis that trainees in this leader group would benefit more from SST. The negatively skewed distribution indicates that a significant number of trainees' Aggression scores moved to the higher end of the distribution. A square-root transformation was performed on these outcome variables in order to transform these variables to normality (Tabachnick & Fidell, 1989). Following this transformation all variables were normally distributed and also met the assumption of homogeneity of variance except for the low sociability leader group with respect to the outcome of sociability. Consequently, a log transformation was performed on this variable (Tabachnick & Fidell, 1989). This resulted in normalizing the low sociability group on the sociability outcome, however, the high sociability group was not normally distributed. For those groups where data was transformed, these transformed variables were utilized in subsequent analyses. Given the difficulty in normalizing the distributions for the high and low sociability groups on sociability, analyses on these two groups were conducted using non-transformed data. According to Keppel (1982), violations of the normality assumption do not pose a serious problem unless the violations are particularly severe.

Analyses of Differences Between High and Low Hostile Leaders. Six leaders had been initially selected on the basis of their Hostility scores (the three highest and lowest ranked candidates) forming two extreme groups; a High Hostile group and a Low Hostile group. Results of t-tests indicated that these two groups differed significantly on level of Hostility ($t(4)=7.28$, $p<.01$), however, the High hostile and Low hostile groups did not differ significantly on

Sociability ($t(4)=-1.33$, $p>.05$), or Quality of Feedback ($t(4)=-.52$, $p>.05$).

In order to address the question of whether High and Low Hostile leaders' trainees differed on SST outcome (trainee post-treatment scores on aggression, sociability, self-control, empathy, cooperation, and assertion), six separate one-way between groups ANOVAs were conducted. Results indicated that the High and Low Hostile leaders' trainees did not differ significantly on any of the outcome variables.

Analyses of Differences Between High and Low Sociability Leaders. Six leaders had been selected on the basis of their Sociability scores (the three highest and lowest ranked candidates) forming two extreme groups; a high sociability group and a low sociability group. Results of t-tests indicated that these two groups differed significantly on Sociable scores ($t(4)=16.10$, $p<.001$) and Quality of Feedback scores ($t(4)=3.52$, $p<.05$); however, the High Sociability and Low Sociability groups did not differ significantly on hostility, the other selection variable ($t(4)=-.905$, $p>.05$).

In order to determine whether High and Low Sociability leaders' trainees differed on SST outcome (trainee post-treatment scores on aggression, sociability, self-control, empathy, cooperation, and assertion), six separate one-way between group ANOVAs were conducted. Results indicated that High and Low Sociability leaders' trainees did not differ significantly on any of the outcome variables.

Analyses of Differences Between High and Low Quality of Feedback Leaders. High and low quality of feedback leader groups were formed by choosing the three leaders who scored highest on quality of feedback and the three who scored lowest on quality of feedback, respectively. T-tests indicated that these two groups differed significantly on quality of feedback ($t(4)=5.49$, $p<.01$), but did not differ significantly on the selection variables (hostility, $t(4)=-0.58$, $p>.05$; or sociability, $t(4)=1.65$, $p>.05$).

To determine whether High and Low Quality of Feedback leaders' trainees differed on SST outcome (trainee post-treatment scores on aggression, sociability, self-control, assertion, cooperation, and empathy), six separate one-way between groups ANOVAs were conducted. Results indicated that High and Low Quality of Feedback leaders' trainees did not differ significantly on trainee outcome variables.

Power Analyses

An important consideration in designing a study is a sample size of sufficient magnitude to maximize the likelihood of detecting an effect if that effect in fact exists. According to Denenberg (1987), beta error refers to the error of rejecting the alternative hypothesis when it is true. Conversely, the power of a test of significance is 1 minus beta, or the likelihood of rejecting the null hypothesis if the alternative hypothesis is true. Power tables are available such that, given any two of three entries (power, critical effect size, and sample size), the third can be calculated (Kraemer & Thiemann, 1987). Given the general lack of significant findings in the present study,

it is important to determine retrospectively the power level of the significance tests conducted. Power was calculated for the ANOVAs conducted to compare high and low hostile leaders, high and low sociability leaders, and high and low quality of feedback leaders on the various outcome measures. Power was determined according to the procedures outlined by Kraemer and Thiemann (1987) for one-way ANOVAs where the means of two groups are compared. The critical effect size was determined based on Glass's effect size. Since previous research on therapist variables has produced generally small effects, Glass's effect size of .30 was chosen to calculate the critical effect size. The corresponding critical effect size was 0.15. Using the power tables (Kraemer & Thiemann, 1987), and entering a critical effect size of 0.15 with 30 subjects (the total number of subjects used in each ANOVA), the power was 20%. Therefore, assuming small differences between group means and with a total sample of 30 cases, there was only a 20% probability of rejecting the null hypothesis for a one-tailed test using an alpha of .05. The power tables indicated that, given a critical effect size of 0.15, the number of subjects required to reach power levels of 40%, 80%, or 90%, would be 86, 280, or 378, respectively.

Discussion

The goal of the present study was to investigate the impact of different leader variables on the effectiveness of children's SST. It was hypothesized that leader sociability and quality of feedback would be positively related to SST outcome. Leader's level of hostility was hypothesized to be negatively related to SST outcome. No significant differences were found between the various leader groups on SST outcome. Therefore, the results of this study failed to provide support for any of the hypotheses.

Strengths and Limitations and Directions for Future Research

The present study has several strengths and limitations. First, this study represents one of the few pieces of research which has investigated the role of therapist variables in child therapy. While no support was found for the role of therapist variables in SST outcome, it is possible that a more powerful test of these hypotheses might have yielded significant results. Researchers are encouraged to carry out more powerful studies to investigate leader variables in child therapy.

Both self-report paper-and-pencil measures and process measures (independent observer ratings of videotaped SST sessions) were utilized to provide assessments of therapist characteristics and actual in-session behaviour. The inclusion of process measures allowed for measures which were perhaps less susceptible to social desirability response sets and they were perhaps also more specifically relevant to training of therapists.

Multiple outcome measures were utilized in the present study, including both peer and self report measures. This provided a comprehensive range of outcome measures on which to evaluate the relationship between therapist variables and outcome while reducing the effects of a bias specific to one type of respondent. Many previous research studies allowed for only 2 to 3 sessions of therapy, resulting in little time for the potential influence of the therapist's personality style to become manifest (e.g. Morris & McGrath, 1979). In the current study, each child spent enough time with the therapist (10 sessions) for this influence to occur. Therapists were trained and supervised on a regular basis using a highly structured program. Moreover, sessions were videotaped and coded for compliance to the manual. Consequently, it was possible to demonstrate that the program content was consistently delivered across therapists. Therefore, potential differences found across groups were more likely to have been due to therapist differences than to differences in the program itself.

The small sample size utilized in this study was a serious problem which affected the analyses that could be performed and the subsequent interpretation of the results. As originally conceptualized, the number of leaders assessed in this study was inadequate to provide sufficient power to detect possible therapist effects. In addition, the number of therapist variables and SST outcome variables of interest was so large relative to the small number of trainees nested within a small number of trainer groups that it would have resulted in an unacceptably high experiment-wise error rate. Several steps were taken to deal with these problems. First, the number of therapist variables evaluated in the analyses was reduced from 7 to 3. In addition, given that the

leaders were originally selected on the basis of extreme scores on two variables (sociability and hostility), ANOVA analyses were conducted to compare these extreme groups on the various SST outcome scores. A third therapist variable, Quality of Feedback, was treated as an extreme group, and analyses comparing groups high and low on this variable were conducted. Despite these changes, the power level still remained very low. Power calculations indicated that the probability of detecting a therapist effect if it existed was 20%. Thus, the absence of significant results in this study is not surprising given this low statistical power. Future therapist variable research should follow the example of Rotheram's (1982) study which focused on only one therapist variable and measured its effects on outcome in assertiveness training. For example, the role of therapist hostility on children's SST could be investigated in a more thorough fashion. Multiple sources of ratings of therapist hostility could be collected including self-ratings, trainee ratings, and supervisor ratings. In addition, process measures could be obtained of in-session leader hostility as well as of related behaviours such as positive reinforcement and classroom behaviour management techniques. More leaders should be utilized and each leader should conduct more than one group of children. This would increase sample size, unconfound leader effects from group effects, and increase the power of the design to detect possible differences between hostile and non-hostile leaders. Leaders should also be selected from a large pool of potential leaders based on an extreme groups design to maximize differences between them (at least as much as ethical questions of exposing children to hostile individuals in a therapeutic context would allow). Hostile leaders could subsequently be provided with additional training and

supervision to reduce their hostile in-session behaviour. Additional SST groups, run after this training, would allow an evaluation of whether trainee outcome was improved.

An additional limitation of this study was the lack of overall effectiveness of the SST program. No significant differences were found between pre- and post-treatment scores on self-reported self-control, or peer-rated aggression and sociability. These results are consistent with the equivocal findings of social skills interventions with aggressive children (see Schneider, 1992; Elliot & Gresham, 1993; Lochman, 1992; Guevremont & Foster, 1993). The limited overall success of social skills interventions with aggressive children has been ascribed to several potential causes, including the complex etiology and stability of aggressive behaviour and the possibility that interventions have focused too heavily on cognitive mediation of aggressive behaviour (Schneider, 1991). Others have suggested that interventions should focus on the specific deficits identified in homogeneous subgroups of children (Lochman, et al., 1993; Coie & Krehbiel, 1984), on generalization programming (Guevremont & Foster, 1993), and on more intensive interventions carried out over a long period of time (Middleton & Cartledge, 1995). The program utilized in this study did not address any of these factors. First, as required by the design, the intervention had to be held constant across all the children in the study. It was therefore not possible to train to the specific deficits of the children in each group. This may have affected the overall success of the SST program. Moreover, no training for the generalization of skills to other environments such as the classroom was provided. Finally, the program involved only 10 sessions, while recent research advocates long-term intensive intervention with aggressive children

(Middleton & Cartledge, 1995). Given that research on therapist variables in adult psychotherapy has generally only produced small effect sizes (Beutler, et al., 1994), it may be necessary to maximize the overall effectiveness of the treatment to provide the opportunity to detect therapist effects if they indeed exist. Since the SST program in the current study did not lead to behaviour change, the likelihood of detecting any differences that may have been caused by therapist differences was probably reduced substantially.

In order to interpret of the findings of this study it is necessary to consider whether there were appreciable differences among the therapists on the therapist variables. The greater the magnitude of such differences, the greater the chance of detecting effects due to these differences if they in fact existed. If there were only small differences between leaders on the therapist variables, then the likelihood of demonstrating their effect would probably be very low. Leader sociability demonstrated the greatest differences between the high and low leader groups. More specifically, the average sociability score of the high sociability group was at the 91st percentile, while the average in the low sociable group was at the 21st percentile in comparison to a normative group. In contrast, the high hostility group average score on hostility was 13, while the low hostility group's average score was 3. This corresponds to percentiles of 42 and 3, respectively, compared to a general normative reference group of 400 males (Mauger & Adkinson, 1980). While these scores were significantly different, both the high and low hostility groups of leaders scored at the low or average range in hostility. Therefore, labelling a group which scores in the average range in hostility as high hostile may be a misnomer. The low range in

leader hostility scores may, however be inevitable when selecting leaders from a group of self-selected advanced university undergraduate students. These students were self-selected in that they volunteered to participate in the study as SST leaders. They probably represented a group of individuals who were highly socially motivated and interested in helping others. It is therefore not surprising that these individuals did not score higher than average on hostility.

Part of the difficulty in testing the importance of hostility in leaders relates to the ethical concern of using individuals scoring very high on hostility as therapists for children. In a similar vein, although the between-group difference was significant, the high and low feedback groups did not differ markedly on scores of quality of feedback. Potential scores on this variable range from 1 (low quality feedback) to 6 (high quality feedback). The average of the high feedback group was 3.95 and the average for the low feedback group was 2.92. Thus, a possible reason for the lack of positive findings in this study may have been the small differences between the supposedly extreme groups of leaders on the principal variables of interest.

An additional limitation of this study may have involved the use of self-report measures to select leaders. Since individuals generally like to present themselves in a favourable light, self-report instruments may not be as sensitive as instruments using reports of other informants.

The current study would perhaps have been strengthened by the inclusion of trainee ratings of therapist qualities. Several researchers have concluded that client-rated therapist variables are more strongly related to outcome than self-ratings by therapists or ratings by independent observers (e.g. Najavits & Strupp, 1994). A possible further limitation was the use

here of a non-clinical client population. The use of a non-clinical population may have limited the amount of change that could be produced by an intervention because of the lower initial magnitude of behaviour problems. However, trainees were selected from the top 20% in aggression of grade 3 and 4 boys using a peer nomination measure very sensitive to aggression.

To summarize, the present study failed to provide support for the role of leader variables in outcome in children's social skills training. However, it is possible that a more powerful test of these hypotheses might have produced significant differences between groups. Several limitations may have contributed to the lack of positive findings, including low power, the overall lack of effectiveness of the SST program, the use of self-report measures of perhaps questionable validity, and a reduced range in the sample on the leader variables of interest. However the present study represents one of the few studies that has investigated therapist variables in child therapy. Clearly, more studies in this area are needed in order to identify important moderator variables in child therapy. This study represents a first attempt at investigating this variable in children's social skills training. Future research should investigate the role of these variables in a more in-depth manner with more powerful research designs.

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Table 1

Potential Leaders' Scores on General Aggressiveness-Rational

General Aggressiveness -Rational	Leader #
23	7[a]
22	
21	
20	17[a]
19	
18	
17	
16	25[a]
15	12[b], 14[c]
14	1[b]
13	31
12	9[d], 18[a]
11	24, 29[b], 36[d]
10	15[d], 16, 30[d], 32[d], 39
9	26
8	5, 20, 33[d], 35
7	2, 10, 13, 23
6	3, 4, 11, 34
5	8, 19, 27, 28
4	6, 21[b], 22, 37[b]
3	
2	38[b]

[a]Excluded on the basis of T-score above 70 on the SCL-90-R Global Symptom Index.
[b]Selected on the basis of General Aggressiveness Rational score.
[c]Offered a position as leader, but refused.
[d]Selected on the basis of Sociability score.

Table 2

Potential Leaders' Scores on Sociability

Sociability	Leader #
96	33[d]
93	27
90	21[b], 28, 36[d], 37[b]
86	2, 4, 6, 12[b], 15[d], 20, 24, 26
82	8, 13, 17[a], 23
73	18[a], 19
66	11, 16, 22, 31, 35, 38[b]
58	1[b], 3, 5, 39
50	10
34	25[a], 29[b]
27	9[d], 34
21	32[d]
16	14[c], 30[d]
2	7[a]

[a]Excluded on the basis of T-score above 70 on the SCL-90-R Global Symptom Index.
[b]Selected on the basis of General Aggressiveness Rational score.
[c]Offered a position as leader, but refused.
[d]Selected on the basis of Sociability score.

Table 3

Leaders' Scores on Variables Used in the Selection of Leaders

Leader	Hostility	Sociability	Basis for selection
1	14	58	High Hostility
2	15	86	High Hostility
3	11	34	High Hostility
4	4	90	Low Hostility
5	4	90	Low Hostility
6	2	66	Low Hostility
7	10	86	High Sociability
8	8	96	High Sociability
9	11	90	High Sociability
10	12	27	Low Sociability
11	10	16	Low Sociability
12	10	21	Low Sociability

Table 4

Descriptive Statistics for Revised Class Play (RCP) Aggressive-Disruptive Scores for Boys by Individual School

		RCP Agg-Dis		
School	N (boys)	Mean	SD	Range
1	51	1.17	1.15	0 - 4.94
2	35	1.08	1.18	0 - 4.24
3	33	0.86	0.75	0 - 2.92
4	49	0.98	1.03	0 - 4.24
5	88	0.69	0.83	0 - 4.35
6	70	0.79	1.06	0 - 4.00
7	55	1.03	0.99	0 - 3.32
8	69	0.93	1.13	0 - 5.73

Table 5

Means for Leader Variables by Leader Group (N=3 per group)

Leader Variables	High Hostile	Low Hostile	High Sociable	Low Sociable
Hostility	13.33	3.33	9.67	10.67
Sociability	59	82	91	21
Empathy	78	82	65	50
Self-Confidence	14.33	13.67	14.66	14.33
Warmth	4.46	4.86	4.38	3.84
Enthusiasm	3.97	4.06	4.37	3.78
Quality of Feedback	3.56	3.79	3.72	3.12

Table 6

Descriptive Statistics for Pre- and Post-Treatment Trainee Outcome Variables (N=59)

Trainee Outcome Variables	Pre-Treatment	Post-Treatment
Aggression	Mean = 2.77	Mean = 2.77
	SD = 0.88	SD = 1.14
	Range = 1.36-5.35	Range = 0.69-5.56
Sociability	Mean = 1.05	Mean = 1.24
	SD = 0.78	SD = 1.15
	Range = 0-3.18	Range = 0-5.00
Self-Control	Mean = 11.63	Mean = 10.86
	SD = 3.33	SD = 3.99
	Range = 4-20	Range = 2-19

Appendix A

LEADER CONSENT FORM

CONSENT FORM

I hereby do __ / do not __ agree to participate in the study being done by Richard McCendie, M.A. and Barry Schneider, Ph.D. of the University of Ottawa.

I understand that:

1) The study has two components. First, a screening process (this will require completing several paper-and-pencil personality questionnaires; approximate administration time of 2.5 hours) to identify potential leaders for the second component which involves conducting social skills training groups.

2) Leaders will be selected to continue in the treatment portion of the study based on pre-established criteria. If you are not chosen, this does not mean you are unsuitable to conduct social skills training groups, but instead means that you did not match the study's pre-established criteria.

If you are not chosen for the treatment phase, all questionnaire data will be destroyed at the conclusion of the study. In addition, all leaders and questionnaire-only participants will be invited to a meeting at the completion of the study to discuss the hypotheses and design of the study, as well as the method used to select the therapists. A question period will follow.

3) All social skills training sessions will be video-taped.

4) Videotape and questionnaire data will be maintained in the strictest confidence. All video-tapes will be erased upon completion of the study.

5) The information you provide will not be identified with you in any way.

6) Results of this study will be reported as group results. Individual results will not be reported.

7) Questions regarding this study may be directed to Richard McCendie (564-6578).

Signature:_____ Date:_____

Thank you for your assistance and cooperation.

Appendix B

PARENT INFORMATION LETTER (SCREENING)

September/October 1992

Dear Parent,

Social skills training is designed to help children who would benefit from a bit more help in making and keeping friends. The format is educational and children are taught several skill steps to deal with different types of potentially problematic social situations (e.g. making friends, dealing with teasing, and dealing with conflict).

Richard McCendie, M.A. and Dr. Barry Schneider of the University of Ottawa will be conducting a study entitled: The Role of Leader's Social Competence in Children's Social Skills Training. In the next few weeks we will be screening all grade 3, 4 and 5 children to discover whether any might benefit from social skills training. We ask that you permit your child to participate in this initial screening. Note that this is not a request to authorize participation in the actual social skills training component of the study. Also, we are requesting the participation of all children, even those who may not need social skills training, in order for our measures to accurately assess the workings of the entire classroom.

Screening consists of each child filling out two short questionnaires which will indicate how he/she sees the other children in his/her class. All participating children will do this on two occasions. Results of this screening will be held in the strictest confidence. If your child is deemed eligible for the social skills training component, you will be contacted by telephone to be invited to enrol your child.

Please find attached a consent form which we kindly request you complete and return to your child's home room teacher by _____. If you have any questions do not hesitate to call Richard McCendie at 564-6578 or 776-9967. Thank you in advance for your consent.

Sincerely,

Richard McCendie, M.A.
Doctoral Student

Barry Schneider, Ph.D., C.Psych.
Associate Professor

Appendix C

PARENTAL CONSENT FORM
(SCREENING)

CONSENT FORM

I give permission for _____ to participate in the screening and questionnaire
(child's name)
components of the study being conducted by Richard McCendie and Dr. Barry Schneider of the University of Ottawa entitled The Role of Leader's Social Competence in Children's Social Skills Training.

I do not give permission for _____ to participate in this study.
(child's name)

I understand that:

1) The purpose of the screening is to identify grade 3, 4 and 5 children who might be in need of a bit more help with friendships.

2) The purpose of the questionnaires is to gather information on how each child in grades 3, 4 and 5 views the other children in his/her class.

3) Participation will involve my child filling four questionnaires requiring four periods of 30 minutes to complete.

4) The information obtained from these questionnaires will be maintained in the strictest confidence and my child can withdraw from participation at any time.

5) Questions regarding this study may be directed to Richard McCendie (564-6578 or 776-9967).

Signed:_____ Date:_____
(Parent's signature)

Thank you for your assistance and cooperation.

Please have your son/daughter return this form to his/her home room teacher by

Appendix D

PARENT INFORMATION LETTER (SOCIAL SKILLS TRAINING)

January 1993

Dear Parent,
A short time ago you gave consent for your child to participate in the screening phase of the study entitled "The Role of Leader's Social Competence in Children's Social Skills Training" being conducted by Richard McCendie and Dr. Barry Schneider of the University of Ottawa.

The screening portion of the study is now complete and we are presently preparing the second phase, during which selected children will be invited to participate in social skills discussion groups. We would like your child to participate in one of these groups. If you consent to your child's participation, he will be assigned to a group which will take place between January and April 1993. Groups will meet for 10 sessions over a period of 10 weeks at school during school hours. Each session lasts for approximately 45 minutes and will cover such topics as "Joining others", "Understanding how others think and feel", "Dealing with teasing", "Dealing with other's anger", and "Saying nice things to others". Groups will be quite small, consisting of 4 to 7 children, to allow each child ample opportunity to participate. Children will be asked to fill out a questionnaire both before and after the social skills group to determine the impact of the program on each participant's knowledge of social skills. Feedback concerning your child's progress will be made available to you through a telephone call which will take place after the 10th session. In addition, a summary of the study's major findings will be mailed to you upon completion of the study (Fall 1993).

Please find attached a consent form which we kindly request you complete and return to your child's teacher as soon as possible. By signing the consent form, you agree to allow your child to participate in the social skills training and evaluation portion of the study, and to be videotaped during the course of each session. All tapes will be held in the strictest confidence and will only be used for supervision, training and data collection purposes. If you have any questions please do not hesitate to call Richard McCendie at 776-9967. We would be happy to speak with you and thank you in advance for your consent.

Sincerely,

Richard McCendie, M.A.
Doctoral Student

Barry Schneider, Ph.D., C. Psych
Associate Professor
University of Ottawa

Appendix E

TRAINEE CONSENT FORM

CONSENT FORM

I give permission for _____ to participate in the social skills training
(child's name)
component of the study being done by Richard McCendie and Dr. Barry Schneider of the University of Ottawa entitled The role of Leader's Social Competence in Children's Social Skills Training.

I do not give permission for _____ to participate in this study.
(child's name)

I understand that:

1) Participation will involve 10 sessions. Sessions will take place at school during school hours, with each session lasting approximately 45 minutes.

2) My child will be asked to fill out a self-report questionnaire concerning his/her frienships, both before and after the 10 session program.

3) For the sole purpose of this study each session will be videotaped for supervision, training and data collection.

4) Videotapes and questionnaire data will be held in the strictest confidence. Feedback on each child's progress will be made available to parents.

5) My child can withdraw from participation in this study at any time.

6) Questions regarding this study may be directed to Richard McCendie (776-9967).

Signed:_____ Date:_____
(Parent's signature)

Thank you for your assistance and cooperation.

Appendix F

MANUAL FOR THE MODIFIED McDANIEL OBSERVER RATING SCALES AND THE COMPLIANCE CODING SCHEME

Instructions for Coding of SST Leader Tapes

The SST leader tapes will be coded using two different coding systems, the Modified McDaniel Observer Rating Scale (MMORS) and the Compliance Coding Scheme. The MMORS is a coding instrument designed to describe four dimensions of leader behavior in social skills training (SST) sessions. While the Compliance Coding Scheme was devised to measure the degree to which the leaders complied to the SST manual (i.e. did they teach the content of each lesson or did they provide their own version of SST). Below is a description of each coding system, followed by instructions on how to use them.

Modified McDaniel Observer Rating Scales

Description. The original McDaniel Observer Rating Scale is an observation rating system designed to record teaching behavior on nine different dimensions (McDaniel, 1974). This instrument has previously been utilized in the therapist variable literature in a study on group treatment for depression (Antonuccio, Davis, Lewinsohn & Breckenridge, 1987). Of the nine original scales, three have been modified for use in the present study: Warmth, Enthusiasm, and Feedback (this modified version will now be referred to as the Modified McDaniel Observer Rating Scale - MMORS. The original McDaniel Observer Rating Scale was modified in two ways for the present study. First, only three of the original nine scales were utilized. In addition, these three scales were adapted for coding leader variables in social skills training sessions).

Comprehensive descriptions of the three scales are provided at the end of this document. For each scale the observer rates the leader's behavior on a six-point scale. For example, for the Enthusiasm scale, ratings range from (1) dull to (6) enthusiastic. Furthermore, each point is operationally defined. The MMORS scales are termed high inference scales; after observing a segment of leader behavior for several minutes, the observer must summarize the "major thrust and intent" behind the many leader behaviors observed. The original McDaniel Observer Rating Scale manual provides training films (which we do not have) in which 4 teachers were observed. Descriptions and rationales for how they coded each teacher are presented. The observer should read through these (see the back of this document) to get a feel for how the authors of the instrument did the coding.

Instructions. Five-2-minute segments of each leader's 9 sessions (there are 12 leaders) will be randomly selected to be coded. Most sessions are 25 minutes in length, so the first step is to fast-forward to a pre-chosen 2-minute segment (I will prepare a list of which segments you should code). Next, view the entire 2-minute segment and complete your ratings on the three scales (see the MMORS coding sheet at the end of this document). Refer to the scales' descriptive sentences to rate a given leader. Video-taped segments may be re-played as many times as is necessary to code the segment. Occasionally you might encounter a leader who does not seem to fit into the descriptive sentences for one of the scales. In such a case, concentrate on the descriptive paragraph introducing

the dimension and consider the continuum as a whole, with the midpoint falling between 3 and 4. Then try to place the leader on this continuum at the appropriate point. In these cases disregard the specific examples associated with the numbered scale positions in order to arrive at a rating.

Compliance Coding Scheme

The compliance coding scheme was devised to measure the degree to which the SST leaders complied with the program manual.

Instructions. Two sessions per leader will be randomly selected and reviewed by the observer (a list of which sessions to do will be provided). After reviewing the tape, rate the leader's compliance using the coding scheme provided (see end of this manual). As with the previous coding scheme, the observer should consecutively code one tape from each leader, and continue in this manner until 2 tapes have been coded for all 12 leaders.

Confidentiality

Please be aware that it is paramount that you respect the confidential nature of the data that you will be working with. This requires that you not discuss any information that you observe or code concerning individuals on the SST tapes. Furthermore, data should not be left around for others to view. When not being utilized, data should be stored appropriately.

Modified McDaniel Observer Rating Scale
Description of Scales

Scale 1: Warmth

This dimension refers to the extent to which the atmosphere of the group is relaxed and comfortable or tense and uncomfortable. It also encompasses the degree to which the leader maintains positive interpersonal relationships with pupils.

A group that is **warm** is one in which the leader is positive to the trainees, demonstrating friendly, warm behavior. The trainees show signs of feeling secure and appear to like or enjoy the group experience. There is an atmosphere of acceptance of trainees. The leader is sensitive to the private lives of the trainees, and is concerned about the personal and social growth of each trainee. Trainees are praised and reasoning is used. The leader smiles and uses humour in a positive way.

A group that is **cold** is one in which the leader is demeaning to trainees. The leader is critical and stern. The atmosphere is one of apparent insensitivity to trainees. This leader seems to think of trainees as "things" or "objects" to be dealt with. Sarcastic humour may be used to degrade or ridicule. There may be some differential treatment of trainees. Trainees exhibit feelings of insecurity and tension.

Rate this leader on the warmth continuum.

1 2 3 4 5 6
cold warm

1. A cold leader treats trainees in a rejecting way. This leader rejects not only undesirable behavior, but the trainees as well. By using negative words and a harsh tone of voice when correcting trainees, a cold teacher leaves trainees feeling bad and guilty. His speech is commanding and scolding. Sarcasm may be used to ridicule or degrade trainees. This leader has an angry or cross disposition and a frowning appearance.

2. This leader is formal and distant in his relationships with trainees. He is insensitive to trainees' feelings. This leader is lesson oriented to the extent that getting the job done takes priority over responding to trainees in a tactful or considerate way.

3. This leader is not always aware of trainees' feelings or may ignore them. While the leader tries to temper the tone of his corrections, the child still senses the negative overtones.

4. This leader is business like and intent is on getting the group lesson done. He tries to be friendly and is interested in his trainees. If the leader disapproves of trainee behavior, he is tactful and understanding when correcting trainees. In general, he uses more praise than criticism.

5. This leader is sensitive to trainees' feelings. He uses positive words when correcting trainees, leaving the trainees feeling secure even when corrected. This leader is helpful and supportive. Trainees feel safe enough to present personal examples in the class. He frequently praises and compliments.

6. A warm leader treats all trainees in an accepting way. He responds to each trainee as a person. When a trainee's behavior is undesirable, this leader remains accepting of the trainee, but rechannels the behavior or suggests an alternate behavior in a positive way. He uses positive words and his tone of voice is gentle. This leader has a pleasant disposition and a smiling appearance.

Scale 2: Enthusiasm

This dimension refers to the enthusiasm or interest level expressed by the leader during group sessions.

The **enthusiastic** leader conveys a great sense of commitment, excitement, and involvement in the lesson material. The trainees seem responsive and appear to enjoy the sessions. The leader seems to expect the trainees to do their best. The leader's tone of voice varies.

The **dull** leader does not appear interested in the lesson material. The trainees seem nonresponsive and do not appear to be involved in the session. The leader doesn't seem to care whether or not the trainees do their best.

Rate this leader on the enthusiasm continuum.

1	2	3	4	5	6
dull					enthusiastic

1. This leader does not seem to care about what he is teaching. He is both apathetic and boring. His voice is generally monotonic. This leader usually remains stationary in the classroom. He uses few gestures and has little eye contact with the trainees. Most trainees direct their attention elsewhere.

2. This leader is dry; he sticks strictly to the facts. This leader uses little voice modulation or eye contact.

3. This leader is poised and controlled. He wants his trainees to learn but his presentation lacks sparkle. Most trainees pay attention, but they are not inspired.

4. This leader is interesting and confident. He demonstrates and earnest desire for his trainees to grasp the material. His presentation is attractive and most trainees appear eager to answer questions posed by the leader.

5. This leader is stimulating. He uses expressiveness and variety in tone of voice and eye contact. He includes facts or ideas which stimulate interest. Trainees are willing to do more than just answer the leader's questions. Trainees offer their opinions to add to the ideas of the leader. There is much interaction between the leader and the trainees.

6. This leader is a dynamic showman. He dramatizes the lesson and captures the attention of trainees by facial expression, gestures and voice modulation. There is constant leader-trainee interaction. There is never a dull moment. The trainees are in the middle of the action. The activity in the group

is lively and it is obvious that both the leader and trainees are enjoying the lesson.

Scale 3: Quality of feedback

This dimension refers to the extent of communication to the trainee of information about the adequacy, acceptability, completeness, or correctness of his response or roleplay. This communication may be done verbally, through the token system (an explanation of the token system follows this section) or using both.

Effective feedback indicates to the trainee the specific characteristics of the response or roleplay that make it adequate, inadequate, correct or incorrect.

Ineffective feedback does not provide the trainee with specific information about his response or roleplay and therefore has little or no effect on improving performance. Feedback is ineffective if it is very general, inconsistent or unclear.

Rate this leader on the feedback continuum.

1	2	3	4	5	6	
ineffective feedback						effective feedback

1. This leader does not frequently respond to his trainees' verbalizations or the adequacy of his roleplays. Information about the trainee's performance is rarely communicated.

2. This leader responds to trainees' verbalizations or roleplays with general feedback, such as "O.K." or "Good", without going into detail about what is good or bad about it.

3. This leader gives general feedback, with some specific comments about the overall quality of the verbalization or roleplay.

4. This leader lets trainees know which aspects of the participants' responses and roleplays are right or wrong without indicating what is right or wrong about them.

5. This leader lets trainees know which responses or aspects of roleplays are right or wrong, and tries to be as specific as possible, pointing out those parts that are well done and those parts that need improving.

6. This leader uses methods which provide the trainee with a constant step by step check on whether each answer or roleplay is adequate.

MODIFIED McDANIEL OBSERVER RATING SCALE CODING SHEET

Leader:_____ Observer:_____

Complete the ratings at the end of the 2-min observation period. Circle the rating for each coding variable.

Sess #	Observ. period	Coding variable	Rating
__	1	1. Warmth	1 2 3 4 5 6
		2. Enthusiasm	1 2 3 4 5 6
		3. Feedback	1 2 3 4 5 6
	2	1. Warmth	1 2 3 4 5 6
		2. Enthusiasm	1 2 3 4 5 6
		3. Feedback	1 2 3 4 5 6
__	1	1. Warmth	1 2 3 4 5 6
		2. Enthusiasm	1 2 3 4 5 6
		3. Feedback	1 2 3 4 5 6
	2	1. Warmth	1 2 3 4 5 6
		2. Enthusiasm	1 2 3 4 5 6
		3. Feedback	1 2 3 4 5 6

COMPLIANCE CODING SCHEME
CODING SHEET

Leader:_____ Observer:_____

a) Did the therapist include all the minimally prescribed components for each session? (refer to list of major session components)

1 - All components included
2 - A few minor components missed
3 - Several major components not included
4 - Session bore little resemblance to protocol

b) Were there any treatment aspects introduced which represented significant departures from the stated intervention protocol?

1 - complete or near complete compliance with protocol
2 - A few minor but noteworthy additions to the protocol
3 - Several major additions to the protocol
4 - Session bore little resemblance to the protocol

Session #	Scale	Rating
__	a) Inclusion of prescribed components	1 2 3 4
	b) Presence of significant additions	1 2 3 4
__	a) Inclusion of prescribed components	1 2 3 4
	b) Presence of significant additions	1 2 3 4

List of Major Session Components

All sessions

- Each session begins with a brief review of the major points presented the previous week.
- Each session ends with a brief summary of the major points presented that day.

Modeling, Roleplay & feedback (sessions 1,3,6,7,8, & 10)

- First, the leader presents the skill steps.
- Modeling - The leader demonstrates or models the expert performance of these skill steps.
- Roleplays - The trainees practice the skill steps by roleplaying a contrived situation.
- Feedback - The leader asks the group to comment on what the actors did well and how they can improve their roleplay.

*** The skill steps for the aforementioned sessions are as follows:

Session 1: Joining Others

1 - Plan what to say
2 - Plan when to join in
3 - Walk over and do it

Session 3: Dealing with Teasing

1 - Self-statement
2 - Decide if you're being teased
3 - Think about ways of dealing with teasing
4 - Choose the best way and do it

Session 6: Giving Compliments

No formal skill steps. However, the children are encouraged to smile and be friendly, and to be sincere when they compliment.

Session 7: Dealing with Other's Anger

1 - Stay calm
2 - Listen to his side, don't interrupt

3 - Try to understand
4 - Is his anger fair?

Session 8: Making Suggestions

No formal skill steps. Children are encouraged to refrain being bossy and are encouraged to be friendly. When faced with the rejection of a suggestion, the children are encouraged to keep a positive attitude.

Session 10: Coping with Failure & Rejection

No formal skill steps. Children are encouraged to maintain a positive attitude and respond in an appropriate manner when rejected.

Social Problem Solving (session 2)

- Social problem solving attempts to develop a child's skill in solving social problems. This procedure is divided into 3 steps:

1 - generate alternative solutions to the problem
2 - evaluate each solution
3 - choose the best option and do it

Self-Statements (session 3)

- The current program teaches children different ways of "talking to themselves" or self-statements that help them stay calm in conflict situations, to prevent further escalation due to inappropriate, impulsive responding. Sample self-statements include: "I'm going to chill out, because getting mad won't help" or "Stay cool Tom, it's not worth getting in trouble.

- Steps to teach self-statements:

1 - state rationale behind the use of self-statements (a self-statement is something you say to yourself that helps you calm down when you're mad).
2 - the leader models the proper use of a self-statement.
3 - the children practice generating self-statements.

Role-Reversal (session 5)

- The objective of this lesson is to help the children appreciate and understand the different viewpoints in a given situation. Role-reversal accomplishes this by requiring a child to role-play both roles in a situation, thereby experiencing both roles.

- First, the leader models a sample roleplay, followed by a discussion of each actor's feelings. Then two children perform the same roleplay, followed by discussion. The same actors are then asked to switch roles and repeat the same roleplay. A discussion of the respective actor's feelings ensues.

Playing a game (session 9)

- Through actually playing a game with the leader (Snakes & Ladders), the children discuss and learn the following skill steps:

1 - Know the rules
2 - Decide who starts the game
3 - Make sure everyone gets a turn
4 - Don't be in a rush
5 - At the end of the game, say something nice to the other players

Appendix G

REVISED CLASS PLAY

CONFIDENTIAL

REVISED CLASS PLAY

NAME: _____ DATE: _____

TEACHER: _____ GRADE: _____

BOY OR GIRL ?

INSTRUCTIONS:

We are trying to learn about how people get along with each other. These answers will only be used for our project. Your answers will not be given to school staff or to your parents. Please do not discuss your answers with anyone else.

Pretend that you are a director of a play starring the students in this classroom. The director of a play has to do many things but the most important job is to select the right people to act in the play. So, your job is to choose students from the list provided who could play each part or role best. Try to pick students who seem to fit each part in real life.

Remember, you can pick up to three names for each role. You can also pick the same person for many different roles. Also, you cannot pick your own name.

1.	Who is a good leader?			
2.	Who gets into lots of fights?			
3.	Who would rather play alone than with others?			
4.	Who has good ideas for things to do?			
5.	Who loses his or her temper easily?			
6.	Who shows off a lot?			
7.	Who is someone you can trust?			
8.	Who interrupts when others are speaking?			
9.	Who has many friends?			

10. Who will wait his or her turn?			

11. Whose feelings get hurt easily?			
12. Who is it that everyone listens to?			
13. Who plays fair?			
14. Who has trouble making friends?			
15. Who acts like a little kid?			
16. Who has a good sense of humour?			
17. Who can't get others to listen?			
18. Who is very shy?			
19. Who is polite?			

20. **Who makes new friends easily?**			

21.	Who is too bossy?			
22.	Who is often left out?			
23.	Who helps others when they need it?			
24.	Who is usually sad?			
25.	Who is it that everyone likes to be with?			
26.	Who can get things going?			
27.	Who teases other children too much?			
28.	Who is usually happy?			
29.	Who picks on other kids?			

30. Who likes to play with others rather than alone?			

Appendix H

SOCIAL SKILLS TRAINING MASTERY TEST

SST MASTERY TEST

Joining Others

1) You have to tell Jimmy the worst wrong way to join in a game - so they really won't want to let him play.

a) What mistakes could Jimmy make so that they probably won't let him play?
b) What is important to remember about joining in their game?
c) Give me an example of a good thing to say so Jimmy can join in properly.

Dealing with Teasing

2) Let's say that someone is teasing you right now, and you're really mad.

a) What is the best thing to do?
b) Could you give me an example of a good self-statement?

3) Pretend that I'm teasing you. "Ha ha do you ever look like a nerd with those pink sneakers. Bobby is a girl, Bobby is a girl".

a) Tell me what you would do.
b) What if you tease the person back. Would that be a good thing to do? Why or why not?

Understanding Other's Feelings

4) You and Tom play on the same hockey team and you just lost the championship game. Tom is the goalie, and he's upset because everybody is mad at him for letting in so many goals.

a) How many sides to this story?
b) How does Tom feel?
c) How do you feel?
d) What could you say to make Tom feel better?

Giving Compliments

5) Your friend in art class just made a really nice painting.

a) What would be a friendly thing for you to do?
b) When would be a good time to give this compliment?
    i) When he is mad
    ii) When he is in a bad mood
    iii) When he is in a good mood

Dealing With Other's Anger

6) Billy is angry because you accidentally hit him with the soccer ball. He's mad and he's telling you off.

a) How should you handle this situation?
b) What if you get mad back at him. Would that be a good thing to do? Why?
c) What are some of the skill steps you learned to deal with this problem?

Making Suggestions

7) Pretend that you're with your friends during recess and you want to suggest that you play touch football.

a) Show me how you would do this.
b) What would you do if they say no?
c) How might they react if you say, "We're playing football and that's that!"?

Playing a Game

8) Pretend that you're playing a game of snakes & ladders with three friends.

a) How would you decide who goes first?
b) Is it okay to play out of turn? Why?
c) What is a good thing to do when the game is over?

Coping with Failure and Rejection

9) Pretend that Jeffrey asked two friends if he could join their game of catch and they said no.

a) He's feeling bad. Is there some way he can make himself feel better?
b) What could he say to his friends after they said no?
c) What are some things that Jeffrey might be thinking or saying to himself that could make him feel worse than he has to in this situation?

Appendix I

SOCIAL SKILLS TRAINING MASTERY TEST SCORING SHEET

SST Mastery Test Scoring Sheet

Child's Name: _____ School: _____

Question #		Score		
1	(a)	0	1/2	1
	(b)	0	1/2	1
	(c)	0	1/2	1
2	(a)	0	1/2	1
	(b)	0	1/2	1
3	(a)	0	1/2	1
	(b)	0	1/2	1
4	(a)	0	1/2	
	(b)	0	1/2	
	(c)	0	1/2	
	(d)	0	1/2	
5	(a)	0	1/2	
	(b)	0	1/2	
6	(a)	0	1/2	1
	(b)	0	1/2	1
	(c)	0	1/2	1
7	(a)	0	1/2	1
	(b)	0	1/2	1
	(c)	0	1/2	1
8	(a)	0	1/2	1
	(b)	0	1/2	1
	(c)	0	1/2	1
9	(a)	0	1/2	1
	(b)	0	1/2	1
	(c)	0	1/2	1

Total score (22): _____

Appendix J

SST MASTERY TEST SCORING KEY

SST Mastery Test Scoring Key

1 (a) 1 point for any of the following:

- forget to plan what to say
- join in at an inappropriate time
- be unfriendly
- do it in a bossy way
- or any other mistake

1/2 point for any of the following:

- forget to say please

1 (b) 1 point for any of the following:

- plan what to say
- join in at an appropriate time
- be friendly

1/2 point for any of the following:

- say please

1 (c) Any polite, friendly request (1 point)
e.g. "May I please play?"
"Hey guys, can I join in your game?"

2 (a) Use a self-statement or try to calm down (1 point)

walk away, ignore (1/2 point)
or any other appropriate way of dealing with teasing (1/2 point)

2 (b) e.g. "Count to ten" (1 point)
"I'm going to cool down"
"Calm down it's not worth getting into trouble"

3 (a) Any appropriate response designed to de-escalate the situation and not reinforce the teaser (1 point)
e.g. walk away
ignore
reason with the person

Tell an adult (teacher, principal, parent) (1/2 point)

3 (b) No, because you're reinforcing his teasing & he'll target you in the future (1 point)

No, because it'll cause the situation to escalate into a verbal or physical fight (1 point)

No + moderate/poor reason (1/2 point)

No + no reason (0 points)

4 (a) Two (1/2 point)

Three (1/2 point if he identifies himself, Tom, and the rest of the team)

(b) Tom is upset, feels bad, embarassed (1/2 point)

(c) upset that we lost (1/2 point)
bad, sad
feel bad for Tom
mad at Tom (0 points)

(d) Any empathic response designed to cheer up Tom or make him feel better (1/2 point)
e.g. "It's OK Tom, you did your best"
"Don't worry, we'll get them next year"

5 (a) Give a compliment (1/2 point)

(b) (3) when he's in a good mood (1/2 point)
(1) or (2) 1/2 point only if child states that the compliment was timed in order to cheer up the person, otherwise give 0 points.

6 (a) Any two of the following (1 point)
Any one of the following (1/2 point)

stay calm (self-statement)
listen to his side, don't interrupt
try to understand
ask whether his anger is fair

tell him you hit him by accident (1/2 point)

be friendly, smile (0 points)
deny you did it

6 (b) No, because it might escalate the situation into a verbal or physical fight (1 point)

No (0 points)

6 (c) Any two of the following (1 point)
Any one of the following (1/2 point)

stay calm (self-statement)
listen to his side, don't interrupt
try to understand
ask whether his anger is fair

tell him you hit him by accident (1/2 point)

be friendly, smile (0 points)
deny you did it

7 (a) Any suggestion made in a +ve, friendly manner, that respects the other person's right to agree or decline (1 point)

If suggestion is pushy or bossy (0 points)

(b) Any response indicating that a cheerful, +ve attitude is maintained (1 point)
e.g. "OK maybe some other time"

"I'd just go and play with someone else" (0 points)
Any negative response

(c) Any response indicating that the children would react in some negative manner or indicating a -ve consequence (1 point)
e.g. may not want to play with you in the future
may not want to be your friend
may verbally get mad at you
would be upset or mad

8 (a) Roll dice or any other fair manner of deciding (1 point)

(b) No, it's not fair, because the other person loses his turn (1 point)

No + no reason (1/2 point)

(c) congratulate the winner (1 point)
say something nice to the other players

bragging (0 points)

9 (a) Remind himself that "every time I ask someone to play that they are not always going to say yes" (1 point)
play with someone else (1/2 point)

(b) Any response indicating that a cheerful, +ve attitude is maintained (1 point)
e.g. "OK maybe some other time"

"I'd just go and play with someone else" (0 points)
Any negative response

(c) Any negative, self-defeating thought (1 point)
e.g. "Oh, I'm no good"
"No one wants to be my friend"
"No one wants to play with me"

Appendix K

CHILDREN'S SOCIAL SKILLS TRAINING PROCEDURES MANUAL

Table of Contents

Introduction

Welcome to social skills training! We hope that the next few weeks will prove to be a valuable learning experience for you. In addition to the workshops, the following manual will provide the information necessary to conduct a social skills training (SST) group. Prior to starting the group, you should thoroughly familiarize yourself with the contents of this manual. The manual is divided into three sections. First, you will be introduced to some basic concepts in the area of social skills training. This will be followed by a description of the training techniques used in our program. The final section will outline the ten sessions which you will teach in your SST group. So sit back, read on, and good luck!

Social skills - a definition

What are social skills? Here are a few definitions developed by leading researchers in the field:

"Social skills are the ability to interact with others in a given social context in specific ways that are societally acceptable or valued and at the same time personally beneficial, mutually beneficial or beneficial primarily to others." (Combs & Slaby, 1977)

"In general, social skills are seen as socially acceptable learned behaviours that enable the person to interact with others in ways that elicit positive responses and assist in avoiding negative responses from them." (Cartledge & Milburn, 1986)

"(social skills are) the tools used to initiate and sustain peer relationships that are a vital part of our psychological well being." (Schneider, Rubin & Ledingham, 1985)

Social skills training

Extensive research suggests that poor peer relationships in childhood are associated with high risk for later maladjustment and social difficulties (Ladd & Asher, 1985). Studies have reported that early peer isolation and rejection is associated with poor self-esteem (Percell, Berwick & Beigel, 1974), delinquency (Roff, Sells & Golden, 1972), depression (Wolpe, 1973), poor academic achievement (Hartup, 1970), adult alcoholism, antisocial behavior, and other psychiatric disturbances (Lovaas, Freitas & Whalen, 1972). In addition, Hartup and his colleagues reported that children's ability to act in a positive social manner was directly related to being well liked by one's peers (Hartup, Glazer & Charlesworth, 1967). These findings have led investigators to develop intervention programs, such as SST, designed to foster positive peer interaction and promote peer acceptance (Bierman, 1986). The goal of SST is to teach social skills assumed to be missing in a child's social repertoire, which thereby impede satisfactory peer relations (Ladd, 1985). For example, a child who is aggressive is considered deficient in skills required to deal appropriately with conflict situations. Training for this child might focus on building skills such as coping with teasing, dealing with other's anger, and self-control (Michelson, Sugai, Wood & Kazdin, 1983).

The effectiveness of SST has been well documented. Ladd and Asher (1985) reviewed nine studies on the outcome of SST and found that seven of the nine studies reported an increase in popularity among peers for children who received training compared to no-treatment controls. Schneider (1988) in a review of 79 SST outcome studies reported that SST is moderately effective

and is comparable, in terms of success, to other interventions conducted with children.

Who will receive SST?

In the present study, the trainees will be grade 3 & 4 boys, aged 8-10 years who have been identified as high on aggression. Aggressive children behave in a manner that is unpleasant to other children (Michelson, et al., 1983). Aggressive behaviour has been described as including verbal and physical assaultiveness, teasing, provoking, quarreling, fighting, and violating/ignoring the rights of others (Patterson, Reid, Jones, & Conger, 1975). In the short run the aggressive child may achieve his/her goal, but the longterm negative effects of this type of behaviour (e.g. rejection, avoidance and punishment by other children, loss of friends, decreased interpersonal contact, and feelings of guilt) outweigh the benefits (Michelson, et al., 1983). Consequently, these children are often the targets of counteraggression and experience higher rates of social rejection. Moreover, aggressive children are considered at high risk for later maladjustment (Parker & Asher, 1987). It is for these reasons that aggressive children were chosen to be the recipients of SST in the present study.

Basic information about the groups

Each leader will be responsible for conducting one SST group at a local elementary school. Each group will consist of 8 trainees (who have received permission from their parents to participate in the study) who will participate in 10 sessions of SST over a 10 week period (one session per week). Sessions will take place during school hours. Each session will last approximately 35 minutes and will provide training in the following skills: how to greet others, coping with teasing, dealing with other people's anger, expressing dislike, dealing with other's aggression, understanding the feelings of others, coping with rejection and failure. All sessions will be videotaped. In addition, supervision will be provided every two sessions to answer any questions the group leaders may have and to provide ongoing training. Prior to starting the groups all leaders will participate in an all day workshop to be held during the Fall 1992.

What is your role as a volunteer?

In the present study leaders will be required to provide SST to several children under the supervision of a licensed psychologist. Needless to say, this is a responsibility that should not be taken lightly. The following quote from the Canadian Code of Ethics for Psychologists (Canadian Psychological Association, 1988, p 32) addresses this issue:

> "One of the most basic ethical expectations of any profession in our society is that its activities benefit members of society or at least, do no harm. Therefore, ethical conduct by psychologists is characterized by an active concern for the welfare of any individual, family or group with whom they come into relationship in their role as psychologist. This concern includes both those directly involved in their service, research and teaching activities... In order to carry out these steps, psychologists recognize the need for and the value of competence and self-knowledge. They consider incompetent action to be unethical per se, as it is unlikely to be of benefit and likely to be harmful. They engage only in those activities in which they have competence, and they perform their activities as competently as possible."

This quote is an excerpt from an ethical principle termed "responsible caring", which speaks directly

to your role as a leader of an SST group. First, your activities must benefit and do no harm to the children you will work with. Second, you must confine your activities to those for which you have been trained for. In order to honour these values you must assure that you are well prepared for each lesson. You should therefore allow yourself ample time prior to the lesson day to plan your lesson and thoroughly familiarize yourself with its contents. Parents, teachers or principals may ask your opinion about the behaviour of one of your group members. Do not under any circumstances offer an opinion, an assessment, or any recommendations concerning a child. **You are not trained to do this.** Inform the party that you will refer their question to the project coodinator. Furthermore, it is paramount that you respect the confidential nature of your relationship with each child in the group. Consequently, **you should not discuss information concerning a child with any person.** This includes school personnel such as teachers, vice-principals, and principals.

Finally, remember that you are a guest in a school that is under the direction of teachers and principals. Please keep your "guest status" in mind when interacting with school personnel.

When should you call for help?

The general rule is that anytime you are unsure or unclear about something give me a call day or night (Rick McCendie, 776-9967). In addition, please call me if any of the following situations occur:

- if you are unable to attend a lesson in a dire emergency situation, call me and together we will make arrangements to reschedule the lesson. Please remember that the teachers and children are expecting us, we can only rearrange things in a dire emergency.

- if a teacher, principal or parent has any questions or concerns about the study or the group you are running, inform them that you will refer their question to the project coordinator and I will call them as soon as possible.

- if a child is not complying with the program (i.e., his behaviour is seriously disrupting the group).

- if you have any questions concerning a child's behaviour.

- if a child is being seriously interpersonally inappropriate with you or with another child in the group (i.e. touching another child's genitals).

- if a child reports any thoughts of suicide.

- if a child reports an instance of sexual abuse, physical abuse or any situation in which they are endangered.

- if you feel the lesson has gone especially poorly and you feel the children did not learn the skill objectives.

- if any equipment is not working.

- if there are too many kids missing that day (e.g., due to bad weather) (if 3 or more children are missing, you should cancel the group)

- if there is a problem getting access to a room, or teachers are not getting children to the group sessions.

How to prepare a lesson

Lesson preparation should require about 3 to 4 hours of your time each week. To prepare each lesson, start by reading the lesson and the corresponding training technique (see the prerequisite reading section at the beginning of each lesson). Next, condense the lesson into a page of notes which you can refer to when giving the lesson. Notice that much of each lesson has been written in script form in order to demonstrate to you how to deliver the material in language that grade 3 and 4 children will understand. **Do not read this script to the class!** Finally, practice giving the lesson several times. Use the ideas and notes on your reminder page to prompt you. **Do not read from your notes!** You will lose the children's interest and attention. On the day of the lesson re-read your notes. Good luck and have fun!

Training Techniques

Token economy

The token economy has two important purposes. First, to help children maximize learning during the sessions by increasing attention and minimizing disruptions. And second, to reward the use of appropriate social behaviour, especially during unstructured times before and after the session.

Prior to the start of each session, 10 tokens are placed in each child's cup (each child has a plastic cup with their names on it). Since the child may have tokens left over from previous sessions, the total number of tokens is recorded on a chart. Children can earn extra tokens for certain behaviours including: first volunteer for a role-play, good participation, friendliness, etc. Conversely, tokens are lost for being silly, not paying attention, interrupting, arguing about a lost token, etc. Figure 1 outlines a list of the behaviours that are rewarded and punished. This list will be reproduced on a bristle board which should be placed at the front of the classroom to remind the children. All 8 cups will be kept near the leader. When a child performs a behaviour to be rewarded or punished, the leader should add or remove the token from the child's cup (this should be done as soon as possible after the behaviour has occured. However, do not interrupt your lesson needlessly. Finish making your point, and then remove/add the token.). State why the child has earned or lost the token (e.g. "You both earned tokens for volunteering for the first role-play"). Tokens should be removed in a positive manner, without excess verbalization (e.g. "I have to take a token away for not paying attention"). If children argue after they have lost a token, they immediately lose another token, and should be reminded that the decision of the "judge" is final. At the end of the session, tokens are counted and recorded. Children can then buy items in the store for which they have enough money. Tokens may be saved for future sessions. However, children cannot borrow tokens from others or obtain a "line of credit" from the leader!

Items for the store will be provided and will include baseball & hockey cards, stationary, stickers, erasers, paper clips, etc. Items should be displayed on a table in similarly priced groupings. Prices for each group of items should also be indicated with a sticker.

In the first two sessions, the leader should ask the children for additional ideas of what kinds of items they would like in the store. Items should cost between $0.10 - $2. Simply let Rick McCendie know what is needed.

Remember, the token system is designed as an aid to your teaching. Do not let it take precedence over the lesson. Interrupt the lesson only if it is absolutely necessary (e.g. when a child is interrupting). Give tokens judiciously. Do not give a token every time a child participates. Instead give a child one or two tokens per class for participation. A maximum net loss or gain of 5 tokens per class per child should be used as a guide.

Modeling, role-play and feedback

Modeling, role-play, feedback is an important training technique which has been popularized in Arnold Goldstein's structured learning method of teaching social skills (Goldstein, 1988). This method is also an integral component of the present program. Skills are first broken down into component skill steps (e.g. Greeting others skill steps are: 1. Think how to greet the person, 2. Walk over, 3. Say hi, tell your name, 4. Ask for his/her name, and 5. Do something together). The leader then demonstrates or models the expert performance of these skill steps for the trainees to observe. Next, the trainees practice the skill steps through role-playing and receive feedback from the other trainees and group leader. Each of these three components will now be discussed in more detail.

Modeling. Research indicates that children can learn a new behaviour by observing an individual model this behaviour, and then imitating the observed behaviour (Bandura, Ross & Ross, 1961). For example, new slang expressions (such as "chill out dude") will filter through a school as children observe and imitate their use (McGinnis & Goldstein, 1984). Modeling has been used effectively to teach children appropriate social behaviour.

Modeling is used extensively throughout this manual as an aid in teaching children various skills. The leader must first select and coach a trainee to serve as the co-actor in the modeling sequence (it might be a good idea to do this before the session starts). The leader and co-actor then perform the modeling sequence (this is referred to as a demonstration role-play in the manual) in a relaxed and expert manner. It is important to note that you are providing the yardstick against which all other role-plays will be measured. To be effective, the modeling sequence must demonstrate the skill steps in a clear and detailed fashion, and should include as little irrelevant detail as possible. Positive reinforcement for appropriate social behaviour should be incorporated into the modeling sequence. The principle of positive reinforcement states that if an individual performs a behaviour that is followed by a rewarding consequence, then that person is more likely to repeat that behaviour in the future when he/she encounters a similar situation. For example, if the co-actor smiles at the leader as he greets him, the leader should reinforce this by smiling back (the leader's approving smile reinforces the co-actor's smiling behaviour and increases the likelihood that the co-actor will smile in a similar situation in the future). Finally, the modeling sequence should be followed with a brief discussion in which relevant features of the modeled skills are highlighted. Accomplish this by asking the children to comment on which skill steps were used in the modeling sequence and what they liked about them. The leader should reinforce appropriate observations of important skill steps: "Yes, good, that's an important step". If you find the children have not observed and understood the skill steps, perform the modeling sequence/discussion a second time.

Role-playing. Role-playing has been defined as "a contrived situation in which an individual

is asked to play a role, or behave in a certain way, in order to aquire specific behaviours or responses, which may then be employed in an unrehearsed, real-life situation" (Schneider, Raycraft, Poirier & Oliver, 1986, p.11). Role-playing has been used effectively by mental health professionals to help individuals change their behavior and attitudes (McGinnis & Goldstein, 1984). In this manual, role-playing is considered an essential technique in teaching children social skills. Clearly, knowledge of social skills is a necessary but insufficient factor for a child to become socially competent. In addition, a child must learn to act skillfully through practicing the various skill steps in a spontaneous and friendly manner.

After the modeling sequence has been demonstrated, the leader should introduce the role-playing by saying, "Let's practice what you've just seen by doing some role-plays". Volunteers are chosen and briefly coached concerning their roles. Remind the actors that they should perform each skill step in their role-play. It is essential that the actors focus on the main objectives of each skill. If a role-play is clearly not meeting these objectives (i.e. the children are completely missing the point), stop the action, explain where the role-play went wrong, and restart. At the completion of each role-play, reward all actors with a token for effort and participation.

Feedback. Follow each role-play with a brief feedback period. Feedback is designed to inform the student on how well he approximated the model's expert performance of the skill steps and should encourage the student to attempt the role-played behaviours in real life.

Begin by asking the group to comment on what they thought went well in the role-play (e.g. "What skill steps did Tom do well" or "What did you like about Tom's performance"). Remember, the feedback is directed at the main actor, who is supposed to be enacting the skill steps. Encourage the group to structure their feedback in terms of whether the main actor has followed the skill steps. Once the group has finished, the leader should comment on points that were missed by the group. It is essential that the leader reinforce each actors efforts. This should be done through token reinforcement and verbal praise. For instance, if a group member comments that Tom acted in a friendly manner, the leader could reply, "Yes, I agree. Tom did appear very friendly. That was excellent". Remember, because of the negative nature of their behaviour, aggressive children do not receive much positive reinforcement from adults or peers. Consequently, these children are very responsive to praise or approval. End the feedback period by asking the children to comment on how the main actor could have improved his performance. Remember, the children should be encouraged to structure this criticism in a constructive, friendly, and helpful manner. Any members of the group who make fun of an actor should lose a token.

Social Problem Solving

Social problem solving is a cognitive behavioural technique which is based on the view that deficient social skills result in part from inappropriate cognitive strategies that children use in interpersonal situations. It is purported that a change in social behaviour will occur if these maladaptive cognitive strategies are changed. The strength of this method is that the child is trained to deal independently with social problems, instead of relying on a prescriptive solution from an adult.

Social problem solving attempts to develop a child's skill in solving social problems. This procedure is divided into 4 steps: 1. generate alternative solutions, 2. evaluate each solution, 3. choose one option and do it, and 4. evaluate the effects of the final chosen response.

1) Generate alternative solutions. Socially deficient children often respond in a repetitive fashion to social situations because they are unable to think of different ways of dealing with the same

situation (e.g. an aggressive child might always respond to a teaser by teasing back, causing the situation to escalate). The goal of this first step is to train the child to generate alternative solutions. The children must generate as many different, but plausible solutions as possible, regardless of suitability. It is important that the leader does not comment upon or discourage any negative solutions that are offered. The leader acts simply as a facilitator or guide in the problem solving process. He must not evaluate the solutions in any way whether they are appropriate or highly unsuitable. Ask the children to generate about 5 or 6 solutions which should be recorded on the chalk board. The only stipulation is that the answers be realistic (e.g. the child's invisible friend cannot ride in a save him from the bullies). If the children are experiencing difficulty, the leader may prompt the children (e.g. "what if someone is teasing you and you get really mad. What might you do?" Answer = fight). When doing this exercise it is best that both positive and negative solutions are provided, so that the children gain practice in evaluating both types of solutions. If an obvious inappropriate solution has been overlooked by the children, the leader should prompt.

2) Evaluate each solution. Here the children are required to anticipate the probable outcomes of each solution. The leader facilitates this discussion by asking, "tell me what you think might happen if when someone teased you, you teased them back? Do you think that's a good or bad thing to do? Why?"

3) Choose one option and do it. After all the solutions have been evaluated, the children should indicate which solution they think is best.

4) Evaluate the effects of the final chosen response. In an actual social situation, children would be required to evaluate how well the solution they chose turned out. If the situation ended favourably, then the child should "pat himself on the back" and "tell himself that he did a good job". If the child's response did not turn out favourably, then the next best solution should be implemented.

Self-Statements

Cognitive behaviour modification techniques assume that cognitive factors (such as thinking to oneself) play a central role in guiding behaviour. According to Donald Meichenbaum, internal speech (what a person says to himself) is one such cognitive factor that if changed may result in a change in that in an individual's thoughts, feelings and behaviour. The goal is to change self-defeating modes of inner speech to more adaptive modes.

This technique has been used successfully with aggressive children as a means of controlling anger and impulsive reactions to conflict situations. The current program teaches children different ways of "talking to themselves" or self-statements that help them stay calm in conflict situations, to prevent further escalation due to inappropriate, impulsive responding. Sample self-statements include: "I'm going to chill out, because getting mad won't help" or "Stay cool Tom, it's not worth getting into trouble".

When teaching self-statements, first begin by stating the rationale behind the use of self-statements (a self-statement is self-talk or something you say to yourself that helps you calm down when you're mad). Then the leader should model the proper use of a self-statement. Finally, the

children practice generating appropriate self-statements that are directed at reducing their anger.

Lesson 1: Joining Others

WARNING: Much of the following lesson is written in script form. This has been done to demonstrate how to deliver the material in a language that grade 3 and 4 children will understand. **DO NOT READ THIS SCRIPT TO THE CLASS!** Translate these ideas into your own words and strive to deliver the lesson in as natural a manner as possible.

Prerequisite reading: Token economy
Modeling, role-play and feedback

Lesson objectives:
By the end of this session, the children should be able to ...
1) understand that the gaining and losing of tokens is contigent on their behaviour (i.e., what specific behaviours will result in gaining and what specific behaviours will result in losing tokens.).
2) identify two of the three "joining others" skill steps as an appropriate means of joining a game that is ongoing.
3) identify an appropriate time to join a game (i.e., when there is a break in the game).
4) appropriately demonstrate how to join an ongoing game using the "joining others" skill steps.

Introduction
- welcome children to the group
- explain that they will be taking part in a friendship group which will meet once a week for 10 weeks. In this group they will learn some tips on how to make and keep friends.

Helpful hint:
- The children may ask many questions. Remember, you only have 30 minutes to complete the session. Field a few questions and if the questioning persists, explain that you must continue with the lesson and you will answer questions at the end of the session.

Explain the token system
- materials: Bristle board outlining behaviours that are rewarded and punished (see figure 1).
-"Now I would like to tell you about a special system we have called a token system."
- Explain that all children will receive 10 chips (show the tokens) or tokens at the beginning of each class. More tokens can be gained by performing certain behaviours (point to the list of behaviours that are rewarded). Review this list. Conversely, tokens can be lost for other behaviours. Review this list. At the end of each session tokens will be counted and may be used to purchase prizes from the store. Remind the children that they are in charge of whether they gain or lose tokens. "If you do these things (point to positive behaviours listed on bristle board) you will receive tokens, and if you do these things (point to negative behaviours) you will lose tokens. So remember you're in charge. Does anyone have any questions?" Inform the children that the token system is now in effect!

Joining Others

Introduction:
"Now we are going to talk about how to join a group of children that have already started playing a game. Do you find that it is sometimes difficult to do this?"

Skill steps:
Materials: Bristle board outlining "Joining Others" skill steps.

Describe the "Joining Others" skill steps sequentially through the use of a role-play demonstration. Ask for two volunteers. Direct the volunteers to pretend that they are playing a game of catch. At various times the actors should pretend to drop the ball. The leader will demonstrate how to join in.

Demonstrate step 1: Plan what to say.
For example, say out loud, "There's Tom and Brad playing catch. I think I'll ask them if I can join their game." Ask the children why this step is important (answer = some people get nervous when trying to join in a game. If you don't have a plan you might walk up to the group with nothing to say and look foolish.

Demonstrate step 2: Plan when to join in.
For example, say out loud, "I think I'll wait till there's a break in their game, so that way I won't interrupt them." Ask the children if this plan is a good idea (answer = yes, because you should'nt interrupt, they may not like it and may not let you play). Ask the children for examples of a break in the game (answer = when one person drops the ball, or when the players take a rest).

Demonstrate step 3: Walk over and do it.
As one of the children drops the ball, the leader walks over says, " Hi guys, can I join in? or Would it be okay if I played catch with you guys?"

Smiling: Ask the children if and why it is important to smile when you are joining in (Answer = Yes. Because it shows the other person that you are friendly and worth having as a friend.)

The leader and volunteer should now role-play all 3 steps in a spontaneous and friendly manner.

Role-plays:
"Now it's your turn to do the role-play". Ask the two volunteers to remain as the "ball players". One at a time, have all the children play the role of the person who wants to join the game of catch. Briefly coach the actors on their respective roles (i.e. "Let's pretend Tom and Brad are playing a game of catch. Dave, I want you to use the steps we just learned and show us how to join in. Remember be friendly!").

Feedback:
First, ask the children which steps were performed well and generally, what they liked about the performance (note: The actors should be given the first opportunity to comment). Now ask the children to indicate what the actors could do to improve their performances. Continue the role-play/feedback sessions until all children have played the role of the "joiner". If time is running out, conduct as many role-plays as possible.

Closure:
"Today you learned how to join in a game that is already under way. First, plan what you are going to say. Second, plan when to join in, so that you don't interrupt their game. And finally, walk over and do it in a friendly way!"

Lesson 2: Dealing with Teasing I

WARNING: Much of the following lesson is written in script form. This has been done to demonstrate how to deliver the material in a language that grade 3 and 4 children will understand. **DO NOT READ THIS SCRIPT TO THE CLASS!** Translate these ideas into your own words and strive to deliver the lesson in as natural a manner as possible.

Prerequisite reading: Social problem solving

Lesson objectives:
By the end of this session, the children should be able to ...
1) identify three ways of dealing with teasing, including at least one appropriate solution.
2) identify a non-aggressive response as the appropriate response to teasing.
3) state the likely consequences of an aggressive and a non-aggressive response to teasing.

Review:
Briefly review last week's lesson (maximum time = 3 minutes). "Remember, last week we started the token system. You get tokens for doing things like paying attention, participating and being the first volunteer. You can lose tokens for being silly, not paying attention and not putting your hand up before you talk. And remember, you're in control. You decide whether you lose or gain tokens. Last week we also learned how to join a group of kids that are playing a game". Ask the children to name the three steps and briefly say why they are important. (Answer = Plan what to say, plan when to join in, and walk over and do it. And remember be friendly)

Demonstration Role-play:
The leader and one volunteer should perform a role-play (choose a child before the class starts and plan the role-play) where the leader teases the volunteer.

Introduction:
"What was going on in the role-play that Tom and I just did? (Answer = You were teasing Tom.)

Good, that is what we are going to talk about today, what to do when someone teases you." Ask the children to close their eyes and pretend that they are in the playground at their school. "A boy walks up to you and starts to tease you about your new haircut. Hey, what happened to your head? Boy, did you ever get beaned! You look really stupid, you should just stay home instead of coming to school looking like that! Bobby got a haircut, Bobby got a haircut. Nah, nah, nah", "How does it feel to be teased like that?" (Answer = sad, mad, embarrased, really angry, makes me feel like hitting him) "Sounds like teasing is really a problem. It can get you mad, make you feel sad or embarrased. Does everyone agree that teasing is a problem? (Answer = Yes) "Today we are going to talk about different ways of dealing with this problem called teasing".

Problem Solving Session:
Materials: Blackboard and chalk.

Step 1 - Generate alternative solutions: Again, ask the children to imagine they are being teased. Have the group generate 5 different ways to respond to teasing. Record each response on the blackboard. Accept both appropriate and inappropriate responses (In fact, it is important to elicit both types of responses so that the children can see the different results of such responses. **However you must stipulate that the children's answers be realistic**.) (possible answers = walk away, ignore, reason with him, tell the teacher/principal, tease back, yell, fight). It is important that the leader does not offer any evaluation of the positive or negative responses generated. The leader is simply a guide in this proccess. The children must do the work of evaluating the solutions in the next step.

Step 2 - Evaluate solutions: "Wow, looks like you guys came up with lots of different things to do when someone teases you. That's very good. Now let's go through each one, and tell me if you think it's a good thing to do or a bad thing to do." Have the children discuss and evaluate each solution. Why is it a good or bad solution? The leader can help the children structure their evaluations by introducing the concept that a child's response may either encourage or discourage the teasing. Ask the children what they think the teaser is looking for when he teases them (Answer = The teaser is looking to get a rise out of you). So, for example, if you are evaluating `yelling' as a response, ask the children if they are giving the teaser what he wants by yelling back (Answer = Yes, because you are showing the teaser that he is `getting a rise out of you or bugging you'). So if you are giving the teaser what he wants by yelling back, do you think he'll tease you again? (Answer = Yes, because he knows that you'll get upset when he teases you and that's what he wants).

Step 3 - Choose a solution: Ask each to choose and tell the class the solution they think is best and they might use the next time they are teased.

Closure:
"Today we learned that if teasing is handled poorly it can lead to big trouble like a fight, losing a friend or getting in trouble with the principal. We also learned that there are many things we can do when someone teases us, some good, some bad. The good things to do like ignore or walk away, don't give the teaser what he wants. The bad things to do like tease back or fight shows the teaser that

he is bugging you and makes him want to tease you again. So next time someone teases you, remember what you learned today!"

Lesson 3: Dealing with Teasing II

WARNING: Much of the following lesson is written in script form. This has been done to demonstrate how to deliver the material in a language that grade 3 and 4 children will understand. **DO NOT READ THIS SCRIPT TO THE CLASS!** Translate these ideas into your own words and strive to deliver the lesson in as natural a manner as possible.

Prerequisite reading: Self-statements
Modeling, role-play and feedback

Lesson objectives:
By the end of this session, the children should be able to ...
1) identify a self-statement as a means of controlling their anger (i.e., keeping your cool).
2) understand that self-statements are self-instructions that are not spoken out loud, but instead are spoken covertly.
3) give examples of appropriately worded self-statements.
4) identify the differences between mean and good-natured teasing.
5) correctly identify at least 4 of the 5 "Dealing with Teasing" skill steps.
6) role-play a non-aggressive response to a teasing situation.
7) appropriately demonstrate how to deal with a teasing situation by role-playing at least 4 of the 5 "Dealing with Teasing" skill steps.

Review:
Briefly review last week's lesson (maximum time = 3 minutes). "Remember, last week we talked about different things you can do when someone teases you." Ask for two examples, one good, one bad. Why are these good or bad responses to teasing? (Answer = Either because they do or do not give the teaser what he wants)

Introduction:
"How does it feel when someone teases you? (Answer = mad, sad). Let's say that someone teases you and you get mad, what might happen next? (Answer = He might tease me some more because I'm giving him what he wants; I might get really mad and hit him.). Okay, so by getting mad, the situation may get worst and blow up in your face. Today we are going to talk about how not to get mad when someone teases you. We are going to learn a trick to use to help us keep our cool."

Self-Statements:
"That trick is something called a self-statement". Ask the children if they ever talk to themselves when they do something difficult like playing level 5 of Super Mario. You might say to yourself, "Keep going and get ready to hit that bell 3 times to make some extra points. Okay, now I have to jump over that hole, here it comes, now hit the button. Phew, made it, that was close." "Sometimes we talk to ourselves and give ourselves instructions. A self-statement is like that. A self-statement is

something that you say to yourself (in your head, not out loud) to calm yourself down when you get mad or when you think you're about to get mad. It's like giving yourself instructions to stay cool." The leader should now offer examples of self-statements.

Sample self-statements:
"Stay cool Rick, getting upset won't help"
"Chill out dude, if you get mad it'll only make things worse"
"Count to ten and calm down. 1,2,3,4,5,6,7,8,9,10."
"I'm not going to let him get to me."

To make sure the group has understood the concept of self-statements, ask the children to tell you what a self-statement is. Ask them why they would use a self-statement. Is a self-statement something you say out loud? (Answer = no, it's something you say to yourself in your head)

Now, ask each child to devise his own self-statement that would help him when being teased. Each child should say his self-statement out loud to the group.

Skill steps:
Materials: Bristle board outlining "Dealing with Teasing" skill steps.

Describe the skill steps sequentially.
Step 1: Self-statement.
"I want everyone to imagine that some guy is coming up to you right now, and starts teasing you about your new haircut. Hah, hah you got a haircut, you got a haircut. Do you ever look like a nerd." "How do you feel right now?" (Answer you are trying to elicit = Angry) "Now, what did we just learn that we could use in this type of situation to calm down?" (Answer = Self-statement) Point to the skill steps and say, "That's right, a self-statement. And that's the first step to use when someone teases you. Use a self-statement to calm yourself down. Why is it important to stay calm when someone teases you?" (Answer = Because if you don't stay calm, it'll show the teaser that you're giving him what he wants and he'll probably tease you again.) "Also, if you get mad, he'll tease you some more, then you'll get even more mad. And then what might happen?" (Answer = A fight) "Good, so step one, use a self-statement to stay calm."

Step 2: Decide if you're being teased.
Ask the group if sometimes friends tease each other a little bit. Is that different from mean teasing when someone is trying to make you mad and get your goat? (Answer = Yes. There is good and mean teasing. Sometimes friends might tease each other, but it's not meant to hurt you or make you mad. On the other hand, some people tease you in a mean way. They try to bug you and make you feel bad or mad.) In step 2 you need to decide if it's mean teasing or if it's just good-natured teasing between friends. If it's good-natured teasing then you just need to laugh it off. But if it's mean teasing then go on to the next step.

Step 3: Think about ways of dealing with teasing.
"In this step you need to think of different things to do when someone teases you. Can anyone think of things you can do when someone teases you?" **(Only accept realistic answers.** Possible Answers

= Walk away, ignore, tease back, tell the teacher, reason with him, etc.)

Step 4: Choose the best way and do it.
"In this step you need to choose one of the things you came up with and do it. Which one would you choose?"

Step 5: Did it work out for you?
"In this step ask yourself if what you chose worked out for you. Did the teaser stop teasing you? If he did, then pat yourself on the back. If he did'nt, then choose another way to deal with teasing and do it."

Demonstration role-play:
Ask for a volunteer. The volunteer should tease the leader, who in turn will demonstrate how to properly respond by utilizing the 5 "Dealing with Teasing" skill steps.

Role-plays:
"Now it's your turn to do the role-play". Select two volunteers and briefly coach them on their respective roles (i.e. "We're going to pretend that Bob is teasing Tom about his new haircut. Now Tom, remember to use all 5 Dealing with Teasing steps that we just learned."). Instruct Bob to begin the role-play.

Feedback:
First, ask the children which steps were performed well and generally, what they liked about the performance (note: The actors should be given the first opportunity to comment). Now ask the children to indicate what the actors could do to improve their performances.
Continue the role-play/feedback sessions until all children have played the role of the person who is teased. If time is running out, conduct as many role-plays as time allows.

Closure:
"Today we learned what to do when someone teases you. First, it's important to stay calm. You can do this by using a self-statement like - chill out Rick, getting upset won't help. Second, you need to decide if the teasing is mean teasing. Next, think of different things you can do when someone teases you. Then, choose one and do it. Finally, ask yourself if it worked. Did the teaser stop teasing you? If he did great! If he did'nt, then choose another way of dealing with teasing and do it. Remember next time you get teased try these steps out and let me know how it worked out."

Lesson 4: Understanding Another's Feelings I

WARNING: Much of the following lesson is written in script form. This has been done to demonstrate how to deliver the material in a language that grade 3 and 4 children will understand. **DO NOT READ THIS SCRIPT TO THE CLASS!** Translate these ideas into your own words and strive to deliver the lesson in as natural a manner as possible.

Lesson objectives:
By the end of this session, the children should be able to ...
1) indicate that there can be more than one side to a given story.
2) identify the viewpoints/perspectives of different actors in a given situation.

Review:
"Last week we learned a trick to cool us down when we get mad. What was that trick? (Answer = A self-statement) Let's say someone is teasing you right now and you're mad. give me an example of a self-statement you could use to cool yourself down. We also learned some other steps to use when someone teases you. What were they? (Answer = 1. Decide if you're being teased, 2. Think of ways of dealing with teasing, 3. choose the best way and do it, and 4. Did it work out for you?)

Introduction:
"Today we are going to start by watching a filmstrip about Ms. Meany and Mr. Lookaround. They will help show us that there can be more than one side to every story."

Filmstrip:
Materials: Filmstrip #5 Look at both sides (11 min)
filmstrip projector
cassette recorder

Description:
This filmstrip shows two characters, Ms. Meany and Mr. Lookaround, watching four different situations. Ms. Meany views each situation from one perspective only, while Mr. Lookaround considers the viewpoints of each character in the story. Mr. Lookaround shows Ms. Meany that there can be more than one side to every story.

Show the "Look at both sides" filmstrip.

Discussion:
At the end of each of the four stories stop the filmstrip and ask the children to state the viewpoints of both sides in the story. Point out that there are two sides to the particular story.

Story and discussion:
"I want everyone to listen closely to the story I'm about to tell. It's called the football game."

<u>The football game</u>
I want you to imagine that you're at an Ottawa Roughriders football game and the opening kickoff is just about to get under way. The visiting team kicks the ball down the field. Eliah Washington, the punt returner for the Roughriders, catches the ball and runs downfield. Twenty yard line, 30, 40, 50, he's halfway down the field. Forty, 30, 20, 10, Touchdown!!!!! Everyone in the stands jumps up cheering. As your friend Tom gets up, he accidentally spills his coke all over you.

Discussion
Ask the children the following questions: How many actors are there in this situation? (Answer = Two main actors, you and your friend Tom. The children might mention Eliah Washington) How does each actor feel about spilling the coke? (Answer = You are probably mad because you got coke spilt all over you and you feel all sticky. Tom feels bad and embarassed that he did this.) How many sides to this story? (Answer = Two.) What are they? (Answer = Yours and Toms.) Does Tom see the situation the same way you do? (Answer = No, he's feels bad and embarassed and I feel mad.)

Conclusion:
"Looks to me like there are two sides to this story, yours and Toms."

- Closure:
"Today we listened to several stories that showed us that there can be two sides to a story. It's important to remember that whenever we are doing something with others, each person has their own way of seeing things. The other person might feel the same way as you do or he might feel differently."

Lesson 5 : Understanding Another's Feelings II

WARNING: Much of the following lesson is written in script form. This has been done to demonstrate how to deliver the material in a language that grade 3 and 4 children will understand. **DO NOT READ THIS SCRIPT TO THE CLASS!** Translate these ideas into your own words and strive to deliver the lesson in as natural a manner as possible.

Lesson objectives:
By the end of this session, the children should be able to ...
1) appreciate and understand the different viewpoints in a given situation.

Review:
" Last week we learned that there are two sides to a story, yours and the other persons. And sometimes we forget that each person sees things in his own way."

Introduction:
"Today we are going to do some roleplays that will help us see that there can be two sides to every story."

Demonstration role-play and discussion:
Ask for a volunteer. The scenario involves two students who have just received their report cards. The volunteer brags that he got all A's, and does'nt pay attention to the leader's feelings (The leader got very poor grades and is feeling sad). Briefly coach the volunteer. The role-play should be loosely based on the following:

Robert: Hey Dave did you get a good report card?
Dave: Not bad (without much enthusiasm)

Robert: I got mine, and did I ever do well! How did you do?
Dave: Not bad (unhappily)
Robert: This report card is one of my best! I got five As and two Bs. Did you get any As?
Dave: No (walks off, looking sad)

Discussion
Ask the children the following questions: How did Robert feel in this situation? Why? (Answer = He felt great, because he got all As) How did Dave feel and why? (Answer = He felt sad, because he did'nt do very well on his report card) Was Robert paying attention to Dave's feelings? (Answer = No) How could you tell? (Answer = He just kept on bragging, even though he could see that Dave was feeling bad) Is it important to know how others are feeling? Why? (Answer = Yes, because if you see they are feeling sad, like with Dave, then you can try to help them out) How many sides to this story? (Answer = Two) What are they? (Answer = Robert who felt great and Dave who felt sad)

Roleplay and discussion:
Roleplay #1
"Now it's your turn to do the roleplay." Select two volunteers and briefly coach them on their respective roles (e.g. "Let's pretend the hockey tryouts have just finished and Bill made the team and Tom did'nt. Bill does'nt brag. Instead he tries to make Tom feel better by letting him know that he might make the team next year.")

Discussion
Ask the actors to comment upon the following: How he felt in his role? How he felt towards the other actor? How many sides to this story?

Roleplay #2
Have the same actors repeat the previous roleplay, reversing roles this time.

Discussion
Ask the actors to comment upon the following: How he felt in his role? Did it feel different compared to the previous role? How many sides to this story?

Continue the role-play/discussion sessions until all children have played both roles. The scenarios should be varied. Other scenarios may include the following: One character is mad at the other because he took his ball and glove and played with it without asking. One boy feels badly for the other who just lost his brand new watch that he got for his birthday. A three person role-play where two of the characters decide to play with each other leaving the other person out of luck (only switch roles once).

- Closure:
"Today, when we switched roles we learned that there can be two or more sides to every story. It's important to remember that when you are doing things with others, each person has his own way of seeing things. They may see things the same way as you or in a different way."

Lesson 6: Giving compliments

WARNING: Much of the following lesson is written in script form. This has been done to demonstrate how to deliver the material in a language that grade 3 and 4 children will understand. **DO NOT READ THIS SCRIPT TO THE CLASS!** Translate these ideas into your own words and strive to deliver the lesson in as natural a manner as possible.

Prerequisite reading: Modeling, role-play and feedback

Lesson objectives:
By the end of this session, the children should be able to ...
1) appropriately demonstrate how to compliment another child in a sincere manner.
2) appreciate that compliments should be delivered only at appropriate times.
3) appreciate that compliments should be given on occasion.

Review:
Briefly review last week's lesson (maximum time = 3 minutes). "Last week we learned that there can be how many sides to a story? (answer = two or more). Good! And it's important to remember that other people may see things the same way as you do or in a different way. Either way it's okay!"

Introduction:
"Today we are going to talk about how to say nice things to others or give compliments. For example someone might compliment you by saying - hey, those are great Reebok Pumps you're wearing! or you did a nice job on your science project, I really liked it."

Discussion:
Ask the children how it feels when someone says something nice to you or compliments you (answer = feel good about yourself, feel happy, you know that others like you, etc.). How does it feel to give a compliment? (answer = it feels good to say nice things to others).

Demonstration roleplay/Discussion:
Ask for a volunteer. Explain that the volunteer just received a new bike as a present on his birthday. The leader will demonstrate how to compliment the volunteer on his new gift (e.g. "Wow! Awesome bike Tom! Did you get it for your birthday?"). Ask the children what they liked about how you gave the compliment. Ask the children if it looked like you meant the compliment (was the compliment given in a genuine, sincere manner). Why is it important to be sincere? (answer = Because, when you say something nice to someone else you should mean it. If you don't, the other person may feel hurt or sad). State that it is also important to choose the right time to give a compliment. Ask the children to raise their hands when any of the following are good times to give compliments - 1. When the person is mad, 2. When the person is in a bad mood, 3. When there are a lot of other people around, 4. When the person is alone, 5. When the person is busy doing something, and 6. When you're arguing with the person. Why are they good or bad times to give compliments? Thirdly, the compliment should be delivered in a friendly way. How do you show that you are being friendly when giving a compliment? (answer = smile, pat the person on the back, give them a high five, etc.). Finally, ask the children how often compliments should be given? Is it okay to give a person 20 compliments in one day? Why not? (Answer = Because, it will look like you don't mean it). Suggest that compliments should be given periodically (i.e. every second day) so they do not lose their impact.

Role-plays:
"Now it's your turn to do the role-play". Ask the children to break up into groups of two. Each group has 3 minutes to make up a situation where one person gives a compliment to the other. The leader should circulate among the children to offer assistance if needed. After the practice period is over, have each group perform their role-play for the class.

Feedback:
First, ask the children what they liked about the performance (note: The actors should be given the first opportunity to comment). Now ask the children to indicate what the actors could do to improve their performances (Was the compliment delivered in a sincere and friendly manner? Did the person give the compliment at a good time?) . Ask the actors how it felt to give and receive a compliment. Continue the role-play/feedback sessions until all groups have role-played.

Closure:
"Today we learned that it's important to give compliments or say nice things to others. It makes others feel good and it makes you feel good too. It's a friendly thing to do. In fact, friends say nice things to each other all the time. This week try giving a compliment every day. You can do this to a friend, your brother, your sister or one of your parents. Let me know how it works out!"

Lesson 7: Dealing with Other's Anger

WARNING: Much of the following lesson is written in script form. This has been done to demonstrate how to deliver the material in a language that grade 3 and 4 children will understand. **DO NOT READ THIS SCRIPT TO THE CLASS!** Translate these ideas into your own words and strive to deliver the lesson in as natural a manner as possible.

Prerequisite reading: Modeling, role-play and feedback
Self-statements

Lesson objectives:
By the end of this session, the children should be able to ...
1) remain calm in the presence of an angry person.
2) appreciate the importance of not responding to an angry person in an aggressive manner.
3) indicate why one should let the angry person tell his side of the story and not interrupt.
4) try to identify with the angry person's viewpoint.
5) state at least 3 of the 4 "Dealing with Other's Anger" skill steps.
6) appropriately demonstrate how to deal with an angry person using the "Dealing with Other's Anger" skill steps.

Review:
Briefly review last week's lesson (maximum time = 3 minutes)." Last week we learned how to

compliment or say nice things to others. How does it feel to give a compliment? receive a compliment? Is giving a compliment a friendly thing to do?" Ask the class if anyone tried this new skill out; how did they feel?; how did the person receiving the compliment react?

Introduction:

"Today we are going to learn what to do when someone is angry or mad at you."

Discussion:

Ask the children why it might be important to learn this skill (Answer = the situation won't escalate into a fight, won't get into trouble, friends will enjoy child more if he respects their anger).

Skill steps:

Materials: Bristle board outlining "Dealing with other's anger" skill steps.

Describe the skill steps sequentially and discuss their importance.

Step 1: Stay calm.

Ask the children to imagine that someone is angry with them because they saw you ride their bicycle in the playground without asking permission. The person comes up to them and starts telling them that they are really mad. Ask, "What might happen if you get mad and start yelling back at the person?" (Answer = It might make the angry person even more mad, then you shout back some more, and he gets more mad, and then what might happen next? Answer = A fight.) "Would it be a better idea to stay calm? Why?" (Answer = Yes. Because there's a better chance the situation won't escalate into a fight.) "What did we learn a few classes ago to help us stay calm?" (Answer = Self-statements) "Can anyone give me an example of a self-statement that you could use to stay calm in this situation?"

Step 2: Listen to his side, Don't interrupt.

Ask the children why it is important to listen to the person's side of the story (Answer = Because you need to find out and understand why he is mad at you). Ask them why it's important not to interrupt (Answer = Because you need to give the person a chance to vent his anger and "say his peace". If you interrupt, you're not giving him a chance and this will probably make him more angry.). Ask, "is it important to look at the person when you're listening to him?" (Answer = Yes, because it shows that you're paying attention to him) Mention that by staying calm, listening and not interrupting, the person has a chance to "say his peace" and his anger usually goes down. This is what you want to happen. You want to act in a way that is going to help the person calm down, not get angrier.

Step 3: Try to understand.

"In step 3 you must try to understand why the person is angry. What did we learn in the last two weeks that might help us do this?" (Answer = Understanding another's feelings by putting ourselves in their shoes. A person might ask themselves, "If I was in his shoes, would I be angry to?") "Good, so in this step you need to try to understand why the person is angry at you. You can do this by putting yourself into his shoes and seeing how he feels. Ask yourself whether you would be mad if someone took your bike without asking?"

Step 4: Is his anger fair?

"In step 4 ask yourself if his anger is fair. If it is fair what should you do? (Answer = Apologize) If his anger is not fair, then calmly explain your side of the story. For example, I understand you're angry, but ..."

Demonstration roleplay:
Ask for a volunteer. The volunteer should get angry at the leader for having taken his bicycle without asking (Briefly coach the volunteer). The leader should demonstrate the use of the 4 "Dealing with other's anger" skill steps.

Role-plays:
"Now it's your turn to do the role-play". Select two volunteers and briefly coach them on their respective roles (i.e. "Let's pretend Bill is mad at Tom for accidentally hitting him with a soccer ball. Tom, show us how you would handle this situation using the skill steps you just learned. Remember to say your self-statement out loud so we can hear it".). Instruct the actors to begin the role-play.

Feedback:
First, ask the children what they liked about the performance (note: The actors should be given the first opportunity to comment). Now ask the children to indicate what the actors could do to improve their performances. Continue the role-play/feedback sessions until all children have played the role of the person who deals with the other child's anger. The scenarios should be varied. Other scenarios may include: A child is mad at you because you accidentally hit him in the face during a snowball fight or someone is mad at you because they think you cheated while playing monopoly, but you really did'nt. If time is running out, conduct as many role-plays as time allows.

Closure:
"Today we learned that it's important to stay calm and listen to an angry person. Also you should try to understand why he's mad at you. If his anger is fair, then you should say you're sorry. If it's not fair, then you should calmly explain your side of the story."

Lesson 8: Making suggestions

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Prerequisite reading: Modeling, role-play and feedback

Lesson objectives:
By the end of this session, the children should be able to ...
1) demonstrate how to make a suggestion in an appropriate and friendly manner.
2) appreciate the negative consequences of making a suggestion in a bossy, aggressive manner.
3) remain friendly and keep a positive attitude when a suggestion has been refused.

Review:
Briefly review last week's lesson (maximum time = 3 minutes). "Last week we talked about what to do when someone is mad at you. Can anyone tell me what the first step is? (answer = stay calm). Why is it important to stay calm? (answer = so the situation won't escalate into a fight). What trick did we learn to help us stay calm? (answer = self-statement)." Ask the children to elicit the remaining steps (answer = listen to his side, don't interrupt, try to understand, is his anger fair).

Introduction:
"Today we are going to talk about how to make a suggestion or how to ask someone to do something with you. An example is walking up to a friend and suggesting that you both play a game of catch. Another example is suggesting to your friends that you play soccer during recess."

Discussion:
"Now there are good and bad ways to make a suggestion. Let's say you want to throw the football around during recess with someone. What if you walk up to Tom and say - HEY, YOUR PLAYING FOOTBALL WITH ME AT RECESS, BE THERE!!!! (Say this in a demanding, loud manner). Do you think this is a good way to make a suggestion? (answer = no, because you're being mean, unfriendly, bossy, rude, impolite, etc.) Do you think Tom would want to play football with you? (answer = probably not, because you were to pushy and unfriendly) How would you feel if someone did this to you? (answer = Bad) Do people want to be friends with someone who treats them this way? (answer = no, because they are not friendly people). What if you walk up to Tom and say - Tom, why don't we play catch with the football during recess (this should be delivered in a friendly, non-bossy manner). Is this a better way to make a suggestion? (answer = yes, it's more friendly, plus it's not bossy) Do you think there's a better chance Tom will want to play if you ask him in this way compared to the more bossy way? (answer = yes) Good! It sounds like when you ask or make a suggestion in a friendly way, others will like you better and will want to be friends with you. What if you suggest that you and Tom play football in a nice, friendly way and he says no. Is that okay? Does Tom have the right to say no? (answer = Yes, it's okay. Tom does'nt have to play ball with you, he might want to do something else. Tom is his own boss of what he wants to do, just like you're your own boss of what you want to do.) Let's say Tom says no. Should you be mean to him or treat him badly? (answer = No. Tom has the right not to play football. If I treat him badly that would be unfriendly.) What should you do if he says no? (answer = Remain friendly, and say "maybe some other time". It's important to remain positive so that he'll stay your friend.)

Demonstration role-play:
Ask for a volunteer. Briefly coach the volunteer (For example, "I'm going to suggest that you come over to my house after school and play nintendo. I want you to say that you will come). The leader will demonstrate how to appropriately make a suggestion in a friendly way. Ask the children what they liked about the role-play (briefly). Repeat the same role-play, except this time the volunteer refuses. The leader will model an appropriate response to this refusal by remaining friendly and perhaps by saying "okay, maybe next time".

Role-plays:
"Now it's your turn to do the role-play". Select two volunteers and briefly coach them on their respective roles (e.g. "Brad ask Bill if he wants to look at your baseball card collection after school.

Bill you can say yes or no it's up to you. Remember Brad, be friendly). Instruct the actors to begin the role-play.

Feedback:
First, ask the children what they liked about the performance (note: The actors should be given the first opportunity to comment). Remember to give feedback on how the main actor responded to the second actor's response. Now ask the children to indicate what the actors could do to improve their performances. Continue the role-play/feedback sessions until all children have played the role of the person who makes the suggestion.

Closure:
"Today we learned how to make a suggestion to a friend. If you ask in a friendly way the person will like you better and is more likely to say yes. We also learned that it is important to respect a person's right to say no. Everyone has the right to says yes or no to something. If the person says no, it's important that you remain positive and friendly."

Lesson 9: Playing a Game

WARNING: Much of the following lesson is written in script form. This has been done to demonstrate how to deliver the material in a language that grade 3 and 4 children will understand. **DO NOT READ THIS SCRIPT TO THE CLASS!** Translate these ideas into your own words and strive to deliver the lesson in as natural a manner as possible.

Lesson objectives:
By the end of this session, the children should be able to ...
1) suggest two or more ways of deciding which player should start the game.
2) appreciate that each player must have a turn.
3) indicate that playing out of turn is an unfriendly act and that it can make others angry or feel bad.
4) demonstrate how to say something nice to the other players upon completion of a game.
5) demonstrate how to play a game in a friendly, appropriate manner using the "Playing a Game" skill steps.

Review:
"Last week we learned how to make a suggestion or in other words, ask someone to do something. Are there good and bad ways to make suggestions? (Answer = Yes. A good way is to do it in a friendly manner, where the other person has the right to say yes or no. Making a suggestion in a mean, bossy way is an example of a poor way.) Someone give me an example of a good way. Is it okay if the other person says no to your suggestion? (Answer = Yes, everyone has the right to decide what they want to do)"

Introduction:

"Today we are going to talk about how to play a game in a friendly way."

Discussion:

Start a discussion by asking the following question: "Can things sometimes go wrong when you play a game?" (Answer = argument over rules, yelling, playing out of turn, fight, etc.) Are these types of problems good for friendships? Why not? (Answer = Because if you fight and yell all the time you will wreck up your friendship) Close the discussion by noting that it is important to learn how to play a game in a nice and friendly manner because that is what friends do."

Skill steps:

Materials: Bristle board outlining the "Playing a game" skill steps.
Game of "Snakes and Ladders"

Describe the skill steps sequentially and discuss their importance. This will be accomplished by involving the children in a game of "Snakes and Ladders". Have the children gather around the "Snakes and Ladders" game board. Ask each child to choose a marker.

Step 1: Know the rules.

"Why is it important to know the rules to this game before playing it? (Possible answers = so you'll know how to play the game, because you might get into an argument if your way of playing the game is different from the other person's, etc.) What should you do if you don't know the rules? (Answer = Ask someone to explain the rules, sit out one game and watch how it's played, etc.) Does everyone know the rules to Snakes and Ladders? (If not, have one child explain the rules)"

Step 2: Decide who starts the game.

Point to one of the children and ask "Is it okay for you to say I'm going first? (Answer = No. Because the others may not like it and it isn't really fair) Then how should decide who starts the game? (Answer = roll the dice, one person might suggest that the another person goes first, etc.) So what should we do here? (Wait for one child to make a suggestion. However, if he decides that he should go first, ask the class what is wrong with this suggestion.)" Start off the game by having one child roll the dice and move.

Step 3: Make sure everyone gets a turn.

Continue the game for two more rolls, then ask: "Why is it important that everyone gets a turn? (Answer = Because it would'nt be fair if everyone did'nt get a turn.) Now it's your turn John (point out and name the next person to play), how would you like it if Tom over here (point out and name a child who is scheduled to play several turns later) jumped in a took your turn? (Probable answer = Would'nt like it very much.) Would that be a friendly thing to do? (Answer = No. Friends wait their turn.) Good! So it is important that everyone waits their turn. One trick you can use to help you know when it's your turn is to remind yourself that you play after Tom plays. Have everyone point out the person who plays right before them.

Step 4: Don't be in a rush.

Give the dice to the person who plays before the leader, and have him play out his turn. Right after he rolls (while he is moving his man), grab the dice away and roll before he has finished his turn. Ask the children if that was a friendly thing to do. (Answer = No.) How do you think Tom felt when I grabbed the dice away from him, did it spoil his turn? (Answer = He did'nt feel very good and it spoiled his turn. It's hard to enjoy yourself and have fun when people are playing like that.) So remember, take your time, don't be in a rush. Let everyone have their turn and give them the time they need.

Step 5: At the end of the game, say something nice to the other players.
Say, "Let's pretend that the game is over and Tom won (point out and name one of the children). What if Tom started bragging that he won, would that be okay? (Answer = No, because he would make the others feel bad) What is most important when playing a board game like Snakes and Ladders, winning or just having a good time? (Answer = Having a good time. It does'nt really matter who wins, it's just a game) What if you lose, should you feel bad? (Answer = No, again it's only a game. You're only playing to have fun with your friends) Good! The point of the game is to have fun with your friends. So if you brag about winning or act sad because you lost, then you're not having fun, and that's not very good. So if you lose or win, keep a good positive attitude and be nice. Say something nice to the other kids like : Good game guys or Thanks for the game guys, I had a good time. Can anyone give me examples of nice things to say when the game is over?"

Group Activity:
Have the children start up a new game of "Snakes and Ladders" using the steps just discussed. Remind them to think about and use the steps that they just learned. After everyone has had one or two turns (time permiting), end the game. Give the group feedback on how well they played (i.e. Did they use the skills learned? Where they friendly?) Point out what the children did well and what they could have improved on.

Closure:
"Today we learned how to play a game in a friendly way. When playing a game , you have to make sure you know the rules. If you don't, just ask someone to explain them to you. Next, decide who goes first. One fair way of doing this is rolling the dice. During the game, remember that everyone must get a turn. Don't be in a rush and play out of turn, because that is not friendly and others will not want to play with you anymore. Finally, end the game by saying something nice to the others like: Good game guys!"

Lesson 10: Coping with failure and rejection

WARNING: Much of the following lesson is written in script form. This has been done to demonstrate how to deliver the material in a language that grade 3 and 4 children will understand. **DO NOT READ THIS SCRIPT TO THE CLASS!** Translate these ideas into your own words and strive to deliver the lesson in as natural a manner as possible.

Prerequisite reading: Modeling, role-play and feedback

Lesson objectives:
By the end of this session, the children should be able to ...
1) keep a positive attitude and say (covertly) that "sometimes people will want to play with me and sometimes they won't, and it's not the end of the world" in response to rejection.

Review:
Briefly review last week's lesson (maximum time = 3 minutes).
"Last week we learned how to play a game in a friendly way." Ask the children to name the 5 skill steps.

Introduction:
"Today we are going to talk about what to do when you feel sad or angry because someone does'nt want to play with you or be your friend."

Discussion #1:
Materials: DUSO discussion picture #23.
Present DUSO discussion picture #23. Point to the girl feeling rejected and ask: "How does this person feel? (Answer = She feels sad.) Why does she feel that way? (Answer = Because the two other girls have left her alone, and won't play with her.) Does this ever happen to you? How does it make you feel? Today we're going to talk about what to do when someone does'nt want to play with you or be your friend."

Discussion #2:
Begin by asking the children if it is possible that everyone you ask to be your friend will say yes. Is this possible for anyone? Point out that for everyone there are times when they ask someone to play or be their friend and they say no. Ask the children what they should do when this happens to them. Suggest that rejection happens to everybody, that they should keep a positive attitude and find someone else to play with. They should say, "sometimes people will want to play with me and sometimes they won't, and it's not the end of the world." Have the children repeat this saying all together. In the same fashion explore the following question: Is it possible to be good at everything you do? (For instance is it possible to be amazing at basketball, baseball, hockey, math, english, nintendo, monopoly, chess, etc.) Ask the children to volunteer things they are not good at and things they are good at. Remark that it seems that everyone has things they are good at and things they are bad at. "Do you sometimes feel bad when you play a sport that you're not so good at? Like when people make fun of you because you have trouble dribbling the basketball?" Ask the children to elicit some examples of this (2 brief examples will suffice). End by suggesting that when this happens to them they should say to themselves, "there are some things I am good at and there are some things I'm not so good at, and it's not the end of the world". Have the children repeat this saying all together.

Demonstration roleplay:
Ask for two volunteers. Briefly coach the volunteers (e.g. both are sitting at a table playing monopoly and the leader will ask them if he can play. The children will respond in a friendly way that he cannot play because they have already started the game). The leader will respond inappropriately by saying, "Well I did'nt really want to play with you guys any way." Ask the group if the children in the roleplay will want to play with the leader in the future (Answer = Probably not, because the leader

was being unfriendly and mean). Repeat the same roleplay with the leader demonstrating a positive response to rejection (e.g. The leader keeps an upbeat attitude and responds in a friendly manner, "Okay, maybe next time."). Again ask the group if the children in the roleplay will want to play with the leader in the future (Answer = They probably will, because he was friendly).

Roleplays:

"Now it's your turn to do the roleplay". Select two volunteers and briefly coach them on their respective roles (i.e. "Let's pretend Bob asks Tom if he can join his soccer game, and Tom says no). "Bob I want you to deal with this situation in a friendly and positive way and remember to tell yourself: Sometimes people will want to play with me and sometimes they won't, and it's not the end of the world.".

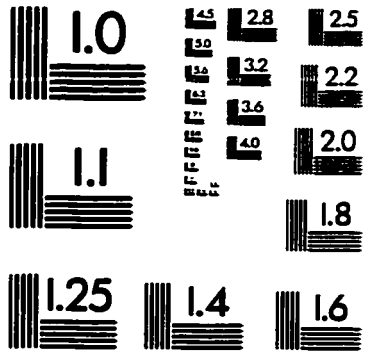
Feedback:

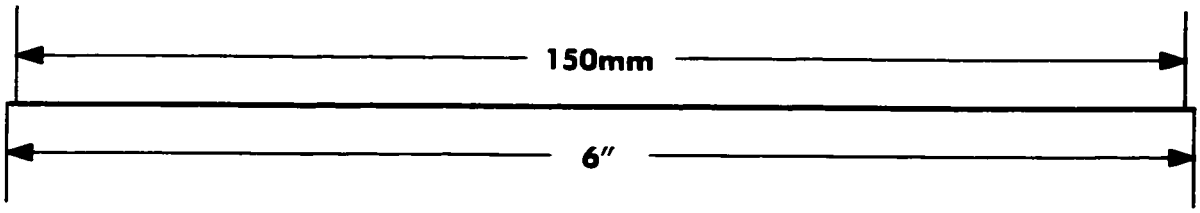
First, ask the children what they liked about the performance (note: The actors should be given the first opportunity to comment). Now ask the children to indicate what the actors could do to improve their performances. Continue the role-play/feedback sessions until all children have played the role of the person who is rejected. If time is running out, conduct as many role-plays as time allows.

Closure:

"Today we learned what to do when someone does'nt want to play with us or be our friend. Remember to keep a positive attitude when this happens and say to yourself: sometimes people will want to play with me and sometimes they won't, and it's not the end of the world."

IMAGE EVALUATION
TEST TARGET (QA-3)





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