children's friendship training

Fred Frankel and
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CHILDREN'S FRIENDSHIP TRAINING

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Brunner-Routledge
New York & Hove

Published in 2003 by
Brunner-Routledge
29 West 35th Street
New York, NY 10001
www.brunner-routledge.com

Published in Great Britain by
Brunner-Routledge
27 Church Road
Hove, East Sussex
BN3 2FA
www.brunner-routledge.co.uk

Brunner-Routledge is an imprint of the Taylor & Francis Group.
Printed in the United States of America on acid-free paper.

10 9 8 7 6 5 4 3 2 1

Library of Congress Cataloging-in-Publication Data
Frankel, Fred
Children's friendship training / Fred Frankel and Robert Myatt.
p. cm.
Includes bibliographical references and index.
ISBN 1-58391-308-4 (pbk : alk. paper)
1. Behavior therapy for children. 2. Social skills in children—Study and teaching.
3. Friendship in children. I. Myatt, Robert. II. Title.
RJ505.B4 .F736 2002
618.92'89142—dc21

2002009812

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Foreword

The intervention described in this volume was developed in a clinical setting with patients who were paying for treatment and hoping that their children would benefit. Our previously published studies reported the results of diagnostically homogeneous groups of children having attention deficit/hyperactivity disorder (ADHD) with or without comorbid oppositional defiant disorder (ODD) or subjects who qualified for no research diagnosis. In actuality, we have presented this treatment to over 800 children since 1991. Only a small proportion of these children fell neatly into research categories and could be reported in research journals.

We have adopted a process-oriented perspective of social competence (Taylor & Asher, 1984) in which we select important social interaction processes and address the specific components that contribute to successful social transactions. Our goal is to give children the skills to have mutually satisfying social interactions with peers, which lead to higher regard within the peer group and the development of satisfying best friendships. The program described in this book addresses the friendless child's relationships with peers in four crucial areas:

1. Abating the effects of the child's reputation within his current peer group (cf. Bierman, 1989) by reducing intrusive and inappropriate behaviors.
2. Diminishing the importance of the rejecting peer group for the child by giving him or her skills to expand his or her peer network.
3. Instructing parents and children as to how to work together to promote more successful *play dates*. (We define play date as an appointment made between two children to play in the home of one of them). It was hypothesized that this would allow the development of best friendships despite a nonfunctional peer network. Best friendships might promote continued acquisition of social skills (cf. Hartup, 1983).
4. Supporting the child's efforts to "lay low" in a rejecting peer group where he or she has a bad reputation. The results of Nangle, Erdley, and Gold (1996) suggests it is relatively easy to decrease a bad reputation but harder to increase liking by peers. Avoiding continuing provocation from peers was the goal in improving the child's competence at nonaggressive responses to teasing and to conflicts with children and adults.

Preface

This book is about building bridges: bridges between what clinical professionals know about interventions for social skills and what developmental psychologists know about children's friendships; bridges between research on effective treatment for the child without friends and professionals interested in effectively helping these children; bridges between parents who are worried about their children's friendships and don't know what to do and professionals who want to use parents more effectively in the treatment; bridges between what children learn about making and keeping friends in treatment and what they see socially competent children doing at school; bridges between what parents learn through social skills training and how they can apply it to help their child make sustainable friendships in their neighborhoods.

I first realized something was missing in the social skills groups I offered, when I saw my wife networking with other parents to make play dates for my then 6-year-old child. I had read nothing about this in the social skills training literature. Together, Bob Myatt and I worked out a way for us to teach parents to do this while teaching their children to effectively use this. Although adults operate primarily by the golden rule, children also operate by what I call the prime directive of childhood: Play with others who are fun to play with. Our job was to make children more fun to play with.

—F. F.

* * *

My first exposure to the power and limitations of social skills training took place in my role as a research assistant at a VA hospital in 1981. I was able to see the many practical benefits that a comprehensive social skills training program provided to a very challenging clinical population—chronic schizophrenic veterans. However, the experience also underscored the shortcomings of this type of program and the need for constant revision, development, and enhancement of the intervention. Through the years, I have had the opportunity to provide social skills training to teenagers who have become involved in the criminal justice system, depressed/suicidal adolescents who have been psychiatrically hospitalized, children on an inpatient psychiatric ward, and shy/withdrawn children in an elementary school setting.

While completing my dissertation, I saw fourth- and fifth-grade children who were experiencing high levels of clinical depression and beginning to develop suicidal ideation related to their social deficits and social isolation. During my psychology training at the UCLA Neuropsychiatric Institute, I had the opportunity to begin what has turned out to be a 14-year partnership and journey with Fred Frankel, Ph.D., to develop a comprehensive social skills training program for children. Throughout the years, we have sought feedback from the children, their parents and teachers, the psychology interns, social work trainees, and child psychiatry fellows we have trained, and professional colleagues who have referred their young clients to us. This book represents a compilation and distillation of all that we have learned. We hope that it will be helpful to other clinicians who recognize the importance of providing friendship training to their clients.

—R. M.

Purpose and Organization of This Manual

A Self-Contained Guide for the Clinician

The purpose of this book is to provide a complete, self-contained guide for the clinician who wants to model a social skills program after our approach. It is hard for many clinicians to change gears and learn new techniques. Although we have designed the program as an integrated entity, clinicians may prefer to try it piecemeal. We don't feel this will ruin the intervention but will rather add spice to what a clinician is more comfortable doing. We have enjoyed leading the parent and the child sessions and are confident that other clinicians will find this rewarding.

Training Socially Valid Behaviors

An intervention has *social validity* when it targets behaviors that discriminate children having peer difficulties from children who do not. Social validity has been an important influence in the development of our training modules. Few components used in social skills training studies have been assessed for social validity (Budd, 1985). Evidence suggests that focus on socially valid behaviors enhances the likelihood that children will be better accepted by peers after training. For instance, cooperation with peers and peer support skills (e.g., active listening skills) have been shown to differentiate accepted from rejected children (see Chap. 9.2, for a more complete discussion of categories of peer acceptance and peer sociometrics). Studies that trained these skills demonstrated improved peer sociometric ratings (Bierman & Furman, 1984; Gresham & Nagle, 1980; Hepler & Rose, 1988; Oden & Asher, 1977; Tiffen & Spence, 1986). Another example is Oden and Asher (1977), who focused on coaching children to have fun and make sure the game partner had fun as well. The children chosen were initially the least popular within their class, as derived from peer sociometric ratings. At follow-up, researchers found lasting improvement in peer acceptance.

Training socially valid behaviors may help in three ways. First, children may be better able to focus on key behaviors to observe in their social milieu. Second, they are more likely to observe better accepted children perform these behaviors with desirable social outcomes. Third, they are more likely to have successful outcomes when they perform these behaviors (if performed in situations in which they have no prior negative reputation to interfere with the outcome). The approach taken in this volume is to present the evidence establishing the social validity of behaviors targeted for each intervention session and then to describe ways we have found successful in getting children to employ them outside of the treatment situation.

Maintaining Treatment Integrity

Treatment integrity is defined as the correspondence between session plans and the way treat-

ment is actually delivered. *Clinician drift* is a phenomenon that decreases treatment integrity. Clinician drift is defined as the tendency of a clinician to change features of an intervention each time it is presented. We have been able to maintain treatment integrity and avoid clinician drift by maintaining an outline of each treatment module and collecting pre and post data on each patient (when parents have consented). The percentage of patients showing improvement is provided to our clinicians after each treatment group is completed. Clinicians know that if this percentage falls below 90% of parent report or 70% of teacher report, they are asked to examine any features they may have changed. In this way, we have held ourselves accountable to maintain adequate levels of positive treatment response.

We believe that a treatment manual, such as the present volume, is the best way to ensure faithful delivery of empirically validated treatments (Wilson, 1996). Manuals may benefit both novice and experienced clinicians (Chambless, 1996; Eifert, Schulte, Zvolensky, Lejuez, & Lau, 1997). Detailed manuals have been found to produce greater positive intervention effects (Weisz & Weisz, 1990).

Organization of This Manual

This book is divided into three major sections. Part I presents the rationale for the present treatment. Part II presents methods to help the clinician compose groups. Section III devotes a chapter to each treatment session in the order the sessions are given. The empirical foundation of each module is briefly summarized. This is to allow parent session leaders to be sufficiently versed in the theory to provide guidance to parents and to speak extemporaneously to the parent groups on the rare occasion in which the material does not fill the entire parent session. The description of methods also includes clinical examples of the "average cases" as well as the instructive exceptions (Hibbs, Clarke, Hectman, et al., 1997). The important points are outlined in the parent and child session outlines for quick reference by group leaders during each session. Our field-tested parent handouts are also included. These are meant to be self-contained, abbreviated descriptions to which parents can refer quickly between sessions. The clinician should thoroughly review the contents of Sections II and III before beginning the first treatment groups and use the Parent and Child Session Plans while delivering treatment.

We have trained six other child group leaders and seven different parent group leaders and have replicated improvement levels. This suggests that the effects extend beyond a *founder's effect*, in which only the original developers see a high level of improvement. Your experiences will hopefully continue to confirm this.

Related Resources

A parent self-help book based on these modules (Frankel, 1996) is also available as a supplement, not a replacement, for parent participation. It can also be used as an extended program brochure, a means to give parents some immediate help while they are waiting for the start of the next treatment group, or a referral for parents having children too young to benefit from the intervention.

BACKGROUND

PART I

CHAPTER 1

Reasons to Treat Peer Relationship Problems

Operating within an outpatient child psychiatry clinical training program, we are constantly struck by the relatively little attention paid by many clinicians to the peer relationships of their patients. Children in therapy are twice as likely to have peer problems than children not in therapy (Malik & Furman, 1993; Rutter & Garmezy, 1983). Peer problems have been only peripherally included in diagnostic schema. Often, when the presenting psychopathology has been treated, the peer problem doesn't go away and yet is usually not addressed by further treatment. It is estimated that as many as 10% of children without any known risk factors have problems making and keeping friendships (Asher, 1990). In a 1-year follow-up study of 10-year-olds, Bukowski, Hoza, and Newcomb (1991, cited in Hartup, 1996) found that having friends had subsequent positive effects on self-esteem. Peer problems in childhood have effects on functioning in later life. In their 12-year follow-up study, Bagwell, Newcomb, and Bukowski (1998) found that peer rejection and lack of at least one best friend in childhood contributed equally to psychopathology of young adults.

We define a *quality friendship* as "a mutual relationship formed with affection and commitment between two individuals who consider themselves as equals."[1] Maintaining quality friendships is perhaps the single most salient measure of a child's successful adjustment. In order to have quality friendships, children must suspend egoism, treat the friend as an equal, and deal effectively with conflict (Hartup, 1996). Friends share a "climate of agreement" much greater than that among nonfriends (Gottman, 1983; Hartup & Laursen, 1993). Children's problem solving is generally better when done with friends as compared with nonfriends (Azmitia & Montgomery, 1993). Friendships may moderate the negative impact of divorce (Wasserstein & La Greca, 1996). Friendships are the context for learning social skills, learning about and feeling good about oneself, and providing resources for support (Hartup, 1993). According to Malik and Furman (1993), "peers are not only playmates but also confidantes, allies and sources of support in times of stress" (p. 1303).

[1]The best definition of friendship we have encountered. Unfortunately, the original author for this has been lost to us.

PART I

CHAPTER 2

Assessment of Outcomes

It is difficult to evaluate the research literature on social skills training without first examining the measures used to demonstrate outcome. A frequent misconception among parents and therapists about formal outcome assessment within a clinical context is that assessment is always associated with some kind of research. Although rarely done, formal outcome assessment should play an integral part in clinical practice for the following reasons:

1. We and others have noted that even the best clinicians are subject to clinician drift over time. Perhaps because creative clinicians get tired of delivering the same intervention repeatedly, they are constantly injecting new features. They may consider these new features acceptable variations on a standard treatment. We have also noticed that our clinicians can successfully present an approach 40 or 50 times but are thrown when it doesn't work quite as well just once. They may then modify their time-worn procedure without consideration of how successfully it usually has worked. We have detected these variations when outcome on teacher measures for a particular group drops (parent measures seem to be less sensitive to procedural variations).
2. We have attempted treatment upgrades on three occasions. On one attempt, we noticed that teacher outcome substantially worsened when compared to the previous groups. We reverted back to our original approach and recaptured previous levels of positive teacher outcome.
3. Posttreatment teacher calls are completed usually within 3 weeks after the last treatment session. We have found that about 30% of parents will call for this feedback. When parents call for this posttreatment feedback, we use the occasion to encourage parents to maintain treatment gains.

Types of Outcome Assessment

There are six types of outcome assessment procedures used by researchers and clinicians: peer assessment, informal "clinical" indexes, ratings from the child patients, behavioral ratings, teacher reports, and parent ratings.

Informal clinical indexes of improvement, such as unstructured parent feedback, clinician ratings of child behavior changes in session, and the clinician's impressions global impression of change, have very little validity for the assessment of changes in peer acceptance of the rejected child: Parents are usually glad they brought their child to the groups and children almost always have a good time (or they leave and aren't around for the posttest). When effective behavioral control techniques are used within the

group, the children are better behaved. It is the generalization of these changes to the child's social environment that is of paramount importance.

As a training and clinical tool, we ask the child group leaders to rate improvement and then compare these ratings with formal parent and teacher measures. The correlation is close to 0. For instance, our clinicians will typically rate a child who disrupts the group or challenges the leader as unimproved. Yet parent and teacher ratings often show some benefit of treatment (this finding has served as impetus for our clinicians to persist with these children). The following subsections briefly review the types of formalized assessments that have been used to measure improvement in social skills training programs.

Assessment Using Peers Without Social Problems

Peer assessment entails having members of a peer group evaluate each other. According to Gresham and Stuart (1992), peer ratings are the most frequently employed types of peer-referenced assessment in research studies. Many researchers consider this form of assessment as the most valid because peers frequently observe each other and operate from a child's frame of reference (Daniels-Beirness, 1989). As Landau and Moore (1991) pointed out, children are more aware of interpersonal interactions of their peers than are teachers and parents.

Peer assessments are too cumbersome to use in typical clinical outpatient settings. For example, our outpatient program draws from more than 200 different schools. Visiting each school and setting up peer ratings for each patient would be a logistic nightmare. Peer assessments are presented here in order to help the reader to better understand and evaluate research studies and categories of peer acceptance (see Chap. 9) that are derived from them. Two types of peer assessment are ratings and nominations.

In a *peer nomination* procedure, a classroom of elementary school children are asked to list the other children in their class they would like to play with the most and the least (Dodge, Coie, Pettit, & Price, 1990). Peer status is tabulated for each child using *social preference* (number liked nominations - number disliked nominations) and *social impact* scores (total number of nominations; Asher & Hymel, 1981; Coie & Dodge, 1983). Gresham and Stuart (1992) found that liked least nominations showed the most stability with test–retest correlations of .60. Extensive research (e.g., Coie & Dodge, 1983; Coie & Kupersmidt, 1983; Dodge, 1983) has indicated the stability of status and predictability of negative outcomes. There has been some concern that the negative nomination procedure might subsequently lead to more negative behavior toward low-status children (Asher & Hymel, 1981), although two studies have failed to show negative effects (Bell-Dolan, Foster, & Sikora, 1989; Bell-Dolan, Foster, & Christopher, 1992).

A *peer rating* procedure requires each child to rate each other child in his or her group using predefined criteria. A simple example is the "roster and rating" sociometric procedure (Singleton & Asher, 1977). Children are given rosters of all same-sex classmates and are asked to rate how much they like each one on a 5-point Likert scale with endpoint anchors of *like a lot* and *dislike a lot*. Other examples are, "How much does _____ get picked on?" and "How much does _____ cooperate?" (endpoint anchors would be *not at all* and *very much*). Average rating is tabulated for each child.

Rating procedures are more apt than nomination procedures to pick up children who have low visibility but are enjoyed as playmates (Asher & Hymel, 1981). The average rating received from classmates (or from same-sex classmates) is highly stable over time even with young children (Asher, Singleton, Tinsley, & Hymel, 1979), is sensitive to the effects of intervention (Ladd, 1981; Oden & Asher, 1977), but is also sensitive to variations in the wording of the criterion (Oden & Asher, 1977; Singleton & Asher, 1977). Another important advantage of the rating-scale method is that children are not required to list anyone as disliked. Due to the advantages and disadvantages of each type of peer assessment, we have used both in our 5-year National Institute for Mental Health (NIMH)-funded study (Frankel & Erhardt, 2001). Individual interviews take about 8 minutes per student and most children seem to enjoy doing them.

Ratings from Child Patients

Ratings from child patients are easily obtained, but show the least correlations with other assessments and may be susceptible to social desirability response set (Ledingham, Younger, Schwartzman, & Bergeron, 1982). Children's actual behavior may not correspond to their responses to queries about what they would do in hypothetical situations (Bearison & Gass, 1979; Damon, 1977). An example of this was a study by Grenell, Glass, and Katz (1987). They asked 15 boys diagnosed with attention deficit/hyperactivity disorder (ADHD) and 15 comparison boys what they thought they should do in 16 hypothetical situations. Adult judges rated their responses on friendliness, impulse control, assertiveness, and effectiveness in relationship enhancement. Raters also observed and rated them in free play, a cooperative puzzle task (where one boy was the worker and another was the helper), and a persuasion task (where they tried to persuade their partner to play their choice of game). Correlations of ratings of the responses to hypothetical situations with observed prosocial behavior were low (absolute value of correlations ranged from .37 to .43) although statistically significant.

Another example is the Preschool Interpersonal Problem Solving measure (PIPS; Spivack & Shure, 1974). The psychometric properties are adequate, although there are no normative data. Similar to the ratings of Grenell et al. (1987), the number and quality of solutions generated to various hypothetical situations are scored. However the content areas of the PIPS has been criticized as not representative of social problems encountered by preschoolers (Brochin & Wasik, 1992) and not adequately covering the domain of peer issues (Getz, Goldman, & Corsini, 1984). Others have suggested enhancements in responses to teasing (Feldman & Dodge, 1987) and management of conflict with other children (Brochin & Wasik, 1992).

Asking child patients to list who likes them seems also to be of limited value. Children without friends can usually list "friends" when asked (Hartup, 1996). Sociometrically rejected children were the least accurate in their judgments of who liked them, when compared to average and neglected status children (see Chap. 9, for more on these sociometric categories; MacDonald & Cohen, 1995). On the other hand, asking child patients to rate peer behaviors yields more valid results. Whalen and Henker (1985) reported similarities between their summer camp cohorts of 24 children diagnosed with ADHD and 24 non-ADHD peers: Both cohorts rated their peers' negative behaviors similarly. Correlations between the cohorts ranged from .80 for "causes trouble" to .85 for "noisy." Correlations with teacher ratings were comparable for the cohort diagnosed with ADHD (.69) and those that were not (.65). Hinshaw and Melnick (1995) reported systematic distortions: Boys diagnosed with ADHD were less likely to give positive nominations to non-ADHD peers than the non-ADHD peers were. Behavioral ratings may therefore be useful outcome measures in contexts where children with peer problems are mixed together with peers without social problems.

Although we have avoided the use of ratings from child patients, assessment of self-esteem has been an exception, because the child is uniquely qualified to be asked about perceptions of self-competence. We have used the Piers-Harris Self Concept Scale (PHS).[2] The PHS is an 80-item yes–no self-report measure that takes about 20 minutes for a child to complete. Among instruments commonly used to measure self-esteem, the PHS has been regarded as the most psychometrically sound. The coverage of the relevant domain is adequate (Ross, 1992), and the factor structure of specific self-esteem scales is well-known (Hughes, 1984; Jeske, 1985). The PHS manual provides factor scores on six scales measuring specific self-esteem (Piers, 1984) and a Global score that is a weighted composite of items from the specific self-esteem factors. Among children scoring in the low range of PHS self-esteem at baseline (only about 20% of children enrolled in our groups), we have noticed that about 80% show some improvement on posttreatment assessment.

Behavioral Ratings

Behavioral ratings of negative peer behaviors by adult observers may provide a objective measure of an important aspect of peer relations. An example is a study by Pelham and Bender (1982).

[2]The domain of this assessment is very similar to the Harter scales (Harter, 1982), which may yield similar results.

They formed play groups of one child diagnosed with ADHD and four non-ADHD peers. The children played together for 36 minutes of arts and crafts (which involved sharing the same materials) and free play. Results showed that children diagnosed with ADHD were rated by observers as spending significantly more time in conversation and asking questions, and engaging in 2 to 10 times more negative behavior (e.g., loud repeated yelling, hitting, noncompliance, interrupting another's activity) than comparison children. Hinshaw and Melnick (1995) compared 101 boys diagnosed with ADHD with 80 non-ADHD peers during their participation in a summer camp. Observers rated several categories of behavior in free-play situations. Results showed that boys diagnosed with ADHD had significantly more rule violations, defiance, and disruptive behaviors than the non-ADHD cohort, regardless of the levels of aggression rated by teachers.

In contrast, behavioral ratings of prosocial events, such as, frequency of peer contact and percentage of time interacting with peers, have long been discredited as valid measures of peer adjustment (cf. Gottman, 1977). Correlations between these behavioral ratings and peer ratings have been low. Rate of peer interaction without consideration of quality of interaction is not related to measures of peer acceptance (Asher, Markell, & Hymel, 1981). For example, rejected children may "bug" others more in unsuccessful attempts at entry, whereas liked children may be successful on the first or second attempt (or take no for an answer, cf. Chap. 12). Behavioral measures of attempts at peer entry might therefore favor the rejected child. Valid behavioral measurement of treatment success may entail focus on "critical events" that occur too rarely to be observed under usual procedures (Bierman, Smoot, & Aumiller, 1993).

We have not employed behavioral observations in judging outcome to our interventions, due to severe limitations on their usefulness. Training observers and data reduction involve an extensive time commitment, with only limited reward within an outpatient clinical setting.

Teacher Reports

Teacher reports of peer relationships correspond more closely than any other informant to peer ratings (Glow & Glow, 1980). Hinshaw and Melnick (1995) found that asking teachers and parents to rate their child's popularity on a Likert scale from 1 (*extremely popular*) to 5 (*not at all*) correlated at .62 with each other and .43 with peer preference ratings. Teachers may be able to make finer differentiation than peers, but may not be able to observe important social contexts (i.e., how children behave without adults present) and may be biased by what they see in the classroom (Bierman et al., 1993). Teacher reports must be supplemented with standardized assessments using parents in order to tap into best friendships.

One of the most commonly used teacher report scales is the Pupil Evaluation Inventory (PEI; Pekarik, Prinz, Liebert, Weintraub, & Neil, 1976). It consists of 35 items, each rated as "describes child" or "does not describe child" by the child's teacher. The scales take about 5 minutes to complete. Withdrawal, Likability, and Aggression subscales were derived through factor analysis of peer ratings (Pekarik et al., 1976). Correlations between peer and teacher ratings exceeded .54 on all scales (Johnston, Pelham, & Murphy, 1985; Ledingham et al., 1982). Teacher and peer assessments in first grade have been shown to be equally good predictors of antisocial behavior 7 years later (Tremblay, LeBlanc, & Schwartzman, 1988). La Greca (1981) and Ledingham and Younger (1985) reported that Aggression and Withdrawal scale scores provided an accurate basis for classifying peer acceptance in children when compared with peer ratings of preferred playmates.

We have used the PEI for the past 14 years. The assessment takes about 5 minutes (once the teacher and investigator are through playing "telephone tag"). Most teachers are happy to comply, although some would rather have an open-ended format rather than the yes–no format of responses. The instrument is treatment sensitive, with about 50% to 70% of teachers reporting improvement (outcome interacts with diagnosis and medication status of the children; cf. Frankel, in press; Frankel & Myatt, 2002).

Parent Ratings

By its nature, the best friendship network cannot be observed by the teacher or most peers,

but parents must be relied on for this assessment (Frankel, Myatt, Cantwell & Feinberg, 1997b). A widely used parent questionnaire is the Social Skills Rating System (SSRS; Gresham & Elliott, 1990). It consists of 48 items rated as either "never," "sometimes," or "very often." The parent form should be administered to the mother. The instrument has been divided into two major scales. The Social Skills scale (38 items) inquires about social situations with peers and parents. The Problem Behavior scale (18 items) concentrates on behavioral problems. Correlations with teacher (r = .36) and peer versions (r = .12) of the instrument are low but statistically significant.

Due to the lack of measures available to assess play interactions in the home, we developed the Quality of Play Questionnaire (QPQ; Frankel, 2002b). It is a measure completed by the parent in which the quality of the last play date and the frequency of play dates are assessed. The Conflict factor-based scale was refined through factor analysis of data collected for 112 nonclinic and 48 clinic-referred children (75 boys and 85 girls). A cut point of 3.5 on the Conflict scale resulted in correct classification of 66.7% of the clinic group and 72.3% of the nonclinic group. A cut point of 2.5 for number of play dates at other children's houses resulted in correct classification of 66.7% of the clinic group and 60.7% of the nonclinic group. A cut point of 2.5 for number of play dates at the index child's house resulted in correct classification of 66.7% of the clinic group and 59.8% of the nonclinic group.

We have been using the SSRS Social Skills scale to measure outcome for the past 14 years. We have found that about 90% of parents report some improvement on this scale as a result of our intervention (Frankel, Cantwell, & Myatt, 1996). Comparisons with wait-list control subjects have been highly significant (Frankel et al., 1997b). We have recently begun to use the QPQ to assess outcome. Pre and post data were available for nine children who were in the problematic range of functioning at baseline. Seven of the nine children fell within the nonclinic range at posttest.

PART I

CHAPTER 3

Types of Children's Social Skills Treatment

Most children's social skills treatment takes the form of small groups of children meeting within a school setting, without the involvement of their parents (Beelman, Pfingsten, & Lösel, 1994; Erwin, 1994). Unimodal programs were more effective for 3- to 8-year-olds, while multimodal programs more effective for 9- to 15-year-olds. Beelman et al. (1994) reported that parent and teacher reports showed the least improvement of all types of outcome measures. The typical degree of generalization of treatment gains to children's actual environment from these groups has been small (Kavale, Mathur, Forness, Rutherford, & Quinn, 1996). Perhaps due to these limited gains or the difficulty in implementing this type of treatment, clinicians and researchers have sought alternative treatments. This chapter briefly reviews these alternatives.

Individual Treatment to Enhance Friendships

Malik and Furman (1993, p. 1316), in commenting on group versus individual approaches to social skills enhancement, concluded, "Although inclusion of peers makes this approach much less practical for individual practitioners, we have found little evidence that training sessions with adults will generalize to interactions with peers." In a test of this contention, Bierman and Furman (1984) found that small-group training of conversational skills was more effective in changing peer ratings than individual coaching. Many friendless children prefer the company of adults rather than other children. It is difficult to see how individual treatment with an adult therapist would make a friendless child more comfortable with other children.

One interesting variant of individual treatment for social skill problems was a small study done by Kehle, Clark, Jenson, and Wampold (1986). They videotaped four behavior-disordered, hyperactive males, aged 10 to 23 years. The subjects were shown an 11-minute videotape with their disruptive behaviors edited out. Three subjects decreased disruption through 6 weeks of follow-up, whereas one subject who viewed the unedited tape of his behavior increased disruption. While appearing to be promising, this technique has only obtained limited replication in one other small sample of subjects (Possell, Kehle, Mcloughlin, & Bray, 1999). No evidence was presented that these individuals were better accepted by their peers.

Peer Pairing

Peer pairing is another technique used to improve the social status of rejected children. Pairing unpopular children with more popular peers alone was not as effective as peer pairing with concomitant social skills training (Bierman, 1986a). For example, developmentally disabled children were paired with more popular nonretarded children. Once the pairing stopped, social relationships were not maintained (Chennault, 1967; Lilly, 1971; Rucker & Vincenzo, 1970).

Two studies used competent peers both as instructors in sessions and as prompters within the classroom situation. Middleton and Cartledge (1995) used two or three socially competent peers as models during instruction with each of five highly aggressive first- and second-grade African American males. The peers also gave prompts to each target child in the classroom. Although hitting and arguing were reduced to 16.8% of baseline, there were no effects on acceptance by other peers. Prinz, Blechman, and Dumas (1994) paired groups of four aggressive children with four socially competent children (total *n* was 48 aggressive and 52 competent children) during a median of 22 sessions of 50 minutes each. Each session employed role playing, in which the socially competent child first demonstrated the correct example. Although aggressive behavior decreased in comparison with an attention control group, changes in peer rankings failed to materialize.

Peer pairing has been proposed as an effective alternative on several grounds. First, it may make a friendless child more comfortable around peers. Second, socially competent peers can model appropriate behavior in a way that is more salient to the friendless child. These suppositions seem reasonable in the light of the results obtained. In contrast, other suppositions have not been supported. There is little evidence that the friendless child will become friends or that the peer tutor might facilitate friendships within his or her friendship circle. Anecdotal accounts suggest that the tutor rarely wants to mix socially with his or her pupil outside of the tutoring situation.

Parent Involvement in Social Skills Acquisition

According to Ladd, LeSieur, and Profilet (1993), parents may directly influence young children's peer relations in four ways: First, they integrate their child into social environments outside the home. Second, they help their child select playmates and arrange play dates. Third, they supervise interactions with peers; fourth, they help their child solve interpersonal problems. Despite the major role of parents in their child's friendships, parents have been notably absent from contributing to social skills training programs (Budd, 1985; Ladd & Asher, 1985; La Greca, 1993; Sheridan, Dee, Morgan, McCormick, & Walker, 1996). It is reasonable to expect that parental involvement would enhance treatment generalization (Frankel, 1996; Ladd, Profilet & Hart, 1992; Lollis & Ross, 1987, cited in Ladd, 1992).

Collateral Parent Management Training

One way of integrating parents into their children's social skills training has been to train parents to better manage the conduct problems of their children in the home (collateral parent management training). This approach comes from a research tradition that focuses primarily on the reduction of aggressive behavior as opposed to the enhancement of friendships. The rationale for application of this approach to friendship problems is that rejected children are usually aggressive (Dishion, 1990) and their aggression is a key cause of peer rejection. Bierman and Smoot (1991), using a standard method of classifying rejected children, found that only about one-third of boys with poor peer relations fit this model. Other authors (Bierman, 1986b; French, 1988) find that about half of all rejected children exhibit conduct problems at school. They note that conduct problems at school (but not at home) correlate significantly with peer acceptance in the classroom.

Thus, collateral parent management training may be successful in addressing social problems in a segment of children who are rejected by peers. Home-based reward programs have

been successful in eliminating aggressive behaviors in school (cf. Barth, 1979, for a review; Kazdin, Esveldt-Dawson, French, & Unis, 1987). However, for many rejected children, collateral parent management training may not address key issues in establishing friendships, for instance, the ability of children to play together harmoniously (Powell, Salzberg, Rukle, Levy, & Itzkowitz, 1983).

Parents as Promoters of Negative Peer Interactions

Not only have parents been missing from the corrective experiences of social skill training, but there is evidence that some parents may directly or indirectly promote behaviors that result in peer rejection. Putallaz (1987) found that mothers who were highly aversive to their children tended to be more highly aversive with other mothers in a laboratory setting. These mothers were not only training their children to be aggressive, but were less likely to be helpful in securing play dates because of their own demeanor. Mothers of rejected children were less likely to appropriately monitor play experiences (Ladd et al., 1992; Pettit, Bates, Dodge, & Meece, 1999) than mothers of popular children and had less social competence themselves (Prinstein & LaGreca, 1999). Mothers of rejected children may fail to teach their child conflict management skills and rules of behavior (Kennedy, 1992) and also may unwittingly allow their child to maintain coercive control of play (Ladd, 1992).

Several researchers have found processes in mothers of rejected children that parallel the social errors of their children. Dodge, Schlundt, Schocken, and Delugach (1983) found that mothers of rejected children were more likely to dominate a group of children at play and ignore ongoing activity than mothers of popular children. Russell and Finnie (1990) found that mothers of rejected preschool children would coerce an ongoing play group to integrate their children rather than help their children observe ways to fit in. Perhaps the view that parents may lack social skills themselves and are thus less able to teach them to their children has inhibited development of social skills programs involving parents (Budd, 1985; Cousins & Weiss, 1993).

Teaching Parents to Better Manage Children's Friendships

Several landmark studies refute the contention that parents of friendless children are unable to help in delivery of treatment components to their children. Shure and Spivak (1978) trained parents to be surrogate teachers of a prepackaged social problem-solving program. The focus of the program was decreasing aggression in children rather than increasing peer acceptance and friendships. This was a very ambitious program that intensively trained parents. It demonstrated that parents could be counted on to institute detailed programs. Results clearly indicated improved problem solving in the children.

Cousins and Weiss (1993) implemented a treatment combining training children in social skills with training parents in management skills relevant to peer relationships. They advocated teaching parents to organize the child's social agenda and having the parents debrief the child after social contacts. Pfiffner and McBurnett (1997) demonstrated that social skills training benefits readily generalized to the home when parents were trained to promote this generalization. Sheridan et al. (1996) taught parents supportive listening skills, helping their child solve social problems, setting social goals, and helping their children transfer skills to the home environment. Parent and teacher reports suggested general improvement for most boys.

We have found that most parents of friendless children possess adequate skills in most areas of social functioning, with the exception of a few localized "blind spots." With a little information from us, parents can help each other to improve the way they manage their children's peer relations. The techniques described in this volume were readily used by most parents of children enrolled in our program.