

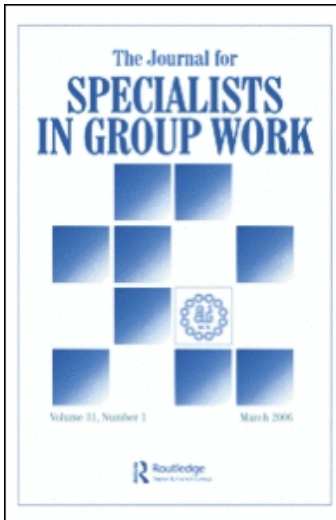
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Prevention Groups With Children and Adolescents

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Primary prevention has increasingly become a focus of child and adolescent research literature over the past 25 years. Given the amount of time that children and adolescents spend with their peers both in and out of classrooms, the group is the logical choice for the delivery of preventive services. The purpose of this article is to familiarize the group practitioner with prevention concepts and methods for use with groups for children and adolescents. This article also provides recommendations for measuring process and outcome variables in prevention groups based on a comprehensive review of the prevention group literature.

Primary prevention has increasingly become a focus of the child and adolescent research literature over the past 25 years. Moving away from the secondary and tertiary (remedial) models of mental health, primary prevention in children's and adolescents' mental and physical health is now riding the proverbial crest of a research, literature, and practitioner wave. Entire journals have been devoted to the ideals of primary prevention (*Journal of Primary Prevention*), special issues have covered the topic in detail through both narrative reviews and meta-analyses ("Special issue," 1997), and major local, state, and federal research agencies have funded cross-sectional and longitudinal prevention-oriented research projects for some time now.

Given the amount of time children and adolescents spend with their peers both in and out of classrooms, the group is the logical choice for the delivery of preventive services. The group is a primary socializing influence through the early developmental stages of life (Erickson, 1966) and provides the context within which children and adolescents will receive preventive interventions and will practice and utilize them in real life.

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The group format is also desirable given the high level of research-based efficacy that has been demonstrated in a wide variety of applications over the past several decades. In a meta-analysis of child and adolescent group treatment, Hoag and Burlingame (1997) evaluated 56 outcome studies published between 1974 and 1997 and found an effect size of 0.61, which indicates that "the average child or adolescent treated by group treatment is better off than 73% of those in control groups" (p. 234). Therefore, it seems wise to design primary prevention programs within the efficacious bounds of the group format.

The Association for Specialists in Group Work (ASGW) defines four different types of groups and the tasks expected of counselors in these groups in a set of professional standards for the training of group workers (Association for Specialists in Group Work, 1991):

Task/work groups: The task/work group specialist is able to assist groups such as task forces, committees, . . . community organizations, . . . learning groups, and other similar groups to correct or develop their functioning.

Guidance/psychoeducational groups: The guidance/psychoeducation group specialist seeks to use the group medium to educate group participants who are presently unaffected by a potential threat (such as AIDS), a developmental life event (such as a transition point), or how to cope with an immediate crisis (such as suicide of a loved one), *with the goal of preventing an array of educational and psychological disturbance from occurring* (italics added).

Counseling/interpersonal problem-solving groups: The group worker . . . seeks to help group participants to resolve the usual, yet often difficult, problems of living through interpersonal support and problem solving. *An additional goal is to help participants to develop their existing interpersonal problem-solving competencies that they may be better able to handle future problems of a similar nature* (italics added).

Psychotherapy/personality reconstruction groups: The group worker . . . seeks to help individual group members to remediate their in-depth psychological problems . . . to reconstruct major personality dimensions. (p. 13)

Prevention is an idea whose time has come. A recent meta-analysis of primary prevention program studies designed to prevent behavioral and social problems in children (Durlak & Wells, 1997) yielded mean effect sizes ranging from 0.24 to 0.93; Durlak and Wells (1997) report that "the average participant in a primary prevention program surpasses the performance of between 59% to 82% of those in a control group, and outcomes reflect an 8% to 46% difference in success rates favoring prevention groups" (p. 115). An additional finding was that "Most categories of programs had the dual benefit of significantly reducing problems and significantly increasing competencies" (i.e., enhancing resilience) (p. 115).

The purpose of this article is to familiarize the group practitioner with prevention concepts and methods to use with groups for children

and adolescents. This article also provides recommendations for measuring process and outcome variables in prevention groups, a neglected but necessary activity. These recommendations are based on a review of the prevention group literature that examined more than 1,500 articles; the final pool of reviewable studies contained 66 studies. These 66 studies were culled from 44 different journals spanning the gamut of the social sciences. A complete listing of all journals cited and number of citations per journal is available from the authors.

SUGGESTIONS FOR PRIMARY PREVENTION GROUPS FOR CHILDREN AND ADOLESCENTS

The first task to complete when planning a prevention group is to define the population (Durlak & Wells, 1997). Within prevention, there are many different points to intervene. Interventions may target entire populations without regard to risk, such as an entire age or grade group, which is known as the global approach. Interventions may also target a group that may be at risk for future problems, known as the at-risk approach, such as children from low-income, single-parent families. Interventions may also target a group that is involved in a transitory period, known as the transition approach, such as children whose families are undergoing a divorce or similar family problems.

A group should possess some in-group heterogeneity but not so much that the group members have nothing in common on which to work. When defining a group population, the group members should be within a relatively restricted age or grade range, due to the vast developmental differences between certain age ranges. With younger children it is better to separate along gender lines; ethnic and cultural diversity within the group is desired; finally, do not mix already troubled children in the group—it is difficult to mix members along clearly prevention or intervention lines.

It is also important to document the exact characteristics of the individuals in the group being run; when documenting treatment efficacy, it is important to be able to specify with whom the intervention did and did not work. In addition, when publishing the results of the group treatment, these variables are required, or else the study becomes another interesting case study instead of research someone else can use in practice.

An overwhelming majority of the studies (54, 80.6%) in the current review were conducted in school settings. This is not surprising given that children and adolescents spend a large part of their day in school; this is also an encouraging statistic, because it demonstrates that

prevention research is taking place in our schools, one of the primary settings in which prevention services need to be implemented to reach the widest possible audience. Hospitals and residential care facilities are not expected to be primary prevention providers as they are likely already dealing with a population that has reached the secondary and tertiary intervention stages. Hoag and Burlingame (1997) reported that another of the four statistically significant variables in their meta-analysis (out of 28 variables) was setting; more than 70% of the studies in their meta-analysis took place in schools, with the remaining studies in a clinical setting, either inpatient or outpatient. They report that studies in the school setting were significantly less effective than those studies in clinical settings. An argument could be made that treatment occurring in a clinical setting is likely to be secondary or tertiary in nature, resulting in a greater gap to be crossed going from "ill" to "healthy." In schools one is more likely to see prevention-oriented treatments (i.e., divorce or self-esteem/self-concept groups), and therefore there is a much smaller gap to be crossed. In purely primary prevention there should exist no gap, because one hopes to enhance functioning that is already present (enhancing competencies and strengthening resiliencies).

When planning prevention groups in schools, it is important to define specifically what it is the group intervention is designed to prevent. Prevention efforts in the literature are often aimed at raising self-esteem, self-efficacy, and other similar variables. This approach may work if there are no specific behavioral goals to meet; otherwise, target specific thoughts, feelings, and/or behaviors. Also, prevention efforts should not become interventive—these efforts often require different strategies. It is easy to become discouraged if the groups conducted seem to not be as effective as they should; prevention is often a long-term goal and, like many other early interventions, it often takes time to see the fruition of group prevention work. It can also be tempting to document a specific variable with which to document change, but the danger of this approach is in picking a variable that is easily documented but of little significance to prevention efforts.

Another important documentation decision involves the type of interventions chosen. Whether using prepackaged interventions or those created for the study, document what is done with prevention groups. This documentation helps to keep focused on the group's prevention goals, demonstrates that an attempt is being made to standardize treatment, and allows others to either (a) gain the knowledge that the prepackaged intervention works, or (b) use your intervention knowing that it is effective. Who knows, those of you who thought you would never have the desire to publish in the professional literature might find yourself with a

great prevention group format that you believe must be disseminated to your colleagues!

The very least that can be done with documentation is to note what types of techniques are used, how they are used, and what theoretical orientation they fit. The best way to document a treatment is through the creation of a treatment manual. A treatment manual will outline for other professional group workers exactly how to conduct the type of prevention group created, step by step, and typically includes pretest and posttest measures of treatment effectiveness. Treatments typically have seven levels: (a) dosage of treatment, (b) orientation of the treatment, (c) degree of treatment standardization, (d) setting of the treatment, (e) frequency, (f) length, and (g) number of sessions.

Length of treatment is an important variable to attend to; prevention groups typically tend to run 1 to 3 months, fewer run 3 to 6 months, fewer still will run any longer than that. Though groups run in the schools tend to be limited by the school year, recent research has pointed to the efficacy of longer-term treatment (Seligman, 1996), whether it be individually or in groups; the tendency toward shorter treatment times appears to be an outgrowth of the advent of managed care, though in schools this is somewhat less of a concern. Still, shorter, research-proven efficacious treatments have tended to become the norm in the literature, with manualized, strictly controlled studies examining discrete variables in the treatment of relatively simple disorders becoming the mode. Prevention-oriented group counseling carries with it the possibility of offering relatively short, efficacious treatments with long-term results, but it appears from the current state of the literature that more long-term studies need to be carried out with longer follow-up times to discern what the best combination(s) of treatment dosage(s) will be. Hence, do not time limit treatments, if at all possible; prevention work often will be carried out in a longer term format and certainly needs to be followed up in the long run. The prevention-group worker should possess good delay-of-gratification skills, and find short- and long-term variables to work on, and measure, in their groups.

When publishing the results of a prevention group, randomization of participants is an important consideration. When planning to run a prevention group and report the results, it is important to do so in what is known as a true experimental fashion. What this means is that in addition to having a treatment group, a control group must also be included. Simply put, the control group does not receive the treatment that the treatment group receives; it either receives no treatment or a very small amount of treatment, such as unstructured time together doing an activity. The participants in both of these groups need to be randomly assigned; this is completed by first gathering all participants into one

group, then finding a way to divide them, randomly, into two groups. This can be simply done by throwing all group members' names in a hat and then drawing from the hat to form two separate groups, the treatment and the control.

Follow-up assessment is an incredibly important part of research and treatment design. Because the legacy of the current research is one-shot pretest/posttest designs, it has been important for the research community to recognize the place of follow-up assessment in their designs. Follow-up measures the truest test of success—whether the effects of an intervention stand the test of time. If not, booster sessions are often needed, if not an actual revision to the original intervention.

Follow-ups typically range from 1 day after posttest to 3 years later; the three most popular categories of follow-up times are 3 to 6 months, 6 to 12 months, and 1 to 3 months. It is during follow-up that researchers often find interesting or even more significant results than immediately after their intervention. For instance, some researchers find that control groups actually worsen over time, whereas treatment groups stayed the same or even improved, indicating an important preventative effect. In other cases, though, follow-up demonstrates that treatment effects did not take hold for an extended period of time, indicating the need for a possible revamping of the intervention or simply putting in place booster sessions that would help to make the intervention more effective over the long run.

Assessment, to be as complete as possible, needs to come from several sources. Self-report is somewhat unreliable on its own, as children have been shown to self-endorse items reflecting attitudes or behaviors they do not exhibit, yet self-report is often used as the primary source of information. Parent and teacher reports, and documented information such as grades, can often serve as multiple assessment points for the practitioner. Multiple types of assessments are necessary to be confident that results are both significant and useful. The type of instrument(s) used in assessing the outcome of a prevention group can also affect its results. Using instruments with good reported reliability and validity figures and those that have a significant norming base is going to result in more acceptable, interpretable data. Using instruments constructed solely for one's own study or those with limited reliability/validity data may not be as useful or informative.

The following point cannot be overemphasized: Fidelity of treatment is based on proper training of group leaders, especially in unstructured group processes such as interpersonal group therapy. Manualized therapy requires less training due to the resources available but actually requires more adherence to treatment procedures due to the strict implementation needed to demonstrate efficacious results. Absence of

leader training denotes an unwillingness to ensure that interventions are appropriately delivered. Without the assurance of proper delivery of preventive services, it will be difficult, if not impossible, to implement any type of group prevention program on a large scale—results will either not support the use of the particular intervention or will appear as if they should not. Simply put, when implementing prevention groups leaders need to have more than adequate training and experience for the task; if multiple group leaders are to be involved they must possess the knowledge and skills necessary to run groups in general and the specific type of group that is being implemented in particular. It is recommended that all group leaders undergo some type of training experience specific to the group task at hand, even if they are already experienced group leaders. Practitioners with lots of experience but without adequate continuing education in their field are not necessarily better group leaders—they may actually become more entrenched in their bad habits.

CONCLUSION

Prevention and groups are a natural combination to use in enhancing the health of children and adolescents. Prevention-oriented group treatment needs to attend to the details as well as the generalities of treatment and research. To be effective over the long haul, it is of the utmost importance to know what works. Prevention is an inherently difficult variable to measure, especially when dealing with a slippery variable, such as primary prevention with groups that may not be very at-risk. It is important to be able to pinpoint what works with whom, how, and for how long. The continuing efforts of both practitioners and researchers to implement and document their preventive group efforts will result in a knowledge base that will help carry the art and science of group-based prevention into the 21st century.

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