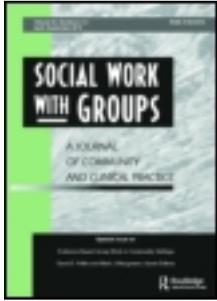


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“We may not like it but we guess we have to do it:” Bringing Agency-Based Staff on Board with Evidence-Based Group Work

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“We may not like it but we guess we have to do it:” Bringing Agency-Based Staff on Board with Evidence-Based Group Work

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In this article the authors describe our experience of developing a manualized model of group treatment for early adolescents with learning disabilities. We review the process of developing and piloting the manual as part of a school-based intervention research project, and the process and complexities in using this model in a community agency with a long history of conducting groups. The authors provide the leaders' feedback on their experience of co-leading a manualized group approach. They conclude with practice principles and recommendations based on the staff's feedback, with respect to bringing agency-based workers on board with an evidence-based approach to group work practice.

KEYWORDS *manualized group, group for students with learning disabilities, self-advocacy group, learning disabilities, adolescents, school-based social work, group work, co-leadership*

INTRODUCTION

The growing demand for evidence-based practice (EBP) presents a healthy challenge for group work practitioners (Macgowan, 2006; Pollio, 2002). To undertake this challenge, practitioners have begun to develop, pilot,

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evaluate, and disseminate group work models that demonstrate effectiveness. Dissemination of effective models of group work allows these to be further piloted and modified for diverse audiences. Treatment manuals typically comprise descriptions of the group purpose and content, targeted participants, and implementation procedures. The manualization of group work models enhances the likelihood of fidelity and accurate replication (Galinsky, Terzian, & Fraser, 2006).

Along with a significant increase in the number of manualized group models, the use of manualized curricula in groups is growing and is seen as an asset (Comer, Meier, & Galinsky, 2004). Nevertheless, there are well-documented critiques of treatment manuals (Carroll & Nuro, 2002; Galinsky et al., 2006; McMurrin & Duggan, 2005). These include beliefs that manuals are overly focused on content to the exclusion of process, are overly prescriptive and do not consider the needs of individual members, and are not tailored to diverse populations (Carroll & Nuro, 2002; Chorpita, 2002; Kurland & Salmon, 2002; Westen, Novotny, & Thompson-Brenner, 2004).

In this article we describe our experience of developing a manualized model of group treatment for early adolescents with learning disabilities (LDs). We review the process of developing and piloting the manual as part of a school-based intervention research project, and the process and complexities in using this model in a community agency with a long history of conducting groups. We provide the leaders' feedback on their experience of co-leading a manualized group approach. We conclude with practice principles and recommendations based on the staff's feedback, with respect to bringing agency-based workers on board with an evidence-based approach to group work practice.

CHALLENGES FOR GROUP WORKERS

Present-day social workers who deliver group services face a number of challenges. First, with a renewed demand for generic practitioners who are expected to be competent in a broad range of practice and research, social workers must develop and maintain skills in a number of modalities, such as practice with individuals, couples, and families, advocacy, evaluation, and group. This increasing demand is coupled with a decline in the teaching of group work practice in social work programs (Goodman & Muniz, 2004; Kurland et al., 2004; McNicoll & Lindsay, 2002).

A second challenge that goes along with the need to attain multiple skills is the advent of managed care in a time of shrinking resources (Kurland & Salmon, 2002; Kurland et al., 2004). One result is the need for practitioners to "do more with less," as quickly and cheaply as possible. Group work is considered less expensive (McDermott, 2003) and at least as beneficial as individual psychotherapy (Burlingame & Krogel, 2005).

A third challenge in social work and other fields is the important and increasing focus on EBP. According to Pollio (2006), EBP includes the “conscientious and judicious use of current best practice in making decisions for individual treatment” (p. 225). EBP has also been described as “the intersection of current best external evidence, client values and expectations, and practitioner expertise” (Shlonsky & Gibbs, 2004). EBP demonstrates the value, quality, and effectiveness of service (Mace, 2006).

Over the past number of years there has been a greater amount of research conducted on the effectiveness of group intervention (Ward, 2004). Despite cautions about the potential for harm in groups (Galinsky & Schopler, 1977; Roback, 2000), there is evidence that “groups work” (Barlow, Burlingame, & Fuhriman, 2000; Burlingame, Fuhriman, & Mosier, 2003; Hoag & Burlingame, 1997). Group work benefits individuals across the life span (Bratton, Ray, Rhine, & Jones, 2005; Hoag & Burlingame, 1997; Page, Weiss, & Lietaer, 2001; Weisz, Weiss, Han, Granger, & Morton, 1995), including children and adolescents (Cramer-Azima, 2002).

In a meta-analysis of group treatment with children and adolescents, Hoag and Burlingame (1997) examined 56 outcome studies and found that the average child or youth in group treatment is better off than 73% of those in control groups. Kulic, Horne, and Dagley (2004) examined 94 studies of prevention groups for children and adolescents and discovered that though studies demonstrated effectiveness, many did not have adequate descriptions of their intervention procedures, thus limiting the opportunity for other clinicians to use the models in practice. The authors asserted, “we are past the point where we can simply say that ‘groups work’ . . . and omit details of how they work” (p. 143) and commented that the lack of detail makes the findings of little clinical or practical value. Kulic and colleagues further proposed that research in group work must include explication of intervention procedures, preferably through the development of treatment manuals. According to the authors, the use of manuals prevents the delivery of group interventions based on inaccurate interpretations of poorly described procedures.

EVIDENCE-BASED PRACTICE

The Code of Ethics of the National Association of Social Workers, the Practice Statement of the Canadian Association of Social Workers, and the *Standards for Social Work Practice with Groups* emphasize the importance of basing practice on recognized knowledge, maintaining currency with emerging knowledge, promoting evaluation and research that contributes to the development of new knowledge, and disseminating knowledge of effective practices relevant to social work (Association for the Advancement of Social Work with Groups, 2005; Canadian Association of Social Workers

[CASW], 2000; National Association of Social Workers [NASW], 1999). These statements are congruent with the principles of EBP described above.

Evidence-based group work comprises appraising systematically, collected evidence from a variety of sources, evaluating the outcomes of practice, implementing models of practice consistently, attending to individual differences in practice decisions and incorporating evidence in understanding group process, leadership, and development (Macgowan, 2006; Pollio, 2002). Practitioners who subscribe to evidence-based group work must maintain currency about research, learn about new models, carefully consider the rationale for treatment decisions, evaluate their own practice, and report findings from their experiences in group work practice journals (Pollio, 2002). This clearly requires the commitment of considerable time and resources by practitioners and sponsoring agencies, ideally including time and resources to design interventions, supervision on group leadership, and consultation on evaluation procedures. With today's limited resources, the commitment to EBP may be present, whereas the resources may not.

Although many group work practitioners may be current with respect to evidence-based approaches to research and evaluation, they do not necessarily employ them (Brower, Arndt, & Ketterhagen, 2004). Difficulties that group workers associate with evaluation and research include ethical problems related to randomly assigning and withholding treatment from control groups in random controlled studies, the small number of participants in groups that do not achieve statistical power, adherence to treatment methods that do not meet the unique needs of group members, and methods that fail to capture the "groupness" of groups.

TREATMENT MANUALS

Treatment manuals are guides to the application of therapeutic procedures. A well-designed treatment manual describes treatment strategies and the ways to apply them in a specific approach (McMurran & Duggan, 2005). Included are details about the theoretical framework, the model of intervention, and implementation guidelines.

There is growing recognition of the importance of treatment manuals in evidence-based intervention (Galinsky et al., 2006; Scaturro, 2001). Advantages of manuals include their explication of treatment models and their underlying theories. Manuals encourage adherence to a treatment model, thus increasing integrity. Manuals assist training of experienced group workers in new models and contribute to the development of less experienced staff (Carroll & Nuro, 2002; McMurran & Duggan, 2005). Manuals permit clinicians to follow a prescribed sequence of events that can be replicated by others (Kendall, Chu, Gifford, Hayes, & Nauta, 1998).

Finally, manuals foster comparisons among treatment approaches and permit multiple treatment trials, which leads to refinement of treatment approaches. Thus, treatment manuals are major contributors to the development of a collection of evidence-based resources.

A number of disadvantages to the use of manuals have been identified. A great deal has been written about clinicians' reluctance to adopt manualized programs (Addis & Krasnow, 2000; Beutler, 2002; Carroll & Nuro, 2002; Kendall et al., 1998; Kurland & Salmon, 2002; McMurren & Duggan, 2005). Other critiques include the lack of applicability to complex client populations and attention to group dynamics and treatment alliances (Carroll & Nuro, 2002; Kurland & Salmon, 2002), the overly restrictive structure and lack of room for clinical judgment and flexibility (Kendall et al., 1998; McMurren & Duggan, 2005), and for the development of mutual aid (Kurland & Salmon, 2002). Further, manualized programs are depicted as offering a "one-size-fits-all" approach to treatment, therefore not meeting the specific needs of individual clients (Beutler, 2002) or of diverse groups (Chorpita, 2002). Some practitioners view manuals as driven by managed care and catering to approaches that "do more with less" in response to diminished resources (Kurland & Salmon, 2002). Others consider manuals as cookbooks that lack the cook's creativity (Kendall et al., 1998, p. 178), and as diminishing the "art" of therapy (Galinsky et al., 2006).

Research that examines therapists' views of manuals has yielded mixed results. Addis and Krasnow (2000) conducted a survey on practitioners' attitudes and beliefs about treatment manuals. One third of the respondents were not clear what a treatment manual was, and 40% had never used one. Although many of the practitioners had given very little thought to the use of manuals, a significant number viewed manuals as "a treatment protocol imposed by a third-party payer" (p. 336), or a technique that turns clinicians into technicians. Another study of therapists' satisfaction with a specific group treatment manual (Najavits et al., 2004) found that although the therapists viewed the treatment program positively and appreciated using a new approach, they reported that it took an average of 8 months to feel comfortable with the approach and they would not likely use the manualized approach, without modifications. The therapists felt that manuals did not offer sufficient guidance about treatment dilemmas and turned to supervision, rather than the manual, to address these issues.

Other writers challenge practitioners' critiques of manuals. Kendall and colleagues (1998) asserted that if a manual does not explicitly describe therapeutic techniques or relationships, clinicians must utilize their clinical skills. Further, they proposed that manuals should be used as guides to be applied with flexibility and creativity, and not as routinized procedures. According to this perspective, clinicians should be well versed with the treatment approach and the needs of the targeted population. Because manuals cannot address all potential treatment issues, supervision is vital for successful

implementation. Finally, Galinsky and colleagues (2006) asserted that group leaders who use manuals must be skilled in group work, including the ability to foster relationships, nurture mutual aid, and pay attention to individuals' needs and group stages.

It is therefore prudent for researchers and practitioners to collaborate on the development of treatment manuals. Although treatment manuals are often developed by researchers, manuals need to be piloted in clinical settings and modified as needed. Continual modification is recommended as successful pilots are applied to more diverse populations (Galinsky et al., 2006).

THE DEVELOPMENT OF A MANUALIZED APPROACH TO GROUP WORK: CASE STUDY

In this article we describe the process of developing and piloting a group treatment manual for early adolescents with learning disabilities (LDs). Group treatment has been offered for many years at Integra, a children's mental health center in Toronto, Canada, that specializes in the mental health needs of children and youth with LDs. An approach to group work has been developed at the center (Mishna & Muskat, 2004) that utilizes self-psychology (Kohut, 1984), mutual aid (Gitterman & Shulman, 1994; Steinberg, 2004), and interpersonal group theory (Yalom & Lescz, 2005), and which accommodates the members' LDs (Mishna, 1996).

Group work is one modality offered at the center to address the struggles experienced by the children and adolescents receiving service. These include difficulties with academic performance, school failure, adjustment issues, depression, anxiety, social difficulties, and peer victimization (Cosden, 2001; Maag & Reid, 2006; Margalit & Al-Yagon, 2002; McNamara, Willoughby, Chalmers, & YLC-CURA, 2005; Morrison & Cosden, 1997; R. Pearl & Bay, 1999; Svetaz, Ireland, & Blum, 2000). Groups provide a setting for these children and youth to connect with others who also have LDs, to discuss their concerns, discover that others have similar struggles, and to address their psychosocial problems in a natural social environment (Mishna & Muskat, 2004).

The ability of individuals to understand and take control of their learning difficulties is a predictor of adult success (Raskin, Goldberg, Higgins, & Herman, 1999); this includes developing awareness of one's learning difficulties and strengths, and understanding the concept of "learning disability" and its specific academic implications. Best practice for students with disabilities includes delivery of programs that enhance self-determination (Wehmeyer, Field, Doren, Jones, & Mason, 2004). Self-determination includes self-advocacy, or awareness of one's rights to access support and accommodations, familiarity with needed accommodations, and

the skills to communicate one's learning needs (Merchant & Gajar, 1997). The original group model developed at the center did not routinely or explicitly include discussion of the members' LDs or development of self-advocacy skills. It was important to incorporate discussion about LDs and self-advocacy in the revised group treatment model developed for the manual.

PILOT ONE: GROUP AS PART OF RESEARCH PROJECT

This manualized group approach was developed as one component of a school-based research project addressing the psychosocial needs of middle-school students with LDs. Together with university-based researchers and education personnel, the center was a partner in developing and implementing the project. The project objectives were to increase these students' understanding and ability to take control of their LDs; increase parents', teachers', and peers' understanding of LDs; and increase the support of the school environment in which the students function. The group model was developed to address the first objective, that is, increase the students' understanding and ability to take control of their LDs. The other two objectives are not discussed in this article.

Development of Group Manual

The manual was created primarily by an experienced agency-based group worker (BM) with the input and support of the university researcher. The manual was created using the "stage model" of manual development described by Carroll and Nuro (2002). Accordingly, development of a treatment manual is not considered a one-time event, but rather, a long-term process in which details of the approach are fine-tuned and enhanced based on pilot testing. The process includes a first stage during which an initial version of a manual is piloted, measures of adherence are created, and a training protocol is developed. In Stage 2, a series of controlled clinical trials are carried out and elements of the approach, either content or process related, are further developed. During Stage 3, the manual is piloted with diverse populations and is assessed for cost effectiveness. We are currently completing Stage 1 of development with respect to the "stage model."

The development of the manual was informed by (1) the group model used in the agency (Mishna & Muskat, 2004) and (2) the literature on best practices in working with students who have learning difficulties, including addressing self-awareness and self-advocacy (Raskin et al., 1999; Wehmeyer et al., 2004). Thus we included topics that had been used in the agency groups and were considered valuable and added topics that were identified in the literature, such as understanding LDs (Eisenman & Tascione, 2002;

C. Pearl, 2004), self-advocacy skills (Barga, 1996; Merchant & Gajar, 1997), and bullying experiences (Mishna, 2003, 2004). The manual was revised after use in the research project based on ongoing feedback from group leaders in the project and continues to be revised based on feedback from leaders of agency-based groups.

The primary focus of the manual is on the content of group sessions with the assumption that all the group leaders were trained in the group therapy model described previously (more details to follow). The group model described in the manual comprises 12 sessions (Muskat, 2004). The following information was presented for each session: check-in with members, outline of the session's purpose and objectives, didactic material /content, selected activities to illustrate the topic, snack, summary, wrap-up, and introduction of following week's theme. The first session included introductions including "ice breakers" and other activities to help the members become comfortable, brief review of the group purpose and goals, and development of group norms such as confidentiality and group safety as well as norms developed specifically by each group. The topics of the group sessions were as follows: (1) introductions, purpose, group rules, goal setting; (2) definition and description of LDs; (3) members' strengths and interests; (4) members' specific learning difficulties; (5) supports that help members learn and complete school work; (6) standing up for oneself/dealing with bullies; (7) role-playing and practicing standing up for oneself; (8) asking for help with school work; (9) learning to calm down and relax; (10) relaxation and problem-solving; (11) practicing lessons learned; and (12) summary, wrap-up, celebration, and awards. The aims of the sessions were to deliver content, utilize activities to illustrate content, allow for discussion, practice of self-advocacy skills, and promote fun. Information presented in the sessions, members' drawings and art, and worksheets used in sessions were placed in folders that were given to members at the end of the group. A list of relevant and accessible resources and readings were included at the end of each session.

Description of Group Intervention in the Research Project

The group comprised students in Grades 6–8, identified by special education staff of the school as having LDs, and invited by school staff to participate in the project. Participants were excluded if they scored in the clinical range for conduct problems on a standardized teacher report measure (Achenbach, 2001).

Each group was co-led by two leaders, one of whom was an agency social worker with clinical experience with this population and the other was a school-based social worker or psychologist. All of the leaders participated in a one-day training session on use of the manual as well as the group treatment approach used by the agency. The training was provided by one

of the authors (BM) and comprised didactic and discussion modalities as well as analysis of videotapes of agency groups for children and youth with LDs. Throughout the project, a number of meetings were held with the group leaders, to obtain their comments and responses to the group process in general, and working with the manual more specifically.

Each group consisted of 12 weekly sessions, 60 minutes in length, with five to seven members. Groups were held in classrooms in the schools, either at lunchtime or during the school day.

Evaluation

The research group intervention was delivered to a total of 50 students in Grades 6 through 8, who participated in seven groups. All students were diagnosed with LD by a psychologist. The project as a whole was evaluated using quantitative and qualitative measures, to examine the students' self determination and adjustment. There were five waves of data collection (see Table 1).

The final sample of the whole project included 68 students (35 in immediate intervention and 33 in intervention withheld group). Of this sample, 18 withdrew from the study. Two students in the immediate intervention withdrew, as they no longer wished to participate; 16 students in the intervention withheld group withdrew (12 no longer wanted to participate and four moved). The final sample that received the intervention was 50 (33 in the immediate intervention, 17 in the intervention-withheld group).

We conducted individual interviews with selected participants in the group treatment to complement the quantitative data and tease out complex issues that other methods can overlook (Nastasi & Schensul, 2005). We used purposive sampling with respect to such variables as school and gender to obtain a range of experiences (Lincoln & Guba, 1985). Interviews focused on the participants' views of the group and the intervention. In addition, these students' teachers and parents were asked to participate in interviews to probe their impressions of the children's group involvement and of the overall program. Interviews were recorded and transcribed. We conducted interviews with 14 students, and their parents and teachers, for a total of 42 interviews. The student and teacher interviews took place at the schools and lasted approximately 1 hour, whereas the parent interviews were conducted over the phone. Several measures were taken to ensure

TABLE 1 Research Data Collection Schedule

Condition	Time 1	Time 2	Time 3	Time 4	Time 5
Immediate	Pretest	Posttest	6 mo. follow-up	12 mo. follow-up	18 mo. follow-up
Control/ Withheld	Pretest	Pretest	Pretest	Posttest	6 mo. follow-up

trustworthiness (Lincoln, 1995; Lincoln & Guba, 1985). The researchers' prolonged engagement through many years of practice and research with children who have LDs helped to build trust. Triangulation was achieved through the multiple perspectives obtained by interviewing the children as well as their parents and teachers. The data were analyzed through constant comparison to develop groupings of similar concepts of participants' perspectives (Creswell, 1998).

The findings of the individual interviews with the students who participated in the group, and their parents and teachers, suggest that the group contributes to ameliorating risk factors and promoting protective factors that are identified in the literature and that correspond with the aims of the group treatment. These factors include the students' knowledge of their LDs, increased ability to ask for help and self-advocate, and increased self-esteem and confidence. The details of the results are presented in manuscript separate article (Mishna & Muskat, this issue).

Participants' self-advocacy skills were assessed with The Self Advocacy Interview for Students, a 30-minute structured interview that evaluates knowledge of LDs, learning style, resources, accommodations, and communication skills (Brunello-Prudencio, 2001). Overall test-retest reliability was .875.

The means and standard deviations and *F* statistics for the Self Advocacy Interview (SAI) for the treatment and control groups are presented in Table 2.

The results indicate that (1) there were no significant differences in baseline SAI between the treatment and control groups, (2) both groups showed significant improvement in SAI from pretest/Time 1 to posttest/Time 2, and (3) there were no significant differences in posttest/Time 2 of assessment between the treatment and control groups.

We used general linear models repeated measure procedures to examine changes in self advocacy skills over five times of assessment. The results that are shown in Table 3 indicate that (1) at the one-year follow up, the treatment group made substantial gains in self advocacy knowledge and (2) students in the control-intervention group who received the self-advocacy

TABLE 2 Changes in Self-Advocacy Knowledge from Baseline to Posttest

Measure	Control (<i>N</i> = 51)			Withheld Intervention (<i>N</i> = 35)		
	<i>M</i>	<i>SD</i>	Range	<i>M</i>	<i>SD</i>	Range
SAI 1	29.0	6.11	11–42	28.33	5.38	18–39
SAI 2	32.8	6.22	12–46	33.15	5.11	23–43

Note. SAI 1 = Self Advocacy Interview Time 1; SAI 2 = Self Advocacy Interview Time 2.
Main Effect of Time: $F(1, 83) = 62.24, p = .000, \eta^2 = 0.43$; Time x Group Effect: $F(1, 83) = 0.72, p = .399, \eta^2 = 0.009$.

TABLE 3 Changes in Self-Advocacy Knowledge Across the Immediate and Delayed Intervention Groups

Measures	Immediate-Intervention (<i>N</i> = 33)			Withheld Intervention (<i>N</i> = 17)		
	<i>M</i>	<i>SD</i>	Range	<i>M</i>	<i>SD</i>	Range
SAI 1	29.17	6.077	18–39	28.20	7.51	11–42
SAI 2	32.98	6.224	23–43	30.47	6.81	12–46
SAI 3	30.28	7.637	23–44	29.20	7.66	13–42
SAI 4	35.14	5.187	20–41	34.73	5.24	20–41
SAI 5	35.00	4.914	25–44	35.00	4.91	26–42

Note. SAI 1 = Self Advocacy Interview Time 1; SAI 2 = Self Advocacy Interview Time 2; SAI 3 = Self Advocacy Interview Time 3; SAI 4 = Self Advocacy Interview Time 4; SAI 5 = Self Advocacy Interview Time 5.

Main Effect of Time: $F(1, 48)=23.44, p = .000$, and $\eta^2 = .33$; Time x Group Effect: $F(1, 48) = 4.65, p = .004$, and $\eta^2 = .09$.

treatment after Time 3 of assessment also showed considerable increase in self-advocacy skills after the treatment.

These findings suggest that middle-school students with LDs can significantly increase their self-advocacy ability, an important protective factor. Results highlight the importance of adults discussing LDs with students, and understanding associated issues. As the project included the group, in addition to workshops for staff, teachers, and students, it is not possible to determine the isolated effects of the group component.

Pilot Two: Clinical Population

The process of piloting the manual led to adaptation and revisions, based on feedback from project group leaders collected throughout the project. Modifications include flexibility in the timing of delivery of content, development of activities linked to content, and less didactic material covered in each session. The revised manual was then piloted with the clinical population served by the agency.

With respect to timing of content and the nature of the material, leaders expressed frustration when they could not focus on a topic that a group member raised because the topic was assigned to another date in the manual. This critique corresponds to criticism in the literature about the tendency for manualized groups to be prescriptive rather than flexible according to the needs of the particular members. Accordingly, an explicit change to our manual entailed the room for leaders to adjust the timing of certain topics based on the needs of the group and issues raised by members. An example of this is the topic of bullying, which was assigned to be covered in the sixth session in the original manual. Leaders found this topic was often brought up in earlier sessions by members. The manual was then changed

to encourage addressing this topic when it arose rather than holding it off to Session 6.

A second significant concern raised by group leaders was the large amount of didactic material and the limited number of activities offered in the manual through which the material could be communicated. The leaders found it difficult to engage the group members through this amount of material which they felt resembled school work. They also found that the children became restless in groups. This critique corresponds to the concern identified in the literature regarding lack of creativity, lack of attention to group dynamics, and inflexibility often found in manuals. Thus, effort was devoted to finding and developing appropriate activities that addressed the content in a way that engaged the group members and that fostered their active participation. For example, one group leader developed a bingo game about LDs. Another created a passport that used descriptions of specific learning difficulties to represent countries and had members receive stamps representing their specific struggles.

Four groups using the manual have been offered at the agency for its clinical population. The groups were co-led by agency staff members and university students. The agency staff members are experienced in individual, family, and group intervention, and the university students receive training in approaches used at the agency. The staff is accustomed to an unstructured, process-driven approach to group work, which typically consists of discussion and activities that foster socialization and communication (Mishna & Muskat, 2004). Therefore group leaders who did not participate in the school project were oriented to the new approach through participation in a day-long training session in use of the manual, provided by one of the authors (BM).

Historically, staff members have been quite pleased with the traditional approach to agency groups, in which group members are offered a positive social experience and the opportunity to experience mutual aid, which often results in members feeling better about themselves. Staff were not concerned about the fact that groups did not explicitly aim to increase members' understanding and coping with LDs. However, in agency-wide discussions on "best practice" with this population, this was identified as a gap in the group approach.

After using the manualized approach to group, the agency group leaders identified additional concerns with the approach. First, group members in agency groups are generally younger than the age group for which the manual was designed and are generally more active and distractible. Second, agency groups occur after school rather than during school hours, which is when they took place in the school-based project. Members attend agency groups after spending a day in school, and they have difficulty sitting still and absorbing information. The leaders also identified the 1-hour length of the agency groups as too short to effectively deliver the information presented in the manual.

Some leaders found it difficult to deliver the curriculum due to the concerns described above. Some did not want to make their own adaptation to the manual material and adhered quite rigidly to the material, albeit feeling dissatisfied. Others however, who were more supportive of the approach used in the manual, followed the core of the manual while altering activities to meet the developmental needs of their group members.

Some group leaders felt constrained by the structure of the manual and believed that children in groups needed and wanted to come to group to play and interact with others in an unstructured format. Some of these leaders resisted using the didactic material in their groups. However, other leaders appreciated the guidance provided by the manual. Several leaders approached the content quite creatively, for example, developing a "Guess the Learning Disability" game in which members asked questions of one another to discover what was written on pinned descriptions of LDs on their backs. Another leader had members create and videotape commercials in which the members practiced asking for help. Agency group leaders continue to use the manual in their groups and are involved in the process of making changes to the manual, eliminating and reordering some of the content, and creating a wider range of activities that address the content as well as the age and activity level of the group members.

Each agency group comprised six members for a total of 24 members. An evaluation is currently underway, utilizing qualitative and quantitative methods. The Self Advocacy Interview for Students, a 30-minute structured interview that evaluates knowledge of LDs, learning style, resources, accommodations, and communication skills (Brunello-Prudencio, 2001) that was used in the school-based project, is also being used in the agency pilot. Selected participants and parents will be interviewed as well to gain their views of the group experience. Following this, it is expected that there will be further decisions about the use of the manual and potential modifications to it.

PRACTICE PRINCIPLES IN DEVELOPING AND IMPLEMENTING A MANUAL

1. Work collaboratively with practitioners/group leaders: It is essential to obtain practitioners' views from the first conception of manual development, and to listen to and address their concerns. The ultimate objective is to assist practitioners to assume ownership of the group and the development and application of the manual. Even though the decision to utilize a manual may not be the choice of practitioners, it is imperative that their input and knowledge is recognized, appreciated, and taken into account. Practitioner input must be integral in the development of the approach, the crafting of the manual itself, and throughout the operation of the group.

2. Match the manual to the nature of the setting and to the characteristics of particular groups: The manual should take into account the specific culture of the setting, the theoretical approach used in the setting, and physical resources available for groups; for example, the room groups take place in, the time groups are offered, and the ability of members to sit still.
3. The manual should explicitly articulate and pay attention to group process as well as content: Although manuals are often associated with didactic content, it is imperative that manuals also contain information to assist in building, monitoring, and maintaining group process. The extent to which content or process is highlighted will be context dependent.
4. Stress that the leaders' creativity, skills, and knowledge of group work are vital: Encourage leaders to contribute their energy and creativity to enhance the group experience. Clarify that using a manual does not mean (1) throwing out group work knowledge, theories, and skills and (2) is not comparable to following a recipe. It is essential to communicate this throughout development and use of the manual to alleviate the group leaders' understandable resistance and fears.
5. Make it clear whether topics have to be followed sequentially: Although some manuals are constructed to build knowledge and skills from session to session, others contain material that can be covered in any order. Manuals should explain whether the order of presentation is essential and whether all content must be covered to achieve desired objectives.

CONCLUSION

In this article we report on the process of developing a manualized model of group treatment for early adolescents who have LDs, for students in a school-based intervention research project, and for clients in a community agency. Despite reluctance to adding didactic material and structured curriculum, group leaders in the research project and the agency were willing to pilot a new method of group work, which incorporated these components. Paradoxically, though many of the leaders stated that they did not enjoy leading the manualized group, they believed that most of the group members enjoyed and benefited from the experience.

The group leaders' feedback on the manual mirrored much of the criticism described in the literature. They were concerned about the suitability of the manual for a clinical population, the greater attention to content over group dynamics or mutual aid, and the manual's perceived restrictiveness. Similar to concerns expressed by Galinsky and colleagues (2006), group leaders believed incorrectly that inflexible adherence to the manual was essential, which in some cases resulted in the group leaders relinquishing some of their own group skills and creativity. Finally, the group leaders

agreed that they would like to continue using the core of the manual, albeit with modifications.

The development of this manual will likely be a long-term process requiring much fine-tuning and enhancement. However, the end product represents a step toward employing the use of current best practice. This, we believe, is a step in enhancing the quality and effectiveness of group intervention.

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