8 Group therapy for children

Summary

In this chapter we discuss the rationale for group therapy methods. Psychotherapy attempts to ease human problems by psychological methods. Group, as opposed to individual, therapy can be useful in various ways and, for young children, play therapy may also be helpful.

We describe the numerous previous studies of group therapy of various types, but conclude that they were on too small a scale to have properly assessed the problem, which requires a wide spread of measures, an adequate size of sample with comparable control groups, full descriptions of the treatments, and long-term follow-ups.

We discuss the development of our programme, in which six trained social workers held discussion sessions for seventeen groups of four to five same-sex senior children, and play-group sessions for seventeen groups of four to five mixed-sex juniors, within the ordinary school setting. There were ten sessions for each group, over a three-month period. This group therapy gave good results and the outcome was significantly better for all categories of children, with the exception of antisocial and overall behaviour at mid-point for juniors. As far as the main improvement measures were concerned, accounts of favourable changes occurred mostly in teacher and parent reports of behaviour and, for the senior children, in the self-report ratings. The only inconsistency was that the significant improvements found in academic performance of the seniors at the first (eighteen-month) follow-up had disappeared by the final (three-year) follow-up.

Fundamental ideas and assumptions underlying group therapy methods

Every activity in school takes place in the context of human groups. This is true of formal classroom work and also of all other areas of school life. A child's successful adjustment in school will be largely dependent on how well he or she adapts and relates to groups of peers and to the authority structure that is necessary for the education of a large number of children. Indeed, this realization is a theme that runs throughout our book.

In this chapter we focus on one particular aspect of groups: their use as a therapeutic medium. Group treatment has an obvious application in situations where professional time is limited, and there is an analogy here to education, where classroom teaching is more economical than individual tutoring. Also, as every teacher knows, there are ways in which groups, in themselves, can influence the behaviour of children. While clinicians have for many years discussed and explored the therapeutic potential of groups, social psychologists have looked at their qualities in experimental studies. The results of such studies shed light on some preliminary questions.

WHAT IS A GROUP?

There is general agreement that a human group is more than a mere collection of individuals. Freud (1922) believed that of central importance to any group was the existence of a leader, who was a father figure for the group members. Having shared their leader, the group members then recognized their common identification and dependency and the feeling of group identity developed.

Recently, academic social psychologists have attempted a tight and operational definition of the group. For example, Sherif and Sherif defined a group as a 'social unit consisting of a number of individuals who stand in role and status relationships to one another, stabilized in some degree at the time, and who possess a set of values or norms of their own regulating their behaviour, at least in matters of consequence to the group' (Sherif and Sherif 1969:131). Many features of groups are contained in this brief definition and Freud's idea of the leader is broadened to include any role and status relationships. The idea of a sense of group identity is implied in the concept of a social unit, which delineates that some people are inside and some are outside the group. It is this that, on a subjective level, gives a feeling of 'we-ness' to the group. The formation of a group is dependent on the same set of people being involved with one another over a long period. This is sharply different from many role and status relation-

ships, such as doctor-patient, officer-men, which may be transient ones with no continuing interaction over time between individual people.

The above qualities of groups in general can be turned to good effect in therapeutic groups. The therapy group becomes a microcosm of other social group situations and is thus a vehicle for the full range of potential in social relationships, including those maladaptive mechanisms that may have a bearing on the patients' problems. Many theorists have attempted to develop a model of group functioning that would have relevance to the therapeutic process. One sensitive example was that of Whitaker and Lieberman (1965). These authors considered that the behaviour of patients in therapy groups is governed by a balance of emotional forces. On the one hand there are those individual needs and concerns that, in their expression, carry the danger of disrupting group function – the 'disturbing motives'. Examples of disturbing motives might be a wish to have the therapist for oneself or angry feelings about other group members. The introduction of a disturbing motive generates destructive forces and anxiety in the group and this in turn influences the behaviour of members, encouraging them to cope and compensate – the 'reactive motives'. The balance of disturbing and reactive motives leads to a group solution to the problem. The solution may be helpful to the therapeutic effort – an 'enabling solution' – or one that stunts development – a 'restrictive solution'. The therapist's task is to understand this interplay of forces, which is in constant flux through the life of the group. We found this set of ideas useful in understanding adolescent groups.

One of the most sensitive writers on groups (Yalom 1975) outlined eleven ways in which they may be therapeutic. It is worth reviewing these in terms of their application in group therapy with children.

(i) *Instillation of hope.* This is a most important principle which applies to all forms of therapy, not just groups. It is very important in the case of children to give a feeling of hope and optimism, not only to the child but also to the key figures in his or her environment, such as the parents and teachers. A particular advantage of group treatment is that the children are able to see their peers at various stages of improvement in their difficulties.

(ii) *Universality.* Children have a great need to 'belong'; it is particularly helpful if, through group treatment, they can observe that their peers have problems they thought they alone had to suffer.

(iii) *Imparting of information.* Education traditionally concentrates on

the cognitive aspects of child development. There is movement, reflected in the American literature (Jones 1972; Catterall and Gadza 1977; Gadza 1978), towards including a component of understanding of self and feelings in school work.

(iv) *Altruism*. It is often forgotten that human beings like to give as much as to take and this may emerge in the group situation. For example, a very disruptive and disturbed seven-year-old came to one of our playgroups one day, very upset because his father had just been sent to prison. One of the girls in the group spent the rest of the day with him and was able to give considerable comfort. This was a mutually beneficial experience.

(v) *Recapitulation of the primary family group*. Experience with families soon teaches us that children's techniques, often maladaptive, of coping with strong effects are moulded by patterns learnt in their own family. The group experience provides an opportunity to examine and correct these maladaptive patterns.

(vi) *Development of socializing techniques*. Group treatment allows opportunities for children to learn social skills, such as turn-taking, delaying gratification, persuasion, and so on. This may be particularly true of play and activity groups.

(vii) *Imitation*. In group treatment children have a chance to observe and model themselves on their peers. Some studies have capitalized on this by setting up groups where modelling is systematically encouraged (e.g. Hansen, Niland, and Zani 1969).

(viii) *Interpersonal learning*. This is a most important aspect of all group therapy, in which the therapist uses the interpersonal encounters of the children to deepen their understanding of their own feelings and their relationship to others. This is likely to be the main aim of any dynamic group technique.

(ix) *Group cohesiveness*. This is a very central concept in social psychology; it simply means the mutual attraction of members of a group for each other. Research on small group functioning has uncovered many ways in which individuals in small groups are affected by the level of cohesiveness of the group. These were summarized by Goldstein and Simonson (1971) and included eleven items of the greatest relevance to psychotherapists: for example, members of cohesive groups are more open to influences from other group members, they place greater value on group goals and are more accepting of other members' hostility than are members of less cohesive groups. Ginott (1961) claimed that group cohesiveness was of little importance with young children. However, as we show later in this chapter, it may be of much more importance in adolescent groups.

(x) *Catharsis.* This is an important principle, particularly in play-groups where children are permitted to discharge affect within overall limits. Sometimes aggressive impulses have to be channelled, as when a child's attack on a peer is diverted to a punch ball or drum.

(xi) *Existential factors.* Under this heading Yalom listed a number of issues that confront us all, adults and children alike. Some of these are particularly relevant to children; these are: (a) recognizing that life is at times unfair and unjust; (b) recognizing that there is ultimately no escape from some of life's pain; and (c) learning that people must ultimately take responsibility for the way they live their own lives, no matter how much guidance and support they get from others.

This last issue is, *par excellence*, the problem of adolescence – the stage when responsibility for one's own life becomes a key issue (Erikson 1950).

A group discussion may help members to become aware of these problems of living.

WHAT ARE PSYCHOTHERAPY AND COUNSELLING?

In a survey of the literature on this topic Nicol (1979) concluded that psychotherapy can be characterized by two main features. First, it involves a special confidential relationship deliberately and freely entered into by therapist and client, or clients, with the aim of helping with a problem. The nature of the problem and the approach should be agreed between them in advance, if only in a general way. The second feature is that the proceedings of psychotherapy should be guided by some form of psychological theory. The main ones that have been used are psychoanalytic and related theories, behaviourist theories, derivatives of existentialist ideas, and, finally, didactic-rationale theories (Patterson 1973).

The therapist's and client's understanding and agreement about the nature of therapy is commonly called the treatment alliance (Sandler, Holder, and Dare 1970). This concept may not hold true for children and young adolescents because in such cases the patient has usually been brought to treatment by someone else. Nevertheless, those responsible for the child should have an understanding of the nature of the treatment and, except in the case of the very young, the child itself should have some age-appropriate comprehension that treatment is taking place. In the area of educationally based therapy the nature of the treatment alliance needs careful thought, as we shall see later in this chapter.

WHAT IS PLAY?

Play is not a necessary component of child psychotherapy but, like groups, it incorporates phenomena that have often been turned to therapeutic account. Many authors baulk at defining the seemingly heterogeneous group of activities that are usually considered as play, and some, such as Berlyne (1969), think that the term should be dropped from scientific discourse. Garvey (1977), though, has suggested some criteria by which play can be differentiated from children's other activities. For example, play is intrinsically pleasurable, is undertaken spontaneously and voluntarily by the child, and demands his or her entire engagement. It has no intrinsic goals and constitutes an enjoyment of means rather than effort devoted to some particular end. Again, play has certain systematic relations to what is not play. These defining features, while not providing a watertight definition, do suggest ways in which play may be used for psychotherapy, for example, by channelling the arousal of interest and involvement and, perhaps most important, by determining its relation to non-play. This last point merits particularly close examination and we must now attempt to put play into the context of the developing child.

Piaget (1951), in a major work on the subject, attempted a classification of different types of play. He dismissed mere content as being an unsatisfactory basis on which to classify play – for example, both a one-year-old child and a seven-year-old may play with marbles: the former is likely to be exploring the properties of the balls and the effect he or she may have on them by moving them about, whereas the older child is likely to be involved in social, rule-bound games with the marbles. It is the contrast between the more immature sensori-motor behaviour and the rule-bound game that Piaget saw as the important differentiating feature. He recognized three major stages in the development of play, each with a number of finer gradations. The most important of these from our point of view was the second stage: symbolic and representational play. Except at its simplest level, this type of play is unique to humans. It consists of 'make-believe', 'fantasy', and 'sociodramatic' play. It first becomes manifest in the second year of life and is of the greatest importance with regard to the therapeutic potential of play.

How can we use play in psychotherapy? Basically in two separate ways: first, for its potential in facilitating communication between the patient and the therapist and, second, as a means of bringing about beneficial behaviour change.

We will first talk about the potential of play for facilitating communication as in our short-term treatment regime this was its most

important function. In young children the observation of play may reveal the feelings they are struggling with and give clues as to how they are coping with them. There are different opinions in the various schools of psychotherapy as to the use of play in the therapy process (Bentovim 1977). One group of techniques, including activity group therapy (Slavson and Schiffer 1975) and client-centred approaches (Axline 1947a), considers that play or activities in themselves have an important function and that the task of the therapist is to provide conditions within which the child can use the play materials to promote self-discovery and learn to cope with strong and potentially dangerous feelings. This technique is well illustrated by the examples of Conn (1939).

At the opposite extreme the psychoanalytic school of Klein (1928) considers play to be of use purely as a means of access to the child's unconscious thoughts and feelings. Winnicott (1971) also saw play as closely linked with the child's inner reality. The theme of psychotherapy as, basically, an act of communication, whether with self, with therapist, or between both, is an important one, and one of the main ways in which 'dynamic' forms of psychotherapy can be distinguished from those therapies aimed directly at changes in behaviour or attitudes. Rycroft (1966) considered psychoanalysis to be a communicative activity. He argued that this view resolved all the difficulties about the status of psychoanalysis: the means of communication are through such channels as dreams, mistakes, actions, free association, non-verbal material, and play. Anyone who has observed or participated in psychotherapy must have sympathy with this viewpoint. In our regime the function of play as a means of communication was particularly important.

There are many ways in which play may have an important developmental function. A brief review of these will show ways in which play may come to the aid of psychotherapy. One theory is that play allows the child to rehearse bits of behaviour and perfect these without damaging consequences. For example, a little girl can make a 'pretend' cup of tea and pour it into the cups without the danger of pouring scalding water over her hands. Reynolds (1972), from his studies of rhesus monkeys, has suggested that play can be considered in this way. He pointed out that few behaviour patterns occur only in play and also that few occur in 'real life' that are not reflected in some way in play: the difference is that the play sequences are divorced from their consequences (e.g. damage to another in aggressive play or impregnation in sexual play).

Play is a very sociable phenomenon – maybe this is because human beings are in all ways a very sociable species. Even isolated play often

includes an imaginary companion (Newson and Newson 1976) or revolves around social themes. A considerable amount of work has appeared recently concerning play and social behaviour in young children. Social play has traditionally been described along one dimension, ranging from unoccupied behaviour through solitary play, onlooker behaviour, parallel play, and associative play to co-operative play. This sequence of behaviour is supposedly related to increasing maturation (Parten 1933; Smith and Connelly, 1972); however, more recent evidence (Roper and Hinde 1978) has suggested that solitary play may be a sign of maturity as well as immaturity. The suggestion was that individual differences in social play are consistent over quite long periods (Rose, Blank, and Spalter 1975; Roper and Hinde 1978), although there is less consensus about whether the behaviour of individuals is consistent from one situation to another (Kohn and Rossman 1972; Rose, Blank, and Spalter 1975; Roper and Hinde 1978). These findings illustrated the complexity of social play, and suggested ways in which the analysis of social relationships in the small group play setting could help the therapist to understand the idiosyncracies and needs of the individual child.

Another important function of play is as a component of learning: this is certainly relevant to the learning of instrumental tasks, as Kohler (1925) showed many years ago, and also probably to learning how to cope with feelings and relationships.

Sylva (1977) carried out experiments with young children which illustrated the function of play in the learning of instrumental tasks. Children of various ages sat at a table and were given sticks and clamps. They had to use these to retrieve a small prize from a box. There were three experimental groups: in the first, the children were allowed to play with the implements; in the second, they watched a demonstration by the adult; and, in the third, they had little prior acquaintance with the problem. The results of the experiment suggested that the children who had been allowed the play period approached the problem on a far more flexible and exploratory way and were less liable to 'opt out' than were the children in the other groups. These experiments illustrated well the way in which play may influence children's subsequent problem solving behaviour.

The part of play in the emotional organization and development of the child has received a great deal of attention in clinical studies by psychoanalysts and other psychotherapists. The original Freudian notion was that play and fantasy originate in the context of deprivation of immediate gratification (Freud 1911). Under these conditions, the infant 'hallucinates' the object of his or her instinctual need. This forms the basis of thought, play, and, subsequently, ego develop-

ment. Anna Freud (1936), who was one of the pioneers of child psychoanalysis, was very sensitive to the special difficulties of applying psychoanalytic techniques with young children. The main problem is that children cannot easily be induced to lie on a couch and give free rein to their fantasies, so that the mainstay of analysis with adults is not available. Anna Freud pointed out that unconscious conflicts can be understood not only by uncovering them, but by understanding the ways in which their painful effects are kept out of consciousness. These constitute the 'ego defence mechanisms'. The importance of play and make-believe is that by observing and understanding it, we can see how the child attempts to cope with painful conflicts.

Freud's original notion of fantasy and play as responses to deprivation was at most a partial explanation. Their functions are, as indicated in Sylva's experiments on problem solving, far more important. Erikson (1950) gave play a central place in his theorizing. He saw the development of the ego identity as a synthesis of the personal experience of the developing child, cultural pressures, and training. Play becomes an essential mediator in this process in that it enables the child to rehearse and experiment with his or her responses in the relatively safe world of make-believe. The importance that this may have was illustrated in a study by Biblow (1973). This author submitted groups of high and low 'fantasy prone' children to a frustration task and then measured their aggressive behaviour and mood changes in a play situation. The low fantasy children showed higher overt aggression and aggressive mood than did high fantasy children or control groups. If fantasy and aspects of imaginative play are parts of the same phenomenon then further research on play and the regulation of behaviour and affect could be extremely fruitful.

The importance of play in developing problem solving and social skills has become an article of faith among many child-centred educationalists. This has led to a number of experiments that have sought to enhance imaginative play by different training methods (Marshall and Hahn 1967; Smilansky 1968; Freyberg 1973). While showing that under the right circumstances training is effective in increasing children's predisposition to imaginative play, none of the studies has looked at whether or not this has an enduring effect on skill development.

To summarize this discussion of some of the important ideas and assumptions underlying group therapy methods, group, as opposed to individual, therapy can further psychotherapy in a variety of ways, and play, particularly its communicative function, may also do so

where young children are concerned, in either a group or an individual setting. In the present study we had to keep these principles in mind in designing our treatment regime.

Previous studies that evaluated outcome

In this section we report and analyse a group of previous research studies (see list at end of chapter) designed to evaluate the helpfulness of psychotherapy techniques with school problems. We found sixty studies that seemed broadly relevant and fulfilled the minimal requirement of comparing a treatment sample with a control sample. All the studies reviewed were concerned with children's problems as manifested at school, and all the subjects reported were of normal or borderline subnormal intelligence. We excluded those that evaluated the effectiveness of group therapy on essentially normal populations of children in reference to such universal problems as improved studying techniques or career choice. The majority of the studies come from the USA.

The reports varied widely in their presentation and in some cases were available only in summary form or in a review (Abramowitz 1976; Henry and Kilmann 1979). The samples of children within the studies were in most cases within a year or two of the same age, but a wide age range (seven to eighteen years of age) was covered in the various studies overall. We included a small number of studies of individual therapy where these focused centrally on school problems or employed a non-directive technique (Dorfman 1958; Winn 1962; Lawrence 1973). Some of the studies incorporated behaviour modification principles within a group context (Clement and Milne 1967; Hansen, Niland, and Zani 1969; Hinds and Roehike 1970; Hubbert 1970; Warner and Hansen 1970; Kelly and Mathews 1971; Abraham 1972; Randolph and Hardage 1973). Unfortunately, many of the studies were based on such small numbers as to be dubious on this ground alone.

In most of the studies the subjects were allocated to treatment and control samples either at random or by a matching process. In three the various comparison groups were in different schools (a between-schools design) and in one the more severe cases tended to be allocated to the treatment rather than the control group. These designs were unsatisfactory. In particular, the between-school situation did not allow for the fact that it was well known that children's development is quite markedly influenced by factors in the environment of the school they attend, independent of any specific treatment they may receive.

The studies can be fairly clearly classified according to the aspect of functioning that they sought to modify. The largest group of studies (twenty-five) was aimed mainly at improvement in academic performance. The rationale of this was that the retarded reader is in such constant difficulties in class that he or she feels 'labelled' and loses enthusiasm for work. Clearly, more and more attempts at remedial reading are likely to be self-defeating in this situation; this is why investigators have turned to less direct approaches, such as group therapy.

Children for these studies were selected in various ways. In some the criterion was attendance at a special remedial reading class, while in others teachers were simply asked to refer those children they felt needed special help. More objective screening methods, such as simple reading tests or more complex assessments such as 'under-achievement' were also sometimes used. The rationale underlying 'under-achievement' is that children of high ability should also show high attainment. Unfortunately, the authors of the various studies did not seem aware of the theoretical and statistical problems associated with the concept of 'under-achievement' (Thorndike 1963).

In view of these potential faults in design, and the generally gloomy prognostications about the effectiveness of psychotherapy (detailed with destructive panache by Levitt 1971 and Shepherd, Oppenheim, and Mitchell 1971), it is interesting that sixteen of the twenty-five studies that tackled educational problems gave a positive result. Overall, the group of twenty-five studies varied in many ways. The average size of treatment samples was twenty-seven subjects; however, the range was from six subjects in the two smallest studies to ninety in the largest one. Some of the studies reported results on incredibly small samples, for example Fisher (1953) reported positive gains in reading with six children, whereas the study with the largest sample, comprising many small groups of children (Ewing and Gilbert 1967), came to negative conclusions.

The most commonly reported positive result in the attainment studies was a gain in 'grade point average'. This is a composite continuous assessment score that is part of normal school routine. While this type of measure may have advantages, it is necessary to have some estimate of its reliability and to be sure that the assessment was not contaminated by knowledge of the fact that the child was taking part in a special treatment project. As this was not commented on in any of the studies, the results must remain in doubt. In only seven of the studies was there a significant change in more formal measures of attainment, such as a reading test (Fisher 1953; Shouksmith and Taylor 1964; Deskin 1968; Vriend 1969; Moulin 1970; Barcai *et al.* 1973;

Lawrence 1973). In some studies there was no formal attainment testing; it was therefore impossible to tell whether the results were positive or negative.

The studies also varied in the type of therapy that was offered. Description of the therapy process is one of the most difficult aspects of psychotherapy research: for example, Lieberman, Yalom, and Miles (1973) found little relationship between the professed type of therapy, in encounter groups, and the results of objective observations. Many of the studies gave scant details of the therapy process beyond a label such as 'non-directive' or 'didactic'. Summarizing from within these severe limitations, there seems to have been a slight tendency for the more successful treatments to have been focused on solving academic issues, thus emphasizing the more 'didactic' aspect of group therapy described earlier in this chapter.

Twelve studies were aimed primarily at improving the children's peer relationships. In all but one of these, the children were selected for study by a sociometry instrument. Each child chosen by this means was selected because he or she had few friends rather than because they were unpopular with other children. Five of the twelve studies reviewed showed an improvement in sociometry scores (Kranzler *et al.* 1966; Schiffer 1966; Hansen, Niland, and Zani 1969; Bevins 1970; Thombs and Muro 1973). Another study in this group showed changes on a self-concept test (House 1971), although the children were selected by low scores on sociometry.

As with the studies based on improving academic performance, the peer relationship studies varied enormously among themselves. The size of the treatment groups ranged from eight to forty-five subjects; some of the smallest-scale studies gave positive results. One ingenious study (Hansen, Niland, and Zani 1969) used a structured modelling approach where underchosen children (i.e. children least selected by others as close friends) were mixed in groups with very popular children (so-called sociometric stars). This was one of the studies that yielded a clear, positive result; there were others that reported success using more conventional, non-directive approaches.

In the next group, of eight studies, the main problem was teacher reports of bad behaviour. Some of these studies were, as one might expect, based on behaviour modification principles, but not all of these were successful in generalizing better behaviour to the classroom. (The successful behaviour modification studies were those of Hinds and Roehike (1970) and Randolph and Hardage (1973).) Other studies were successful using group therapy (Barcai and Robinson 1969; Hubbert 1970) and indirect consultation approaches (Taylor

and Hoedt 1974). Again, there were major variations in the sizes of subject samples.

Six studies centred on other aspects of adjustment. All but one of these showed some positive result, although the sample sizes were in all cases very small indeed, the largest treatment group being a mere twelve subjects. The presence of positive results may be due to the fact that in this group of studies more outcome measures were made than in the other groups so far discussed.

The final homogeneous group of six studies focused on improving children's self-concepts. This seems to be a useful area for group methods with four of the six studies yielding positive results (Dorfman 1958; Hume 1967; Mann, Barber, and Jacobson 1969; Hugo 1970). There were also four positive results from other studies: three of the studies of academic performance showed some changes in personal adjustment or self concept (Baymur and Patterson 1960; Broedel *et al.* 1960; Winn 1962) and, as mentioned above, one of the studies of peer relationships gave a positive result (House 1971).

Finally, four studies do not fit easily into the above classification. The first was a study by Persons (1966) of group and individual therapy among delinquents. This was successful in lowering the conviction rate among institutionalized delinquents. Irwin, Levy, and Shapiro (1972) compared children treated with psychodrama and activity therapy with a control group. The treatment groups were very small, only five subjects in each, but the authors claimed positive results. Tolor (1970) carried out a wide-ranging study based on clinic referrals, comparing combinations of individual and group therapy approaches applied to different ages of children. The results showed mixed changes of self-concept and teacher reports. The final study, by Crow (1971), was available only in a secondary report (Abramowitz 1976); it is reputed to have shown gains in self-report and sociometry in a sample given group therapy.

Having briefly surveyed the individual studies we can make some general comments on their standards and methodologies.

The first striking point was that although most of the studies took place in school there was, with one exception (Barcai *et al.* 1973), no mention of the general climate or staff relationships in the schools concerned, nor, for that matter, of whether or not the therapists had any contact with the staff at all. We have discussed the special characteristics of school psychotherapy elsewhere (Nicol 1979).

A second, very serious problem with many of the studies was that they were based on numbers too small to make group comparisons reasonable.

The types of statistical analyses used in the studies also require

some comment. While in most there was some form of group comparison by analysis of variance, there was no consensus on the correct way to proceed. Some studies, for example, compared change scores between measures taken before and after therapy. Others relied on comparison of levels at follow-up, having checked that there were no significant differences at baseline. None of the studies made adequate allowance for the effect of initial level on rate of change. As explained in Chapter 3, this is necessary because statistical considerations dictate that change is greater if the initial level is more extreme.

Finally, only two of the studies (Mezzano 1968; Warner 1971) had any kind of follow-up measures, apart from the immediate post-treatment ones. As we show in the present study, long-term follow-up measures are essential in order to study the effects of psychotherapy adequately. It is interesting that both the above studies showed gains at follow-up.

To sum up, there have been many previous studies of group therapy of various types. The drawback is that they are on far too small a scale to do justice to the problem, which requires a wide spread of measures, an adequate size of sample with comparable control groups, adequate descriptions of the treatments, and long-term follow-ups (Wright, Moelis, and Pollack 1976). Despite this criticism, in view of the limited nature of such studies and, in many cases, the encouraging results, the gloomy commentaries of Levitt (1971) and Shepherd, Oppenheim, and Mitchell (1971) seem unwarranted.

The development of the Newcastle upon Tyne playgroup and group therapy programmes

Our programmes for both junior and senior children were based on the same philosophy, that developed by Carl Rogers (Rogers 1959; Hall and Lindzey 1970), but both differed considerably in detail. We have fully described the setting-up of the groups in previous publications (Nicol and Bell 1975; Nicol and Parker 1981; Parker and Nicol 1981). The therapists were the same six social workers who took part in the parent counselling-teacher consultation programme (see Chapter 7).

THE JUNIOR PLAYGROUPS

In adapting the group therapy technique to younger children we were greatly influenced by the excellent account of Virginia Axline (1947a). It is not possible to summarize Axline's book here, but we should point out that one of its strengths is its provision of a clear set of eight principles that can be followed in practical play therapy. These are: that the therapist must develop a warm, friendly relationship with the

child, must accept the child exactly as he or she is, must develop a feeling of permissiveness in the relationship, must be alert to the expression of feelings in the child, must maintain a deep respect for the child's ability to solve his or her own problems, must not attempt to direct the child's actions or conversation in any manner, must not hurry the therapy along, and must establish only those limitations that are necessary to anchor the therapy in the real world.

The technique allows the play to speak for itself, and the children to work on their problems unhurried by therapist interventions. At the same time, while the children may be sensitive to all their feelings and may express them verbally, they are not necessarily allowed to act as they please. In this connection we found both Axline's (1947a) and Ginott's (1961) accounts of limit-setting to be very important. The setting of a minimal number of necessary limits both allowed the groups to function in the difficult environment of the school and also seemed important in strengthening the ego controls of the more impulsive children.

Ginott emphasized that group cohesiveness and, hence, many of the phenomena that are so important in adult groups do not occur in those of young children. However, Axline's principles were complicated by the presence of other children. The therapist must be careful to establish contact with all the children in the group.

Every session ran for one lesson period (forty minutes to one hour), and each group consisted of four to five boys and girls. Each group had ten sessions within a single school term. There was a total of seventeen groups in the six junior schools in the study, so that two or three groups were running in each of the schools during the same term.

THE SENIOR GROUP THERAPY

There were seventeen discussion groups, consisting of four or five children of the same sex. Ten sessions for each group ran for one lesson period each (thirty to sixty minutes) over one school term. The focus of discussion was always on the 'here-and-now' interaction in the group and the therapist did not direct the discussion in any way. This was in keeping with the method of Rogers (1952), where the therapist's task is to discover how the world looks through the client's eyes. The emphasis on the group *as* a group was reflected in the physical arrangement of chairs in a circle. The somewhat greater maturity of the children meant that there was more opportunity for cohesiveness to develop in the senior groups than in the junior ones.

Other methods of group work were considered in developing the programme but in the event they were rejected. One that was considered particularly carefully was activity group therapy (Forward

1965; Jeffrey 1973; Slavson and Schiffer 1975; MacLennan 1977). We decided not to use this therapy because it did not suit the skills of the social workers, and required specialized accommodation and equipment. In addition, it is commonly considered to be a longer-term treatment, incorporating a large educational-cum-developmental component that, we hoped, could be provided in the ordinary classroom.

The more traditional approaches to activity therapy advocate great freedom and lack of limits, but this tends to lead to great difficulties in school, as some of the accounts have suggested (Schiffer 1971; MacLennan 1977).

THE TRAINING PROGRAMME

A key issue in any type of intervention is not only its quantity and type but, perhaps most important, its quality. The techniques employed in the present programme, while not as highly specialized as some psychoanalytical types of psychotherapy, required considerable levels of sophistication, maturity, and experience on the part of the therapists. Group work with well-motivated adults involves special problems, such as the complicated phenomena of group dynamics, that are not present in individual therapy. To this must be added the particular requirements of child management, the fact that the clients were poorly motivated, indeed, in some cases had no subjective distress at all, and the fact that the project was located in school, an institution which had different goals and methods than those envisaged for the groups.

As described in Chapter 7, the therapists were well-trained and, in most cases, experienced social workers, which meant that they had a grounding in the client-centred approach (Rogers 1952). Some had even previously run adolescent groups in different settings. The problem was to train the therapists to a uniform technique of reasonable standard, with, needless to say, limited resources. To this end each therapist started by taking clinic children for individual treatment. They had experience with two to five children in this way for a period of up to one year. In addition, as a pilot group experience, for ten sessions each therapist took both a playgroup and a senior therapy group in schools separate from those involved in the main treatment programme. During this period, training sessions were arranged with a psychotherapist who had experience of child psychotherapy. The psychotherapist also attended sensitivity groups. These consisted of groups of trainee therapists in the role of group members. Their purpose was to provide an opportunity for the trainees to gain insight into their own feelings and responses, the effect they have on others,

and the functioning of groups through a personal experience. This self-knowledge is essential if a psychotherapist is going to do his or her job properly. There were also opportunities to consult the child psychiatrist who was supervizing the project.

During the treatment programme itself, each therapist was allotted a half- to one-hour personal supervision session per week with the child psychiatrist and there was an opportunity each week to take special problems to the psychotherapist. During the latter part of the programme the therapists ceased to feel the need for such close supervision, but regular weekly sessions for individuals or in small groups continued.

This training should not be considered to have constituted a thorough grounding in psychotherapy. On the other hand, if such workers prove helpful to children, it does mean that there is a realistic basis for the introduction of such trained personnel on a wider basis. The point that needs greatest emphasis is that the therapists had continued supervision and access to skilled back-up resources. We could not envisage such work being undertaken by isolated workers in the school.

COMPOSITION OF THE GROUPS

The different circumstances of the children in the two age groups led to rather diverse criteria being adopted in constituting the groups. First, there was a general consensus in the literature that sexual anxieties among twelve-year-olds are likely to severely inhibit interaction if their groups are of mixed sex. The groups at this age level were, therefore, constituted on a single-sex basis. Among the seven- to eight-year-olds the groups were all mixed-sex. The literature also, in general, advocated a mixture of problems in any one group. The complexities of school timetables made it impossible to achieve this criterion among the senior groups and they had to be taken on a class-by-class basis. Among the junior groups, problems were mixed so that they comprised, as far as possible, a selection of conduct, neurotic, and educational problems. It should be stressed that the children were allocated to groups by the programme organizer, so that the therapists remained ignorant of the 'objective' assessments of the children's problems.

JUNIOR GROUPS – THE SELECTION OF TOYS

As Ginott (1961) pointed out, there is little consensus on the correct equipment of a therapeutic playroom, although many therapists have dogmatic opinions. In looking for general principles to guide us, we were impressed by Schiffer's (1971) concept of *valence* as the potential

of a toy for facilitating communication. Thus, a family of doll figures is likely to have high valence and a game of draughts low valence (the latter being likely to allow a child to conceal his or her thoughts or feelings rather than to express them).

We were aware that our programme was brief and that we should therefore concentrate on the psychotherapeutic aspects of play (i.e. its potential to build relationships, its diagnostic function, its potential to promote interaction and communication and to facilitate insight and change, and the opportunity it creates for experimentation with social roles) rather than on its more general developmental function, such as the promotion of creativity and the attainment of skills.

It was important to have a range of equipment that allowed the children to function at different developmental levels (Jeffrey 1973). With this in mind we used the following materials (Schiffer's classification (1971) modified):

A. Objects representing significant persons and animals
   - miniature dolls' family and furniture
   - simple, dressable baby doll
   - glove puppets

B. Objects identifiable with significant persons
   - old clothes for dressing up

C. Plastic media with variable valence
   - plasticine
   - paper and crayons

D. Materials to enhance social play
   - toy soldiers
   - toy cars
   - toy telephone

This classification was necessarily a loose one: each of these materials could be used – and misused – in a multitude of ways. We would emphasize that no materials designed primarily to enhance craft or manipulative skills were provided, and there were no competitive games.

Accommodation

Schiffer (1971) described the ideal playroom for therapeutic purposes as being soundproof, breakproof, free from interruption, and situated at a distance from the ordinary classroom. The range of accommodation in the present study fell far short of this and was as follows:

(i) a cloakroom, with the inevitable interruption of children passing through on their way to the lavatories;

(ii) an empty classroom with desks, other children's work, and the classroom atmosphere;

(iii) a hall in which were housed percussion and other musical instruments that the children were forbidden to touch;
(iv) a school secretary's office, complete with typewriter, books, and out-of-bounds medical scales;
(v) the large hall of a nearby comprehensive school – a difficult environment, as limits had to be set on the children moving out of a marked-off corner of the room, where it was found necessary to invoke prohibition frequently and where little provision was made for the relaxed and permissive atmosphere that the treatment aimed to achieve;
(vi) a room in the Maternal and Child Welfare Clinic across the road.

Each of these environments had disadvantages and increased therapeutic difficulties. The school staff were, in every case, most helpful and offered the best accommodation available. There was no reason to think that better accommodation would be available, on average, in other schools in the UK.

The accommodation in the senior groups posed less of a problem than that in the junior schools. Two of the leaders had to take groups in large, empty classrooms, with the accompanying temptations for the children to run about and draw on the blackboards; however, the other groups were accommodated in appropriately sized rooms.

PREPARATION OF CHILDREN FOR THE GROUPS

A series of studies in adults has shown that preparation may have an effect on the subsequent process and, possibly, outcome of therapy. Some studies found effects on the frequency and type of statements made in therapy (Yalom and Rand 1967; Heitler 1973). Two have focused on outcome of therapy as well as process; thus, Hoehn-Saric *et al.* (1964) showed differences between prepared patients and controls, not only in a number of process measures, including rate of attendance at the group, but also in therapist and self-ratings outcomes. Sloane *et al.* (1970) attempted to disentangle the effects of information about therapy from expectation of success of therapy. They found that the information group showed a reduction of target symptoms. However, this study is difficult to assess because, for example, 50 per cent of the patients had received previous treatment. Holmes and Urie (1975) carried out a study in which eighty-eight children were randomly allocated to a preparation interview or a control group before therapy. It was found that the prepared group showed a better understanding of therapy, and also that there was better attendance among them in comparison with the controls; however, there was no difference in outcome between the two groups. The results of preparation, although

rather inconsistent, have suggested that this is an aspect of therapy that deserves our attention.

The present study posed different problems from that of Holmes and Urie and whereas those authors focused on target symptoms in their role-induction interview, we followed the logic of Rogers's method. This meant that our therapists did not know any details of the children's problems, as such knowledge might have prevented them from participating in the authentic person-to-person encounter so essential to Rogers' approach. The fact that the project was located in the school also meant that care had to be taken not to put the children in a situation in which they would appear 'sick' or special in any way.

The social workers who undertook the project were already familiar with the schools where they were to work. Some months before the programme was due to start they began to talk to the teachers about the work that was to come. This was aimed at allowing the teachers, particularly those with pastoral responsibilities, to talk to the children about the groups. Teachers took different lines with the two age ranges. With the seniors, it was stated that there would be discussion groups in which the children would have a chance to say whatever they wanted. With the juniors, it was stated that there would be a special lesson where the children would be free to play with some toys. In two instances the social workers felt that a more definite introduction was necessary for the children and in these cases, the project leader visited the school and addressed the children as a group, repeating the teachers' message. In the event, there was no evidence that this extra input was particularly helpful.

Confidentiality and relationships with school staff

The problem of confidentiality was one that concerned us in preliminary discussions, particularly in the senior groups. Most of the groups at some time raised the topic and the following example illustrates its importance to the children:

> As part of the programme of assessment the parents of each child were visited by a research interviewer who obtained information about the child's social background. On one occasion such a visit to a boy's home took place after the group meetings had started. The group had already met for two sessions and the therapist had reported that the boys seemed glad to discuss their problems openly without fear of 'comeback'. However, the boy concerned was very upset by the visit and took it to mean that the therapist had talked about what went on in the group. He continued to attend the group but remained distrustful and for the next three sessions contributed little to the group. After this he began to relax again.

With this sort of problem in mind, it was decided that all the groups should be strictly confidential and that the therapists should not see themselves as providing a bridge between children and teachers, but more as a sounding board for the children, as outlined by Rogerian principles. On the other hand, it was clearly nonsense to have no contact with staff and it was therefore decided that the therapists would make appointments to meet them, to talk about the children's problems. At the beginning of contact with staff, it was pointed out that because it was necessary to group members' security (and to the senior children's in particular), confidentiality would be observed and nothing would be passed on without the permission of the child. Therapist-teacher discussion therefore centred rather on the child and his or her problems than on the content of the group. It was hoped that each discussion would allay any anxieties or antagonisms that might occur, increase insight, and offer suggestions as to the handling and management of the children.

In the senior groups there were large numbers of staff teaching any one child. It was therefore felt that each therapist should make the decision about which staff to work with and that the decision should be made according to the organization of the school. Pastoral staff were most often involved, and, occasionally, other staff members who were particularly interested joined in discussions.

In the junior groups the problems of therapist-teacher relationships were simpler, as there was only one teacher to contact for each class. However, there was the problem of noise in the groups, and the difficulty in explaining to teachers that the therapists' permissiveness was a valuable part of therapy, not just a 'free-for-all'. Again, each therapist was left to organize contact in their own school and this varied according to the therapist and willingness of staff, but normally consisted of a weekly meeting.

A further problem of which we were aware was the possibility of attempts by the children to get the therapist to side with them against staff and school rules. Children in the senior groups *did* attempt this on occasions, for example by attempting to smoke during sessions. The form of the therapy, though, with its prescribed and clear limits, meant that this behaviour did not in fact present a problem but provided a further opportunity to encourage the children to understand their feelings and motivations.

The setting of limits

An important aspect of planning was to reach agreement on what constituted acceptable behaviour in the group, so that the six therapists were able to set limits on certain types of conduct. The actual situations encountered in therapy were so varied and unique that detailed planning of limits in advance would have been of little value. However, there was general agreement on guidelines for forbidden behaviour, as follows:

(i) any infringement of the general school rules, such as smoking, climbing out of windows, damaging school property, and so forth;
(ii) any behaviour that seriously disrupted group interaction, such as wandering about or leaving the room;
(iii) any overt physical aggression shown either to other children or to the therapist.

The limits were not outlined to the children in advance, as this would have led to a negative atmosphere and suggested to them that the therapist was expecting trouble. Instead, they were made clear to the children as the situation demanded.

THE PROCESS OF THERAPY – JUNIORS

The therapist coded the child's behaviour (see Parker and Nicol 1981); a child was rated positive on any of the scales of behaviour if he or she demonstrated this behaviour during the playgroup session. The proportions (expressed as a percentage) of the children demonstrating the behaviour in any session, over all seventeen groups, were examined. The following comments on these results and reports on the types of behaviour, as set down in the therapists' descriptive accounts.

Absenteeism

The small increase in the number of absentees, as in the senior groups, was probably attributable to the fact that the sessions took place in the summer term. Towards the end of this term it is usual for children to be away on school trips or on family holidays.

Aggression

Aggression tended to increase during the course of the playgroups. Examination of the written accounts suggested that it covered a number of situations. In some groups one particular child seemed to need to retain control of the group in an omnipotent and domineering way and would challenge all comers – sometimes including the therapist – who threatened this. In other cases aggression was no

more than enjoyable horse-play, but in others horse-play rapidly escalated into group excitement and frayed tempers. In some cases the behaviour labelled 'aggressive' came at the end of a chain of interactions that was more subtly enticing or provocative. Boy-girl conflict was a feature of some groups. In some cases more disturbed children seemed only to bring their inner turmoil and rage to the group. In the last sessions the therapists thought that for some children frustration at the ending of the sessions was an important factor in relation to their aggression. The ending of the groups is an important topic and is dealt with on page 245.

Isolation

Isolation and its obverse, co-operative play, showed little in the way of overall change, although there were fluctuations from group to group. It is noteworthy that isolated play was relatively infrequent. Only 55–65 per cent of the children on average demonstrated this behaviour in any session over the seventeen groups.

Isolation in the early sessions was often seen as a manifestation of shyness and of the child's witnessing the situation as strange. The isolated children preferred to play alone, although this was often parallel play which later became co-operative play. Later on, timidity during a rowdy game was quite common. The isolated children often seemed to want to join in but could not bring themselves to do so, even if encouraged by the other children. Very occasionally a depressed child would be sitting at the edge of the group waiting for the session to end, or sulking after having lost a game, but by far the most usual pattern was for an isolated child to be playing contentedly alone, or drawing. Two other types of partial isolation were communication indirectly, via the toy telephone, and passive watching of activity while ostensibly playing alone.

Attention-seeking behaviour

This declared itself in many ways, the important feature being the therapist's feeling that the child was putting him- or herself in a dependent role or seeking to monopolize the therapist's attention. Some common types of behaviour described were asking numerous questions, general complaints, and complaints by girls that only the boys were receiving attention. Showing pictures, wanting to give pictures and presents, eye contact in shy children, and telling tales about other children were also common.

THE PROCESS OF THERAPY – SENIOR GROUPS

Attendance

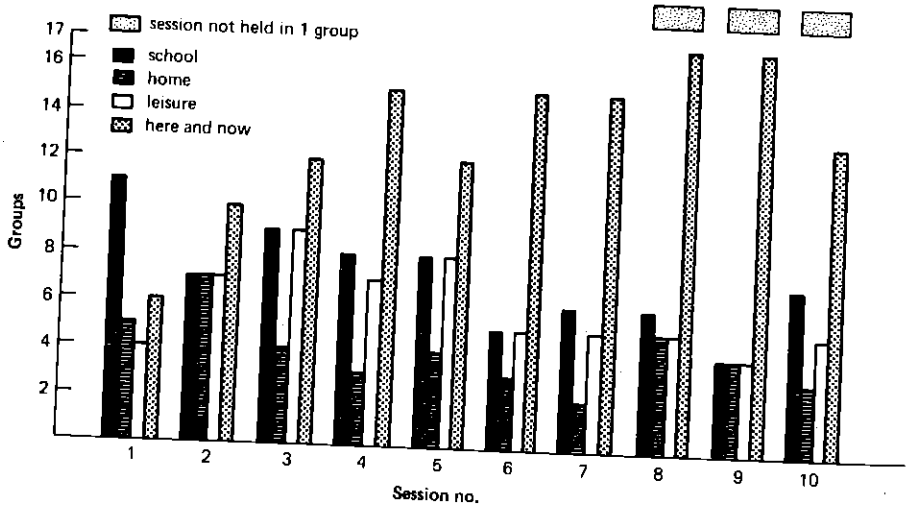
Among a disturbed population of children, especially if unselected by a referral mechanism, truancy from school is likely to be a problem, and, if too great, will severely handicap any school-based treatment efforts.

The total mean attendance rate in the senior groups fell slightly during the programme, starting at a mean of 87.2 per cent and ending with a mean of 71.4 per cent. As the programme took place in the summer term, a fall-off in attendance might be expected as a general trend towards the end of term. We were able to confirm, by examining attendance registers, that the children were absent from school as a whole, not just from the groups.

Content of sessions

In recording the senior sessions the therapists were asked to make a rating of the amount of group time spent discussing subjects in four broad categories – school problems, home problems, leisure, and here-and-now interaction (see Nicol and Bell 1975). *Fig. 8(1)* shows that there was a marked shift in the content of the sessions as time progressed. (A pilot study on twelve groups had shown that the inter-rater reliabilities of the content ratings were: school problems 75 per cent agreement; family problems 100 per cent; leisure 83 per cent; and here-and-now 92 per cent).

Figure 8(1) Number of groups out of 17 where more than 10 per cent of group time was spent on a given topic: senior groups



In the first session discussion was heavily centred on school, likes and dislikes of teachers, peers, school rules, and discipline. In many cases it was possible to recognize disguised communication of anxiety about the purpose of the groups and the school at large. The therapists attempted to label the feelings brought to the group, as well as to provide explanations.

School as a focus of discussion became less prominent after the first session and the children began to focus on home problems, although there was great variation between the groups in the extent to which home issues were brought up for discussion. In one very silent boys' group home life was never mentioned, whereas in one girls' group home problems were focused on at all sessions – following the lead of a talkative girl who used the first session to discuss her new step-father. In later sessions similar confidences were shared by the other girls.

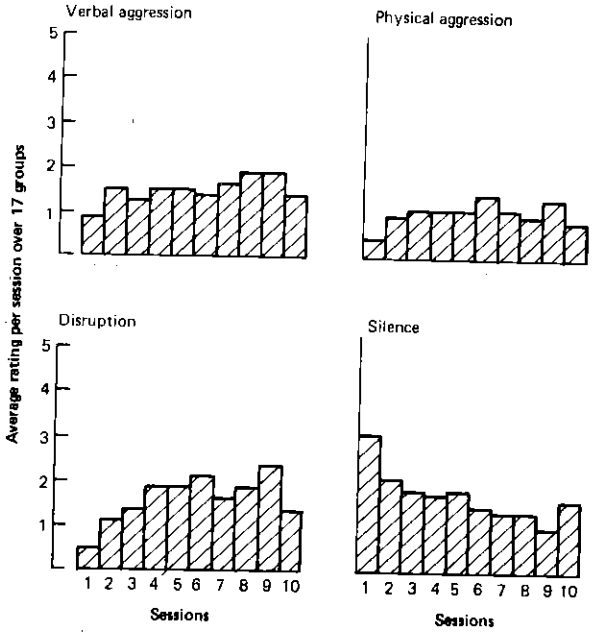
In addition, in these early sessions, leisure activities assumed a prominent place, particularly in the third session. Many different topics were discussed under this general heading and some, such as boys' boasts about their own, their brothers', or their friends' violence and delinquency, clearly represented rivalry within the group, or a bid for the therapist's attention.

Attention-seeking behaviour was not always expressed noisily or even verbally. Quiet and inhibited children would often engage the therapist in eye contact or position themselves next to the therapist in successive group sessions. To the practitioner of adult psychotherapy these overtures often show an engaging simplicity and straightforwardness.

After the first three or four sessions the trend of discussions began to be directed away from topics outside the group and towards interaction between members of the group. Various aspects of non-verbal group interaction were recorded, using operational definitions of the various behaviours.

Fig. 8(1) shows how the focus shifted to here-and-now interaction, and *Fig. 8(2)* shows that this was accompanied by an increase in the expression of negative affect, both verbal and non-verbal, and a reduction in the frequency of prolonged silences by group members (defined as any member remaining silent for more than five minutes). All these changes were statistically significant. *Fig. 8(3)* shows that there were changes in the rates of other behaviours as well, such as a marked reduction in giggling, some reduction in lateness, and an increase in leaving the room (often a corollary of major disruption). There was a marked increase in the amount to which limits had to be imposed.

Figure 8(2) Here-and-now group interaction I. senior groups



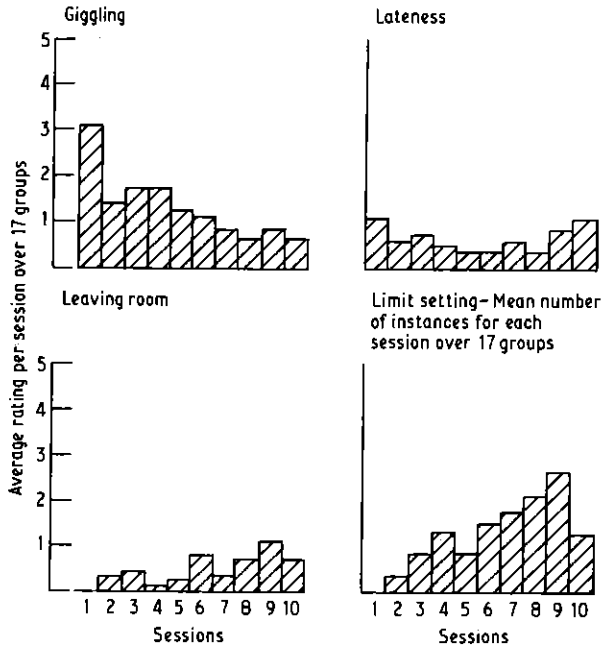
Another feature of the groups was the fact that the last group session was often quite different from the others and on average represented a return to the situation of the first group. Unlike the overall changes, these trends achieved significance only in the case of silence, but certainly merit further research.

These findings raised the question of the stages through which a therapeutic group has to pass in order to achieve maturity. MacLennan and Felsenfeld (1968), in talking of adolescent groups, mentioned an initial stage of orientation after which testing operations and defences came into play. This seems to be very much what happened in our groups. Yalom (1975) spoke of three stages, the first two of which corresponded with those found in our study, although he was writing about adult groups. His stages were:

(i) the initial orientation stage with hesitant participation and a search for meaning;
(ii) the second stage of conflict, dominance, and rebellion;
(iii) the third stage of increasing cohesiveness and working through.

We have referred to the concept of group cohesiveness, the attraction of a group for its members, earlier in the chapter: it is a central concept in small group research, with many implications of

Figure 8(3) Here-and-now group interaction II: senior groups: mean number of children exhibiting behaviour per session across 17 groups



therapeutic importance. For example, a cohesive group has more ability to modify the attitudes of its members than a non-cohesive group.

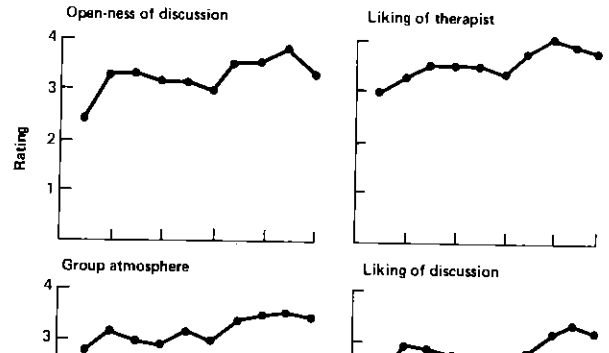
Fig. 8(4) shows the therapists' estimates of the cohesiveness of their groups in three dimensions. These ratings had a moderately high level of agreement with ratings made by an outside observer who sat in on one group session of each group. Correlations ranged from 0.53 to 0.76. It can be seen that the seeds of Yalom's third stage seem to have been sown in the groups, as the mean cohesiveness rose significantly over the course of the programme.

Dynamic group themes

Dynamic group themes have been described by MacLennan and Felsenfeld (1968), and were readily identifiable in our senior groups, as the following examples show. It is important for the therapist to recognize these themes as they may block the groups' progress towards higher functioning.

(i) *Monopolization of the group by one member.* This, with the tacit agreement of the other group members, was commonly demon-

Figure 8(4) Mean ratings for 17 groups of aspects of group cohesiveness over 10 sessions: senior groups



strated. In the first session, a simple, guileless, and rather disinhibited girl launched into details of her home life. Other members at first welcomed her constant talking, but in later sessions brought pressure to bear by grumbling that they couldn't get a word in edgeways. She continued, despite this, to be the most active group member.

(ii) *Taking the therapist role.* A small and deprived boy obviously shared the group discomfort in the first session, but dealt with this by a flood of chatter about his hobbies and activities – all of which he did very well! In later sessions he became the 'question master' of the group and, in particular, took it upon himself to speak up for another very silent member.

(iii) *Conflict about self-disclosure.* One group was very silent in the first session, but the ice was broken in the second by one girl who launched into a description of her family. Although this was only a superficial description she seemed to feel herself out on a limb and put pressure on other girls to talk more, as well as blaming herself for being a chatterbox.

(iv) *Splitting the group to avoid anxiety.* An active member positioned her chair away from the therapist and began a private conversation with two other girls. The therapist brought the group's attention to this manoeuvre.

(v) *Scapegoating.* A boy's group showed terrific aggression that consistently spilled over into fights from the second session onwards. On some occasions the boys seemed unable to cope with the situation they had created, and left the room before the session had ended. The therapist persisted in her effort to help the boys to understand and channel their feelings, but they focused their aggression on one boy who took up a stance of cowering in the corner. In later sessions the boy was coaxed out of his corner and the situation became considerably calmer.

The problems of limit setting

This problem could well rank as another 'dynamic group theme', but is dealt with separately, as it created some of the most difficult problems encountered in the groups. One of the most effective ways that children could avoid personal anxiety or conflict was to engineer a limit-testing confrontation with the therapist, making it extremely difficult for the inexperienced therapists to avoid a head-on clash (which the child was likely to win). The correct and effective manoeuvre in this situation, but one requiring considerable intuitive skill, was to point out the limit but, at the same time, to show an understanding of the feelings that had led to the situation. With experience, the therapists were largely to master this technique.

The termination of the groups

The children were warned at an early stage that the groups would run for ten sessions. In later sessions the subject was reintroduced. In some groups the members dealt with their feelings in a very direct way: they wanted to know what the therapist would be doing, whether sessions would be continuing the following term, and whether the therapist would continue to work in the school. Some children showed great sadness that the groups were ending. At the close of the final group session, the children were given a short questionnaire concerning their feelings about the groups. Many expressed great resentment at this, as if it symbolized the therapists' rejection of them as merely parts of a research project and, as such, could be abandoned at the end of treatment.

The uniqueness of the last session was reflected in the objective data collected by the therapists, as shown in *Figs 8(2)* and *8(3)*.

The therapists' assessment of the children's progress

At the completion of the treatment period the therapists were asked how much they thought the children in their groups had progressed.

Table 8(1) *Therapists' assessment of progress*
(a) *Senior groups: frequency of children in various categories of progress*

degree	*sympton improvement*		*positive dynamic change*	
	n	%	n	%
marked	1	1	3	4
moderate	10	13	26	33
slight	35	45	33	42
unchanged	31	40	15	19
worse	1	1	1	1

(b) *Junior groups: frequency of children's progress in various problem areas*

degree	*aggressive, impatient*		*stands up to others*		*co-operative play*		*less isolated*		*attention-seeking*		*observes limits*	
	n	%	n	%	n	%	n	%	n	%	n	%
definite improvement	3	4	12	18	12	18	10	15	0	0	2	3
somewhat improved	18	27	26	39	32	48	19	28	15	22	18	27
unchanged	17	25	6	9	7	10	8	12	25	37	17	25
never a problem	29	43	23	34	16	24	30	45	27	40	30	45

For the senior groups the therapists made simple ratings of symptom change and of underlying psychodynamic change, whereas for the junior groups ratings were made of the children's progress in various problem areas. The results are set out in *Table 8(1)*. It can be seen that in the senior groups, at the point of termination, the therapists were somewhat more optimistic in their assessment of dynamic change than they were in actual behavioural change. In the junior groups the therapists seemed to have seen the main progress to comprise the children being more able to stand up for themselves, having more capacity for co-operative play, and being less isolated, whereas there was relatively less progress in the control of aggressive behaviour, attention-seeking, and ability to observe limits without therapist intervention. The therapists based all these ratings on the behaviour observed in their groups, but also on reports and discussions with the teachers of the children's behaviour in class.

Outcome and improvement on objective measures

Throughout this book outcome is defined as change score derived from clinical ratings whereas improvement is defined as change derived

from statistical analysis of behavioural dimensions. The main findings of this chapter can be presented in various ways, the most important of which are answers to the main hypotheses presented in Chapter 3. These hypotheses consist of a comparison of all the regimes, at each age level, and look for differences between them in changes in the various measures used.

In the present section we focus on comparisons between the group therapy regimes and the controls at both the seven-year-old (at-risk) and eleven-year-old age (maladjusted) levels. This perspective will be of use to those who are committed to group techniques and who want guidance as to which problems might be helped by them. Two follow-up assessments were made at the junior level. These were at eighteen months and three years after the baseline. The same two follow-ups were undertaken at the senior level, but in addition some measures were repeated immediately after the end of treatment.

THE PSYCHIATRIST'S ASSESSMENTS OF DISTURBANCE (OUTCOME MEASURES) FOR JUNIORS

As has been described above, and by Wrate, Nicol, and Kolvin (1981), all the information from the study was gathered together and an overall judgement was made of the diagnosis, the overall severity, and the severity of neurotic and antisocial aspects of disturbance. The judgements were made independently at each level of follow-up, three separate judgements being made thus: at baseline, first, and second follow-ups. Outcome scores were then computed according to Sainsbury's formula (see Appendix 2). The results for the junior group are set out in *Figs 8(5), 8(6),* and *8(7).* For clarity only good and poor outcomes are shown in the diagram. It can be seen that for neurotic behaviour, the playgroups showed a considerably better (and statistically significant) outcome compared with the at-risk controls, both at first and at final follow-ups. For antisocial behaviour, there was little change at first follow-up, but at final follow-up there was a trend favourable to the playgroups, although this did not reach statistical significance.

Taking all aspects of behaviour into consideration, a rating of outcome in overall severity showed playgroups making significant progress compared to the at-risk controls at final follow-up.

Figure 8(5) Neurotic behaviour: juniors: per cent outcome (good and poor categories)

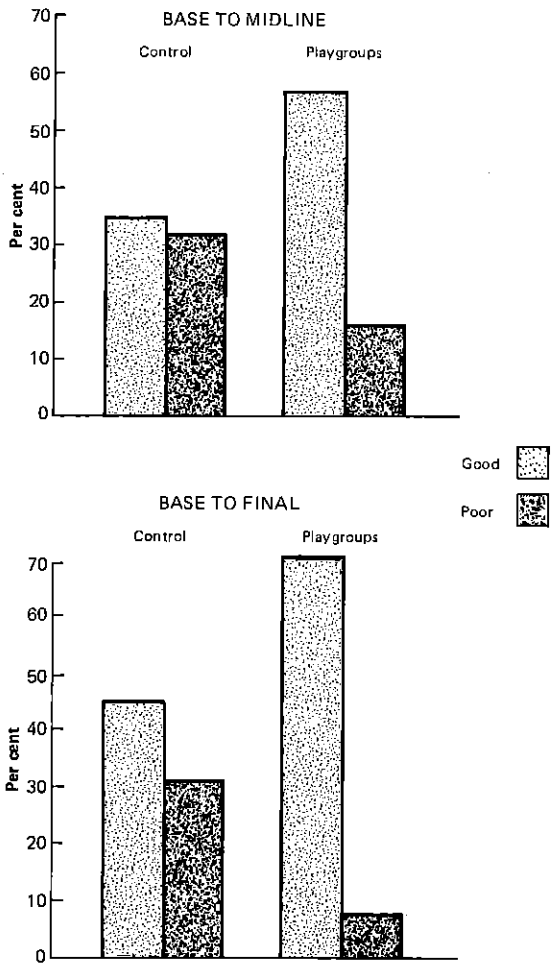


Figure 8(6) Antisocial behaviour: juniors: per cent outcome (good and poor categories only)

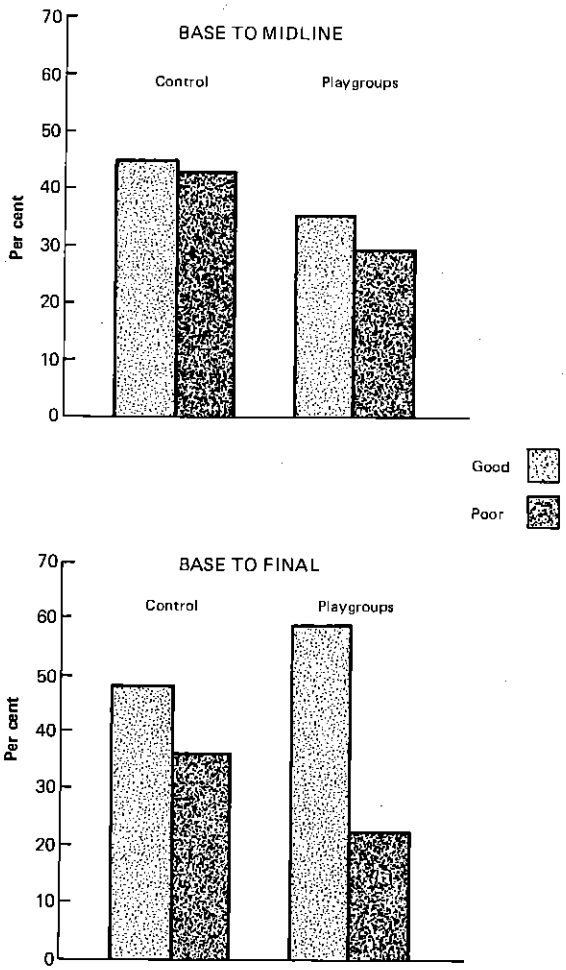
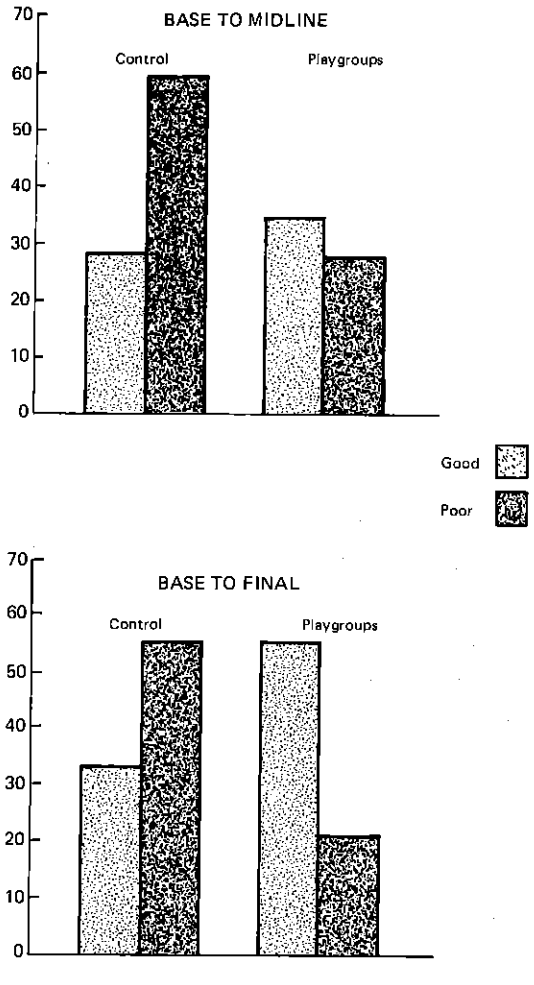


Figure 8(7) Overall severity: juniors: per cent outcome (good and poor categories)



IMPROVEMENT MEASURES IN THE JUNIOR PLAYGROUPS

These are set out in *Table 8(2)* overleaf.

Academic performance

The teachers' report of comprehension on the Devereux scale, showed significantly greater improvement for the playgroup children than for the at-risk controls at both follow-ups. The individual questions of this scale were: 'gets the point of what reads or hears in class'; 'able to apply what has learned to a new situation'; and 'likely to know the material when called on to recite in class'. Two further items showed significant improvement for the treated children: these were 'quits easily' and 'slow to complete work'. These items, of course, concerned behaviour as much as academic performance.

The ability and attainment tests showed some improvements for the treated children at the eighteen-month follow-up, but, for technical reasons, these were difficult to interpret (see Appendix 3).

Peer relationships

The playgroup children showed no significant improvement compared with the at-risk controls on sociometric measures.

Teachers' reports of behaviour

Here there were a number of significant results. At the eighteen-month follow-up the Rutter B2 scale showed significant improvements for the playgroups when compared with the at-risk controls. This was true also of the antisocial sub-scale. The Devereux scale also showed significant improvement for the playgroup children on the classroom disturbance sub-scale. The aggregate score on the Devereux scale also showed their significant improvement (this was a sum of all the Devereux items).

At the final three-year follow-up the playgroup children's improvements as measured by the Rutter B2 scale were even more pronounced, as were the changes on the aggregate score on the Devereux scale. The 'impatience' sub-score in particular showed their significant improvement, as did the category 'unable to change' and the classroom disturbance sub-scale.

Parental reports of behaviour

At the three-year follow-up playgroup children's improvement was seen in antisocial behaviour, psychosomatic disturbance, and the aggregate of behaviour interview.

Table 8(2) *Significant differences between at-risk controls and playgroup children (for detailed results see Appendix 3)*

1. *Eighteen-month follow-up*

academic performance

Devereux lack of comprehension**
Devereux quits easily*
Devereux slow work*

teacher reports

Rutter B2 total**
Rutter B2 antisocial**
Devereux classroom disturbance**
Devereux aggregate*

2. *Three-year follow-up*

academic performance

Devereux lack of comprehension**

teacher reports

Rutter B2 total**
Rutter B2 neurotic**
Rutter B2 antisocial**

Devereux impatience**
Devereux unable to change*
Devereux classroom disturbance*
Devereux aggregate**

parental reports

behaviour interview: antisocial**
behaviour interview: psychosomatic*
behaviour interview: aggregate of neurotic, antisocial, and psychosomatic**

global reports

global behaviour**
global neurotic*
global antisocial**

Note: *significantly greater change than at-risk controls at 5% level; **significantly greater change than at-risk controls at 1% level.

Global scores

It can be seen from the above results that there were widespread changes in the playgroup children's behaviour. Such change was also reflected in the global composite score (see Chapter 9), in which there was significant improvement in the total global behaviour scale and, particularly, in the antisocial, though also in the neurotic, global scales.

THE PSYCHIATRIST'S ASSESSMENT OF DISTURBANCE (OUTCOME MEASURES) FOR SENIORS

The overall assessments of disturbance for seniors were carried out in the same way as for the junior groups (see *Figs 8(8), 8(9),* and *8(10)*). For neurotic behaviour, children undergoing group therapy showed significantly better outcome than did the maladjusted controls, both at first and at final follow-ups. The same was true for antisocial behaviour: the group therapy children showed significantly better outcome over the maladjusted controls both at the midline and at final follow-up, and on overall severity they did so again, also at both follow-ups.

IMPROVEMENT MEASURES IN SENIOR GROUP THERAPY

These are set out in *Table 8(3)*, on p. 257.

Academic performance

There were significant improvements on the National Child Development Study test (NCDS) at the eighteen-month follow-up for the group therapy children. This was both on the total score and on the verbal and non-verbal sub-scores. By the three-year follow-up, however, the maladjusted control children had caught up with them.

School attitudes

Results of the Barker Lunn self-report questionnaire showed significant improvements for the group therapy children on the 'liking for school' sub-scale at the immediate six-month follow-up. At eighteen months there were improvements among the sub-scales reflecting school anxiety and good peer relationships. At the final three-year follow-up these improvements had washed out.

Self-report

At the eighteen-month follow-up there was improvement on the JEPI 'N' scale. In other words, at eighteen months the group therapy children showed less neuroticism than did the maladjusted controls: however, at three years the difference seemed to have washed out.

Figure 8(8) Neurotic behaviour: seniors: per cent outcome (good and poor categories)

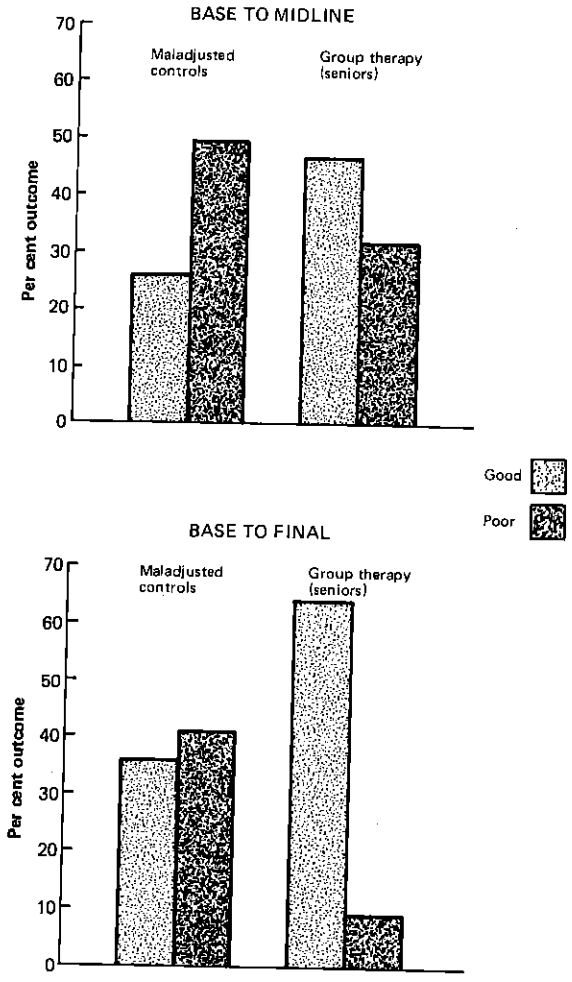


Figure 8(9) Antisocial behaviour: seniors: per cent outcome (good and poor categories)

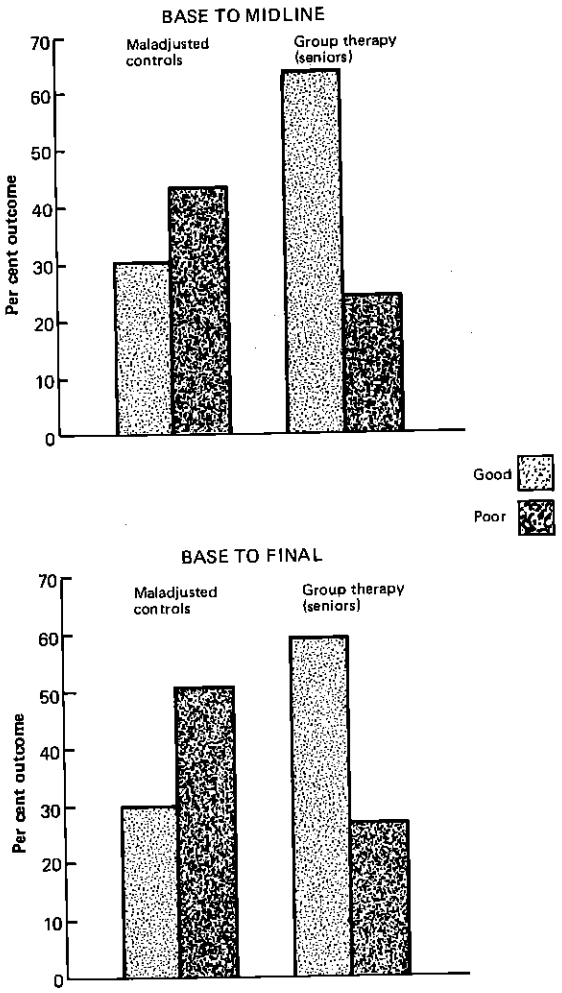


Figure 8(10) Overall severity: seniors: per cent outcome (good and poor categories only)

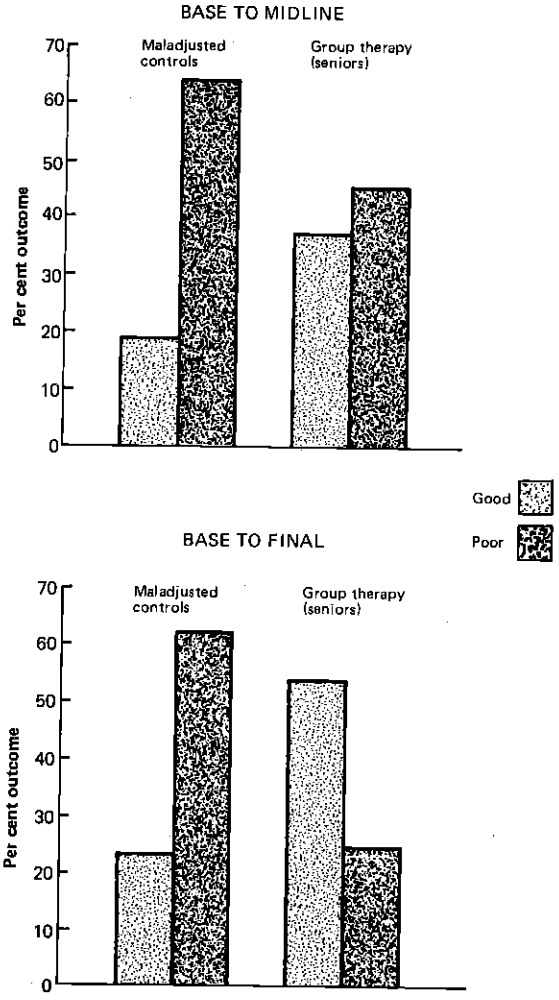


Table 8(3) *Significant differences between maladjusted controls and senior group therapy regime (for detailed results see Appendix 3)*

1. *Immediate post-treatment follow-up*

   Devereux needs more closeness**
   Barker Lunn liking of school*

2. *Eighteen-month follow-up*

   academic performance

   verbal ability test (NCDS)**
   non-verbal ability test (NCDS)*
   total ability score (NCDS)**

   school attitudes

   Barker Lunn social adjustment*
   Barker Lunn neurotic anxiety about school*

   self-report

   JEPI neuroticism*

   parental reports

   behaviour interview: psychosomatic*
   behaviour interview: aggregate of neurotic, antisocial, and psychosomatic*

   global reports

   global maladjustment*
   global antisocial*

3. *Three-year follow-up*

   teacher reports
   Rutter B2 total**
   Rutter B2 neurotic*
   Rutter B2 antisocial*

   peer relationships

   isolation*

   parental reports

   behaviour interview: antisocial*
   behaviour interview: aggregate of neurotic, antisocial, and psychosomatic*

   global reports

   global maladjustment*
   global neurotic*

Note: *significantly greater change than maladjusted controls at 5% level; **significantly greater change than maladjusted controls at 1% level.

Peer relationships
There was a significant improvement in the group therapy children's level of isolation at the three-year follow-up.

Teacher reports
Apart from the one Devereux measure 'needs more closeness', which showed changes at six months, differences emerged only at the final three-year follow-up, where the group therapy children's behaviour, as measured on the Rutter teacher scale total, neurotic, and antisocial sub-scales, showed significant improvement.

Parental reports
At eighteen months the behaviour interview aggregate of neurotic, antisocial, and psychosomatic behaviour showed significant changes for the group therapy children, while at three years both the aggregate dimensions emerged as significant.

Global measures
A global measure of maladjustment, made up of fourteen measures, showed improvement for the group therapy children at eighteen months and three years, and antisocial behaviour, made up of five measures, showed improvement at eighteen months. This washed out, but there was significant improvement in neurotic behaviour.

How accurate were the therapists' assessments of the children's progress?

As clinicians, we assess most of our day-to-day clinical work in much the same way as the therapists did in the study: simply from the way the children seemed to progress during the therapy sessions. We can see from *Table 8(1)* that the therapists were, in fact, quite guarded in their optimism about progress. How realistic were they? To check this we correlated the therapists' ratings with the clinical measure of outcome in terms of overall severity at follow-up (*Table 8(4)*). As can be seen, fourteen out of the sixteen correlations were high. It seems safe to conclude that the therapists were well aware of the relative progress of the children during treatment.

Did the atmosphere of the groups influence outcome?

We have described the measures of cohesiveness and openness of discussion that were made during the course of the senior groups, and have shown how these seemed to change as the groups pro-

Table 8(4) *Correlation of therapists' assessment of progress during treatment with overall clinical measure of outcome at follow-ups eighteen months and three years later*

junior groups (n = 60)			
		therapists' assessment	
clinical rating of outcome	*improvement in aggression impatience*	*improvement in standing up for self*	*improvement in co-operative play*
	r =	r =	r =
base to midline	0.81***	0.49***	0.81***
base to final	0.82***	0.00 ns	0.48***
		therapists' assessment	
clinical rating of outcome	*less isolated*	*less attention-seeking*	*responds to limits*
	r =	r =	r =
base to midline	0.83***	0.35**	0.72***
base to final	0.45***	0.34**	0.57***
senior groups (n = 60)			
		therapists' assessment	
clinical rating of outcome	*symptom improvement*	*positive dynamic change*	
	r =	r =	
base to midline change	0.01 ns	0.33**	
base to final change	0.70***	0.32*	

Note: * $p < 5\%$; ** $p < 1\%$; *** $p < 0.1\%$.

gressed. Earlier in the chapter we explained that group cohesiveness is a very important phenomenon, with likely implications for therapy. What effect did it have with our groups? To test this we correlated the two indices of cohesiveness and openness of discussion with the outcome measures. The results showed no correlation between the levels of cohesiveness and openness of discussion in the groups and outcome. Thus, the importance of group atmosphere was not confirmed in this study.

We should mention that questionnaires designed to tap therapists' and children's liking of the groups failed to predict outcome (for details of the questionnaires see Nicol *et al.* (1977)).

Summing up

The results of the group therapy regime present a surprisingly consistent picture. In both the junior and senior groups there was better outcome and improvement in comparison with the at-risk and

maladjusted controls. Only in the case of antisocial behaviour at the junior level did the outcome changes not reach significance. On looking at the individual measures the favourable changes seemed to occur mostly in teacher and, to a lesser extent, parental reports of behaviour and, in the senior groups, in self-report ratings and, minimally, in sociometry. In the senior eighteen-month follow-up, there were significant improvements in academic performance. However, these improvements failed to persist at the final (three-year) follow-up.

How can we explain the less-than-exciting results of other studies reviewed earlier in this chapter? We can do so quite simply by saying that these other investigators seemed to have looked for the wrong things at the wrong time in studies that had often been on far too small a scale. Most of them looked for academic gains, yet this area seems the least likely to have yielded positive results (despite this, a substantial minority of the studies *did* show improvement). The second most commonly used measurement in these other studies was sociometry. Again, our study suggested that sociometric 'isolation' indicates only very modest changes as a result of group therapy: nevertheless, some previous studies reported positive results. It is very surprising to find that such meagre resources have been devoted to evaluating the effectiveness of group therapy, considering that it is a technique so widely practiced. The most encouraging results from previous studies were in the outcome areas of teacher-reported behaviour and of self-ratings, the same areas that showed good outcome in the present study. None of the previous studies, though, included parental reports of behaviour as outcome measures. This was unfortunate on methodological grounds alone, as they provide a relatively independent measure, less likely than school-based ones to be influenced by knowledge of the type of treatment the children received. Over and above this, it does seem that behaviour as reported by parents is a sensitive measure of treatment effectiveness.

The other clear lesson that emerged from a comparison of the present with previous studies concerned the importance of long-term follow-ups. Changes may occur over quite a long period after therapy is complete: a clear indication of this was provided by the immediate follow-up in the senior groups, which showed a meagre change on two measures only. Possibly, if other studies had instituted systematic longer-term follow-ups they, too, would have yielded more positive results.

A further set of findings that merit comment were the agreements between the objective outcome measures and the therapists' judgements that had been made nearly three years earlier. The fact that the

therapists seemed to some extent to be aware of which children they were helping gives added weight to the assertion that the changes that were observed were the specific results of the therapy process rather than some relatively extraneous events.

We were not successful in discovering aspects of the process of therapy that correlated with outcome; however, we return to the theme of therapeutic qualities in Chapters 9 and 10 and Appendix 4.

The outcome studies reviewed were:

(i) *Directed mainly to educational problems*: Altmann, Conklin, and Hughes (1972); Barcai *et al.* (1973); Baymur and Patterson (1960); Broedel *et al.* (1960); Cheatham (1968); Coles (1977); Creanage (1971); Deskin (1968); Dickenson and Truax (1966); Ewing and Gilbert (1967); Finney and Van Dalsem (1969); Fisher (1953); Gilbreath (1967); Lawrence (1973); Light and Alexakos (1970); Mezzano (1968); Moulin (1970); Myrick and Haight (1972); Shaw (1962); Shouksmith and Taylor (1964); Speilberger, Weitz, and Denny (1962); Vriend (1969); Winkler, Teigland, and Munger (1965); Winn (1962).

(ii) *Directed mainly at peer relationships*: Bevins (1970); Biasco (1966); Briggs (1968); Hansen, Niland, and Zani (1969); House (1971); Kranzler *et al.* (1966); Lewis and Lewis (1977); McBrien and Nelson (1972); Meyer, Strowig, and Hosford (1970); Schiffer (1971); Thombs and Muro (1973).

(iii) *Motivated by teacher report of bad behaviour*: Abraham (1972); Barcai and Robinson (1969); Hinds and Roehike (1970); Hubbert (1970); Kelly and Mathews (1971); Randolph and Hardage (1973); Seeman, Barry, and Ellinwood (1964); Taylor and Hoedt (1974).

(iv) *On children reported as poorly adjusted*: Clement and Milne (1967); Elliot and Pumphrey (1972); Hargrave and Hargrave (1979); Lisle (1968); Pelham (1972).

(v) *Focused on children's self concepts*: Clements (1963); Dorfman (1958); Hugo (1970); Hume (1967); Mann, Barber, and Jacobson (1969); Warner and Hansen (1970).

(vi) *On child guidance referrals, delinquents and others*: Crow (1971); Irwin, Levy, and Shapiro (1972); Persons (1966); Tolor (1970).