GROUP PSYCHOTHERAPY FOR CHILDREN AND ADOLESCENTS

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SUMMARY

This article updates the previous review (Azima, 1996) and includes new group applications to high risk psychiatric disorders focusing specifically on research advances in these areas. It is clear that there has been a marked shift in theoretical orientations from psychodynamic/psychoanalytic to cognitive/behavioral interactive ones, especially for short term modalities. This shift has encouraged structured and manualized approaches that can be operationalized and subjected to research investigations.

Group as a therapeutic modality has been increasingly confirmed by both clinical and research investigation, in a wide variety of areas. Clinics as well as inpatient, residential, private practice, and community programs have expanded rapidly. Applications to psychiatric, medical, neurologic, community, and social issues have grown at an unprecedented pace.

INTRODUCTION

Between 1995 and 2000, somewhat more than 500 articles, chapters, books and dissertations have been written about group psychotherapy with children and adolescents. From the clinical perspective there have been advances in the treatment of previously contraindicated populations (low intelligence, organic cases, the very young, and the very difficult, acting-out child.) This article updates the previous review (Azima, 1996) and includes new group applications to high risk psychiatric disorders focusing specifically on research advances in these areas.

Increasingly child group psychotherapy is becoming part of a multimodal integrative approach for outpatient and inpatient, day hospital and residential facilities. Psychoeducational approaches with children and parents have become more prevalent, as has their use in schools and communities. As is illustrated, the emerging problems of our society that have affected youth have dictated the increased use of groups for anxiety, depression, suicide, violence, oppositional defiance, drug addiction, post traumatic stress, social phobia, medical disorders, family separation and sexual abuse.

An early report by Toseland and Siporin (1986) that group psychotherapy is an efficient and cost effective treatment has been further confirmed by the meta-analysis of Hoag and Burlingame (1997). Future meta-analyses are necessary to confirm their findings. The current clinical and research overview corroborates positive outcomes in most cases for both clinical and research reports.
Clinicians have continued to be enthusiastic that group psychotherapy for children and adolescents is a treatment of choice. Young, active children can communicate with one another, often without words or symbolic reasoning, as if they have a private language. Therapists have the opportunity to observe the actual behavior of the children, to clarify the diagnosis, and gradually to interpret the meaning of their play and interactions. Psychotherapeutic and educational goals are provided in a safe, supportive, empathic setting where boundaries and rules are established by the therapists. As for adolescents, group settings are particularly advantageous because of their specific need for relationships with their peers. Reciprocal exchange of thoughts and feelings permits self-disclosure in the group often is not possible in individual therapy, where rebellious silences pervade the transference to parental authority figures. In the group, the adolescents themselves are clear about what is acceptable and proper for others of their age group. Learning that problems are not unique and that they are shared by peers can promote faster sharing of information.

This literature review demonstrates a decrease in the use of the psychoanalytic model and a significant increase in cognitive-behavioral, psychoeducational and multimodal approaches. In contrast, cognitive behavioral and psychoeducational models have proliferated with accompanying clinical research. These trends have encouraged the goals of short term, managed care, and the integration with parents, community, and psychopharmacological treatments. Psychoanalytically-oriented theory remains central for long-term groups, and more traditionally trained clinicians whose goals may be more significant ego changes for their patients.

SETTING

A major task facing the therapist is the selection and balancing of the composition of the group, orchestrating the number of acting out children with the quieter, less demanding, more compliant ones and deciding on the play, activities, or toys used to engage and interest the children. The reality is that there is no such thing as an ideal composition, and a group is formed with the available referred candidates. The stronger the group, the more very disturbed children can be included.

As a rule, the children are seen and evaluated with their parents. Often observing the children over time helps clarify the diagnosis (Anthony, 1965; Liebowitz and Kernberg, 1986). Preschool children, boys and girls 3 to 5 years of age, are seen in small groups of three, four, or five and usually by two therapists in a play or activity group. The more active or pathological the children, the greater the need for auxiliary personnel.

The latency therapy group usually is separated into early (5 to 7 years of age), middle (8 to 10 years of age), and late (10 to 12 years of age) groups. Frequently these age groups are intertwined, and more attention is placed on the composition of the range of intelligence, physical size, and diagnoses of the children. In treatment groups, latency boys outnumber girls, at a ratio of 4:1 to 8:1, depending on the population being serviced. There is some current indication of a rise in girl referrals, however. The preponderance of boys in the groups necessitates that one of the therapists or special care counsellors be male to provide a role model and to diminish acting out behavior. Some of the children from single parent families are threatened by the presence of both male and female therapists.

At times the late latency group is combined with the preadolescent group. The older boys and girls usually do better in homogeneous groups with the same sex therapist (Kennedy, 1989). Frequency of sessions varies from once or twice a week to every day in a day hospital. A beginning group may tolerate only 15 minutes and gradually work up to 45 minutes or an hour.

Play and activities are the natural vehicles for child therapy (Bratton and Ferebee, 1999; Sweeney and Homeyer, 1999), and in general, the less complicated and fewer the toys, the better fantasy play is encouraged. The fundamentals are a portable table and chairs, paper, pencil, crayons, playhouse, dolls, and play telephones. The toys should not be unduly stimulating but rather should focus on the projective nature of the action and production. Through the play, the therapist and children begin to understand the meaning of the disclosures. Preparing the children to express themselves is antecedent to further working through of their problems.

SPECIALIZED GROUP APPROACHES

Humor adds a special, and necessary, dimension to work with children (Dana, 1994) A "clown club" (Smith et al., 1985) has been introduced to provide a structured fantasy approach. The therapists dress up and play clowns, to the delight of the children. The psychodrama can be expanded to include the playing of good and bad witches, angry teachers or parents, and the like. A variety of video techniques (Gardano, 1994; Mallery and Novas, 1982) have been used with school age children. Children can produce and watch their own videos. Replaying and redoing scenes allow the children actually to see their behavior and attempt to correct it by activities that strengthen organizational skills and memory. The video camera is an invaluable tool for diagnosis, research, training and follow up. (Smead, 1996; Tellerman, 1998)

Kinetic group psychotherapy (Schachter, 1984) is a technique involving an activity period of exercises or games, followed by a verbal discussion period. The technique has been used with a wide range of children's problems, including childhood autism and depression.
The use of genograms (Davis et al., 1988) is a technique borrowed from family therapy with latency age children. The children, aided by the therapist, map out the family constellation, which helps them to focus on and question the events of the parents’ marriage or separation, new alliances, and catastrophic events. The genograms are shared in the group and encourage each member to divulge hidden fears and learn to distinguish between reality and fantasy.

Other innovative techniques include storytelling, (Gersie, 1997), group sandplay, (DeDomenico, 1999), music therapy (Plach, 1996), and use of masks, puppet plays, and group emblems (Prokoviev, 1999). All such projective activities allow the children to reveal their problems in a nonthreatening manner. A sign of a maturing group process is when the children need less prepared structure from the therapists and suggest and create their own object world. Older, more verbal, intelligent, and stable children are capable of using a talking group as opposed to a holding group for the ego weak children.

For impulse ridden children (Crawford Brobyn and White, 1986), changes in the traditional models may be necessary. Some children can progress from working with another child in a dyad for a time of time to joining the group. The acting out child may be able to tolerate only one of four group sessions, until tolerance is slowly built up. Evans (1998) uses an individual therapy session before the group for children (and adolescents) who act out, are defiant, or fearful of their peers. This author terms this approach as ?active analytic?. Streider et al. (1996) reviewed a wide variety of differential diagnoses and corresponding group structures operating in outpatient treatment of latency age children.

INTERACTIONAL PSYCHODYNAMIC GROUP

This model is applicable to all age groups. The specificities of the approach for children and adolescents include the provision of activity, play, and fantasy according to developmental level, temperament, diagnosis, and goals of the treatment. The interactive context in the here and now, among the peers and the therapists, amplifies the precise nature of the communication difficulties and conveys over time the dysfunctional intrapsychic conflicts within the group paradigm. The degree of permissiveness, structure, and limit setting depends on the activity level and explosiveness of the group and the degree to which regressive acting out is desired or can be tolerated. Greater vigilance is necessary with children who are overly aggressive than with shy children. The thrust of the model is to define the emerging object relations, symbolized by the choice of play objects, and the actual interactions with other group members. The psychodynamics of the group activities are partially translated into meaningful dialogues and understanding by the children. As the therapy progresses, modifications of the explanations and interpretations are appropriately made.

CASE ILLUSTRATION

David was a husky, attractive 7 year old bully when he first came to the day hospital. He kicked the therapist and refused to have anything to do with the other children. His bravado covered his horrifying nightmares, his daily nausea in the car, and his inability to function in the classroom. When he started in the group, the members were working on a large world mural. One youngster was drawing the clinic, another the roadway, and another the school car. At this point David became very agitated and wanted to scribble over the drawing. The group members became somewhat intimidated, and the therapists attempted to calm him down, but to no avail. He was then told that, unfortunately, he could not manage the group that day and was asked to leave, with the comment "When you feel you are able to return and join the activity, please tell Sally [the Special Care Counselor who escorted the child from the room], knock at the door, and let us know when you are ready." It took several weeks before David was able to return to the group; when he did, he announced, "I'll try it out." The other children greeted him with understanding. The group members were drawing different emotions on faces. David first drew an angry face with teeth; when he noticed that others were drawing happy or sad faces, he remarked that he often had such feelings himself. In a subsequent session two or three of the members played with hand puppets and through the play told David that they did not like to be hit. Two years later David was present when a new child joined the group. By chance he and this child again chose the puppets. When the younger child kept smashing the head of the puppet on the table, David said in a soothing voice, "I know what it is like when you are so mad that your head feels like thunder." David worked through a considerable amount of rage. His somatic symptoms, including car sickness, largely disappeared, as did his repetitive drawing of cars. Such a child needed a gradual progression from dyadic to group therapy. His mother profited from parenting management. She was not a psychologically minded individual but was motivated to help her child and cooperated well with the program.

APPLICATIONS FOR CHILDREN

Anxiety Disorders

Increasing attention has been paid to the group treatment and outcome assessment of anxiety in children. Dadds et al., (1997) evaluated the effectiveness of a cognitive-behavioral and family based group intervention for preventing the onset and development of anxiety problems in children. In this
study 1756 children 7 to 14 years of age, were screened for anxiety problems, using teacher nominations and children’s self reports. After recruitment and diagnostic interviews, 128 children were assigned to a 10-week school based child-and-parent focused psychosocial intervention or to a monitoring group. Both groups showed improvements immediately post intervention. However, at 6 months follow-up, the improvement maintained in the intervention group only, with reduction in the rate of existing anxiety disorders and preventing the onset of new anxiety disorders. These results indicated that anxiety problems and disorders identified by child and teacher reports, can be successfully targeted through an early intervention school-based program.

Barrett (1999) evaluated a cognitive-behavioral, family-based group intervention with 60 children, ranging in age from 7to 14 years with diagnosis of anxiety. The study divided the sample into three treatment groups: group cognitive-behavioral therapy, (CBT), group CBTplus family management, and wait list. Posttreatment 64.8% of children no longer fulfilled diagnostic criteria for an anxiety disorder compared with 25.2% of children on the wait list, and the treatment groups maintained the gain at 12-month follow up. Comparisons of self-report measures and clinician ratings of children receiving group CBT with those receiving group CBT plus family management indicated marginal benefits from the addition of family management to the group CBT.

A randomized clinical trial by Silverman et al., (1999) evaluated the efficacy of CBT with concurrent parent sessions versus a wait list control. The treatment group of children showed substantial improvement on the main outcome measures post treatment, at 3 -, 6, -and 12-month follow ups, compared with no gains on the wait list. A group CBT treatment of childhood anxiety focusing on the role of parental involvement was carried out by Mendelowitz et al., (1999) in a study of 62 parents and children. One group was subdivided and randomly assigned to one of three 12-week treatment conditions: parent and child intervention, child-only intervention and parent-only intervention. A battery of tests was used to assess child anxiety, depression, and coping strategies before and after treatment. The results showed that all treatment groups reported fewer symptoms of anxiety and depression post treatment, but children in the parent and child intervention used more active coping strategies post treatment compared with the other two treatment conditions. Parents in the parent and child intervention group reported significantly greater improvement in their children’s emotional well being compared with the other treatment conditions. The short term effectiveness of this group CBT intervention was demonstrated. Comparisons of these 3 studies assessing the effectiveness of parental involvement is difficult, but suggests this issue needs further classification.

Social Incompetence and Phobia

Groups for children emphasising cognitive behavioral and educational models demonstrate effectiveness in reducing social anxiety, shyness, and incompetence. Blonk et al., (1996) studied the short-term effect of group CBT therapy for 72 socially incompetent children (8 to 12 years of age), who were experiencing poor peer relationships. The sample was divided into treatment groups (six children per group) and a wait-list control. Treatment outcome was assessed by teacher and parent reports on social behavior, sociometrics and self reported anxiety and self evaluation. Posttreatment groups showed more appropriate social behavior and an increase in peer acceptance and number of friendships. These effects were sustained at 4- and 5- month follow up assessments. Shechtman (1993) reported increased self-esteem and close friendship in 52 elementary school children placed in 6 small counselling groups compared with matched control subjects. As might have been predicted there was an intercorrelation between intimate friendship and self-esteem.

Depressive Disorders

There has been an increase in the use of groups to alleviate mourning in children. Schoeman and Kreitzman, (1997), used 12 parallel sessions for caretakers and children, and a joint session to work through the death of a parent. MacLennan (1998) reported on the use of children’s groups for both expected and sudden death of family or friends. Glazer and Clark (1999) describe a family-centered intervention for grieving preschool children, and a multifamily and psychoeducation group was described as helpful by Fristad et al. (1998). A group play and activities therapy was described by LeVieux (1999) and an overview of loss and grief groups was provided by Keitel et al. (1998).

An outcome study by Tonkins and Lambert (1996) demonstrated the effectiveness of a short-term, 8-week bereavement psychotherapy group of 16 children, aged 7-11 years, divided into a treatment group and wait-list control group. In the treatment group that shared feelings about the death of a parent or sibling, there was a significant decrease in symptomatology on multiple measures from multiple sources, and participants were able to develop new coping strategies.

Clark et al., (1993) introduced a group for mothers exhibiting postpartum depression and their newborns. Mother and infants participated in 12 weekly group sessions, two of which included spouses or partners. The author’s report is based on 5 years of time - limited groups, which showed improvement in the mother’s depression, problem solving, mutual support, and empathy.

Trad (1994) elaborated a sequential model of mother-infant psychotherapy, integrating the mother?
s individual therapy with the mother’s observation of her infant’s behavior with the therapist, participation in a mother’s group, and family therapy. These last two studies suggest a preventive intervention for high-risk infants.

Groups for Abused and Traumatized Children

Trauma groups have multiplied since the early reports of Green (1978), Cunningham and Mathews (1982), and Mara and Winston (1990).

In 1994, Reichert reported on the use of play and animal-assisted therapy for sexually abused Appalachian children. The focus was on the use of play and fantasy for the children to reverse their role from victims to survivors. DeLuca et al. (1995) evaluated the effectiveness of brief (9 - 12 weeks) structured therapy groups with 35 girls, 7 to 12 years of age, with a history of sexual abuse, showing an increase in self esteem and a decrease in anxiety and behavior problems. Parents also felt that the treatment was helpful, at 9 - 12 month follow-up. Zamanian and Adams (1997) using a time-limited (16 week) psychotherapy group with 4 sexually abused boys, describe the loss of power, helplessness, and the defenses of identification with the aggressor, splitting, dissociation and so forth. The therapist’s conflictual and countertransference is discussed.

Streider et al. (1996) outline a comprehensive ego-enhancing program of 10 session psychotherapy groups for cumulatively and repetitively traumatized children. As part of an elementary school-based violence prevention/intervention program Murphy, et al. (1997) introduced trauma/grief focused psychotherapy groups for children exposed to intrafamilial and extrafamilial violence. The multimodal, interdisciplinary team’s goals were both psychological repair and social adjustment.

A comparison between a psychodrama group with young girls and a control group showed significant decreases in self-reported difficulties, withdrawn behavior, and anxiety/depression (Carbonell and Partelano-Barehmi, 1999).

Peled and Edelson (1992) reported on a 10-session group format for children of battered women. Children who are witnesses to violence and abuse of their mothers sustain significant trauma. The ability to speak about these events with their peers and therapists provides significant support in short-term, manually guided psychoeducational groups. Activity groups (Nisivoccia and Lynn, 1999) and play therapy (Gallo-Lopez, 2000), as well as a multimodal programs have been used with children who have witnessed abuse. Crockford et al. (1993) introduced an integrated program, ?Play Friendly and Safe?, in which there were separate and combined groups for children and abused parents, as well as the inclusion of a non-offending parent support group. A psychoeducational group for grandparents raising inner city, abused, helpless, and depressed children, focused on practical issues of school, home maintenance, and daily problem solving. (Vardi and Buchholz, 1994).

Child victims of extra-familial sexual abuse have been treated in separate, combined, group, and family approaches (Grosz, et al. 1999). Group play therapy combined with psychoeducational techniques, drawing, and story telling have been used for family traumatized latency age children (Leavitt et al., 1997; de Ridder, 1999).

Children who were abused by a school employee were treated individually, in play groups, and with the family (Pelcovitz, 1999). Children and adolescents who have abused others have been treated in trauma-alleviating groups (Erooga and Masson, 1999).

Working with these abused children in all settings is difficult because they are fearful of divulging secrets about their abusive parents (Schacht et al., 1990). In residential settings, they are treated in homogeneous groups, whereas in outpatient clinics, and day centers they more frequently are seen in heterogeneous groups. Negative countertransferential feelings toward the parents must be faced. Often these abused children become the perpetrators, and tend to victimize weaker children. In play groups, several cotherapists often are necessary to control and moderate the acting out.

Learning Disorders, Underachievemt:

Clinic- and School-Based Groups

Gaines (1986) outlines a variety of strategies helpful in the treatment of the retarded children and those with attention deficit disorders, including computer games, videotaping, and expressive arts. The use of structured, time-limited activities is critical with this group (Azima, 1986). Various group models for these underachievers have been used in various settings. Mishna (1996) used a psychodynamic interpersonal model stressing mutual recognition and trust in an outpatient setting. Slavin (1997) using a psychoanalysis-based approach in schools, addressed both academic and behavior problems.

Gupta et al. (1995), used a method of classification and diagnosis of school-aged children seen in clinic groups. Working with ego-impaired groups in a residential program, Winek and Faulkner (1995), used a psychoanalytic, insight-oriented group, conceptualized as a collective superego, to encourage maturation. In school settings, groups using art therapy (Prokoviev, 1999) and psychotherapy (Merydith, 1999) have been used with underachieving students.

In an assessment of brief group therapy with low-achieving elementary school children, Shechtman (1996) examined 142 low achievers, in Grades 2-6, who were randomly divided into an experimental
and a control group. In addition to receiving assistance with school work 4 to 6 hours per week, the experimental children participated in a weekly psychotherapy group. The results indicated significant gains for the psychotherapy group in both academic progress and social well-being, which increased over time period.

Montello and Coons (1998) compared the behavioral effects of an active, rhythm-based group music therapy with a passive, listening-based group music therapy with 11- to 14-year olds in special classes for emotional, learning, and behavioral disorders. The Achenbach’s Teacher Report Form showed that both music therapy interventions (not only the hypothesized active music groups) produced a lowering of scores on the aggression/hostility scale. It was suggested that music was a helpful modality for increasing creativity and self mastery.

Medical and Neurological Conditions

Increasingly, medical and neurologic conditions are being treated in groups for children, adolescents, and parents. Some of the following subgroups overlap with former ones in the review (e.g., learning disorders, school, trauma). Hyperactive children were treated in a semistructured activity group to enhance self-esteem and social competence, diminish sense of shame, and work through unmet exhibitionistic needs (Gnaulati, 1999).

Group therapy with siblings of autistic children increased knowledge of the disorder and allowed the expression of thoughts and feelings related to despair, guilt, and alienation from society (Carmi, 1997). Children with Aspergers’ syndrome have been treated in a social skills group for boys (Marriage et al. 1995), and in a 2-year interpersonal group stressing peer interaction (Mishna and Muskat, 1998).

A structured group intervention for siblings of children with cancer was conducted for a younger (7 to 11 years of age) and an older (12 to 17 years of age). The 6-week program revealed statistical and clinical improvement on post treatment measures in interpersonal and intrapsychic problems, improved mood and communication, and greater cancer-related knowledge (Dolgin et al., 1997).

Habit reversal training for trichotillomania in a group format showed decreases in measures of global severity of obsessions and hair-pulling behavior at 1-month and 5-month follow-ups (Mouton and Stanley, 1996).

Epileptic adolescents were treated in psychoanalytically oriented group therapy for 2 years. The goals were a better understanding of the illness, and provision of information on questions such as the effects on sexuality, pregnancy, and work. The goals included psychological support, comprehension, acceptance, and coping with the disorder (Rossi et al., 1997). A cognitive-behavioral group for adolescents and adults with spinal cord injuries led to improved feelings of self-control compared with a control group at a 2-year follow up (Craig et al. 1998).

The results of these studies of various group models suggest important group applications to these long-standing, chronic medical and neurological illnesses.

Family Issues

Groups for children of divorce, are used in various formats, including psychoeducational, cognitive-behavioral, drawing, and story telling activities. Epstein and Bordium’s game (1985). “Could This Happen” helps focus disclosures of anxiety about angry, “bad” parents.

Roseby and Johnston (1997) introduced a group treatment manual for school-age children dealing with violent separating families. The manual includes drawings, cartoons, and specified themes and activities.

A group intervention for children and separated families, revealed differences posttreatment and 6 weeks later. (Durkin and Mesie, 1994) suggest that children should not be regulated as to with whom they communicate with, or how, but rather that caution be used to allow children to make their own choices regarding visitation rights and the like.

Parents, family, and multifamily groups have used psychoeducational, psychotherapeutic, parallel, combined or integrated programs (Epstein, 1976; Hoffman et al., 1981; Paramenter 1976).

A comparison of multifamily group therapy (42 families) with traditional family therapy (39 families) in the treatment of abusive and neglectful caregivers, showed that the children in the multifamily therapy group became more assertive, had fewer behavior problems, and showed greater self-confidence (Meezan and O’Keefe, 1998).
ADOLESCENT GROUP PSYCHOTHERAPY

Young Adolescent Group

The techniques used with the pubertal group (12 to 14 years of age) approximate those used with latency age children, namely, a combination of activities, play, drawing, psychodrama, and discussion periods. Most therapists tend to treat pubertal children in homogeneous groups with a same sex therapist. These adolescents often are gauche and active and have difficulty in verbalization, especially the more pathologic, who are hospitalized or live in residential care. This age group works best on structured themes related to dependency, attachment, separation, and competition among others. Sessions in general are a maximum of 45 to 50 minutes in length. Both short term and long term models are used. In the latter category, Gordon (1989) has reported a 2 year group with aggressive boys that used the model of working through symbiotic attachment and gradually working toward individuation. Interpretations were made to the group as a whole, dealing with ongoing interpersonal themes, rather than on the intrapsychic material of any one member. Videotaping, music, projective art techniques, and board games (Kraft, 1986) often are stimulating for children of this age, who often are too timid to talk openly about their sexual abuse, drug use, inferiority fears, and marked ambivalence to parents.

Middle and Late Adolescent Groups

The age group of 15 to 19 years is most amenable to verbal psychotherapy. Outpatient models usually group the 15 to 18 year olds. Increasingly, the adolescents referred for group psychotherapy are characterised by depressive reactions, suicidal attempts, and borderline symptomatology, in addition to the usual range of behavior disorders linked to delinquency, rebellion against parents, school dropout, and drug and alcohol use. The more severely disturbed adolescents are hospitalized and placed in residential and treatment centers. School groups focus on learning disorders, low motivation, disruptive behavior, and the like. Outpatient clinic groups treat the largest number of adolescents, whereas private practice groups tend to cluster in the more affluent areas.

The average psychotherapy group size ranges from six to eight and includes both sexes (with the exception of the pubertal group); where possible, heterogeneous composition is preferable. Acutely psychotic, autistic, or very handicapped borderline youngsters are suitable for outpatient groups but may be placed in modified group formats in hospital and residential settings (Speers and Lansing, 1965; Stengel, 1987). The inclusion of borderline and very fragile adolescents depends on the strength of the total membership, which acts as a type of absorption filter and control mechanism. Group sessions vary from 1 to 1 ½ hours, at the rate of once or twice a week, and may be either short or long term.

THEORETICAL CONSTRUCTS

Identity Group Psychotherapy

Rachman (1989) proposes a theoretical model based on the resolution of the adolescent’s identity crisis in the group context and uses a blend of creative introspection, free thought, verbal and fantasy experimentation, and active techniques. The latter include role play, psychodrama, and dream interpretation, as well as specially devised scenarios to permit adequate self disclosure and working through of problems.

Interactional Psychodynamic Adolescent Group Psychotherapy

It is proposed that confrontation, empathy, and interpretation are the therapeutic triad underlying this approach and that all three stem from a common source (Azima, 1989). Confrontation accentuates the verbal enunciation of thoughts and feelings, whereas empathy involves the experiential process incorporating the other person’s feelings and thoughts. It is postulated that the peers in the group are representative of varying confrontational and empathic styles. Some personalities are in need of a more confrontational approach, whereas others need longer nurturance and silent understanding. Interpretation occurs at the point in the therapeutic process when there has been sufficient empathic confrontation and clarification to uncover and give meaning to the underlying unconscious conflicts, and it should occur in synchrony with the individual and the group process.

Case illustration

John was a 15 ? year old with marked narcissistic and grandiose features. For many sessions, he boasted that he could live on his own, that he did not want to be in school, and that he had many friends. The other five group members could hardly get a word in, as he pontificated and analysed everyone. Gradually, certain members began to confront and question him and to express their annoyance. He soon revealed that his mother had divorced his alcoholic, abusive father and later married an older, quiet man. This man could not tolerate the patient, and he was moved into a small
apartment with one of his brothers, who soon left, and he continued there alone. As these facts and feelings came out, he was amazed to regain the empathy of many group members. The therapist in the early stages had assumed an empathic, understanding approach with John and only gradually began to confront the narcissistic defenses. Although the patient was willing to interpret everybody else’s problems, he could not accept other people intruding into his inner life. Many sessions later, a pretty adolescent to whom John was clearly attracted told him in a direct, confronting manner that he would have a hard time making friends, especially with girls, because he was not truly interested in them, and that he was sure to make others very angry by his know it all manner. John was stunned, averted his gaze, bent over, and remained silent. He slowly lifted his head, and holding back his tears, he said, ‘’I think you are right, and that’s what I am afraid of.”

Comment

It may be necessary to confront the silence of adolescent members very early, in an understanding way. The psychodynamic significances of the intrapsychic and interpersonal communications and interactions remains the cornerstone of the interactional psychodynamic group psychotherapy approach. As in all psychotherapies, the goal is for the adolescent to develop self understanding, independence, self esteem, and interpersonal competence.

The preceding clinical example was taken from an outpatient, open ended, heterogeneous group with an average patient attendance of 2 years. In this model, the goal is the development of autonomy and independence. Parents are seen only at intake and at the end of each year’s group, with the adolescents’ consent. Confidentiality is highly protected in this model, and this in turn promotes faster divulgence of material. This approach is facilitated in a country (such as Canada) that provides funds so that parents do not have to pay the bills. In addition, in the Canadian system of health care, any adolescent older than 14 years of age can request treatment without the parents’ knowledge. Outpatient clinics and private practice group psychotherapy often involve a combination of psychopharmacology, combined individual and group therapy, and parallel or conjoint parent or family therapy. In long term treatment necessitated by regressions or traumatic events, a combined network approach has been used effectively (Richmond, 1989).

Inpatient and residential treatment groups

These groups form an integral part of most adolescent units and residential treatment centers (Chase, 1991; Kleiger and Helming, 2000; Stein and Kymissis, 1989). The group format varies indefinitely according to the degree of pathology, intellectual level, and longevity of the group, and number of absences of group members. Inpatient psychotherapy groups (Kymissis, 1996) are advantageous in that they can focus on ongoing resistances and acting out in the group and the hospital network. Conformity and compliance as to weekend passes, attendance at meetings, and taking of medication are strengthened in the group context. The handling of confidentiality in inpatient groups is a delicate issue, and it seems wise to explain at the outset the team’s sharing of information. In ward situations where adolescents are assigned to certain staff members, there often is conflict between the patients and different staff teams.

Adolescents with depression

Parentally bereaved adolescents were treated in a large discussion group format using other parentally bereaved adolescents as therapeutic assistants to help reduce the resistance to talking and giving feedback (Levy and Zelman, 1996). A 7-week anti-depression, anti-suicide group was conducted with 7 teenage women using a collaborative feminist and narrative approach to externalize, empower, support and define the depression (Johnson, 1994).

Clarke et al., (1995) assessed a prevention program targeted for 150 adolescents at risk for future depressive disorder. A randomized 15-session trial of group cognitive intervention was compared with a usual case-control group. Survival analysis indicated a 12-month advantage for the prevention program and a decrease in depressive indices. In a further study (Clarke et al; 1999) compared maintenance cognitive behavioral with acute CBT groups with booster sessions. One hundred and twenty-three adolescents with major depression or dysthymia were assigned to 1 of 3 8-week acute conditions: adolescent group CBT (16 2-hour sessions) separate parent group, or a wait-list control. Subsequently, the members completing the CBT groups were randomly reassigned to 1 of 3 conditions for the 24-month follow-up period, namely assessments every 4 months with booster sessions, assessments only every 4 months, or assessments every 12 months period. Results indicated that acute CBT groups yielded higher depression recovery rates (66.7%) than the wait list (48.1%) and greater reduction in self reported depression. Outcomes for the adolescent-only and adolescent plus parent conditions were not significantly different. Rates of recurrence in the 2-year follow-up were lower than in treated adult depression. The booster sessions did not reduce the rate of recurrence in the follow-up period but appeared to accelerate recovery among the subjects who were still depressed at the end of the acute phase. The authors concluded that CBT was an effective intervention for adolescent depression. It is of some interest that the parallel parent group did not add significantly to the reduction in depression. This confirms this author’s belief that
for adolescents, separate treatment, that protects confidentiality and allows separation from parents may be the treatment of choice whereas young children profit more from parallel, integrated modalities.

Fine et al. (1991) reported on the comparison of two forms of short-term group therapy for 66 outpatient adolescents clinically diagnosed as depressed. Subjects were randomly assigned to either a therapeutic support group or a social skills group. Post treatment, adolescents in the therapeutic support group showed a greater decrease in depressive symptoms and significant increases in self-concept. At the 9-month follow-up, adolescents in the therapeutic support groups maintained their improvements, but adolescents in the social skills group had now caught up in their improvement between the post treatment group and follow-up assessments. The authors postulated that the original gains made in the therapeutic support group were necessary to alleviate the depression before members were able to profit from the problem-solving strategies taught in the social skills groups. The manic defences in the mourning process was described for an adolescent group, using a Kleinian analytic framework. Group-as- a whole focussed on the process and the dynamics of the relationship between the adolescents, staff, and family (Toder-Golden, 1999).

Self-mutilation and self-destructive behavior .

This kind of behaviour has received scant attention in the group literature for children and adolescence. Sansome et al., (1996) have described an integrated psychotherapeutic approach is the management of self-destructive behavior in eating-disorder patients with borderline personality disorder. A group psychotherapy approach was found useful for a reasonable resolution over time of self-destructive behavior.

Hartman (1996) discusses deliberate self-cutting by adolescents in psychiatric inpatient units. The author suggests that the interpersonal aspects of the cutting are neglected, with undue attention given to the individual patient, who may be acting out the groups? conflicts and discontents as well as protesting against inadequate staff supervision.

Social Phobia

Cognitive-behavioral group therapy for social phobia in female adolescents was described by Albano et al., in 1995. The results of a pilot study, (Hayward et al., 2000) compared the outcome results for 35 girls with social phobia at high risk for major depression, 12 of whom were assigned to a treatment group and 23 to a non treatment group. Of the 11 subjects who completed treatment, there was a significant improvement and reduction in the symptoms of social anxiety and depression. However, at the 1- year follow-up there were no significant differences by treatment condition, but there was suggestive evidence that the treatment of social phobia lowers the risk for relapse of major depression among the subjects with a history of major depression. Combining the decline scores for social phobia and depression produced more robust treatment effects for the 1-year follow up. The results indicate that there was a moderate short- term effect of group CBT for female adolescents, and that a decrease in social phobia may also reduce the criteria for major depression. This latter finding suggests the usefulness of group based prevention programs for shy, socially incompetent children. The question of adjuvant pharmacotherapy for social phobia was raised because there have been positive findings with its use in adult social phobia (Heimberg et al., 1998).

Groups for the control of anger, violence, and conduct and criminal disorder

The interest in these disorders has increased in response to the rise in rebellious, destructive behavior in society. The following studies are included because of their innovative clinical and research approaches.

A structured group for undersocialized, acting-out adolescents, that used a pretherapy training program and an initial therapy contract showed positive clinical outcomes (Corder, 1996).

Cognitive-behavioral anger-management groups showed improved arousal control, cognitive restructuring and prosocial skills (Feindler and Scalley, 1998). A CBT group of 11 adolescents showed statistically significant changes in aggressive behavior, attentional problems, self esteem, anxiety, depression and somatic complaints, as shown on post treatment scores on the Youth Self-Report, the Achenbach Child Behavior Checklist, and the Piers-Harris Children's Self-Concept Scales (Kastner, 1998). A brief anger management group of 10 to 12 sessions showed improved functioning in 25 adolescents in hospitalised groups, compared with 25 in control groups (Snyder et al., 1999).

A Teen Abuse Group using a CBT model targeted socio-economically depressed black and white adolescents. The 10- week program was part of a Master?s-level social workers training module. The approach appeared clinically promising. Carlin (1996) describes a large group treatment of 25 severely disturbed, conduct-disordered adolescents. Needs for effective leadership, acceptance of the members’ cultural differences, and the insurance of maximum safety influenced more positive interpersonal relations. Byrnes et al., (1999) compared reductions in criminality in 3 different formats - group, individual and family therapy - in a sample of 532 adolescents in a residential and day-treatment program over a 4- year period. The major findings were: a) the number of hours in
group therapy explained the greatest variance in the reduction of criminal charges, followed closely by hours in individual therapy, whereas hours in family therapy was not a significant predictor; and b) Residential treatment was associated with greater reductions in adult correctional commitments than was day treatment period.

The findings that group therapies are effective treatment for delinquent adolescents confirm the early findings of Bratter, 1989, Friedman and Glickman, 1986, and Raubolt, 1983.

Trauma and abuse

Trauma groups for a variety of disorders have been described for children and adolescents who have become the victims of natural disasters, sexual abuse, violence, atrocities of war. Classification of posttraumatic disorders in the third (revised) and fourth editions of the Diagnostic and Statistical Manual of Mental Disorders emphasize significant cognitive, behavioral, and physiologic somatic effects after the trauma. A variety of group interventions, including supportive, CBT strategies have been used to reduce the posttraumatic stress disorder symptoms to expose the trauma and to work toward improved coping skills. (Foy et al., 2000, Kopola and Keitel, 1998). Glodich and Allen (1998) reviewed the group literature on preventing trauma reenactment in adolescents. Group CBT and psychoeducational strategies are considered important ways of interrupting the pernicious cycle of reenactment and further risk-taking behavior. Everly et al., (1999) compiled a meta-analysis of the effectiveness of psychological debriefing with vicarious trauma. An outline study of 41 sexually abused adolescent girls (13 to 18 years of age) were divided into small structured groups. Each of the seven treatment sessions consisted of a didactic presentation, an art activity, and the development of a positive associational cue. Posttest assessment revealed improved adaptive functioning and skill mastery. Female adolescent survivors of sexual abuse responded to a goal-oriented therapy group Backos and Pagon, 1999); Furniss et al., 1988). Adolescent girls facing the loss of their parents through acquired Immune Sufficiency Syndrome were treated in a 2-year psychoanalytic group. Cohen (1996) analyzed the transference-countertransference in this angry, depressed group of girls. It is likely that through the countertransference, the therapist was able to empathize with the adolescents? plight and work through a treatment plan. Henry (1996) explored human immune deficiency virus-related risk-taking in a psychodynamic group for adolescents.

Alcohol and Substance Abuse

The number of groups for adolescents addicted to alcohol and drugs has increased to meet treatment and prevention needs. A variety of models exist, including multimodal programs (Bratter, 1989; Friedman and Glickman, 1986) in residential and outpatient clinics (Bogdaniak and Percy, 1987; Gonet; (1998); Nastasi, 1998). The use of multi-family play groups for families in addiction recovery, was effective in promoting parent-child communication, the development of a non-blaming attitude, and an understanding of the children’s reactions to their addiction (Cwikala and Mordock, 1997). A therapeutic community drug treatment program that studied 938 adolescents (15 to 17 years of age) who were admitted to residential treatment for substance abuse revealed that one-third of the sample showed histories of sexual abuse. A Cox regression analysis showed that a history of sexual abuse is related to earlier onset of alcohol and illicit drug use. It was suggested that drug use may function to ameliorate feelings of depression and poor self-esteem that accompany childhood abuse (Hawke et al., 2000).

Kaminer and his colleagues (1998) using manual-guided interventions measured the treatment process in CBT and interactional group therapies for adolescent substance abusers. In a 15-month follow-up of a pilot study, Kaminer and Burleson (1999) reported on the comparison of 32 dually diagnosed adolescents, randomized into 2 short-term outpatient group psychotherapy groups, one using CBT and the other an interactional treatment (IT). At the 3-months follow-up, no patient treatment matching effects were shown. However, adolescents in the CBT group showed a significant reduction in severity of substance abuse compared with those assigned to the IT group. At the 15 month follow-up, there were no differential improvements as a function of therapy type. However, subjects maintained significant treatment gains in the substance abuse, family function, and psychiatric status domains of the Teen-Addiction Severity Index, and both CBT and IT were associated with similar long-term gains. This study is the only one to date that demonstrates no superiority for short term group CBT compared with short-term group IT. Pressman and Brook (1999) have described a multiple group psychotherapy approach with adolescents with psychiatric and substance abuse comorbidity, treated in an inpatient psychiatric setting. The involvement of a multidisciplinary team using an integrative approach showed promising results.

A five-phase group model for outpatient adolescents who abuse substances was described by Spitz and Spitz (1996). It includes the following phases: a) evaluation and orientation, b) entry into the group, c) establishing a working climate, d) a middle or working stage, e) transition out of the group. The authors conclude that group therapy is the treatment of choice.
Azima 1992, described an intensive group psychotherapeutic interactional model for outpatients seen in a heterogeneous group. Parental involvement was indicated for the younger but not the older teen group. A variety of techniques and activities, including dramatherapy and guided imagery, are used in short- and long-term eating disorder groups (Moreno, 1998; Wurr and Pope-Carter, 1998).

Mitchell and collaborators (1990) compared the efficacy of antidepressant drug therapy with structural, manual-guided group therapy for a total of 12 weeks. The overall finding was that the addition of the antidepressant to the group psychotherapy did not significantly improve the eating disorder, but did ameliorate features of depression and anxiety. At six-month follow-up (Pyle et al., 1990), 30% of the sample had relapsed; however, group psychotherapy alone or combined with drug therapy showed lower relapse rates than treatment with medication alone. It also was found that neither attendance at the maintenance group sessions nor imipramine maintenance was associated with better outcome.

Leung et al. (1999) evaluated 10-week group CBT with 20 women diagnosed with anorexia nervosa, age 17 to 58 years. At post treatment, Group CBT was found to be ineffective in symptom reduction, and basic core beliefs were irrelevant to outcome. The authors concluded that group CBT in the current short form is insufficient to induce changes, and suggested further group treatments to address the issues of poor motivation, lack of insight, and ambivalence towards treatment.

A clinical study of an expressive group therapy eating disorders program reported positive behavioral change in this adolescent group, but there was no research to support these impressions (Shander and Orbanic, 1995).

It can only be concluded that eating disorders, especially anorexia nervosa, are resistant to change with short term formats. Further research is needed to assess multimodal programs, including motivational preparation before to group treatment. The links of eating disorders to sexual abuse, and borderline and self-destructive behavior need to be noted (Sansone et al. 1996).

Learning disabled adolescents.

These groups overlap with the previous children’s section in this review. Residential, outpatient and school programs offer specialized groups often integrated with other academic modules. Investigators agree that both the learning disability and social/emotional problems must be attended to in the group format, (Coché and Fisher, 1989; Mishna and Muskat, 1998). Computers and videos are helpful adjuncts to the group treatment (Cox and Lothstein, 1989; Gardano, 1994).

Bernstein et al., (2000) investigated the use of imipramine plus CBT in the treatment of 63 school-refusing adolescents with comorbid anxiety and major depressive disorders. The findings were that imipramine plus CBT is significantly more efficacious than placebo plus CBT in improving school attendance and decreasing symptoms of depression in school-refusing adolescents.

Parent and Family Group Therapy are combined more frequently in the treatment of younger children; Parallel and combined groups appear indicated with the acutely ill, traumatized adolescents, and where a return to living in the family is indicated. The use of multi-family group therapy has been recommended in the treatment of dually-diagnosed adolescents (Kymissis et al., 1995), and with abusive and neglectful caregivers (Meizan and O´Keefe, 1998)

A father-adolescent son group was described by Ginsberg (1998). The goal of these groups was the developments of insight, closer communication, and understanding. A combined experimental/psychoeducational format was used as part of group therapy program called the Parent-Adolescent Relationship Development Program.

A multi modal group program for pregnant and parenting adolescents involved collaboration with parents, school and community (Stoiber et al., 1998).

Culture

The influence of culture and society on therapy groups has been the subject of increasing investigation (Serrano and Hou, 1995). Culture-focused group therapy has been reported as an enhancing bonding with both the shy and introverted adolescent, as well as dealing with identity issues in gang-motivated youth (Vargas and Diplato, 1999).

Psychotherapy groups were carried out with youth experiencing war (Schneider and Cohen, 1996) and refugee trauma (Brumen-Budanko, 1999; Forgell 1997). (Azima, 2002) has reported on the use of groups with immigrant and refugee children and their families, and has outlined a training model for mental health professionals.
Functioning in the group context puts greater stress on the therapist, especially with children who act out physically and regress rapidly (Azima, 1986). With adolescents there is the accompanying disrespect and rebellion against authority figures (Azima, 1973). The reports of homogeneous groups for young patients with bulimia, anorexia, diabetes, migraine, thalassemia, and cancer indicate improvement in motivation and compliance with prescribed diets, exercise, and the use of medication.

A leader must solve the quandary of how to be a competent therapist and a respected authority figure, and not an admonishing disciplinarian. There is general agreement that today's child and adolescent group therapists have become more actively involved, less permissive, more spontaneous in their play, more confronting, and in general less distant in their relationship with group members. With adolescents, the therapist tries to assume an emotional/cognitive role model midway between the adolescent and the parent. Therapists with overclose identification with adolescents are put at risk of collusion, passivity, or acting out, while therapists with too distant an identification are rendered vulnerable to possible rebellion against parental figures. A good practice with adolescents is to assume an attitude of controlled curiosity and sophisticated ignorance, especially in the early stages of the group. An overintellectual approach on the part of the therapist is likely to produce silence, fear, withdrawal, and withholding in the group members.

Adding to the therapist's countertransference is the pressure from parents for the therapist to see the child from the parents' point of view. The therapist must be realistically empathic and not overjudgmental. In the clinic or day-hospital setting, the therapist is often caught in a tug of war between team members who side with or against the parent, teacher, or judge.

In many cases the therapist's reaction should not be classified as countertransferential unless. Group psychotherapists who do not overcentralize their position are more likely to be perceptive of the interactive psychodynamics and to reflect on the variety of positive and negative feelings and thoughts that corroborate or differ from their own. Some helpful qualities of the group therapist working with children and adolescents include comfort in a group, spontaneity, flexibility, playful creativity, and the ability to set adequate limits as a rational, empathic role model.

**CONTRAINDICATIONS**

Special problems and hazards are presented by children who are explosive, cruel and vindictive, sexually acting out, overly autistic, seclusive, and depressed. Children with physical stigmata often are scapegoated. When children are enuretic or encopretic, entry into the group usually is postponed until adequate controls are developed. Children of very low intelligence do poorly in verbal psychotherapeutic groups but profit from socialization, compliance, and support groups. Homogeneous groups in residential treatments report better outcome with retarded and delinquent populations.

Some children entering day-hospital programs initially may not be ready or capable of entering a psychotherapy group until they have adequate controls, are capable of listening to others, and expressing themselves. Younger children usually must be involved in multimodal therapeutic school programs with a gradual transition to triadic therapies with another child or parent before group psychotherapy is possible. Short preparatory groups are necessary for children with poor frustration tolerance.

For adolescents, the basic contraindications outlined previously apply as well. For outpatient treatment of adolescents 15 to 18 years of age, contraindications include acute psychosis, heavy medication, drug addiction, and delinquent acting out. The selection of the specific therapeutic modality for children and adolescents should be made in a more sequential fashion, considering the developmental stage, the type of problem, and the degree of intrapsychic or interpersonal deficit. This review shows that clinicians have been increasingly challenged to do groups with children who previously have been considered contraindicated, (e.g., children with autism or Asperger syndrome, the developmentally and intellectually handicapped and the traumatized and abused child).

**CLINICAL AND RESEARCH TRENDS**

Increasingly research has expanded and answered the past paucity (Azima and Dies, 1989; Azima, 1996; Dies and Reister 1986). Meta-analysis confirms the efficacy and efficiency. The trend is toward short-term, cognitive-behavioral, interactive models often using manualized guides. There is acknowledgment that some short-term models are not effective with very resistant disorders, (e.g. eating disorder, severe depressions, and substance abuse). In such cases, multimodal models integrating group therapies with pharmacotherapy may be indicated. A predictive trend is for the use of parent-infant/child groups for healthy development. Schools are becoming increasingly involved in doing groups with under-achievers, the aggressive bullies, and the creative thinkers, as well as research studies. For adolescents at the stage of separation, family therapy may be counterindicated. Studies that have found little therapeutic input with family therapy require replication. For day therapy centers,
parent involvement appears a necessity. At follow-up parents rarely are included in booster sessions, and the decline in their participation likely has a negative impact on the results. Current and future outcome research will likely be easier to carry out with the introduction of more efficient and sophisticated instrumentation. Where results show little clinical effectiveness for the group intervention, other therapeutic modalities should be considered, (e.g. individual or pharmacotherapy), in combination or sequentially. The current trend is toward inpatient multimodal models, involving school and community. The efficacy of outcome is now considered not only in terms of self-esteem, pleasure, and improvement in functioning in the home, school, and work, but in terms of cost of the delivery of mental health care. Here, group therapy has the advantage in that more children can be treated at less cost. It is clear that research supports group therapy effectiveness, and children and adolescents are decidedly excellent candidates for this interpersonal treatment modality.

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