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TYPES OF PSYCHIATRIC TREATMENT

Group psychotherapy for children and adolescents

S Reid, I Kolvin

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Royal Free Hospital School of Medicine, The Tavistock Clinic, Child and Family Department, Tavistock Centre, 120 Belsize Lane, London NW3 5BA

S Reid
I Kolvin

Correspondence to:
Professor Kolvin.

(A) Definition

By definition, group psychotherapy involves the treatment of a number of children in groups by a therapist or co-therapists. There are two main theoretical orientations – psychodynamic and behavioural/cognitive. The latter distinction is not necessarily a clear cut one and a rather simplistic view would be that while behavioural psychotherapy in children would seek directly to alter surface behaviour, psychodynamic psychotherapy is more geared to helping children towards a deeper understanding of their own behaviour. In this paper we address ourselves to the psychodynamic approach.

The original version of group psychotherapy was 'activity' group therapy which, although based on psychodynamic principles, tended not to use techniques of interpretation but focused on activity, appreciating that some young children could reveal themselves better in play and activity than in discussion.[1] Group play therapy developed by Axline[2] utilising Rogers's non-directive principles[3] has been used widely in community settings.[4] In this version, expression of feelings are facilitated in the younger children; the therapist is reflective but not directive, and hence the play is not directed beyond the limits necessary to allow the therapy to continue within the clinic or other setting. For example, the children must stay within the room and are expected not to destroy the fabric of the room or to hurt each other physically. One of the main centres for the development of group therapy with children in the UK is the Tavistock Clinic; their model emerged out of psychodynamic theory, following the work of Klein[5–8] and Bion[9 10] and is described elsewhere.[11 12]

However, even within each orientation there may be variations and thus the approach employed is likely to be determined by the training of the therapist and the nature of the problems addressed. Therapy as described in this paper is based on an understanding of group dynamics, with the main impact being in the context of the 'here and now' situation, with a focus on the personality and behaviour of each child, the relationship between peers, and the nature of each child's relationship with the therapist, rather than an exploration of early life events. The therapist seeks to create an atmosphere that allows each child to feel accepted and respected by the therapist for the person she/he is. A setting is provided that can be experienced by the group as safe and reliable and which enables the exploration of combinations of relationships, dysfunctional communication, and unconscious processes. Group psychotherapy recognises that all children have a range of strengths as well as weaknesses, and an appreciation of these by children has a potential for therapeutic impact on other group members.

The therapeutic aim is to enable four or five *younger* children, or six to nine *older* children/adolescents, to become a group. With younger children the approach in essence may be that of psychodynamically orientated group therapy with a focus on following play principles outlined by a number of group therapists[2 13–16] and with older children/adolescents with the focus on verbal interactions.[3] In becoming a group, the individuals need to recognise and value the uniqueness and sovereignty of each of the other members, and to come to understand those others as also representing aspects of themselves.[15] The group provides an opportunity to explore and capitalise on interactions between peers, the children and the therapist(s), as well as both present and past interpersonal experiences and family relationships. In this model the therapist may set limits, may interpret interactions, and seeks to promote an understanding of social skills and peer relationships.

(B) The nature of the group

It has often been asserted that a group is more than a mere collection of individuals but, rather, that the members have a common task and come to identifying with the group and its aims and are thus interdependent on each other. In addition, Freud argued that the fundamental component of the group was a leader.[17] However, social psychologists offer other definitions of groups, such as 'a social unit consisting of a number of individuals who stand in role and status relationships to one another, stabilised 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'.[18] The latter definition implies that some individuals are inside, whereas others are outside the group; this gives rise to a sense of group cohesiveness for those within the group. However, such cohesiveness may be in danger of potential disruption by 'disturbing motives' of individual members such as a wish to have the therapist for oneself or angry

feelings about other group members. Such disturbing motives need to be explored within the group to enable members to find a constructive or helpful solution. Other theorists argue that the behaviour of clients in therapy groups is governed by a balance of emotional forces.[19]

(C) Some ways in which groups may be therapeutic

It is important to try to understand the ways in which groups may be therapeutic, especially in relation to children, and Yalom makes a major contribution to this.[20] He identifies a number of themes and we address those particularly relevant to children. First, the instillation of a sense of hope; second, children have a considerable need to 'belong' and within the group there is an opportunity to discover their peers have problems that they thought were unique to themselves; third, acquiring a deeper sense of altruism; fourth, correcting maladaptive patterns acquired in the primary family group; fifth, the acquisition of social skills; sixth, the imitation of prosocial behaviour; seventh, interpersonal learning; eighth, group cohesiveness; ninth, catharsis, which essentially consists of allowing children to discharge their emotions within overall limits; tenth, existential factors, which include the notion that life is at times unfair and unjust, that perhaps there is ultimately no escape from some of the hurt of life experiences; and finally that group members must ultimately come to take responsibility for the way in which they live their own lives.

Other writers identify those factors that are of importance to the organisation and the functioning of groups. For instance, Bloch and Crouch point out that the qualities of the group make a contribution, such as the group's goals, size, composition, duration, context, and stages of development (see section on composition of groups).[21]

(D) Some advantages of psychotherapy groups

- Unlike adults in therapy, children are dependent on others for attendance at therapy sessions. Hence, there are many children who would not attend as outpatients for regular psychotherapy sessions because their families are unwilling or unable to provide the necessary support. However, it is possible for group psychotherapy to be 'taken to the child' in other settings, such as those enumerated below.
- Psychotherapy groups can be run in many settings that may not easily provide the conditions necessary for individual psychotherapeutic work[15] – for example in children's homes, ordinary schools and remand homes. For instance, it has proved possible to run groups in what might be considered rather unpromising circumstances of normal junior and even senior schools, by restructuring the environment available, setting sensible limits, and working within timetable constraints.[4]
- Some parents are unable to tolerate the suggestion that their child needs therapeutic help because they perceive this as their child being singled out and for these an offer of group psychotherapy is often less threatening.
- Where assessment indicates that group psychotherapy is the treatment of choice, then it may be a more economic use of the therapist's time.
- Many of the children, but particularly adolescents, referred for psychotherapeutic help suffer a sense of loneliness and isolation. For them a psychotherapy group offers a safe, supportive, empathic setting where boundaries and limits are determined by the therapist and where there is an opportunity for immediate acceptance, first by the therapist(s) and then by the other group members. For many children it is their first experience of becoming an important part of the life of a peer group and an opportunity, in a safe setting, of learning how to make friends.
- Within the group the child is enabled to see the consequences of his own behaviour and to see the impact of the behaviour of others upon himself. This is because the group experience is shared, and children have an opportunity to see not only the consequence of their own projections, but also how they may be vulnerable to the projections of others. For example, the bullied child may be helped to see why he is subtly provoking others to bully.
- Being in the company of children with different personalities, and seeing their weaknesses and strengths, enables the child to rediscover aspects of himself that have been suppressed, and to value the positive qualities she/he already has, thus enhancing a feeling of self worth.
- The group facilitates the exploration of a number of relationships and offers different models of behaviour and different perspectives on situations. This is particularly helpful for many deprived children, and for all children who have little capacity for reflection at the time of referral. Similarly, with older children or even those who are relatively adolescent, group processes and the appreciation that personal problems are not unique may facilitate self disclosure.
- Each member of the group will acquire a memory of all those events that have a significant impact on the life of the group. This is particularly helpful for those children who have been traumatised psychologically by their own life experiences and seem able to retain or learn little. In individual therapy, experiences and events can be denied and responsibility refused, but in the group it is more difficult over time to deny experiences that the group insists have occurred.
- It is hoped that positive group experiences will carry into settings outside the group, such as the family and the school – indeed there is some empirical evidence that group therapy in schools using non-directive principles[3] gives rise to improvement in behaviour in both the classroom and the home.[4]

(E) Who can run psychodynamic psychotherapy groups?

Group psychotherapy can be undertaken by a wide range of professionals whose basic training has enabled them to observe, to listen to, and to communicate with children about their feelings, to clarify issues, and to help them to understand the meaning of their interactions. However, it is mandatory for the above to be complemented by further training which includes regular supervision provided by clinicians experienced in psychodynamic group approaches. It is also possible for those with training and experience to work with those who wish to learn, by functioning as co-therapists. The latter provides an important opportunity for cross disciplinary work; for example, a child psychotherapist or a child psychiatrist with appropriate training might work with a special teacher, a nurse or a paediatrician.

(F) Composition of groups

1. TYPES OF GROUPS

Settings, age, sex

Groups are conducted in many settings, with the nature of the group often determined by the nature of the setting where children may congregate (nursery, school, special educational, residential). Here a mixed group of children share a setting, such as a school, and therefore have some knowledge of each other before and outside the group setting. In other cases they are brought together because of common behavioural problems (clinics, hospital units, and other units for troubled children) and age (children and adolescents). Thus groups can focus on a particular age group, sex group (for example with abused girls) or mixed sex groups.

Families/siblings

If several children in a family are all felt to be in need of help, family therapy may be the treatment of choice; however, some parents may refuse to discuss difficulties with their children present. One solution would be to see the siblings together, which facilitates the exploration of the ways in which they see not only each other but also the parent or parents.[22 23] Similarly, when there is a shared traumatic event, such as the sudden death of a parent with consequent serious distress, then working with the siblings as a group could be the initial treatment of choice.

Other groups

In other groups, the focus may be children who are not in the same family but who may have been exposed to a similar traumatising experience, such as sexual abuse, or who share in a traumatic event, such as a fire or a disaster. These children may have experienced no major psychological difficulties before the event, and this constitutes an opportunity to help the children to work through and to cope with the experience. These groups differ from other groups in that they can usefully be restricted to brief focal work, needing perhaps as few as six sessions.

There is not wide agreement about the composition of groups: some workers prefer to address a heterogeneity of problems within the same group (mixed group), whereas others focus on similar traumas or disorders. Hence, some workers will group together sexually abused children or anorexic young people. Those preferring to utilise a heterogeneity model would argue that even sexually abused children need to have other aspects of their life experiences understood, and to have the opportunity to have their individual strengths and vulnerabilities attended to. Such children sometimes complain that a group of sexually abused children can make them feel like a 'sex abuse case' and may deprive them of their individuality. In a mixed group the sexually abused child can choose when it is the experience of the abuse which she/he wishes to be addressed and when he/she is to be allowed to be seen as a child with other strengths and preoccupations; here, the child sets the agenda. Others would argue that for some children a homogeneous group is a safe and reliable setting for the emergence and exploration of sexual abuse experiences.

In summary while there is a consensus that the composition of the group is critical to its success or failure, some argue for homogeneity of disordered behaviour and others see 'mix' as the essential element including a sex mix. Those advocating mix stress that when selecting children for a group, careful thought should be given to the balance of problems and personalities.[14 15] For example, including an excess of children described as violent or acting out would be unlikely to allow for therapeutic work to be done, as the leaders would be occupied simply in preventing disasters. Similarly, a group of very timid children together is likely to become flat in its emotional atmosphere. A wide range of personalities and presenting problems increases the possibility of identification for the children within the group.

2. SIZE OF GROUPS

Group psychotherapy with children and young adolescents encompasses two distinct subgroups: those who are about 5–11 years old and those about 11–15 years old. Many children are sensitive about the issue of age and, once at secondary school, may see themselves as beyond childish things, even if this may not in reality be reflected by their developmental level; they can be deeply worried by being grouped with 'children'. Younger children's groups are most successful when composed of four or five children. Some group therapist's opt for five in order to make allowance for potential drop outs. However, this is the most that children up to 11 years can relate to therapeutically and the most that often can be contained, as children of this age are prone to acting out and need to be kept safe. Adolescents need a larger group of six to nine young people for two main reasons: first,

absenteeism is not uncommon and it is wise to expect that not all members will arrive for each session and second, they sometimes find a smaller group too intimate.

3. ORGANISATION AND SETTING

In order to run a psychotherapy group successfully, a suitable setting and equipment for younger children need to be available. For example, the room needs to be 'safe' and not, for example, subject to interruption from outside during the sessions. Any potential dangers to children need to be minimised – for instance, by having windows that are securely fastened; the room should be reasonably near a toilet and appropriate play material should be available, which potentially encourages group activities. The duration of sessions should be fixed beforehand and firmly adhered to: an hour for the 5–11 year olds and an hour and a quarter for young adolescents. Holiday arrangements should be agreed before the onset of the group. It is important to meet and prepare each child individually before the group sessions begin, so that they are aware of expectations of them throughout the duration of the group's life and the nature of the therapy; this can lead to improved attendance.[24]

The setting also refers to the atmosphere created by the therapist or co-therapist, within which therapeutic work can take place. To this end, at the first meeting, a group therapist should provide structure and guidance, introducing the children to each other, explaining about the length of the sessions, and suggesting minimal rules. This approach is commonly used in institutional settings for children with antisocial behaviour. Others consider it important for children without major antisocial behaviour to have the opportunity to discover any rules and that these are likely to be minimal – restricted only to limiting behaviour that would physically damage either themselves, other children or the room, or the leaders, or behaviour that might unduly hurt another child's feelings.[3]

(G) Who can benefit? What are the contraindications?

Previously, it was thought that group therapy was indicated for those children and adolescents who could not tolerate or be accommodated by individual therapy. However, this is no longer seen as correct, as clinical experience has shown that children with a wide range of problems can make use of group therapy, provided that careful consideration is being given to the composition of the groups. Children whose difficulties with their peers predominate often seem ideal candidates for a group.[4 25] In paediatric settings, for example, group therapy has been used with children hospitalised for chronic illness or who present with homogeneous and focused problems such as obesity.[26] Nevertheless, commonly individual psychotherapy, where available, might be the treatment of choice. Decisions about whether individual or group therapy should be used, where both are available, will be determined by assessment of the child and local resources.

Different theorists offer different suggestions why some subjects should be excluded: for instance, Aveline argues (for adults) that the brain damaged, the psychologically fragile, those who are not yet able to benefit from group therapy and need the intimacy of the one-to-one therapeutic relationship, and those who deny the psychological basis of their difficulties should be excluded[27]; however (with children), skilled therapists find that they can include a wider mix of disorders.

(H) The role of the therapist

1. LEADERSHIP

Children and young adolescent groups can be led by a single leader. When there are co-leaders for a group it is helpful (but not essential) to have a male and a female therapist; but it is essential that there is a basic respect and liking between these therapists.[15] The role of the therapist or therapists in a children's therapy group differs from that in an adult therapy group in that in children's groups dependency upon the leader is appropriate – for instance, the leader may have to protect certain children; it is acknowledged that such dependency is developmentally healthy.[15] Thus, the therapist (or co-therapist) must demonstrate a capacity to contain and protect all the members of the group. Hence the group therapist has to forge a therapeutic alliance that is age appropriate, aimed at helping the group to appreciate that one of their tasks is to be aware of painful thoughts and feelings and how to share and cope with them.[28] The impact of the group on the therapist or therapists should never be underestimated and vice versa – for instance, where there are co-therapists the group may exaggerate what they perceive to be the individual qualities of each therapist and this could lead to a schism between therapists.[15]

2. THERAPEUTIC BOUNDARIES

As previously indicated, the children must be contained, not only within the physical space provided by the room, but also need to be kept in mind (psychologically) by the therapists. It follows from this that it is essential to know what every member of the group is doing at any one time and this is the skill that most group therapists find the most difficult to develop within the often hurly-burly atmosphere of the group. When the boundaries of the room are firmly kept to and the adults also contain the group firmly in the mind, then it is possible to allow considerable freedom of behaviour, wishes, and impulses within this framework. Without this structure the therapy cannot take place.

3. EQUALITY, ACCEPTANCE, AND RESPECT

The experience of equality is established by the therapist by a concrete demonstration that each individual has equal right of access to the

therapist. Over time, equality comes to be understood as not necessarily equivalent to the same amount of time with or from the leader within any one session. Equality is demonstrated by the therapist noticing, for example, that one child is not asking for time or attention, bringing this to the attention of that one child and also limiting the child who may be in danger of monopolising the leader. As long as this is done by way of observation and not criticism this will also facilitate the experience of equality. Acceptance within the group means accepting each individual child as he or she is when first joining the group, without criticism, but rather with the aim of understanding that child and his/her problems. However, acceptance does not mean putting up with intolerable behaviour. An accepting atmosphere within the group soon seems to become infectious, with the children themselves rapidly developing a capacity to tolerate behaviour that they previously found unacceptable. Acceptance is often followed by a sense of trust and group cohesion.

Stated simply, the therapist strives to create a warm, accepting atmosphere that is friendly to the development of ideas and the exploration of relationships. The therapist should also strive to be alert to any expression of a wish to change in a child, or curiosity by a child about their own behaviour. Each child is respected as the person he or she is and this attitude is encouraged in the other children in the group. The therapists are there to support, encourage, and allow the development of new relationships and to try to understand those things in each child that hinder this.

(I) Efficacy and prognosis

1. INTRODUCTION

Until the early 1980s there were only a small number of studies of group therapy with children that employed non-directive techniques focusing on improving academic performance, peer relationships, or behaviour. Unfortunately, many of these earlier studies provided few details of the therapy process, beyond a label such as 'non-directive' or 'didactic'. Often there were serious methodological limitations with these studies. Nevertheless, there was a trend for the more substantial studies to focus on solving academic issues.

Those studies, which were of reasonable scientific rigour, gave rise to a diversity of outcome.[29–31] For instance some group therapy endeavours have been aimed at intelligence and achievements but systematic research has demonstrated that such therapy can influence socialisation and behaviour more readily than cognition.[4 32] Such studies often lead to an improvement on measures reflecting the views of peers (sociometric measures) and those studies that focused on difficult behaviour reported by the teachers also tended to give positive results.[33 34] Finally, a number of studies have been undertaken that focused on improving children's self concept and almost always these gave positive results.[35 36] An important follow up of a large series of sexually abused children suggests that group forms of therapy are effective.[37] While this gives cause for optimism, there is equally cause for caution, both because the drop out rate was high, and as it was an uncontrolled study there was no way of estimating the extent of the effect of natural reparative processes.

2. THE NEWCASTLE PROGRAMMES

Unfortunately, many of the previously published studies were reduced in value because of serious problems of small sample size, high rates of drop out, questionable statistical analysis and, often, inadequate measures. Nevertheless, despite these limitations, in many cases the results were encouraging. The largest and most systematic of the studies was that undertaken by the Newcastle school.[4 38 39] The aim of that study was the prevention and treatment of psychiatric disturbance reflecting neurotic and antisocial behaviour presenting in the school setting and it involved 7–8 years olds and 11–12 year olds. The children in these studies were identified with a multiple criterion screen, which covered behaviour and sociometric functioning.

Basic philosophy

The group therapies were based originally on the philosophy developed by Rogers.[3 40] The adaptation of the group therapy technique to younger children was influenced by the work of Axline in the USA, especially her eight principles that could be followed in practical play therapy[2]: these included the development of a warm, friendly relationship with the child, accepting the child as he/she is, engendering a sense of permissiveness in the relationship, being alert to the expression of feelings in the child, maintaining a deep respect for the child's ability to solve his/her own problems, having a non-directive attitude – exerting no sense of pressure – and, finally, confining limit settings to those that are necessary to maintain the therapy in the real world. The above therapeutic policy allowed the children to reflect their feelings through play in group situations. Nevertheless, it was necessary to establish some limit setting to allow the groups to function in the complex environment of the school, while at the same time strengthening internal controls of some of the more impulsive children.[2 13] Similar groups were run in secondary schools.

Long term follow ups were undertaken some 30–36 months after the start of the treatment programme. Non-treated control groups were used to establish base rates of moderately good plus good outcome and this occurred in under half the control subjects' but in the case of group therapy such good outcome occurred in about three quarters of the subjects.

Treatment specificity

Another attractive theme in psychotherapy research is that different types of disorders respond to different kinds of psychotherapy.

These kinds of treatment specificity, which are so important in adult disorders, do not appear to be supported by the work described above with children and adolescents. There was no consistent evidence of specificity, such as a better response of children with conduct or neurotic disorders to different treatment or management programmes such as behaviour modification or group therapy; where treatment was effective, it proved to be more so for neurotic disorders and less so for conduct disorders, but there was no particular form of psychotherapy that was more effective for one or other disorder.

Dimension of time: long term follow up and 'sleeper effects'

It is important to try to locate such beneficial changes within a time frame. It is commonly believed that patients respond gradually to psychotherapeutic help, with a maximum response being achieved by the end of treatment, after which patients may reach a plateau or, with the cessation of therapeutic support, the effects of treatment may begin to dissipate. In the Newcastle studies, when examining outcomes across time, it was intriguing to find that treatment effects continued to increase some 18 months or so after the end of treatment. The failure of the controls to catch up by the end of the follow up period also suggests that positive processes had been set in motion by the therapy.

Of particular importance is the subject of long term follow up. As mentioned, the findings from the Newcastle studies suggest that even relatively brief group therapy may have effects long after termination of treatment and these may not be detected unless provision is made for long term follow up. In these school based treatment studies it seemed that it was the type (for example, relatively brief group therapy) rather than the duration of treatment (for example, long term casework with parents) that was a critical factor in intervention. However, this may not be true for more seriously disturbed children in hospital based or other clinical settings.

The concept of 'sleeper effects', that is delayed effects of therapy, and their possible impact on the results of therapy, including group therapy, holds considerable fascination for the therapist and researcher alike. Whereas there is evidence that assessments at the end of treatment and at short term follow up give rise to no major differences between group therapy subjects and controls, such differences proved to be substantial at long term follow up; thus, it would seem that improvement continues after therapy has ceased. The mechanisms behind this remain unknown.[41] Although measurement of these delayed effects poses no problems, the mechanism of the psychological processes that precede the delayed effects is not easy to elucidate. One possible explanation is that positive social interactions within a group may lead to a strengthening of relationships with peers, which may be reinforced by subsequent further contacts outside the groups with these peers. Another possibility is that the child may acquire a new set of skills through group interactional experiences that are not useful immediately, but subsequently become so; for instance, they may help to prepare children to cope with later stressful experiences. Alternatively, there may be subtle shifts in personality that, through feedback mechanisms, give rise to demonstrable changes in behaviour.

Conclusion

Some workers report an immediate response to some forms of group therapy, but even when this does not occur, whatever the mechanism involved, the therapist should not be deterred by lack of evidence of immediate or even short term overt behavioural changes with seriously disturbed children, but should check for the presence of the longer term, more durable effects in due course.

According to Yalom, the child constructs an individual inner world that can be reconstructed through interactions with others.[42] The inner world refers to the notion that each of us has an imaginative life, or world of the mind, in which there is an alive ongoing relationship between all the important figures, particularly parent figures and experiences of the external world. Further, the inner and outer worlds are equally real and important to the child. The crucial influences are the therapist's expectations of the children and also the modification of the children's perception of themselves. Group therapy will enable those in a group to understand how other people function and how their own inner assumptions powerfully determine the pattern of subsequent interactions.[27]

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