Group Counseling and Psychotherapy With Children and Adolescents

Theory, Research, and Practice

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2 The Theory of Group Counseling With Children

A theory of counseling or psychotherapy should guide practitioners in the way they treat their clients. The philosophy on life of my colleagues, my students, and myself; our familiarity with the most current principles of individual and group change; our observations of the process of growth among children and adolescents in groups; and our research results have all led to the following basic assumptions:

1. The group should be an intimate place where children and adolescents can gain a sense of well being and grow personally. This implies that group participants are expected to talk freely about their disturbing thoughts and feelings, release tension, and, if possible, develop insight and make some behavioral change. To meet these expectations, children and adolescents should engage in cognitive and affective exploration of their most disturbing difficulties, those that they choose to discuss with the group, when they feel motivated to do so. Hopefully, these client behaviors will lead to self-understanding and to change of behavior.
2. To achieve such personal goals, the group should be a caring and supportive place in which members are accepted and understood. Only through such relationships can a child develop a sense of trust in self and others. This means that the child should feel close to the counselor and the group members, be involved in interpersonal interaction among group members, help others, and accept the help provided by others.

These two assumptions refer to the interplay between the psychological and social processes that characterize group counseling and psychotherapy. Although they are distinct levels of performance, they cannot be separated. Too much emphasis on the individual level of therapy will result in a mere extension of individual therapy to

the group context; too much emphasis on group dynamics may ignore an individual child's distress (Burlingame et al., 2004). The counselor walks a fine line between these two processes, encouraging both emotional experiencing of personal issues brought into the group and here-and-now group interactions that provide emotional and social support. Therefore, what best describes the modality of group counseling and psychotherapy with children and adolescent used by my colleagues and myself is expressive-supportive therapy. To help explain the way we travel both roads, I review the literature from which we drew our theory, illustrate the processes with case examples, and support our premise with research results. I begin by reviewing research on expressive–supportive therapy, followed by literature on the individual's process of change. This is complemented by a review of studies on the group process of change in the next chapter.

EXPRESSIVE–SUPPORTIVE THERAPY

Piper and colleagues (2002) introduced the distinction between interpretive–expressive and supportive therapy for inpatients and outpatients in individual and group formats. Successful interpretive therapy depends on the patient's willingness to self-disclose, to experience unpleasant feelings, to think about puzzling and frightening interpretations, and to deal with the unconscious. The therapist takes a passive–receptive approach; it is a talker–listener relationship with a focus on transferences. The intention of the therapist is to enhance insight, which will eventually lead to change in behavior. In contrast, supportive therapy focuses on reflection and adaptation. Its goals are to resolve present life concerns and improve the patient's reality testing and coping capacity. The emphasis is on conscious problems, using supportive advisory, informative, clarifying, and confronting interventions, without ignoring the importance of ventilation of feelings. The therapist engages in active listening, conveys concern and understanding, and thereby creates a *holding environment* through the establishment of a secure relationship. Stress is kept to a minimum, and universality and hope are promoted. At the same time, therapy is problem-focused and based on logical and rational processes. As the general goal is to promote ego strength, interventions include supportive collaboration, permissiveness, advising, informing (educating), and managing (setting limits).

Both interpretive therapies and supportive therapies are considered to be dynamically oriented, but the use of interpretive intervention is encouraged in the former and discouraged in the latter. In their extensive research, Piper and colleagues (2002) found that certain patient qualities are conducive to short-term interpretive therapies. Two of the major ones are Quality of Object Relations (QOR) and Psychological Mindedness (PM). In several studies, these characteristics were linked to the therapist–patient working alliance and to outcomes, both in individual and group therapy. A high level of QOR is believed to assist patients in tolerating the interpersonal demands of interpretive therapy, and a high level of PM is believed to provide the ability to work productively in examining intrapsychic conflicts in interpretive therapy. Their conclusion, therefore, was that patients low in both characteristics will do better in supportive therapy. In supportive therapy, there were also fewer dropouts (6% vs. 23%; Piper et al., 2002).

Interpretive interventions are considered to be among the most rigorous helping skills for adults in both individual counseling (Hill, 2005; Ivey & Ivey, 1999) and group counseling (M. S. Corey & Corey, 2006; Cramer-Azima, 1989; Yalom & Leszcz, 2005). However, taking into consideration the low QOR and PM of children and young adolescents—their developmental ability, restricted ego strength, dependency on adults, and sense of helplessness—supportive counseling and therapy seems to be the treatment of choice for them.

SUPPORT FROM RESEARCH

In our long practice of group counseling with children, my colleagues, my students, and myself have observed children's difficulty in handling interpretive interactions in groups. These observations led us to conduct a study designed to specifically investigate the effect of such interventions (feedback, confrontation, and interpretation) on elementary-school children (Shechtman & Yanuv, 2001). Based on transcripts of recorded sessions, we analyzed children's use of these interventions and their responses to them in the group process. Results indicated that the most frequent child intervention was confrontation (57%), followed by feedback (38%); interpretation was rare (5%). Overall, the children used more low-quality interpretive interventions than high-quality ones (54% vs. 46%), mostly owing to differences in confrontations. Feedback was almost equally divided into high- and low-quality categories; interpretations, when used, were usually of high quality. Feedback produced mostly productive behavior; not only was high-quality feedback usually followed by productive behavior (70%), but even low-quality feedback was followed by a relatively high percentage of productive behavior (40%). In contrast, confrontations were mostly followed by nonproductive client behavior, particularly when they were low quality (80%). Interpretations, too, particularly low-quality ones, were followed by nonproductive behavior. In general, the conclusion of this study was that children are not skilled in using constructive interpretative interventions; confrontations, in particular, seem to be quite destructive and should be kept to a minimum in children's groups, unless children are trained to use them constructively.

This study, carried out in a school in which children's groups are often used and led by an experienced counselor, confirms our observations that children are intolerant of criticism and intimidated by negative interactions. It supports the preference of supportive counseling and therapy over interpretive therapy for children. Nonetheless, it is impossible to ignore the vast literature on the importance of experiencing in adult counseling and therapy, which is less common in supportive therapy, as described by Piper and colleagues (2002). Although ventilation of feelings is part of the supportive modality and the counselor or therapist is an effective listener, emotional experiencing is not an actual part of this type of therapy. In fact, it is the main feature of interpretive therapy (hence the name *interpretive–expressive*).

In my attempt to reserve a central place for expressiveness, I raised the question of whether expressiveness is necessarily provoked by interpretive interventions. Could it be part of supportive counseling and psychotherapy evoked through alternative methods and techniques? In my clinical work with children, I noted a strong need to express emotions and disclose private information, and I found that emotional experiencing was a precondition for positive outcomes. One study (Leichtentritt & Shechtman, 1998) investigated children's verbal responses in groups, as well as the counselor's interventions that affected children's responses. All 160 sessions were audiotaped, transcribed, and analyzed based on the Client Verbal Response Mode System (Hill, 1986) for both the counselor and the children, as the latter assume some of the leader's responses. The most frequent child response was self-disclosure; boys and girls alike used it at least once in more than 90% of the sessions, whereas feedback was used in about 50% of the sessions and questions were used in 35%. Moreover, analysis of responses by stage of group development indicated that frequency of self-disclosure was already high at the first stage of the group (first four sessions), with both boys and girls giving an average of 10–14 self-disclosure responses per session, a level that was maintained throughout the group process. For comparison's sake, consider that the next frequent response at the initial stage was feedback (0.95 and 0.49 average responses per session, for boys and girls, respectively), and all other types of responses were quite rare. Thus, the most impressive finding regarding children's behavior was their high level of self-disclosure, which was often self-initiated, from the beginning of the group process through termination. It appears that self-expressiveness is a central need for children in group counseling, which should be allowed and encouraged. This prepares the groundwork for affective exploration and experiencing, which is so treasured in individual counseling and psychotherapy.

How was this high level of self-disclosure possible in these groups? When counselor responses were investigated for their impact on children's self-disclosure, it appeared that the counselor, in contrast to the children, used a variety of responses. Although she also disclosed quite a lot, she asked even more questions, provided feedback, and used encouragement, directives, and paraphrases. For example, the counselor voiced encouragement in 80% of the sessions at least once; the children used this response in less than 10% of the sessions. Interestingly, the two counselor behaviors that stood out in their impact on children's self-disclosure were structured activities and questions, leading to self-disclosure in about 90% of the sessions in both cases. The conclusion of this study was that interpretive interventions are not necessarily the counselor behaviors needed to promote experiencing in children's groups. In fact, other behaviors (questions) and techniques (therapeutic activities) appear to work very well.

Other researchers have also combined expressive and supportive therapies, without necessarily relying on interpretive interventions. Spiegel and Classen (2000), for example, proposed such a model in work with cancer patients, arguing that the two components of expressiveness and support are interrelated. Intimate social relationships both allow and encourage the expression of strong emotions, which, in turn, stimulate the development of social support. Social support is an important mediating factor in dealing with stressful life events. In a group of cancer patients, such support reduced the feeling of isolation and provided new important social connections. But the expression of strong emotion is no less important. In fact, Spiegel and Classen concluded that the central task of the therapist is to follow the affect more

than the content (p. 33). This conveys to the patients that the group is a place where their distress can be expressed and addressed. Positive, as well as negative, feelings are invited because hiding them, denying, or pretending consume considerable energy, which is needed to deal with so many other issues that these patients face. The clinicians encourage open expression of feelings relating to the worst of all—the threat of death, arguing that by facing one's own worst fears openly and directly, patients realize that they can tolerate it, which further lessens the level of anxiety. Indeed, there is vast research that supports this. Not only do the patients feel more empowered, but they also live longer (Spiegel & Classen, 2000). Similar to the support groups described by Piper and colleagues (2002), the emphasis of Spiegel and Classen's expressive–supportive model is on cultivating a realistic optimism, by finding those aspects of life that can be controlled, and making the most out of them. Redefining life priorities, increasing support of friends and family, and improving coping skills are all issues that can be handled on a conscious level. Often instrumental and practical advice coming from people who have been in a similar situation is of imminent importance.

How is support and emotional expression developed in such groups? Because patients have a similar problem and are all in a needy situation, supportive behavior develops quite naturally. The group setting is often the only place where patients feel understood, accepted, and a little less alone. Thus, the need to share similar emotions and experiences stems from intrinsic motivation for many of these patients. However, these emotions are not necessarily evoked through interpretive interventions or the discussion of transference issues. They become present because the atmosphere is of a shared experience of common emotions, a pool of feelings in which the group immerses itself. When these feelings are acknowledged, explored, identified, openly discussed, and understood, therapeutic progress is made. Thus, expressive therapy need not be synonymous with interpretive therapy, and support can be both instrumental and emotional.

A CASE ILLUSTRATION

In illustrating how counseling groups for children can incorporate an expressive–supportive model, I cite the example of counseling offered to children of divorce. Because such children usually feel embarrassed talking about their families with children of intact families, they are often placed in special groups, as is the case described here.

This particular group included six sixth-grade boys and girls. Over the course of several sessions, the group developed a supportive climate and many of the children shared common experiences and difficulties, disclosing that they feel puzzled, insecure, and often lonely. However, it was not until two-thirds of the sessions had passed that Jack whispered at the end of a session, "I hate her, I never want to see her again." The children barely heard his comment, but Margo, the counselor, saw the tears in his eyes and said, "I can see you are very upset. Let's remember to bring this up next time."

Jack had been very quiet to this point, slow in keeping up with the group's progress. Margo was moved by his expression of emotion; understanding how risky it must have been for him and how vulnerable he must have felt, she immediately acknowledged his affect. The next session opened with her turning to Jack, repeating his earlier comment, and suggesting, "You probably mean your mom." She invited him to tell the group more about his feelings. Jack revealed that his birthday was coming up and his mother had not even called. She had called a while ago, asking what present he would like for his birthday, but he responded angrily that he did not need her presents and hung up. The group helped him explore his emotions in various ways. Some children shared similar feelings of neglect and rejection. Others asked questions, helping Jack to understand that he actually needed his mother's attention. In the Echo Game that they played that session, other children expressed the emotions that Jack had not yet able to express: anger, frustration, and disappointment, but also a sense of longing. Sarah, playing Jack's echo, said, "I feel that you gave up on me, you are not interested in me, and this is very painful because I miss you, I want my mom." At this point Jack started crying. When he calmed down, Francine explained, "You do not hate your mother; you love her, but you are disappointed."

The group identified the real emotion and shared mutual feelings that provided Jack with some sense of power. Then they role-played the phone conversation in which he rejected his mother. Jasmine, who played his mother, explained that she felt rejected and confused about future contact with her son. Jack did not know what to do with this information at this point. There were suggestions to call her and explain to her his true feelings, but he was not ready for this yet. The group then decided to write a collective letter to his mother expressing his real feelings, which they then read to Jack. This helped him understand his emotions, but he was not ready to send the letter. However, the next session Jack said he felt much better, and that, although he was still uncertain about sending the letter, he was not so angry anymore. He expressed his love and appreciation for the group; this was the first time that he expressed any feelings so spontaneously.

Mobilizing the expression of emotion is a crucial part of the counselor's role. In this case, the counselor noticed and acknowledged the child's distress; she also led group members to be involved with each other and to learn from mutual experiences. Feelings were explored, identified, and understood, and instrumental steps were taken to resolve the problem. The power of the expressive–supportive model clearly emerges from this case: when emotions are expressed rather than suppressed, the client's emotional health improves. Moreover, this was achieved through therapeutic activities such as the Echo Game and the collective letter, rather than via the discussion of deep interpretations or transference issues.

Emotional experiencing appears to be the heart of counseling and psychotherapy in the current literature (Bohart et al., 1997; L. S. Greenberg, 2002; Wiser & Goldfried, 1998). L. S. Greenberg (2002) stipulated that "the greatest complexity of being human is that, in essence, we are two 'selves' that do not necessarily get along" (p. ix). One self drives the rational stream of consciousness, and the other drives the experiential, sensory stream of consciousness. The resolution to the two selves dilemma lies not in favoring one stream of consciousness over the other, but in integrating the two: allowing emotional experience, attending to it, and reflecting on it. L. S. Greenberg thus offered emotion-focused therapy, which is basically emotion coaching. This involves being at-

tuned to clients' feelings, offering suggestions to help them process their experience more deeply, and using cognition to make sense of emotion.

L. S. Greenberg (2002) suggested that working with emotion is applicable across orientations. Although most approaches to therapy, to some degree or another, involve coaching people in emotions, L. S. Greenberg's (2002) model suggested using emotions as a guide for change. Research has supported the notion that experiencing emotion is the core of many emotional change processes. In many situations in counseling and therapy, arousing emotions seems to be an important precondition for changing them. Mounting evidence that emotional arousal and depth of experience relate to therapy outcomes supports the importance of access to emotion in counseling and therapy (L. S. Greenberg, 2002). However, venting alone is insufficient to promote change. Further processing is needed, in which reflection on emotional experience or the development of awareness is needed. "It is the integration of emotion and reason that results in a whole that is greater than the sum of its parts," he argued (L. S. Greenberg, 2002, p. 10).

Hill (2005) claimed that it is how people make sense of and use their emotional experiences that makes the difference. In her three-stage model and her vast research, she helps one understand and practice the process that leads to emotional experiencing. From her model of change, as well as that of Prochaska (1999), I draw the principles of the change process on the individual level of group work.

INDIVIDUAL PROCESSES OF CHANGE

Hill (2005) and Prochaska (1999) both offered an integrative model of counseling and psychotherapy that I have adopted in my work with groups of children and adolescents, as have many other child and adolescent clinicians (see review in Cramer-Azima, 2002). Both of these stage models of change have enhanced the expressive half of the expressive–supportive model that I apply. Accordingly, I discuss their theoretical principles in this chapter. The supportive part of my model is discussed in the next chapter.

Despite the prevalence of cognitive behavioral orientations in counseling and psychotherapy for children and adolescents (Kazdin & Weisz, 2003), I prefer the more recent trend in psychology that suggests an integrative approach—the use of several theories within a developmental perception of change. Accordingly, the children are first encouraged to express their concerns, explore their difficulties, and understand the reasons for and consequences of their behavior. Only when motivation to make a change in behavior is observed are they assisted in changing their perceptions and trained in areas of skills deficit.

The purposes of this counseling are to release tension, to make life a bit easier for the children, and to empower them. In this respect, the goals resemble those of humanistic therapies, as defined by Kirschenbaum (1979): "The aim of humanistic therapy is not to solve a particular problem, but to assist the individual to grow, so he can cope with the present problem" (p. 113). However, the model goes further in an effort to have the children reflect on their behavior and understand what causes their stress. Other aims include increading the children's motivation to take charge of their behavior, and, of course, to offer help to achieve such change.

This theory suits not only my philosophy of work, but also the needs of the children that my colleagues and I work with (see the first chapter). These children need to talk to someone who will listen to them in a caring way, someone who will accept their feelings and understand their chaotic emotions. They also need to feel that they are liked and appreciated by adults and peers, and that they will be supported with their difficulties. In addition, they usually need guidance and training in areas of social deficit, but will probably reject this if their basic needs for acceptance and understanding are not met first. Motivation becomes a key factor in such a process of change. I believe that children, like adults, must make choices based on free will. Any attempt to set goals for them or impose skills training on them is doomed to failure because the intrinsic motivation is missing. Even young children resent any type of coercion and prefer making decisions on their own. Motivated children are more likely not only to produce change, but also to put effort into maintaining that change. However, they are liable to need considerable assistance in increasing their motivation. This entails more than just raising awareness, as children do not easily make the connection between understanding a problem and making actual change. If child counseling and therapy is to be adjusted to children's developmental needs, it should not be based on a change in theoretical principles, but rather on changing the methods of work, which will be discussed in a later chapter.

I now explore, in greater depth, the two theoretical models that underlie the expressive part of the expressive–supportive model that my colleagues and I apply to child and adolescent counseling groups. In particular, I focus on how each of the influencing theories helped us develop our theory of change for group counseling with children and adolescents.

HILL'S (2005) THREE-STAGE MODEL OF COUNSELING

Hill's (2005) three-stage model begins with exploration, is followed by insight, and ends with action. This model serves as a framework for using helping skills to lead clients through the process of exploring concerns, coming to greater understanding of problems, and making change in their lives. It is based on extensive research (Hill, 2001), suggesting that it is a transtheoretical model. The three-stage model is influenced by client-centered, psychoanalytic, and cognitive-behavioral theories. Each of these theories is the primary influence for one of the model's three stages.

The exploration stage is influenced by client-centered theory. It is intended to help clients explore their thoughts, feelings, and actions. The helpers at this stage develop a therapeutic relationship with the clients, encourage the clients to tell their story, and facilitate arousal of emotions. The insight stage is influenced by psychoanalytic theory. It aims to help clients understand their thoughts, feelings, and action. Helpers work with clients to construct new insight and understanding, to determine their role in their thoughts, feelings, and action, and to work with clients on issues in the therapeutic relationship. Finally, in the action stage, helpers encourage clients to explore possible new behaviors, facilitate the development of skills, and assist clients in evaluating changes and modifying action plans.

The usefulness of this model, beyond its three stages, lies in its inclusion of sets of client behaviors and counselor helping skills, which aid in defining the effective per-

formance of client and helper. Effective client functioning in counseling means reduction of resistance to counseling, as well as fewer simple responses, such as recounting or simple request. In contrast, cognitive and affective exploration, developing insight, and making a commitment and a plan to change should increase. The counselor guides the client through the three stages using a set of helping skills appropriate for each stage. Questions and encouragement are used primarily during the exploration stage; challenges, interpretations, and self-disclosure are used mostly at the insight stage; and information provision and guidance are the main counselor skills during the action stage. Hence, similar to L. S. Greenberg's (2002) model, Hill (2005) considered experiencing as a major mechanism of change, along with the development of insight; but she also added the action stage, emphasizing the need to guide clients to achieve actual change.

A CASE ILLUSTRATION OF THE THREE-STAGE MODEL

This case illustrates the three-stage model, emphasizing the importance of the action stage, which is an important addition where child counseling is concerned. Owing to their weak ego, lack of skills, and dependence on others, children, in particular, need extra help at this stage to guide them to make a change.

Rita had been anxious about her relationship with her father, whom she perceived as highly old-fashioned, with a tendency to restrict her social relationships. Every Friday night was a new battle. For instance, she wanted to return from a party together with all her friends, but he insisted that she come home earlier. They both got angry, and then she gave up and did not go. This made her very angry with her father, and she perceived him as being bossy and inconsiderate of her feelings. She thought that he must not love her if he did not want her to have a good time. So, she told the group she had decided to run away to resolve the issue once and for all. When other girls in the group shared similar family battles, it became clearer to Rita that it was not just her father who acted this way. In exploring their relationship more in depth, she realized that she loved him dearly, and that she tended to give up because she could not bear to see him in pain. It became clear to her that running away was not the right solution, because it would make him suffer even more and she would not be able to stand that. The alternative was to talk to him and try to convince him to give her more freedom. She agreed to try, but was not sure she could do it. Role-playing helped her practice the necessary skills to talk to him convincingly. When she argued that coming home earlier means walking alone, which is less safe, he agreed.

In this case, the action stage was needed to resolve the problem. Although Hill's three-stage model was developed on the basis of individual counseling with adults, I find it useful for group counseling with children as well.

APPLICATION OF THE THREE-STAGE MODEL: SUPPORT FROM RESEARCH

Research by colleagues and I has indicated that the patterns of both client and counselor responses are quite similar in individual and group counseling for children, and they are also similar to adult counseling processes. We found simple response to be the most frequent client response, followed by experiencing and insight; other responses (asking for help, future goals, and counselor-client alliance) were quite rare, in keeping with the literature on individual adult counseling (Hill, 2001). Experiencing was more frequent in group counseling (Shechtman, 2004a; Shechtman & Ben-David, 1999). The higher rate of experiencing in group counseling is not a trivial finding, as it is the heart and soul of psychotherapy (Bohart et al., 1997; L. S. Greenberg, 2002). There were no differences in outcomes between individual and group treatment children. As clients in individual counseling undoubtedly receive more therapeutic attention, we attributed the equal gains to the higher rate of experiencing in group counseling, hence underlining the importance of emotional experiencing in counseling.

In regard to counselor responses, we found that group counselors used mostly questions, followed by paraphrases, encourages, and interpretives, regardless of the treatment format. Other differences were minimal. The conclusion drawn from these two studies is that the client behavior system and the helping skills system can be safely applied to group treatment research and practice with children.

An interesting finding in these two studies (along with an earlier one; Leichtentritt & Shechtman, 1998) is that the most frequent counselor response is asking questions and not providing challenges or interpretations, which were extremely rare. In other words, interpretive interventions are not needed to generate emotional experiencing in children's groups. Rather, there are alternative methods, which I discuss further.

PROCHASKA'S (1999) TRANSTHEORETICAL MODEL OF CHANGE

Prochaska (1999) has suggested a more extended transtheoretical model, in which change involves progression through a series of stages, and, at any given stage, people apply specific processes to progress to the next one. The change process entails six stages: (a) precontemplation, (b) contemplation, (c) preparation, (d) action, (e) maintenance, and (f) termination. Precontemplation is the stage in which people do not intend to change, because they are unaware of their problem, demoralized about the ability to change, defensive about their behavior, or denying that there is a problem. At the contemplation stage, people intend to change and weigh the pros and cons of doing so. The balance between costs and benefits can provoke profound ambivalence, which can keep people immobilized in this stage for a long period. In the preparation stage, people intend to take action in the immediate future and usually have a plan for action. These are the people best recruited for brief counseling. Action is the stage in which people have made specific modifications in their life or changes in their behavior. In maintenance, people work to prevent relapse, and are increasingly more confident that they can continue their changes. Finally, at termination, individuals experience no temptation to return to their previous behavior and are confident about their ability to maintain the change, no matter what the temptation will be.

As in the Hill (2005) model, Prochaska's (1999) recommendation was to match particular processes of change to specific stages of change. In the beginning stages of

change, the intention is to raise awareness and increase information about the causes, consequences, and cures for a particular problem; to help with emotional relief; and to lead to environmental reevaluation. To progress from the contemplation stage to the preparation stage, self-reevaluation and self-liberation are needed. Self-reevaluation combines cognitive and affective assessments of one's self-image. People at this stage reevaluate how they have been as troubled individuals and how their life will be once they are free of the problem. Self-liberation encompasses both the belief that one can change and a commitment to act on that belief. Finally, at the action and maintenance stages, a cognitive–behavioral orientation is in order. These stages require counter conditioning (learning healthier behaviors to replace problem behaviors), contingency management (particularly reinforcement), stimulus control (modifying the environment to minimize temptation), and helping relationships.

Prochaska (1999) offered an integrative model in which therapeutic processes originating from competing theories can be compatible when they are matched to the client's stage of change. With patients in earlier stages of change, counselors or psychotherapists can enhance progress through more experiential processes that produce healthier cognitions, emotions, evaluations, decisions, and commitments. In later stages, the therapist should seek to build on such solid preparation and motivation by emphasizing more behavioral processes that can help condition healthier habits, reinforce these habits, and provide physical and social environments supportive of healthier lifestyles. Techniques are also adjusted to the stage of change. At the first stages, people have low expectations and poor therapeutic alliance, and these problems must be addressed first. A safe and caring relationship and environment can be established through careful listening and accepting; allowing release of emotions; and developing awareness, understanding, and empathy (through direct interactions, such as clarifying processes, and through indirect methods, such as art therapy). Only afterwards is it helpful to confront clients, but this, too, should be done in a sensitive and caring manner.

Perhaps Prochaska's (1999) most meaningful contribution was his emphasis on motivation or the will to make a change, which receives little emphasis in cognitive–behavioral theory. According to his model, only after a person has shown some intention to change and has developed some ideas about possible ways to reach his goal can the therapist work on mastery of skills. I, too, believe that the motivation and intention to change is the key to success, even with young children and certainly with adolescents.

A CASE ILLUSTRATION OF THE TRANSTHEORETICAL MODEL OF CHANGE

My colleagues and I have applied Prochaska's (1999) model in our group treatment, particularly with aggressive children. The following case illustrates the change processes for one boy over the course of a short-term group counseling treatment (10 sessions).

Joe was a 10-year-old boy in the fourth grade who was identified by teachers and peers as highly aggressive. His family history was difficult: his parents were divorced; he had no relationship with his father; his mother, who worked hard to make a living, was seldom around; and he was "bossed around" by his only (older) sister. Joe had a history of physical abuse by both parents; he also witnessed his father abusing his mother. Joe was being treated in a group that included two additional aggressive boys and two nonaggressive classmates. The group was introduced to him as a storytelling group, which he liked. The first session was aimed at breaking the ice, getting to know each other, and introducing the language of feelings. The group plays The Legacy of My Name game. Joe indicated that he did not like his name, because it reminded him of his father's family ties. Next, in a game in which several objects were selected, he chose a rock, explaining that he was strong as a rock and that he liked being in power; he wanted children to know who was boss, to respect his strength, and to fear him. "This way they will never bug me," he explained. At this session, Joe was clearly in the precontemplation stage. Any attempt to probe, confront, or teach him about his behavior was useless. There was no point in showing him the negative side of such behavior before rapport had been established with the counselor and other group members. Realizing the stage he was in, Marie, the counselor, only reflected on what he said, refraining from criticism and exhibiting acceptance. She also acknowledged the positive feeling of being in power. At this point, Joe may have been surprised, even puzzled, at her calm reaction, but it was also a sign for him that the group was safe and that real feelings could be expressed.

In the next session, Marie used the book *The Soul Bird* (Snunit, 1999), which describes a variety of feelings (e.g., happiness, frustration, anger), each living in a drawer that may be opened by a certain behavior (e.g., a hug opens the happiness drawer). Joe opened the anger drawer, explaining, "When someone bugs me or is angry with me, the drawer of anger immediately opens up, and I have no control over it." It was only the second session, and Joe had already moved to the contemplation stage. Marie asked how he felt when he lost control, and he admitted that sometimes it was disturbing. He gave an example of an incident with his mother, because he felt sorry for her. Marie acknowledged his empathy for his mother and his good intentions, suggesting that perhaps one day they would discuss ways to increase self-control. There was no rush to change behavior—although Joe had exhibited a rising motivation to change, there was still too much to risk.

In the following session, Marie presented a picture of an adult abusing a boy quite brutally and asked the children to make up a story about it. Joe's story told of a frustrated father who left his family, but not before taking out his anger on his innocent son, who was trying to protect his mother. It was clear that Joe was going through a cathartic experience; he was highly emotionally aroused when telling the story and then withdrew. The group reacted enthusiastically to his story, acknowledging the son's efforts to help his mother.

The fourth session focused on a poem in which a frustrated boy destroyed his own drawing. In the process of identification with the literary figure, group members described their own experiences of loss of control. Joe shared with the group an incident in which his father smashed his computer, and others related similar instances. Quickly, the children moved to describing their own angry reactions. Joe said, "I can't think straight when I'm angry, my hands move automatically." When asked if he wants to change that, he responded with a "maybe."

Marie introduced a story about an abusive father in the next session. Joe left the room in tears, but came back after a while and shared with the group his experiences of being abused by his father. "I felt really helpless when it happened, because my mom could not protect me. I could not hit back because he was so strong, but I wanted to hit someone, so I chose a younger child and hit him." He continued, "I know it's not right, but I'm not thinking at such moments." This seemed to indicate the development of insight and perhaps the beginnings of motivation to take some action.

In the sixth session, the children drew their own monsters, on the basis of the poem "My Own Monster." Discussion focused on the extent to which they wanted to control their monster. Joe, like the others, said he wanted to control his monster, which looked very ugly and threatening to the children. This was the time for a clarifying process, in which the children investigated the pros and cons of their behavior and were confronted about the consequences of their aggression. Each child placed himself on a continuum of aggression from 1 (*no self-control*) to 10 (*always in control*). Joe considered himself a 4, explaining that he lost control more often than not, but said he used to be a 1, with no control at all. Asked what he would like to become, he chose 7, i.e., usually with control. Probed about the price he paid for his lack of control, he offered a whole list of things: "Kids won't become friends with me, I'm not invited to parties, teachers are angry, my mother suffers." He was also able to foresee the positive consequences of his possible change in behavior: "I will not be that stressed, I will have things to do, I will not be that isolated." It appeared that Joe (like the others) had reached the action stage and it was time to work on change.

The next session featured the film *Madi* (Keymeulen, 1987) in which a child is badly injured as a result of aggressive behavior. This made a strong impression on the boys because of the dramatic consequences of anger and aggression. The struggle for self-control came up again, and more alternatives to aggressive reaction were found. Joe continued informing the group about changes he had already noticed: "We lost the game because the other group was cheating. Normally, I would have been really angry, but I just left." He shared with his mom the fact that he attended the group and she, too, reinforced his progress.

Finally, the group read the poem "I Am My Own Commander," which focuses on taking responsibility and controlling oneself. At this stage, Joe was quite ready to take charge of his behavior. He felt he was moving in the right direction. At termination, in his feedback on the group experience, he said that he liked the way he had been treated in the group, how the counselor listened to him and was nonjudgmental, and that this made him cooperative. "When they yell at me, I do not listen, but when people talk quietly, I can understand." Maintenance and termination were not possible to follow in this course of treatment.

APPLICATION OF THE TRANSTHEORETICAL MODEL: SUPPORT FROM RESEARCH

Prochaska's (1999) theory was further examined in terms of the process of change undergone by various aggressive children receiving individual and group treatment. The first study (Shechtman & Ben-David, 1999) analyzed the change process for 15 children in individual treatment and 15 children in group treatment. Results indicated that about 60% of the children in both formats reached the action stage. Moreover, a correlation between stage of change and session number was revealed, suggesting progress in stages as the treatment evolved. The second study (Shechtman, 2003) analyzed the process of change for 25 aggressive boys in individual treatment and 25 in group treatment. Here, too, a pattern of growth was revealed; as treatment progressed, children moved to higher stages of change. At the onset of counseling, only a few of the boys (about 10%) in both formats had reached the preparation or action stage. In contrast, at termination most of the boys had reached one of these two advanced stages (83% and 79% for individual and group treatment, respectively). Furthermore, a hierarchical analysis confirmed that the probability of reaching a higher stage of change increases significantly as a function of the treatment session.

SUMMARY

In sum, I offer a unique theory of child group counseling and psychotherapy using an expressive–supportive modality. Although we acknowledge the importance of self-expressiveness noticed by Piper and his colleagues (2002), my colleagues and I refrain from interpretive interventions due to the deficit in children's abilities to cope with such interactions. To enhance self-expressiveness, we employ an integrative theory of change based on stages of progress, as suggested by Hill (2005) and Prochaska (1999). This multistage theory is also conducive to the supportive aspect of our model, as the action stage employs numerous techniques that provide instrumental assistance. These three sources of influence are reflected in our long and intensive clinical experience, as well as on a vast body of research. However, they are not the whole process of change; in fact, they only explain the individual process of change in the group and help practitioners work with the individual within the group.

Despite some similarities in both client and counselor behaviors in individual and group treatment formats (M. S. Corey & Corey, 2006; Hill, 1990), there are also unique characteristics of group work (Fuhriman & Burlingame, 1990). Although some (e.g., insight, catharsis, reality testing, hope, self-disclosure) exist at both individual and group levels, owing to the similar goals in counseling there are also factors unique to group counseling situations (such as vicarious learning, role flexibility, universality, altruism, family reenactment, and interpersonal learning). More recently, Burlingame and colleagues (2004) concluded that the best predictors of outcomes in group are the interpersonal (e.g., feedback, positive climate). Others indicated important differences in therapeutic factors between individual and group treatment. In his work with cancer patients, Spiegel and Classen (2000) argued that it is the exchange of self-disclosure and mutual support that affects outcomes. Thus, the second part of the expressive–supportive equation is drawn mostly from group dynamics. As therapeutic factors are an important aspect of process analysis in group counseling and psychotherapy, they are discussed in depth in the next chapter, which addresses the social aspects of the group process.

4 Leadership in Counseling Groups With Children

The effectiveness of group counseling and psychotherapy is largely dependent on the leader's personality, interventions, and skills. M. S. Corey and Corey (2006) have argued that personality has the strongest impact on group members, and have referred to such personal traits as presence (being there for the client), personal power (self-confidence), courage (ability to take risks and be vulnerable), self-awareness, sincerity, authenticity, sense of identity, creativity, and belief in the group process. Research supports many of these characteristics. Group leaders who are warm, supportive, and genuinely interested in individual members, as well as in the group as a whole, have a positive impact on the gains of group members (R. R. Dies, 1994), whereas a leader's negative behavior tends to have a destructive impact on group members (McCallum, Piper, Ogrodniczuk, & Joyce, 2002; Smokowski, Rose, & Bacallo, 2001).

Leader interventions are defined as "purposeful actions of the leader to ensure safety and/or initiate, energize, or enhance the therapeutic factors operating within the group setting" (Morran, Stockton, & Whittingham, 2004, p. 92). Group interventions range from relatively spontaneous leader actions, such as blocking behavior or drawing out group members, to more formal planned exercises, such as structured feedback exchange. They may focus on individual members, a subgroup of members, or the entire group. Some of the most important leader interventions are directing communication traffic, facilitating the group process, blocking harmful group behavior, protecting group members, supporting, linking, moderating discussions, summarizing, and giving feedback (M. S. Corey & Corey, 2006; Morran et al., 2004).

In contrast to individual counseling, the group counselor has a number of tasks, some starting even before the group actually meets (Riva & Haub, 2004). The leader is responsible for selecting group members and pregroup preparation. After the group meets, one of the counselor's most important tasks is to establish and maintain

a positive group climate. As in individual therapy, where the client–therapist relationship has been recognized as the single most important variable for therapy success (Bachelor & Horvath, 1999), therapeutic alliance is extremely important for the group's success. However, in groups this relationship is more complicated, as other significant people are involved in the therapy process. Positive relationships must be maintained among all members of the group, and the group must be attractive to its members to increase involvement and group cohesion. Group cohesion is considered the equivalent to therapeutic alliance in individual therapy, and of equal importance. Indeed, a relationship between group cohesion and therapeutic outcomes is frequently mentioned in group research (Hoag & Burlingame, 1997; Marziali, Munroe-Blum, & McCleary, 1997; Tschuschkle & Dies, 1994).

Another important role of the group leader is responsibility for giving structure to the group. Structure is provided in many ways, such as by establishing group norms, by suggesting topics, and by initiating activities. This is particularly necessary in the early stages of the group (R. R. Dies, 1994; Stockton, Rohde, & Haughey, 1992). Research suggests that structure has been associated with increased self-disclosure, cohesion and risk-taking in the group (Gazda et al., 2001).

The professional skills needed by group leaders are similar to those required in individual therapy. They include active listening, restating, clarifying, summarizing, questioning, interpreting, confronting, reflecting feelings, supporting, self-disclosure, and guidance (M. S. Corey & Corey, 2006; Hill, 2005; Ivey & Ivey, 1999).

How is all this information relevant to group work with children? The following sections explore this question. Because groups with children are conducted mostly by counselors or therapists, I will refer interchangeably to the group counselor or therapist, rather than the group leader.

COUNSELOR ROLES IN GROUPS WITH CHILDREN

There are many similarities between the leader of adult groups and the child group counselor. The latter largely needs similar personality traits, has similar tasks to perform, applies similar interventions, and requires similar skills. As goals of group counseling and psychotherapy at all age levels are similar—to encourage expression of thoughts and feelings, develop insight, and change behavior in a group interaction process—it is understandable where these similarities come from. Counselors in children's groups, as leaders in adult groups, are responsible for establishing and maintaining a positive climate, helping group members work on their personal issues, promoting the therapeutic factors that enhance individual and group progress, and helping each member apply the knowledge acquired in the group to real-life situations. To achieve these goals, therapists in children's groups have to perform similar roles, use appropriate interventions, and effectively apply helping skills.

Nonetheless, the role of group therapist for children may also be very different from that of adult leaders, owing largely to the age of group members. Each task, intervention, and skill must be adjusted to the age of the children in the group, as well as to the type of group. I now examine each of these leader components separately, using my clinical experience and research investigations.

COUNSELOR PERSONALITY

In my clinical work with children, I have noticed several personality traits that are critical for a leader's success. I highlight three of these because of their meaningfulness to groups with children: presence, self-confidence, and creativity.

Presence is reflected in enthusiasm about the group and, particularly, the children themselves. More than adults, children need to hear direct expressions of genuine love. They often do not distinguish well between anger, rejection, and lack of love, and they often interpret criticism and punishment as rejection. Many of the children participating in group counseling carry negative experiences from home, have issues with trust, and lack self-confidence. These children particularly appreciate a warm welcome and an openly expressed message of liking and loving. Moreover, children often perceive the group counselor as a parental figure whose love and feedback they highly appreciate. I have seen them fighting over the seat next to the counselor and expressing love to him or her in verbal and physical behavior. I suspect that the client—therapist alliance has a much stronger impact on children than on adults in groups, although this has not yet been investigated. One of the best counselors at my facility says "I love you" constantly to the children; her group members come to believe that they are loved and are highly attracted to the group. In her groups, there are no dropouts and the level of self-disclosure is very high. Moreover, her behavior sets a model for the overt expression of mutual liking among group members.

Another important counselor characteristic is self-confidence. In groups with adults, this is mainly reflected in risk-taking behavior (e.g., confrontation). In contrast, children challenge group counselors in many ways, as I show in my discussion of the resistance stage. There are also many discipline problems in the groups, particularly at the initial stage. Counselors who demonstrate the ability to face such threats to their confidence enhance the children's trust, both in the counselor and in the group. Children like to test the limits of adults; they know they can rely on a therapist who remains calm yet assertive, that he or she will control the group situation, and that they can be safe in the group under all circumstances. Self-confidence also helps the counselor to be open-minded and honest and to take risks, all of which are particularly important behaviors in adolescent groups (MacLennan & Dies, 1992).

In one of the groups at the center where I work, the children challenged the group counselor at the first session with the question, "Why us?" This is a common issue in children's groups, as they are not clients who selected therapy; rather, they are children referred to counseling because of social, emotional, or behavioral problems. For them, a group may carry a negative label or a stigma. Many novice counselors are afraid of this question, and exhibit insecurity at this point. Here is an example of a leader's sensitive and positive response to this question, posed by an elementary-school group: "I gave it serious thought. I wanted group members who can benefit from the group and also help each other. I consulted with each of you [at the intake interview] and got the impression that this will be a successful group." The encouraging message this counselor gave to her group was that they were each chosen for their capacity to be constructive in the group. She sounded positive, hopeful, and self-confident, and the children's reaction was: "Can't you see she wanted us?" This was, indeed, a good start for a group.

In a group of adolescent girls, Judy, the counselor, was challenged by Billy, a dominating group member who tried to take over. Billy started a game of Telephone, ignoring her leader. Judy hesitated for a moment, then invited Billy to express her feelings openly. Eventually, Billy expressed her disappointment in the activities Judy had introduced. Judy encouraged her to suggest an alternate activity, which turned out to be highly successful. Through this activity, the group progressed to a higher level of self-disclosure, and the leader avoided a power struggle without losing her status in the group.

Finally, a counselor who works with children must be creative and innovative in many ways. Children's group counselors need to prepare sessions that are fun and run smoothly; they need to guide the sessions in a flexible and creative way; and they need to offer a wide range of activities and methods to help children express themselves. Children are not necessarily in the mood to work, unexpected issues often crop up, and always, even in unstructured groups, creative methods must be used to help children express themselves. It is sometimes difficult to proceed with the group process through direct questions, particularly with younger children. The ability to apply creative methods that encourage group members to share their experiences is of utmost importance, because it reduces tension, embarrassment, and anxiety, and it increases playfulness.

COUNSELOR INTERVENTIONS

In respect to interventions in children's groups, Thompson and Rudolph (2000) mentioned similar tasks to those attributed to leaders of adult groups: directing communication traffic, facilitating the group process, blocking harmful behavior, protecting group members, supporting, linking, moderating discussions, summarizing, and giving feedback. R. R. Greenberg (2003) mentioned additional leadership tasks that are unique to children: maintaining discipline, keeping the group on task, establishing and enforcing group rules, encouraging full group participation, and moving the group in the direction of its objectives. Obviously, some of these tasks are more relevant at the initial stage of the group, whereas others are more relevant at the working stage or at termination.

The Initial Stage

In the initial stage, the counselor is particularly active in structuring the group process. This includes the task of creating a therapeutic group climate—that is, establishing group norms of emotional expressiveness and constructive interpersonal interactions that allow such expressiveness with minimal harm. As explained in Chapter 3, the most significant therapeutic factor for children is group climate and cohesiveness. It is hard to imagine children who would be willing to talk about personal matters and disclose emotions unless they felt the group is a safe place.

How does a group counselor achieve a positive working climate? One way is to demonstrate the facilitative skills of emphatic understanding, genuineness, and respect for group members. Counselors must show that they are caring by being nonjudgmental and accepting, and by providing encouragement, support, and guidance. Children learn quite well from modeling, particularly from a respectful authority figure. For example, a counselor may say to a silent group member something like:

> I know how embarrassing it may be to share private information in front of a group of strangers. I was not very brave either when I was your age. But you are an important group member, and I see you listening carefully to others. We will all be happy to get to know you a bit more.

As the counselor models facilitative behavior, group members begin to participate in the helping process and become more active helpers for one another (Thompson & Rudolph, 2000).

Another way to establish group norms of acceptance and support is through guidance and skills training. In group work with children, it is extremely important to attend to the development of norms and to reinforce expected behavior, especially during the first few sessions. For example, in response to a child who was playing with her cell phone, the counselor gently said, "You remember that we have an obligation to listen to each other. Careful attention and listening helps the speaker and helps us to better understand him." This became a group norm, and when such inappropriate behavior was repeated in the group, another member mentioned the rule instead of the counselor.

Unless children are prepared for group counseling experiences, they simply don't know how to behave in a group setting—how to relate to each other, ask questions, comfort and support, convey empathy, or provide feedback. This is not the typical language that children and adolescents use in communicating with each other, as observed in a study on interpretives in groups with children (Shechtman & Yanuv, 2001). The study showed that children challenge and provide feedback to other group members, but often in a nonconstructive way. They tend to criticize, offend, and blame rather than accept and support. These behaviors evoke nonproductive responses from group members. The study highlights the problematic interaction of young children in groups and calls for leaders to train group members in communication skills at the onset of therapy. In our interventions, my colleagues and I train children to talk directly to each other, to make eye contact, and to use a repertoire of emotions so that empathy can be conveyed clearly. We also teach children to refrain from premature guidance and advice, and to ask open questions and give constructive feedback.

Modeling and training are not always sufficient to achieve the goal of establishing a constructive climate. In some situations, the counselor must directly block a negative interaction and protect a vulnerable group member. One common difficult situation is when members try to force group norms, such as when they try to break another's silence. Once members start disclosing, they are eager to get others to do the same because they unconsciously believe that this will enhance confidentiality (if everyone tells a secret, then it becomes too risky to disclose secrets). Moreover, fairness plays a major role in children's, and particularly adolescents', lives; it is only fair to share the responsibility for the group's progress, they believe. Thus, at a certain point they become pushy. When pressure stems from such a rationale, it is usually expressed in a demanding and intolerant manner, which may be quite a

threatening experience for some group members. Although sharing emotions and experiences is extremely important in counseling and psychotherapy groups, it is equally important that the group accepts a norm allowing members to move at their own pace (Smead, 1995). The leader must be very skillful in both encouraging all group members to share and protecting anxious group members from being attacked.

For example, in one group session the children were using picture cards to identify some of their issues. Two girls selected cards and disclosed meaningful information about themselves. Janet chose a picture of a forest to represent her complicated life; Marie selected a picture of two people holding hands to express her need for human contact. Toni, the next girl, hesitated for a moment, and Janet and Marie pressed her to go on. The counselor's intervention was, "We should give her the time she needs to make a decision. It may be quite stressful to make a decision under pressure. Remember, one of our rules was to respect individual needs." She protected a group member by blocking negative behavior and establishing group norms.

Very often, a therapist working with children needs to deal with discipline problems, which are more frequent in children's groups than in adult groups. Counselors usually prefer a nonauthoritarian style of leadership, and indeed, the climate that best fits the group atmosphere is democratic. Nonetheless, at times the therapist must be firm, as well as fair and friendly. To maintain discipline, a counselor may refer to the group rules, or she can use "I messages," thereby also demonstrating this very important means of communication. For example, one therapist said to a fourth-grade group, "Right now I feel that you are ignoring me." Because the relationship with her was warm and intimate, the group responded positively to the message and stopped the noise.

In short, structure is needed to maintain discipline, to develop group norms, to establish trust, and to reduce anxiety, all typical issues of the initial stage. But, at the same time, structure should not foster dependency or block spontaneous reactions. Group members need to be encouraged to speak when they feel a need (not only when they are invited to talk) and to become involved in the group process by taking over some of the leader's responsibility (Berg et al., 1998).

The Working Stage

In the working stage, group counselors are responsible for helping clients identify and define their problems and the related feelings and thoughts. They also assist clients with the exploration process, intensify identification processes and mutual sharing, help increase awareness and insight, offer alternative ways to behave, and encourage all group members to take part in this process. In groups with adults, it is easier to achieve these goals through a direct approach, such as asking a question about goals and difficulties. However, children need structured activities even in the working stage, and the younger they are, the more structure they need at this stage (M. S. Corey & Corey, 2006).

In our groups, my coworkers and I use structured activities mostly to stimulate self-disclosure and sharing; the rest of the time is spent processing personal and group issues. But although they function only as stimuli, these structured activities make a huge difference. Using an activity to generate discussion does not contradict the goals of developing awareness or increasing expression and exploration of feelings. On the contrary, it often facilitates the processing of meaningful personal issues, which would not come up following a direct question. Methods and techniques are explored in depth in Chapter 5; here I offer a few examples to illustrate the effectiveness of using structured activities at the working stage.

I have learned from experience that it is easier for children to select a card that reflects their problem than to respond to a direct cognitive question, such as "What is your problem?" In the picture card game mentioned earlier, Janet, in selecting the picture of a forest to represent her complicated life, responded on an affective level, which was then further explored. And Marie used the handholding figure to express her deep loneliness. Would they have been able to articulate their problems without this activity?

A group counselor who worked with children of divorced parents used photos from their family album as the stimuli to present their problems. Each child responded to a major difficulty in dealing with the divorce through that photograph. For example, Denise, who had presented her father as aggressive and threatening, brought a picture of him in a good mood, playing with her in the park, stating: "You see, he can be very different, warm and fun." This led to an exploration of her complex relationship with him, leading to a more balanced perception of him and reduced anxiety.

Another group leader used bibliotherapy (*The Soul Bird*; Snunit, 1999) to explore some of the children's secrets. In this story, the soul bird has many drawers in which personal secrets are hidden, and only the individual can open the drawer he or she wishes. Rather than inviting the children directly to share a personal issue, the counselor asked the girls to open one of their drawers. It was much easier to respond to this technique than to address a direct question about life difficulties. When Louise opened the drawer of anger at her father, who had abandoned her when she was a baby, she underwent a cathartic experience, followed by a sense of relief. I doubt that such experiencing could have taken place except though such a playful and indirect form of interaction.

This is not to suggest that sessions in the working stage always begin with a structured activity; in fact, many do not. By this time in the group process, most of the children feel free to take advantage of the group. The counselor must be flexible enough to let such processes occur, and be able to help clients work on their problems. In one session of a group of younger children, Eileen asked for help with a dispute she was having with her parents over visiting her grandmother's grave. The topic of death, which had already been briefly raised by Ken (whose dog had died), became the topic of discussion for the next few sessions. The counselor was surprised by Eileen's initiated self-disclosure, as well as by her interest in discussing an issue that is not commonly considered at this young age. She had to change her plan for that session, as well as for the next few sessions, and use a variety of helping skills to help Eileen explore the conflict, reduce her fear of death, and help other group members deal with this difficult issue.

At this stage of the group process, it is important to keep the group on task. The short-term task is to cover what has been planned for each week; the long-term task is to move the group in the direction of the agreed upon goal. Obviously, leaders of structured groups focus more on short-term goals, whereas those of nonstructured groups focus more on long-term ones. In groups my colleagues and I run, the exchange of self-disclosure, feedback, and support promotes such long-term goals as enhancing the children's abilities to express their concerns, difficulties, and problems; helping them understand these issues; and teaching them to help each other meet these goals. Thus, the focus is on both the individual's problem and the group process.

A crucial counselor task at this stage is to encourage full group participation, where members interact with others and are willing to share their feelings and experiences. Eliciting self-expressiveness in groups with children is easier than facilitating constructive interaction. As already mentioned, most children like to talk about themselves and release some of their emotional burdens. They seem to do so in quite a natural way, with little reservation (see Leichtentritt & Shechtman, 1998), unless their sense of trust was badly damaged. However, guiding children to respond to others with respect, empathy, and genuine interest is more difficult. This is a whole new language for most children, who need to be taught to use it. This is particularly true of children with an avoidant attachment style (see Shechtman & Dvir, 2006). Not only do such children disclose very little during the group process, they also react negatively to others' self-disclosure. Such interactions, if frequent, may impede group progress. When these issues come up, it is highly important to deal with them openly, to focus on the emotions involved using more advanced probing skills, to develop insight, and to translate that insight into action (M. S. Corey & Corey, 2006; Yalom & Leszcz, 2005).

For example, a group of children of divorce was stuck in a long silence following several very constructive sessions. Susie, the counselor, acknowledged the silence and asked members to think about reasons for it. Some complained that they had already shared and blamed the silent group members for being stuck. Susie led the group to explore their feelings. "What does it feel like to be stuck?" she asked. Some group members who had already shared said that they felt betrayed and regretted having shared; others said that they did not mind and felt good because they had gained so much; and still others expressed genuine interest in the stories of those who had not yet spoken and invited them to share.

Sandy eventually responded to such an invitation, sharing her difficulties in talking in a group. It often turns out that the silent group members are those with the most serious problems, making them reluctant to self-disclose in the group. The children in this group promised to be careful listeners, reassuring Sandy that they would keep her secret, and encouraging her to trust them. This enabled Sandy to talk about her mother's depression. As Sandy seemed uncomfortable, Susie asked the group for their reactions. Linda shared about her own mother's depression in a most natural manner, explaining that it is an illness and there is medicine for it. This seemed to "normalize" the issue and to make Sandy feel better. The group was very supportive; they reinforced her courage in sharing her secret with the group and offered their positive perspective of the situation: "You are lucky that both parents love you, want you, and fight for you." Sandy was happy she could open up in the group and felt empowered with a new perspective on her situation. Susie, for her part, was very careful to maintain a balance between pressure and invitation, and she had directed part of the discussion to sharing among the rest of the group, to prevent Sandy from feeling like the sole "actor on the stage," which she might have later regretted.

In sum, these examples demonstrate essential therapeutic factors in the group—catharsis and group cohesion—which the therapist must make every effort to enhance. In conflict situations, it is particularly important to remain hopeful and positive, as well as to convey the success of the group, the universality of problems, and the importance of catharsis and interpersonal learning. Most important, the counselor must model honesty and openness and the skills of listening and self-disclosure.

Termination

In the termination stage, counselors must prepare the group for separation, summarize gains of the group experience, and look at ways to transfer what they have learned to situations outside the group. There may be some anxiety and reluctance to terminate, and this may be reflected in regression in the level of participation through expression of strong emotions, such as sadness, mourning, or even aggression. The counselor must deal with these feelings with warmth and courage and without defensiveness. The leader's interventions are directed at helping clients go through separation, deal with unfinished business, evaluate their achievements following group experience, and say goodbye to each other. At this stage, the therapist will be using particularly active helping skills, such as information provision and guidance. More than in earlier stages, structure is required to complete these tasks. Therefore, the therapist continues to use a variety of methods, strategies, and therapeutic activities to achieve the tasks for the ending stage of group.

PROCEDURES FOR OPENING AND CLOSING GROUP SESSIONS

As it is of utmost importance to monitor children's feelings, the groups facilitated by my colleagues and I use a routine procedure for opening and closing a session, to focus on recent events. Every session starts with a brief exploration of expectations—and particularly feelings—as a result of the previous session. This is important to avoid impasses due to hidden issues.

For example, one group counselor opened a session by turning to a child who had disclosed in the previous session: "You left very excited last meeting. Can you share with us your feelings following this experience?" At another session, a counselor was concerned about absenteeism. She opened the session by saying: "Some people were absent last time. We all missed you. Can we share with them some of the main issues that we discussed?" To the members who had been absent, she asked: "How do you feel about having missed that session?" Yet another counselor referred to a difficult session in the previous week: "It was quite stormy here last time. How do you feel right now?"

These group sessions also end with evaluation of feelings or progress. It is extremely important to monitor children's feelings to make sure that no one was hurt and that there is no unfinished business. Sometimes a child may need an individual follow-up session, as suggested by M. S. Corey and Corey (2006).

This evaluation can be achieved in a number of ways. The counselor can use direct questions such as, "How do you feel right now?" or "What have you learned today about yourself?" Another possibility is to use feeling cards or feeling games. Yet another option is to administer a short questionnaire evaluating the session or inquire into each child's critical incident ("What was the most important thing that happened to you in the group?"). In addition, the children often receive an assignment for the following week, such as to practice some of the skills they have learned, to carry out a plan they decided upon, or to write a diary to express some of the feelings and experiences that they have during the week.

THE COUNSELOR'S HELPING SKILLS

Processing is a therapeutic endeavor in groups, just as it is in individual therapy. Therefore, in addition to leader tasks that are unique to the group process, the counselor must be trained in using effective helping skills. This is particularly true of those who conduct nonstructured groups. In structured groups, which are most often used with children (K. R. Greenberg, 2003; Riva & Haub, 2004; Smead, 1995), topics, activities, and materials are all prepared in advance, and the process is led mostly on a cognitive level. This provides confidence to the group counselor and increases his or her sense of self-efficacy. In contrast, in groups that are less structured, the process is less predictable, and the level of processing is highly emotional; therefore, the counselor's effective use of helping skills is particularly important.

Hill (2005) suggested a list of helping skills, including approval and reassurance, questions, restatement, reflection of feelings, challenge, interpretation, self-disclosure, information provision, and direct guidance. Although this list was compiled for individual counseling and psychotherapy, it is applicable to any therapy process. Based on comprehensive research, Hill (2005) suggested that certain skills are more appropriate for one stage of the therapy process and others are more in place at other stages. For example, at the exploration stage, the therapist is expected to use mostly encouragement and open questions to facilitate self-expressiveness and the sharing of past and present experiences. The employment of such skills helps both the counselor and the client get a better grasp of the latter's problem. As reflection of feelings facilitates affective exploration and cathartic experiences, this, too, is a needed skill in the exploration stage. At the insight stage, the counselor is expected to rely more on interpretive skills and self-disclosure. Interpretations, challenges, and feedback expand consciousness of self and help clients understand their difficulties, as well as the causes of their emotions, thoughts, and behavior. The counselor's self-disclosure helps clients develop insight. Finally, at the action stage, guidance and information skills are often used to help clients in instrumental ways to achieve therapeutic change.

It is interestingly that the same skills are used to address group issues, although they may be applied somewhat differently. For instance, they are conducive to using

the here-and-now (Yalom & Leszcz, 2005) as a source for learning and emotional growth, a task that is unique to group counseling. As in groups with adults, therapists in children's groups tend to use helping skills more actively at the beginning stage of counseling, and then gradually reduce direct involvement and let group members take on some of the facilitation tasks (R. R. Dies, 1994; Yalom & Leszcz, 2005). Here are a few examples of how the counselor's helping skills can be used to address both a personal problem and a group problem.

One group was in its seventh session and, following some intense self-disclosures, the group put extreme pressure on the silent group members to talk. Annette said she found it difficult to share private information at that time. Her counselor could have approached this on a personal level and tried to explore those difficulties. She could have asked an open question: "Can you talk to us more about these difficulties?" She could have paraphrased: "You say it is difficult for you to share something personal right now." She could have reflected feelings: "You are a bit embarrassed at having to share." She could have self-disclosed: "I sometimes also feel uncomfortable about being intimate in a group of strangers." Or she could have related to the group, to the here-and-now interaction, using similar skills: "How do you feel about the group pressure to talk?" (question); "Does the group pressure embarrass you?"(question); "Does this silence right now suggest that some of you feel uncomfortable?" (reflection of feelings); "Can the group help somehow?" (guidance).

In a similar situation, Cynthia said she found it hard to self-disclose because she could only talk with people she was close to. The counselor responded with an interpretation: "So you expect the group to express positive feelings to you, so you can trust them more and then perhaps disclose." Cynthia's response ("Exactly") pointed to the accuracy of that interpretation.

In one group, when silence was somewhat prolonged, Sarah, who often tended to take the role of savior in the group, started talking. The counselor used an interpretation: "I can see silence bothers you. You seem to take responsibility for saving the group. Is this something that is familiar to you from other places?" This lead Sarah to explore her behavior outside of the group, where she felt considerable pressure to do things she really did not like to do.

Finally, in another group, Doreen, a teenage girl, said she was going to run away from home. The counselor helped her explore her difficulties at home, then used the following self-disclosure: "When I was in a similar situation, I went to talk with my parents." When Doreen replied she did not know how to approach her parents, the counselor introduced role playing to train her in the required skills. At the next session the following week, Doreen reported talking to her parents.

Group counselors often employ immediacy, i.e., disclosure of their techniques or tactics. On a personal level, a helper is often moved by a personal story and reacts emotionally: "I feel so sad listening to your story" or "I feel angry for the way you've been treated." On a group level, immediacy is used to share the counselor's intentions with the group. For example, after most group members have spoken, the counselor can allow for some silence, explaining: "I do not mean to pressure anyone to talk, but as some people need more time, I will wait for another couple of minutes," or "This

time I will go around the circle, so everyone has a chance to say something." The use of immediacy not only conveys caring and empathy, but also models the use of emotions and empathy for group members.

Information and guidance are skills that are particularly important during the action stage. For instance, when exploration of Eileen's aforementioned conflict with her parents over visiting her grandmother's grave revealed that the real issue was her fear of death, the counselor used guided visualization to help her "leave the sack of stones someplace on the way." She also encouraged the group to share their advice of how to deal with the fear of death. When Doreen did not know how to approach her parents, role-playing was used to prepare her for a constructive conversation.

RESEARCH ON COUNSELOR HELPING SKILLS IN GROUPS OF CHILDREN

Leichtentritt and Shechtman (1998) used Hill's (1986) Therapist Verbal Response Modes System to examine the verbal responses of a single therapist in 10 groups of elementary-school children. Six types of responses were investigated: encourages, directives, questions, paraphrases, feedback, and self-disclosure. Questions were found to be the most frequent counselor response; the counselor asked at least one question in 90% of the sessions. She used self-disclosure, feedback, and encouragement at least once in about 80% of the sessions, and she used directives and paraphrases in over 60% of the sessions. Overall, it appears that the counselor assumed an active role in the group process, using a wide variety of therapeutic responses.

The frequency of the counselor's responses was also investigated at three points of the group process: initial stage, working stage, and termination. On the average, there were about five questions per session, and about three self-disclosures and instances of feedback, throughout the process (paraphrases, encourages, and directives were less frequent). Moreover, all these responses were more frequent at the initial stage of the group and decreased with time. For example, the counselor began with about seven questions per session, reducing them to five in the working and termination stages. Similarly, although there were initially about 5 instances of self-disclosure per session, this dropped to 3.5 in the working stage, and to less than 3 at termination. The counselor's active involvement seems to be particularly necessary at the initial stage; with time, however, she can turn over some of the leadership to group members.

Finally, when the influence of the counselor's behavior on children's self-disclosure was investigated, it appeared that structured activities and questions were most effective: both produced about 90% of children's self-disclosure. This suggests the importance of structured activities in group counseling with children.

Two later expanded studies investigated these same therapist responses (Shechtman, 2004b; Shechtman & Ben-David, 1999) with several counselors. Results of both studies indicated the importance of questions (about 70%) followed by paraphrases; the remaining response types were infrequent. Self-disclosure was much less frequent in these studies than the first one (Leichtentritt & Shectman, 1998). This discrepancy in results may reflect individual differences between counselors; the first study was based on a single skilled and experienced counselor, whereas the later studies involved novice counselors. The child population was also different. The first study was of children with various emotional difficulties; the later studies included only highly aggressive children. Clearly, however, counselor self-disclosure (in addition to questions) is a valuable behavior that needs more attention, as it produced a high rate of children's self-disclosure. Although these therapist behaviors were not related to reduced aggression among the children, some were related to the children's behavior as measured on the Client Behavior Scale. For instance, encourages and challenges had some positive impact on effective participant behavior, whereas guidance had a negative effect (Shechtman, 2004a).

The Shectman and Ben-David study (1999) and the Shectman (2004a) study both compared therapist behavior in individual and group treatments. The findings suggested that the skills applied by counselors in groups are almost identical to those used in individual treatment. Indeed, the most widely used textbooks on groups provide lists of helping skills that are identical to those suggested by Hill (Hill & O'Brien, 1999; i.e., M. S. Corey & Corey, 2006; Gladding, 2003; Ivey & Ivey, 1999), although they also include some interventions that are unique to group processes (such as connecting and blocking). Perhaps these unique interventions deserve more attention in future research on groups.

Finally, a comparison between counseling groups and education groups (Shechtman & Pastor, 2005) indicated use of different skills to achieve goals. Therapists of the counseling groups used more encouragement, reflection of feelings, and interpretation. However, leaders of the educational groups used more guidance and information provision. This suggests that counselors use helping skills according to their theoretical orientation. As they work within an expressive–supportive modality applying an integrative theory, it makes sense that the therapists in the counseling groups used mostly encouragement, reflection of feelings, and interpretation. These are the skills that are more difficult to develop, requiring more intensive training.

SUMMARY

These clinical observations and illustrations clearly indicate that counselors of groups of children and adolescents must be warm people who can openly express and convey their love and caring for children. This is particularly true of the type of counseling and psychotherapy groups described here, where the therapy population is a vulnerable one. It is also clear that counselors need to be skilled in conducting the various stages of the group process and in helping the individual client go through the growth and change process. Although the helping skills used by the group counselor are similar to those used in individual counseling, the group counselor's role is extended beyond helping the individual person in the group. It is the group leader's role to guide the group process toward a climate of trust, positive interpersonal interaction, and mutual support. It is also important to be able to stop destructive behavior and protect the victims in the group. Finally, it is clear that adherence to the theoretical orientation offered here requires the counselor to use appropriate skills, such as encouragement, reflection of feelings, and challenges, more frequently than guidance and information provision. In short, the counselor's role in children's groups is much more active than that of the leader of adult groups.

Moreover, because of the clients' lack of maturity and history of difficult behavior, these processes may not be easy, requiring the counselor's understanding of child development and the acquisition of methods and techniques suitable to each child's age and needs. In contrast to leaders of adult groups, counselors for groups of children and adolescents must also possess a large variety of creative methods and techniques that can be adjusted to children's developmental stages. This unique component of the counselor's roles in children's groups will be discussed in the next chapter.