GROUP INTERVENTIONS FOR TREATMENT OF PSYCHOLOGICAL TRAUMA

MODULE 1: GROUP INTERVENTIONS FOR TREATMENT OF TRAUMA IN ADULTS

By

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ABOUT THE AUTHOR

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I. RATIONALE AND OBJECTIVES

A. This module is designed to provide group therapists and mental health clinicians with information about the use of group interventions for adults who have experienced overwhelming stressful life experiences. It will include:

1. An overview of the common psychological and somatic reactions of adults who have been exposed to traumatic experiences.

2. Information on the range of diagnostic possibilities.

3. A discussion of how groups can be helpful to adults who have had traumatic experiences.

4. A discussion of the ways in which such groups may be modified and structured to meet the needs of adult populations who have experienced psychological effects of trauma.

B. The objectives are:

1. To learn to diagnose a broad spectrum of responses to trauma in adults

2. To learn to identify the situations for which group interventions for trauma are indicated

3. To learn the ways groups need to be modified to meet the needs of this population

4. To learn the types of groups appropriate for each stage of treatment

5. To learn to plan a group for this population including defining the group structure and interviewing the prospective members.

II. FORMAT OF THE MODULE

A. Didactic

B. Audience participation

C. Question-and-answer periods

D. Sharing of work experiences

E. Group exercises

III. BRIEF OUTLINE OF MODULE

A. Introduction to psychological trauma

B. Rationale for group therapy for trauma

C. Individuals and situations for which group interventions are appropriate

D. Types of trauma groups

E. Initial phase—acute interventional debriefing groups (Dembert & Simmer)

F. Second phase—support groups

G. Third phase—cognitive behavioral groups

H. Fourth phase—psychodynamic groups

I. Group exercises

IV. INTRODUCTION TO PSYCHOLOGICAL TRAUMA

A. Define trauma

1. van der Kolk (1997): "result of exposure to an inescapably stressful event that overwhelms a person's coping mechanisms"

2. Klein & Schermer (2000): "situation-specific, severe and stressful violation or disruption that has serious psychiatric consequences for the individual, either soon or long after the event."

3. Yassen & Harvey (1997): results in "the disruption of physical, relational, and environmental autonomy and loss of safety and physical integrity."

B. Take into account context of trauma

1. Trauma often occurs in the context of a community

a. natural disaster

b. accident

c. terrorism

d. crime

2. Ecological framework of trauma—Yassen & Harvey (1997)

a. Trauma needs to be understood in the context of the environment in which it happened.

b. Trauma response is a complex interaction among the person, event and environmental factors.

C. Prevalence of Trauma: When PTSD first recognized as a psychiatric disorder in 1980 the prevalence of exposure to traumatic events thought to be 1%.

D. Recent studies demonstrate rates of exposure to trauma in the general population are higher than anticipated varying from 50.3% to 69%. Random phone interviews between 10/16 and 11/15/01 found significant rates of psychological effects after 9/11/01 including PTSD and depression. (Galea, et al., 2002)

1. 7.5% symptoms consistent with PTSD

2. 9.7% symptoms consistent with depression

3. 20% PTSD in those who live south of Canal Street

E. Psychosocial Effects of Trauma

1. Trauma affects an individual in a variety of ways: (For complete listing of effects see Yassen & Harvey, 1997)

a. Physical

i. Somatic complaints

ii. Fatigue

iii. Startle reactions

iv. GI disturbances

b. Psychological

i. Feeling helpless, powerless, hopeless

ii. Feeling overwhelmed and vulnerable

iii. Fear, terror

iv. Depression, sadness

v. Shame, embarrassment

vi. Anger, feelings of revenge

vii. Loss of pride, dignity, security

viii. Disbelief, denial

c. Relational

i. Withdrawing or clinging to others

ii. Breakdown in trust

iii. Distortions in reactions to others

iv. Alienation from family, friends, and coworkers

d. Cognitive

i. Confusion

ii. Difficulty remembering things

iii. Difficulty concentrating

iv. Assumption that the world is not safe

v. Intrusive imagery (flashbacks)

vi. Disorientation and spaciness

vii. Euphoria or guilt about being alive

e. Behavioral

i. Irritability, moodiness

ii. Regression to more youthful or harmful coping strategies

iii. Disturbance of sleep or appetite

iv. Substance abuse

v. Dangerous behaviors

vi. Dissociation

vii Crying, calmness, hysteria

viii. Silence or talkativeness

f. Spiritual

i. Loss of/clinging to faith

ii. Spiritual doubts

iii. Despair/hopelessness

iv. Questioning the meaning of life

2. Response to trauma and trauma recovery are affected by a variety of factors such as: (For complete list see chart of Yassen & Harvey, 1997)

a. Person

i. Age/developmental stage

ii. Pre-trauma personality, functioning and coping capabilities

iii. Ability to utilize social support

iv. Immediate response/subsequent response

v. Perceptions of and meaning given to trauma

vi. Cultural, religious, and ethnic background

b. Event

i. Severity, duration, and frequency

ii. If applicable, degree of violence/personal violation

iii. Was trauma experienced alone or with others?

c. Environment

i. Quality and continuity of social support

ii. Responses of those who help in recovery

iii. Community attitude and values

iv. Quality, availability and diversity of community resources

v. Amount of physical and emotional safety ensured after the trauma

3. Many individuals are not ready to address the emotional aftermath of the trauma for several weeks until the numbing and shock decrease.

4. Not all individuals exposed to trauma develop diagnosable conditions or require treatment.

5. Some individuals experience a gradual decrease in these symptoms and do not become disabled or develop long lasting psychological symptoms but are able to draw on internal and environmental resources to cope with the traumatic experience and resume their previous level of functioning

6. Some individuals go on to develop significant and persistent symptoms and syndromes that require treatment.

7. Some individuals do not present themselves for help for many months or years after the trauma or disaster.

8. Results of studies of the rates of long-term development of psychiatric symptoms vary and make it difficult to generalize about the long term effects of trauma (McFarlane, 1996).

F. Diagnoses often associated with the aftermath of trauma

1. Acute Stress Disorder (DSM IV Criteria):

a. The person has been exposed to a traumatic event in which both of the following were present:

i. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

ii. The person's response involved intense fear, helplessness, or horror

b. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:

i. A subjective sense of numbing, detachment, or absence of emotional responsiveness

ii. A reduction in awareness of his or her surroundings (e.g., being in a daze)

iii. Derealization

iv. Depersonalization

v. Dissociative amnesia (i.e. inability to recall an important aspect of the trauma)

c. The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, a sense of reliving the experience, or distress on exposure to reminders of the traumatic event

d. Marked avoidance of stimuli that arouse recollections of the trauma (e.g. thoughts, feelings, conversations, activities, places, people).

e. Marked symptoms of anxiety or increased arousal (e.g. difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).

f. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.

g. The disturbance lasts a minimum of two (2) days and a maximum of four (4) weeks and occurs within four (4) weeks of the traumatic event.

h. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

2. Posttraumatic Stress Disorder (DSM IV Criteria)

a. The person has been exposed to a traumatic event in which both of the following were present:

i. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.

ii. The person's response involved intense fear, helplessness, or horror. Note: In children this may be expressed instead by disorganized or agitated behavior.

b. The traumatic event is persistently re-experienced in one (or more) of the following ways:

i. Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.

ii. Recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.

iii. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.

iv. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

v. Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

c. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

i. Efforts to avoid thoughts, feelings, or conversations associated with the trauma

ii. Efforts to avoid activities, places, or people that arouse recollections of the trauma

iii. Inability to recall an important aspect of the trauma

iv. Markedly diminished interest or participation in significant activities

v. Feeling of detachment or estrangement from others

vi. Restricted range of affect (e.g. unable to have loving feelings)

vii. Sense of a foreshortened future (e.g. does not expect to have a career, marriage, children, or a normal life span)

d. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

i. Difficulty falling or staying asleep

ii. Irritability or outbursts of anger

iii. Difficulty concentrating

iv. Hypervigilance

v. Exaggerated startle response

e. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one (1) month.

f. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

i. Acute: if duration is less than three (3) months

ii. Chronic: if duration is three (3) months or more

iii. With Delayed Onset: if onset of symptoms is at least six (6) months after the stressor

iv. Dissociative Disorders (DSM IV): Disruption in the usually integrated functions of consciousness, memory, identity, or perception of the environment

v. Major Depression

vi. Borderline Personality Disorder

vii. Substance Abuse Disorders

G. Effects of Trauma can be categorized under four headings (Klein & Schermer, 2000)

1. PTSD Symptom Clusters

a. Re-experiencing cluster

b. Avoidance cluster: Chu's BASK Model (1998) – Dissociation can occur in:

i. Behavior

ii. Affects

iii. Sensations

iv. Knowledge

2. Changes in the "assumptive world" and cognitive schemata of the victim

a. Loss of trust and sense of safety

b. Sense of helplessness and loss of sense of mastery

c. Shame and guilt

3. Pathology of internalized object relations and the self

a. May have radical changes in core sense of self and object relations

b. May be changes in biological substrate (van der Kolk, 1987)

4. Clinical syndromes other than PTSD

a. Includes major depression, anxiety sleep disorders, substance abuse.

b. Differences exist in explanation for the development of these disorders as a sequellae to trauma

c. Sometimes see exacerbation of existing disorders

H. Questions and Answers

V. RATIONALE FOR GROUP THERAPY FOR TRAUMA

A. The special characteristics and curative factors that groups bring in general to psychotherapeutic treatment apply to the treatment of trauma also. (Klein & Schermer, 2000; Foy, 2000)

1. Yalom's Curative Factors (1970)

a. Instillation of hope

b. Universality

c. Imparting of information

d. Altruism

e. Corrective emotional recapitulation of primary family group (less relevant for most trauma groups)

f. Development of socializing techniques

g. Imitative behavior

h. Interpersonal learning, input (feedback)

i. Interpersonal learning, output

j. Group cohesiveness

k. Catharsis

l. Existential factors

2. Because isolation is such a powerful effect of trauma, the ability of groups to provide support and reconnections for members is particularly important for trauma treatment

B. Group interventions offer unique advantages in addressing the areas in which traumatized individuals have been the most affected (Klein & Schermer, 2000)

1. In the acute phase, provide structure to help individuals resume activities of daily living and practice behaviors that are self-nurturing.

2. Provide assistance in managing symptoms of PTSD

3. Provide opportunity for validation of trauma experience

4. Provide an opportunity to rebuild trust and decrease isolation and shame for all individuals who have experienced trauma and especially for those who have experienced trauma involving interpersonal violence

5. Provide an opportunity to witness and create a narrative about the trauma in a safe and respectful environment

6. Provide an opportunity to grieve trauma and its consequences

7. Provide reality testing to correct distorted views of self and basic beliefs or "assumptive world" that have developed as a result of the trauma

8. Reintegrate personality

VI. INDIVIDUALS AND SITUATIONS FOR WHICH GROUP INTERVENTIONS ARE APPROPRIATE

A. Group therapy is useful for all types of trauma

1. Many recommended that individuals be placed in groups according to type of trauma

2. Often individuals are placed into group according to stage of recovery and symptoms

B. In immediate aftermath of trauma, an individual may feel overwhelmed and not able to relate to a group. At these times individual treatment is recommended until the individual feels able to interact with others.

C. Group placement depends on the structure and goals of the particular group and the characteristics of the particular individual under consideration.

D. Because individuals who have been exposed to trauma are often vulnerable to experiencing overwhelming affect and have a tendency to dissociate, the structure and therapeutic technique employed in trauma groups may differ at times from other types of group therapy:

1. Necessary to put in place mechanisms to help the individual create a safe space and develop coping skills before discussing traumatic material

2. Cannot always assume discussion of details of trauma and re-experiencing of trauma related affect are therapeutic

3. Scrupulous attention to boundaries and the creation of a clear therapeutic agreement necessary for all types of trauma groups

VII. TYPES OF TRAUMA GROUPS

A. Trauma groups vary according to goals, structure and phase of treatment, as well as:

1. Amount of interpersonal processing

2. Amount of information and education provided by leader

3. Amount of transference encouraged and addressed

4. Length of time

5. Whether open or closed membership

6. Screening processes employed

7. The activity level of the leader

B. Four types (Foy; Klein & Schermer, 2000; Herman, 1997; Dembert & Simmer, 2000)

1. Acute Debriefing

2. Supportive

3. Cognitive-Behavioral

4. Psychodynamic

C. Each type designed to achieve different goals and address the needs of a different stage of treatment:

1. Immediately after a disaster or trauma: Acute Debriefing Groups usually meet only once with the goal of helping participants talk of the immediate trauma experience

2. Early stage: Time-Limited Supportive Educational Group designed to help patient manage the overwhelming affect of trauma, decrease isolation and alienation

3. Middle stage: Cognitive Behavioral Group designed to provide an opportunity to share the trauma experience, develop a narrative, and teach coping skills to manage recurrences of PTSD and other symptoms

4. Final stage: General Psychodynamic Group designed to help the individual make meaning of his/her experience, examine his/her view of themselves and their relationships as they integrate their experience into a more general view of themselves in society

D. Questions and Answers

VIII. INITIAL PHASE: ACUTE INTERVENTIONAL DEBRIEFING GROUPS (Dembert & Simmer)

A. Rationale—Provide an opportunity immediately after a disaster for all interested individuals affected by the disaster to come together and share what happened from their own perspectives with the goal of helping them decrease isolation and alienation, correct distorted perspective, and validate their experiences.

B. Goals—Reduce suffering, improve functioning, and reduce long-term effects of trauma

C. Relevant Curative Factors

1. Universality

2. Catharsis

3. Instillation of hope

4. Imparting of information

5. Existential factors

D. Group Environment and Norms

1. Leader sets up a supportive and respectful environment

2. Leader establishes norms that all members may talk

E. Leadership Issues

1. Co-leadership – generally

2. Leadership Style – supportive and active

3. Leader manages affect by using seven-step process that allows for starting with description of details of disaster before presenting emotional reactions

4. Countertransference pitfalls

a. Ignoring possibility of secondary traumatization of therapist and ignoring need to discuss reactions with peers

b. Acting on tendency to become either over-involved or maintaining a stance of distance

c. Inability to experience empathy

F. Criteria for Selection of Members and Group Composition

1. Seldom is there any evaluation and assessment.

2. Members accepted into group by virtue of their direct or indirect exposure to disaster or crisis

a. Groups for traumatized survivors

b. Groups for emergency response workers

3. Exclusion criteria

a. Psychosis

b. Inability to sit through session

c. Inability to follow structure

4. Participants invited to attend group through workplace notice or public announcements

G. Group Structure

1. Usually meet one time

a Session usually two to three hours

b. Membership closed once group starts

c. Leaders develop working alliance by:

i. Validating the trauma

ii. Active engagement with each member

iii. Setting tone of acceptance, respect and tolerance for all points of view

2. Seven-Step Process

a. First Phase: Introduction sets tone for whole session and outlines guidelines for process

b. Second Phase: Fact

i. Each group member introduces him or herself

ii. Each member describes where he or she was when the disaster occurred, indicates his or her role, describes what occurred

c. Third Phase: Thought

i. Each member describes his or her initial thoughts

ii. Goal is to provide a transition from cognitive to affective

d. Fourth Phase: Reaction

i. Invites members to describe what about the disaster was the most difficult to experience emotionally

ii. This portion usually consists of a wide variety of emotional expression

e. Fifth Phase: Symptoms

i. Focuses on stress-related symptoms experienced by members

ii. Designed to provide a transition from the emotional back to the cognitive

f. Sixth Phase: Teaching

i. Education about techniques for surviving stress, caring for self and reintegrating with family, friends and co-workers

ii. Much discussion encouraged in this phase

g. Seventh Phase: Reentry

i. Closure

ii. Questions answered

iii. Summaries made

iv. Encouragement for return to daily routine

H. Difficult Aspects of the Experience

1. An overwhelming affect may be experienced at times by group members as they tell of their experience or as they hear others talk.

2. If members have dissociative symptoms, they may not be able to relate many details of their experience.

3. Dissociated members may re-experience affect as they hear details of the story.

4. Leaders may experience overwhelming affect as they hear the details of the experience.

5. Premature terminations are discouraged; it is not useful for members to leave before they are able to return to the cognitive phase of group.

I. Model Seldom Varied—Used Frequently

1. Sometimes it is offered to individuals

2. Sometimes more than one session offered

J. Outcome Studies Equivocal (Spiegel & Butler, 2002)

1. Some studies failed to show efficacy of this type of intervention.

2. One review (Foa & Meadows, 1997) found that in some instances CISD may have made the outcome worse.

3. Critics hypothesize that opening up the affect without some ongoing relationship or containment makes people worse rather than better.

4. Some studies find it effective.

IX. SECOND PHASE: SUPPORT GROUPS (Goodman & Weiss, 2000; Foy, 2000; Herman,1997; Klein & Schermer, 2000)

A. Rationale: To use the healing qualities of the group such as cohesion, normalization and containment to help the members cope with their physical, cognitive and emotional reactions to the trauma.

B. Group Goal

1. Establish safety.

2. Help members to cope with reactions and symptoms that interfere with everyday functioning.

3. Encourage self-care.

4. Diffuse overwhelming affects and contain overwhelming feelings and reactions.

5. Reduce isolation and alienation.

6. Use validation to help members normalize their reactions to the trauma experience.

7. Help members connect with others who have had similar experiences.

8. Provide cognitive framework of the traumatic event for each group member.

a. Help members to develop new perspectives to encourage hope.

b. Help members to use their strengths to cope with reactions and return to daily functioning

C. Relevant Curative Factors (Yalom, 1970)

1. Instillation of hope

2. Universality

3. Imparting of information

4. Altruism

5. Imitative Behavior

6. Existential factors

D. Group Environment and Norms

1. Supportive and comfortable

2. Members talk when they choose

E. Mechanisms of Change

1. Imitation

2. Identification

F. Group Structure

1. Time-limited (occasionally open-ended)

2. Generally open membership

G. Group Agreements

1. Need to be clearly stated

2. May be stated in pre-group interview, at the start of each meeting or when a new member joins

3. Agreements usually include the following:

a. Speak about your feelings

b. Maintain confidentiality

c. If applicable, pay your bill

d. Come on time

e. Stay for the whole time

f. If applicable, come to each meeting

H. Criteria for selection of members

1. For some trauma groups no evaluation and member selection are possible

   a. Naturally occurring community groups

   b. Agency has pre-selected group members

2. Evaluation and assessment preferable when possible

   a. Interpersonal capacity: can member talk to others and relate

   b. Statement of problem: what leads this person to seek out group

      i. Can patient describe a clear trauma experience?

      ii. Transient crisis or long-term problem both appropriate for support group

   c. Adaptational strengths

      i. Ability to feel safe and trust and flexibility of this capacity

      ii. Ability to tolerate differences

      iii. Ability to bear feelings

   d. Assessment of whether the group will optimally meet this person's needs

   e. Mental status, including:

      i. State of mind during interview

      ii. Psychomotor behavior

      iii. Psychological mindedness

      iv. Capacity for impulse control

      v. Severity of emotional distress

   f. Significant history

   g. Prior experience in group treatment

h. Capacity to accept structure and work within boundaries

i. Manageability of transference

3. Inclusion criteria

a. Ability and willingness to bear uncomfortable feelings

b. Positive anticipation from participation in group

c. Willingness to commit to attend all group sessions (when appropriate)

d. Similarity to target population of group in terms of:

i. type of trauma,

ii. time since trauma

iii. intensity of trauma exposure

e. Ability to relate to leader in interview

f. Ability to articulate reasons for wish to attend group

g. Trauma sufficiently distant in time for member to achieve a sense of safety in group

4. Exclusion criteria

a. Acute psychosis

b. Homicidal or suicidal ideation

c. Severe sociopathic traits

d. Thought disorder

e. Unable to listen to and respond to others and shows no interest in others

f. Primarily relies on massive denial, withdrawal, severe avoidance, projection, externalization of conflict and acting out

g. Severe dread of self disclosure

h. Active substance abuse

i. High level of paranoia

j. Severe non-psychological mindedness

I. Composition and Preparation for Entry into Group

1. Homogeneous characteristics

a. Similar trauma experience

b. Similar phase of trauma recovery

c. Similar level of exposure to trauma

d. Agreement to focus on experience of trauma as defined by leader

e. Age and other life variables match those defined by leader

2. Heterogeneous Characteristics

a. Life history

b. Ability to feel safe

c. Degree of psychological mindedness

d. Level of activity or passivity

e. Sexual identity

f. Gender

g. Trauma symptoms

h. Capacity to be dependent/independent

i. Reasons for wanting trauma support group

j. Ego strength

k. Degree of vulnerability

l. Capacity to tolerate anxiety

m. Adaptational strengths

n. Personality style

J. Characteristics of Leaders and Countertransference

1. Can be lead solo or with a co-leader

2. Leadership style – active and supportive

a. Do not encourage development of transference.

b. Create comfortable and safe group environment.

c. Develop working alliance by actively reaching out to each member, welcoming them and encouraging participation.

3. May assign homework and introduce skill development aimed at reducing symptoms and increasing self-care

4. May provide educational information

5. Management of extreme affect

a. Helpful for therapist to convey his/her belief that there is a reason for all feelings and experiences that seem inexplicable

b. Remain alert for both dissociation and overwhelming affect

i. Keep in mind Chu's BASK model (1998) for dissociation

ii. Teach grounding and use active techniques to help patient connect with leader and group and stay in the present

c. Not useful to foster re-experiencing of trauma in this phase by focusing on the details of the trauma experience

6. Countertransference Pitfalls

a. Failure to acknowledge secondary traumatization in therapist

b. Failure to provide good self care and obtain support from colleagues

c. Acting on inclination or belief that relating details of trauma experience would be good for group member

K. Phases of Model

1. Short Term

a. Beginning Phase

i. Task is to say hello and address concerns about safety

ii. Leader focuses on helping members introduce themselves

b. Middle Phase

i. Task is to accomplish main goals of group including validating and normalizing trauma related affects and developing skills to tolerate affects

ii. Leader facilitates the expression of affect in measured way and helps members to pace their experience and expression of feelings

c. Termination

i. Task is to say good-bye and plan for future treatment, if appropriate

ii. Leader helps members to focus on feelings about ending and helps them plan for the future

2. Long Term

a. Beginning Phase

i. Task is to say hello and address concerns about safety

ii. Leader focuses on helping members introduce themselves

b. Middle Phase

i. Task is to accomplish the main goals of the group including validating and normalizing trauma related affects and developing skills to tolerate affects

ii. Leader helps members to focus on their feelings and pace their expression of affect and encourages members to avoid taking on identity of trauma victim

c. Termination

i. Task is to say good-bye to member who has accomplished goals and is leaving

ii. Leader keeps group focused on good-bye and loss

L. Situations or Phases that Members Experienced as Difficult

1. Member out of control and needing to be removed by therapist

2. Extreme group contagion of affect

3. Rigid denial of affect on the part of one or more members

4. Termination may be difficult for particular members depending on the trauma

5. Abrupt unplanned departure by group member

6. Loss of focus on safety and members become overwhelmed

M. Variations of the Model

1. May be combined with individual treatment

2. May be combined with medication

3. Group member may start with short-term supportive group and if appropriate move to a longer term supportive group instead of a cognitive behavioral group.

N. Outcome Studies: Foy reports that a review of studies of the effectiveness of supportive groups found improvements in self-esteem, anxiety and depression (Foy).

O. Questions and Answers

X. THIRD PHASE: COGNITIVE-BEHAVIORAL GROUPS

A. Rationale: To use the safety of the group container to provide an opportunity for members to construct and tell their trauma narratives in the presence of witnesses, to give meaning to the trauma and to start the process of mourning in the context of a supportive social environment

B. Group Goals

1. "Sharing and working through of the traumatic experiences—the telling and witnessing of each patient's narrative, and the restoration of trust." (Klein & Schermer, 2000)

2. Over the course of the group to develop and achieve personal, behavioral or emotional goals related to the trauma

3. Provide each member with an experience of feeling understood and recognized

4. Help each member achieve a sense of mastery over the trauma experience

5. Help each member to initiate the process of mourning

6. Help each member participate in the termination process and acknowledge the gains he/she and others have made

C. Relevant Curative Factors

1. Instillation of hope

2. Universality

3. Imparting of information

4. Altruism

5. Imitative behavior

6. Group cohesiveness

7. Catharsis

8. Existential factors

D. Group Environment and Norms

1. Leader develops a highly structured and supportive environment.

2. Leader develops norms that members will tell and witness trauma stories with respect and encouragement.

3. Leader establishes clear strong boundaries and a tightly organized framework for each meeting.

E. Curative Mechanisms

1. Sharing the trauma story

2. Witnessing others' trauma stories

3. Imitation

4. Identification

F. Group Structure

1. Time-limited

2. Closed membership

3. Each member develops goal(s) and actively works on it (them).

G. Group Agreements

1. Come to all group meetings

2. Come on time

3. Stay for whole time

4. Pay bill, if applicable

5. Maintain confidentiality

6. Participate in group as best as he/she can by telling trauma story and witnessing others' stories

7. Define and work towards personal goal over course of group

H. Criteria for Selection of Members

1. Evaluation and assessment

a. Must be careful and thorough

b. Prospective members accepted if group leader determines that they have achieved the first step in trauma treatment—the ability to establish safety

c. Member's willingness to commit to group

d. Interpersonal capacity—can individual talk to others and relate

e. Problem

i. Does the trauma fit the category for this group?

ii. Is it of a similar magnitude of the traumas of other group members?

f. Adaptational strengths and weaknesses

i. Ability to feel safe in face of others' stories

ii. Ability to bear feelings

iii. Ability to tolerate differences

g. Assessment of whether the group will optimally meet the needs of this individual at this time

h. Mental status

i. State of mind during interview

ii. Psychomotor behavior

iii. Psychological mindedness

iv. Capacity for impulse control

v. Severity of emotional distress

i. Significant history

j. Prior experience in group

k. Manageability of transference

l. Capacity to accept structure of group and work within its boundaries

2. Inclusion criteria

   a. Ability and willingness to bear uncomfortable feelings

   b. Positive anticipation from participation in the group

   c. Willingness to commit to attend all sessions

   d. Similarity to target population in terms of type of trauma

   e. Ability to relate to leader in interview

   f. Ability to articulate reasons for wanting to participate in the group

   g. Willingness to define goal and work on it

3. Exclusion criteria

   a. Acute psychosis

   b. Homicidal or suicidal ideation

   c. Thought disorder

   d. Inability to listen to and respond to others and no demonstration of interest in others

   e. Severe sociopathic traits

   f. Primarily relies on massive denial, withdrawal, severe avoidance, projection, externalization of conflict and acting out

   g. Severe dread of self-disclosure

   h. Active substance abuse

   i. High level of paranoia

   j. Low level of intelligence or organicity

   k. Severe non-psychological mindedness

I. Composition and Preparation for Entry into Group

1. Homogeneous characteristics

a. Similar trauma experience

b. Similar phase of trauma recovery

c. Agreement to focus on task of group

d. Ability to focus on task of group

e. High level of motivation to participate in group

f. Ability to tolerate strong affects

g. Ability to be vulnerable

2. Heterogeneous characteristics

a. Life history

b. Degree of psychological mindedness

c. Level of activity or passivity

d. Sexual identity

e. Gender

f. Trauma symptoms

g. Capacity to be dependent/independent

h. Ego strengths

i. Adaptational strengths

j. Personality style

3. Pre-group interview

a. Absolutely essential

b. Must be thorough

c. Go over goals of group and group agreements carefully

J. Characteristics of Leader and Countertransference Dilemmas

1. Can be solo or co-leaders

    a. Co-leaders must work together as peers

    b. Co-leaders must have a comfortable and open working relationship

2. Leader needs to be active and clear about his or her tasks

3. Leader needs to establish a working alliance by reaching out to each member, welcoming them and encouraging their participation

4. Leader works to develop strong group cohesion

    a. Clear frame

    b. Positive feeling about group

5. Leader does not encourage development of transference

6. Leader does not address interpersonal interactions among group members unless there is a crisis.

7. Leader discourages conflict among group members

8. Leader may assign homework and introduce exercises for skill development

9. Management of extreme affect

    a. Helpful for leader to convey his or her belief that there is a reason for feelings and experiences even those that seem inexplicable

    b. Remain alert for both dissociation and overwhelming affect

        i. Keep in mind Chu's BASK model (1998) for dissociation

        ii. Encourage use of grounding and other coping skills to help members stay in the present

10. Leader remains fairly opaque and brings in personal details only if it will further the goals of the group

11. Countertransference pitfalls

a. Failure to acknowledge secondary traumatization in the leader

b. Failure to obtain consultation and support from colleagues or supervisors

c. Failure to acknowledge to self effects of personal trauma history

d. Failure to keep clear boundaries or group structure in order to gratify self or group members

K. Phases of Model

1. Beginning phase

a. Leader works to create therapeutic space for work of group

b. Leader works to establish clear boundaries and enthusiasm for group in order to foster strong group cohesion

c. Members meet each other and define goals

2. Middle phase

a. Leader focuses on accomplishing the goals of the group

b. Leader actively introduces tasks and teaches coping skills

c. Members deeply engrossed in telling story, practicing skills and accomplishing personal goals

3. Termination phase

a. Leader reminds members of approaching end of group

b. Members acknowledge gains and discuss impending loss of group

c. Sometimes group members develop good-bye rituals, which include an acknowledgment of each member's accomplishments

L. Situations or Phases that Members Experience as Difficult

1. Both members and leader may have difficulty hearing horrific trauma stories.

2. When experiencing intense affect members may have difficulty focusing on tasks of group.

3. Members may have trouble saying good-bye.

M. Variations of the Model

1. Can use stress management model

a. Has tight organization

b. Each member works toward personal goal

2. Cognitive Processing Model (Resick & Schnicke, 1993)

a. Tightly structured design based on information processing model that assumes symptoms arise from conflicts between one's prior schemata and the traumatic schemata

b. Developed for rape victims

c. 12 sessions

d. Little use of group format—individual treatment in group

3. Interactive Psychoeducational Group Therapy (Johnson & Lubin, 2000)

a. 16-week highly structured approach for individuals with PTSD

b. Education, cognitive restructuring, exposure to traumatic memories and homework.

c. Emphasizes interpersonal learning in group

d. Focuses on members' unimpaired traits not associated with the trauma – supports strengths

N. Outcome Studies

1. One study (Foy, et al., Lambert & Bergin, 1994) reported that six studies have found cognitive-behavioral groups are effective in reducing members' distress.

a. A variety of trauma populations used

b. Groups used a variety of cognitive-behavioral techniques including cognitive processing therapy, assertiveness training, stress inoculation, and affect management

c. Most did not find a decrease in PTSD symptoms, particularly flashbacks

2. Empirical studies of CPT model show positive effect on PTSD symptoms, depression, and general psychopathology (Resick &Schnicke, 1993).

3. Studies using Lubin & Johnson's IPGT model found a significant reduction in PTSD symptoms (Lubin & Johnson, 2000).

O. Audience Participation/Question-and-Answer Period

XI. FOURTH PHASE: PSYCHODYNAMIC GROUPS

A. Rationale is to provide an opportunity for individuals with trauma histories to use the protected supportive therapeutic space of a psychodynamic group to learn about and change their intrapsychic and interpersonal selves and to reconnect with the larger society as a whole person and part of the human community.

B. Group Goals

1. To help members to develop an awareness of and ability to express feelings in the here and now

2. To provide opportunities for each member to learn how he/she affects other people and how they affect him/her through exploration of group interactions

3. To help members to learn about the distortions they bring to their interactions by examining and understanding transference reactions to the group leader and the other group members

4. To help members use the protected environment of the group to take risks to change maladaptive behaviors

5. To help the traumatized individual to experience a sense of commonality with a wide range of individuals and come to see his/her trauma story as one among many

6. To provide an opportunity for trauma patients to understand the ways the trauma experience is carried inside of them and influences reactions to others and gives meaning to their experiences.

7. To emphasize the commonalities with others and discourage the primary identification of self as a trauma victim

C. Yalom's Curative Factors (* those most relevant to psychodynamic groups; + those least relevant; Rutan & Stone, 1993)

1. Instillation of hope
2. Universality
3. Imparting of information+
4. Altruism
5. Corrective recapitulation of the primary family group+
6. Development of socializing techniques
7. Imitative behavior+
8. Interpersonal learning, input (insight)*
9. Interpersonal learning, output
10. Group cohesiveness*
11. Catharsis*
12. Existential factors

D. Group Environment and Norms

1. Set by leader's attitude, behavior and guidelines
2. Supportive
3. Cohesive

E. Mechanisms of Change (Rutan & Stone, 1993)

1. Imitation
2. Identification
3. Internalization

F. Processes of Change

1. Confrontation: point out to group member his/her behavior, emotional states of problems (Rutan & Stone, 1993)

2. Clarification: aims to help group members see patterns that are related to maladaptive behavior or feelings

3. Interpretation: goal is to make unconscious phenomena conscious that is to attach meaning to an event or feelings

a. Group interpretations address interpersonal style

b. Address cognitive and emotional behavior

G. Group Structure

1. Open-ended

2. Closed membership

3. Minimal frequency of meetings is weekly

H. Group Agreements (Rutan & Stone, 1993)

1. Come to every meeting

2. Stay for the whole meeting

3. Pay bill on time

4. Keep identities of members confidential

5. Keep relationships therapeutic not social

6. Put feelings into words not actions

7. Work actively on the problems that brought you to group

8. Stay in the group until you have reached your goals and when ready to leave take time to say good-bye

I. Criteria for Selection of Members

1. Evaluation and assessment

a. Interpersonal capacity

b. Motivation to change

c. Ability to define presenting problem

d. Ability to define goals and areas to be changed

e. Positive anticipation from participation in group

f. Ability to tolerate anxiety and stress

g. Capacity for impulse control

h. Manageability of transference

i. Severity of emotional distress

j. Adaptational strengths

k. Ability to feel safe and trust

l. Capacity to give and receive assistance

m. Capacity to accept structure

n. Ability to understand group focus

o. Significant history

p. Prior experience in group treatment

q. Will the group meet the potential member's needs?

r. Mental status

s. Psychomotor behavior

2. Exclusion criteria

a. Acute psychosis

b. Homicidal or suicidal

c. Severe sociopathic traits

d. Too regressed or thought disordered

e. Overstimulated in groups

f. Relies primarily on defenses such as massive denial, withdrawal, regression, avoidance, projection, externalization or conflict, acting out

g. Severe dread of self disclosure

h. Active substance abuse

i. High level of paranoia

j. Inability to tolerate group setting

k. Inability to agree to the group guidelines

l. Lack of interest in others

m. Low intelligence or organicity

n. Insufficient command of the language

o. Non-psychological mindedness

p. Severe physical illness such as unstable asthma, labile blood pressure, severe angina

J. Composition and Preparation for Entry into Group

1. Homogeneous characteristics

a. Level of ego functioning

b. Capacity to tolerate anxiety

c. Psychological mindedness

d. Adaptational strengths

e. Quality of object relations

f. Ability to be influenced by others

2. Heterogeneous characteristics

a. History

b. Age

c. Gender

d. Sexual identity

e. Presenting problem

f. Active-passive

g. Level of trust

h. Dependent-independent

i. Personality style

3. Pre-group interview (Rutan & Stone, 1993)

a. Provides opportunity to assess prospective group member according to leader's criteria

b. Provides opportunity for patient and leader to establish a preliminary alliance

c. Opportunity to give prospective member information about group

d. Opportunity for individual and leader to come to an agreement on the goals for change

e. Opportunity for prospective member to address his/her anxiety about joining the group

f. Opportunity for leader to present group agreements to member and to obtain his/her acceptance of them

K. Characteristics and Role of Leader

1. Group can be led by one leader or by co-leadership.

2. Co-therapy requires an extensive attention to the development of a trusting working relationship.

3. Psychodynamic groups "presuppose a warm but neutral and fairly unobtrusive therapist who strives to create a safe supportive and therapeutic relationship." (Rutan & Stone, 1993)

4. Through a variety of respectful and thoughtful actions and attention to the group agreements, the leader seeks to create a sense of safety and cohesion in the group.

5. The psychodynamic leader generally is relatively inactive and does not initiate discussion but rather reacts to members content.

6. Leaders range in amount of personal information and reactions they share with the group. Therapist self-disclosure, or sharing of personal information or experiences, should always be for the benefit of the group, not the leader.

7. Leaders vary in the amount of gratification they provide to members. A baseline level of anxiety is necessary in order to meet the group goals.

8. Leaders vary in focus of comments

   a. Past — present — future

   b. Group as whole — interpersonal — individual

   c. In-group — out of group

   d. Affect cognition

   e. Process — content

9. Leaders must provide attention to both understanding and experience as facilitating change.

L. Phases of Group Development (Rutan & Stone, 1993)

1. Formation phase

   a. Development of trust

   b. Finding ways to join group

   c. Development of group norms

d. Finding similarities

e. Member introduce themselves to the group in a variety of ways

f. Members often regress in the process of joining the group

g. Leader focuses on group as a whole and makes statements pointing out similarities

h. Discourage premature disclosure

2. Reactive phase (fight/flight/storming)

a. Members become aware of differences between themselves

b. Members become aware of their own reactions to group

c. Norms tested

d. Group agreements tested

e. Leader addresses breaches of the agreements consistently with curiosity and thoughtfulness

f. Leader absorbs negative feelings and disappointments of group

g. Goal to retain sense of group cohesion and belonging, as well as sense of differentiation

3. Mature phase

a. Focus on intragroup responses and interactions as source of change

b. Group moves from in-group to out-of-group material flexibly

c. Idealization of therapist decreased

i. Therapist is an ally

ii. Therapeutic alliance solid

d. Group confident it can manage anxiety and deal with problems

e. Group members appreciate each other's and the therapist's strengths and weaknesses

f. Members respond to each other with understanding that behavior is interpersonal and intrapsychic

g. Leader stays out of the way as the group does the work

4. Termination phase

a. Happens whenever a member leaves

b. Focus on saying good-bye and on success of member

c. Important for group to have a successful termination as an example for others

d. Leader helps members stay focused on good-byes and loss

M. Situations or Phases that Members Experienced as Difficult

1. Leader may find certain member behaviors difficult to tolerate.

2. Leader may find it difficult to tolerate particular conflicts among members.

3. Members find the lack of structure anxiety-provoking.

4. Scapegoating is problematic for all.

5. Some members may find it difficult to talk about trauma when there is no structure.

N. Variation of the Model

1. Often used in combination with individual treatment

2. May be used as a homogeneous open-ended psychodynamic trauma group

3. Often used in combination with medication

O. Outcome Studies

1. In their meta-analytic study of the effectiveness of psychotherapy, Lambert & Bergin (1994) found that group therapy was as effective as individual therapy.

2. In a study designed exclusively to compare efficacy of group and other forms of therapy, Piper, et al. (1994) found no differences in outcome.

P. Question-and-Answer Period

XII. GROUP EXERCISES

A. Participants divide into small groups and design a trauma group using all the principles discussed in the lecture.

B. Use role play to demonstrate pre-group interview techniques for each type of trauma group.

C. Use role play to demonstrate interventions useful for each group.

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