

GROUP INTERVENTIONS FOR TREATMENT OF PSYCHOLOGICAL TRAUMA

MODULE 8: UNIQUE ASPECTS OF GROUP WORK WITH TRAUMA

By

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ABOUT THE AUTHOR

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I. INTRODUCTION

Group treatment brings with it the possibility of the restoration of meaning in social participation; connection with community has often been swept away as a person swings between feeling empty and being flooded with overwhelming affects. (Herman, 1992).

The format of this module is designed to be both didactic and experiential with the audience. Training is intended to be a dialogue between the presenter and the module participants.

- A. Key Elements of Trauma Therapy
- B. Finding Safe Effective Emotional Balance in the Group
- C. Respecting the Power of a Group

II. OBJECTIVES

- A. To Learn the Similarities and Differences Between Trauma Groups and Other Common Psychotherapy Groups
- B. To Learn the Unique Countertransference Responses and Emotional Risks for Leader(s) of Trauma Groups

III. THEMES

- A. What Are the Similarities and Differences Between Trauma and Other Therapy Groups?
- B. Issues of Special Concern in Trauma Groups Include:
 - 1. Countertransference
 - 2. Vicarious traumatization
- C. Trauma Group Defenses
 - 1. Denial
 - 2. Splitting
 - 3. Dissociation
 - 4. Projection
 - 5. Projective identification

D. Clinical Considerations in Leading Trauma Groups

1. Emotional contagion around the responses to a shared trauma stimulus
2. Trauma related symptoms such as "flashbacks"
3. Addressing how not to re-traumatize people with a prior trauma history
4. Handling inappropriate self-disclosure
5. Distinguishing between adaptive and maladaptive coping mechanisms
6. Identification and management of extreme dissociative reactions (Buchele, 1993).
7. Recognition and management of panic reactions

E. Theoretical Framework

1. According to van der Kolk (1987), it is the group's cohesion that is most therapeutic for trauma survivors, not the insights from the leader. Anna Freud (1974) commented on treating traumatized people ... they need an experience, not an interpretation.
2. Thinking and experiences are presented in a theoretical manner.
3. Multiple modalities are presented. (Rutan & Stone, 1993).

All of the above have merit and are effective at different stages of healing.

F. Starting the Group

1. Trainer introductions
2. Participant introductions, including:
 - a. trauma-treating experience
 - b. work setting
 - c. goals of training participation

G. Considerations About Termination

1. Thinking about endings, about termination, is very important. Feelings about endings influence the work of the group, in particular with trauma groups. (Stearns, 1993).
2. Types of termination (Rutan & Stone, 1993; Yalom, 1995)
3. Endings can happen at all stages of group development.
 - a. Premature
 - b. Planned
 - c. Entire group ends (time-limited groups)
 - d. Leader leaves and the group gets a new leader
4. Termination of beliefs (Klein & Shermer, 2000)
 - a. Termination is a powerful product and process in any group and its importance is often neglected and undervalued.
 - b. After experiencing violations of trust and safety, an ending of certain beliefs and truths about the world occurs

H. Considerations About the Group Setting

1. How does the setting of a trauma group influence it?
2. Is there meaning to a group's setting and seating?

I. Group Format

1. Trust and safety are subjective experiences.
2. The primary focus in doing trauma work is to create a safe space for the work of the group. (Ganzarian & Buchele, 1988). This is true regardless of the nature of the trauma, i.e., natural disaster, industrial accident, intentional act of interpersonal terrorism.
3. Group content and process (Rutan & Stone, 1993) are important components.
4. Parallel process is very important to examine in trauma group work

J. Rationale for Groups with Psychological Trauma (Klein & Shermer, 2000).

1. Benefits of group therapy
 - a. Cost effective
 - b. Can diffuse transferences and attenuate ego regression, which may prolong or complicate treatment
 - c. Provides social supports and facilitates the development of interpersonal skills
 - d. Offers opportunities for acquiring new information, coping skills and self-expectations
 - e. Provides peer feedback, which is easier at time to hear than from the leader
 - f. The mutual identifications and mirroring in the group are powerful therapeutic factors
2. When to consider referring someone to a group (Goodman & Weiss, 2000)
 - a. The patient needs to combat social isolation and feelings of shame associated with the trauma
 - b. When individual trauma work threatens to overwhelm the original focus of treatment.
 - c. The patient desires more trauma-focused experiences.
 - i. The patient wants to remember more about the trauma.
 - ii. The patient needs to mend disrupted interpersonal relations stemming from the traumatic incident.

K. Group Goals

1. Non-trauma group: Change in intrapsychic and/or interpersonal relatedness
2. Trauma group
 - a. Stabilization
 - b. Return to previous level of functioning
 - c. Containment of affect

- L. Discussion of Types and Use of Trauma Groups
 - 1. Psychoeducational
 - 2. Cognitive
 - 3. Psychodynamic
 - 4. Combined or eclectic formats

 - M. Group Focus (Herman, 1992)
 - 1. Crisis-oriented group
 - 2. Short-term trauma focused group
 - 3. Relationship-focused group (not focused on the trauma)
 - 4. Open-ended or time-unlimited groups

 - N. Issue of Group Leadership (Rutan & Stone, 1993): Roles and focus of the group therapist in regular groups
 - 1. Activity versus non-activity
 - 2. Transparency versus opaqueness
 - 3. Gratification versus frustration
 - 4. Historical, "here and now" or future focus
 - 5. Group-as-a-whole, interpersonal, or individual focus
 - 6. Intra- group versus out-of-group interactions
 - 7. Balance between affect and cognition
 - 8. Emphasis on process versus content
 - 9. Combining insight with emotional participation in order to provide a corrective group experience

 - O. Issue Group Cohesion
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1. Focusing on the group as a whole (Ganzarian & Buchele, 1988) will increase group cohesiveness, the primary factor of importance (Van der Kolk, 1987) in the treatment of trauma.
2. Characteristics of groups
 - a. Membership composition
 - b. Setting
 - c. Duration
3. Group size and composition of a trauma group
 - a. How many members in the group?
 - b. How often do you screen someone for the group?
 - c. Do you think about a working alliance?
 - d. What exclusion criteria do you use for trauma groups?
4. Group size and composition of a non-trauma group
 - a. How many members in the group?
 - b. How often do you screen someone for the group?
 - c. Do you think about a working alliance?
 - d. Are there any contraindications for being in a trauma group? (i.e., suicide potential, active psychosis)

P. Issue of Group Member Preparation

1. Do we prepare members for group entry in the same manner in trauma versus non-trauma groups?
2. Would you exclude from a trauma or non-trauma group someone who is:
 - a. Actively psychotic?
 - b. Homicidal?
 - c. Suicidal?

d. Sufficient impulse control?

Q. Do You Have A Choice As To Whom To Include/Exclude?

1. That can depending on the setting of the group, for example, groups clinics, hospitals, trauma site often don't have a choice as to who is in the group or not.
2. How does that impact the leader or the group?

R. Concept of Group Composition—Homogeneity/Heterogeneity

1. We put groups together so as to address the needs of the population we are treating.
2. When all the members of the group have the same presenting problem, we have a homogeneous group.
3. This is a different constellation than when there is a blend of people in the group with different presenting problems.
4. The traditional concept was to form a group with people with homogeneity of ego strength and heterogeneity of defenses. For example, we wouldn't put someone who is psychotic in a group of non-psychotic members, but would add one to a group of psychotic members.
5. When people with similar trauma experiences are put in a group together, the group is initially a homogeneous group. (The trauma experience could be historical or recent.)
6. There are certain characteristics of homogeneous groups.
7. There is an initial assumption of sameness in homogeneous groups due to similar trauma experiences among group members.
 - a. This similarity is crucial in establishing and developing group cohesion.
 - b. Over time, group members will differentiate and individuate from this sameness.
8. Important Screening Questions
 - a. Has the person spoken about the trauma before?
 - b. In what context?

- c. What was their experience of the telling of the trauma?
- S. Setting of the Group
1. How does the setting of the group affect the meaning of participating in the group, i.e., natural groups?
 2. Seating arrangement in the group is also very important.
 3. The leader should sit in the same seat of each group session. This helps develop a sense of safety & constancy in the group.
- T. Length of the Group
1. Open-ended or time-limited
 2. Initial treatment of choice for traumatized patients is short-term homogeneous groups of trauma survivors, followed by entry into a heterogeneous longer-term group treatment.
- U. Time Factors in Trauma Groups
1. Single-session group
 2. Multi-session group
 3. Length of each group meeting
- V. Leadership Decisions
1. Co-leadership
 2. Single leader
 3. How does this impact on the group and on the leader(s)?
- W. Money
1. Fee structure
 2. How does the meaning of money influence trauma group members who either pay for treatment or are seen for free?
 3. Other examples

IV. CONCEPTUALIZATION OF TRAUMA

A. Definitions

1. van der Kolk (1987) defines trauma as: "the experience of an inescapable, stressful event that overwhelms one's existing coping mechanism."
2. Laplace & Pontalis (Ganzarian & Buchele, 1988) define trauma as: "a frightening event defined by its overwhelming intensity, by the victims helplessness to respond adequately, and by its disturbing and long-lasting effects on the person's mental organization."

B. Unique Situations in Trauma Groups

1. Intervention strategies
2. Countertransference
3. Vicarious traumatization
4. Are interventions different in leading a trauma group?

C. Three Levels of Interventions

1. Intervene on an individual level in the group: By intervening with one group member, you are really getting the message across to the entire group
2. Intervene with a pair in the group: By intervening with a pair, you are creating two subgroups, the pair and the remainder of the group. Identifying and working with these their differences can serve a unifying function for the group
3. Intervene at the group-as-a-whole level: By intervening with the group as a whole, you can simultaneously say something to a group member which might be too direct or be experienced as shaming or critical if said directly to the person.

D. Timing of Interventions

1. How it will affect the group and each group member?
2. Interventions need to be understood early on in terms of safety in the group.
3. Knowing the three choices available to the leader takes the time pressure off and allows the leader to follow the group's process.

4. What is the goal of the intervention that makes it appropriate at this point in time?

E. Important Focus for Interventions Following Disclosure of Traumatic Material

1. When someone tells the group something dramatic, such as how they experienced a trauma, or a long kept secret:

a. Process this horizontally, both with the person and the group, not vertically, with the person and the group leader. (Yalom, 1995)

b. Don't ask for more details. Focus on the meaning of the group hearing the information, as well as what it means for the person to be telling this material.

c. This is critical in preventing premature self-disclosure, flooding, and can help prevent re-traumatization.

F. Stages of Group Development (Rutan & Stone, 1993)

1. Formative

2. Reactive

3. Mature

4. Termination

5. Are these linear stages?

6. How are these different with trauma and non-trauma groups? Examples?

7. Stages in the life of a group

8. Why do we intervene differently at each stage?

9. How does the type of group and the leaders theoretical orientation influence the form and timing of interventions?

10. How do we help establish useful trauma group norms at all stages of group development in order to help the members feel safe enough to participate spontaneously?

G. Working With Intense Affect

1. Working with anger, especially in a group of traumatized individuals, is critical for the establishment of a safe holding environments.
2. To know how and when to intervene.
3. How do we recognize anger in a session and how do we decide on the choice of intervention that best addresses it?
4. Examples of working with anger

H. Common Group Problems

1. Premature self-disclosure
2. Monopolizing
3. Silent members
4. Flashbacks triggered by exposure to traumatic group content.

I. Handling Common Group Problems

1. Sometimes in a group, someone will start to talk and remember all the feelings of the trauma at once and begin to either go on and on or appear to fall apart or dissociate.
2. What are our intervention choices?
3. Recognize what is going on first.
4. It's ok to step in and slow someone down.
5. It's ok to let group members know that they don't have to do all their work in one session.

J. Grounding

1. This concept can help the person and the group become stable.
2. Help them to feel solid, to validate the intensity of their emotions.
3. Examples: Would you like me or the group to remind you that you are safe here in this group?

K. Dissociation

1. Definitions
 - a. According to Bromberg (1998), dissociation is the discontinuity either between psychic structures within the self, or between the self and the external world
 - b. It is a split of consciousness that exists along a continuum from mild to severe in nature
 - c. The function of dissociation is to separate from unacceptable aspects of oneself, reflecting the need not to be oneself. (Pearlman & Sasakvitne, 1995)
2. Tasks related to dissociative patients
 - a. To work with the dissociated ego state and find ways to recognize, observe, describe, give meaning to, and integrate these states into a person's awareness and life.
 - b. Respect both the defense and also the process of the defense (when in the group did the person begin to dissociate)
 - c. The BASK Model (Chu, 1998) provides a guide to understanding dissociation. It enables the therapist to have a template to consider what is missing or dissociated in the session with the group member in order to begin to help reconstruct what is out of consciousness. The BASK model includes assessment of the following:
 - i. Behavior
 - ii. Affect
 - iii. Sensation
 - iv. Knowledge

L. Working With Flashbacks

1. Van der Kolk (1987)
 - a. Don't try to eliminate flashbacks in session. That is unrealistic.
 - b. Help the patient understand the meaning of the flashback.
 - c. Help them stay grounded in the present.
 - d. Help prevent them from being carried away by the dissociative memory element in the flashback.

2. Napier (1993)
 - a. The task in working with flashbacks, or pockets of time, is to turn flashbacks into memories.
 - b. Help give a name to all of the feelings from “back then and there” in the “here and now” so that they can be talked about in the perspective of a memory.

M. Common Defenses in Trauma Groups

1. Dissociation and repression
2. Splitting
3. Denial
4. Projection
5. Projective identification

VI. TRUST THE GROUP PROCESS (Beck, 1998)

A. Countertransference and Vicarious Traumatization

1. Definition of countertransference
 - a. Freud (1974) originally conceptualized countertransference as the analyst’s transference reaction to his or her client.
 - b. Racher (1957) considers countertransference as more totalistic. The entire reaction of the therapist to the patient. These include:
 - i. subjective and objective
 - ii. objective is further divided into
 - concordant (feeling with the patient is feeling)
 - complimentary (feeling like the other in the patient’s experience)
2. Definition of vicarious traumatization
 - a. Vicarious traumatization is the transformation of the inner experience of the therapist that comes about as the result of empathic engagement with clients’ trauma material. (McCann & Pearlman, 1990)

- b. The cumulative transformative effect upon the trauma therapist of working with survivors of traumatic life events.
- 3. Relationship between the concepts (McCann & Pearlman, 1990)
 - a. Vicarious traumatization represents changes in the most intimate psychological workings of the self of the therapist.
 - b. The self of the psychotherapist is the context of all of his/her countertransference responses.
 - c. Vicarious traumatization invariably shapes countertransference.
 - d. Vicarious traumatization is a process, not an event.
- 4. Are there common countertransferences in trauma groups?
- 5. How do we know when this is occurring?
- 6. Examples of countertransferences
 - a. Walking on eggshells with group members
 - b. Avoidance of certain material
 - c. Sleepiness
 - d. Shame
 - e. Guilt
 - f. Hypervigilance
 - g. Rescue fantasies

B. Common Trauma Group Phenomena

- 1. Guilt
- 2. Shame
- 3. Rage
- 4. Hate

5. Impotence
6. Crying
7. Depression
8. Anhedonia
9. Sleep Disorders
10. Nightmares
11. Hypervigilance
12. Flashbacks
13. Dissociation

C. Concept of Safety

1. Safety in a group is of paramount importance
2. How can the leader influence how safe a group is experienced?
3. Examples of how to create a safe enough space for the group:
 - a. Focus on boundaries
 - b. Start the group on time
 - c. End the group on time
 - d. Reframe early expressions of anger in the group to the leader. This will prevent scapegoating and let the group know the leader can take the emotional intensity.

D. Temporal Consideration

1. Is the trauma historical or is it a current trauma that is being helped?
2. Is there a difference?

E. Counterresistances (Strean, 1993)

1. We are human, and when we experience powerful affects in groups, and powerful countertransferential reactions, we can experience our own resistances in the group—our counterresistances.
2. Expected level of members' participation in each phase. Is there appropriate self-
3. disclosure and what are the most useful interventions for premature self-disclosure by group members.

F. Clinical Management Issues

1. Dissociative processes
2. Flashbacks
3. Premature termination
4. Monopolizers
5. Silent members
6. Therapists helpers
7. Premature disclosure

G. Somatic Memories

1. Pay attention to all five senses as you lead a trauma group.
2. Trauma is encoded in the body and not just our minds.
3. Pay attention to feelings of fatigue or sleepiness while running a group. This is often a barometer for unconscious anger that the group is projecting into/onto the leader.
4. Pay attention to where your mind drifts in sessions. It is all related to what is going on in the group.
5. Make efforts to control the pace of the unfolding of themes in the group.
6. Consider phase-specific timing of interventions.
7. Emphasize themes of safety and security within the group.
8. Be rigorous about boundary management.

H. Containment of Affect: When the trauma group leader functions as a "container" for intense affects, group members can experience a sense of safety that allows them to deal with their emotions in a constructive way.

I. Natural Groups

1. Natural groups occur when we work with groups where they occur naturally, i.e., in the workplace or school, where the people were traumatized.

2. Do you think there are benefits and risks associated with these groups?

J. Technical Questions

1. Do you allow eating or smoking in the group sessions ?

2. What if someone brings food a pet, or a baby into the group? How do you intervene?

K. The Place of Humor in Trauma Groups

1. What, if any, is the appropriate role of humor in trauma groups?

2. Distinction between sarcasm, criticism and humor.

3. The ability to use humor adaptively in the aftermath of trauma demonstrates higher ego functioning.

L. Therapist Self-Care and the Prevention of Burnout

1. We need to take care of ourselves, especially when working with trauma groups.

2. We are highly susceptible to burnout and vicarious traumatization.

3. Trust the group process and view it not unlike the experience of surfing with or against the waves of the ocean.

VII. EXERCISES

A. Group Exercise 1

You are about to walk into a session of a trauma group you have been leading for one month. Just before you enter, someone takes you aside and tells you one of the group members died over the weekend.

1. What is your internal reaction?

2. How do you intervene with the group?

B. Group Exercise 2

Your agency informs you that you are going to lead a group of incest survivors. They inform you that they will fill the group with clients.

1. What is your internal reaction?
2. How do you intervene initially in the group?

C. Group Exercise 3

A member of your ongoing trauma group begins to space out, and clearly is not himself/herself.

1. What is your internal reaction?
2. How do you intervene?

D. Group Exercise 4

Protecting the scapegoat and monopolizer: A group member is talking on and on and not to any one particular member of the group. Nobody is listening, and other group members are appearing bored, restless and frustrated.

1. How are you feeling?
2. How do you intervene?

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