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Trauma Groups: An Overview

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Beginning with a brief review of trauma and post-traumatic stress disorder, the authors consider the role of group treatment of trauma. Several models of groups are discussed along with available research regarding efficacy. A discussion of the special dynamics of trauma groups and important considerations for group conducting follows and the issue of vicarious traumatization for the group conductor is addressed. A short discussion regarding the need to integrate traumatized individuals back into society concludes the paper.

Key words: trauma, trauma survivors, trauma groups, group therapist, countertransference, vicarious traumatization

Introduction

We begin this paper with a personal story of one of the authors.

In August 1995, while walking in the streets of Buenos Aires on the way to the IAGP conference with a colleague, we had a lively discussion about trauma groups and trauma treatment: my friend argued that there is no need for special knowledge about trauma while leading groups with people who suffered from traumatic events. He also said that these groups do not differ from any other groups we lead, and therefore all we need is to be good psychotherapists and good enough group psychotherapists to treat trauma well in groups. At that time I had just finished Judith Herman's book 'Trauma and Recovery' (1997) and had been deeply

impressed. I passionately debated his attitude and strongly proclaimed that without understanding trauma and the unique processes which occur in trauma groups, the group therapist might be unaware of what is going on under the surface and might make serious mistakes.

This paper is aimed at exploring whether this statement is valid, and if there is a special need for unique groups for trauma survivors.

Definition of Trauma

The Diagnostic and Statistical Manual of Mental Disorders IV defines a traumatic event as an 'event that involves actual or threatened death or serious injury, or other threat to one's physical integrity' (American Psychiatric Association (APA), 1994: 424). There are several threats in the traumatic experience: threat to life, to physical integrity, to injury and loss of close and beloved people, threats to self-image and values. The traumatic event shatters survivors' basic assumptions about the world being a safe place, their known self-image and the values on which they based their lives (Herman, 1997; Janoff-Bulman, 1992), disrupting the normal life of the survivors and rupturing their connection with the surrounding normal environment. The sudden and concrete threat to the survivor's life evokes the sense that s/he has lost the ability to plan the future. Fear of the unknown and helplessness arise. (Kelber and Broom, 1992). Even after the event there remains the worry that the physical or mental injury will decrease the quality of life of the injured, including their ability to continue and maintain an independent and productive life, and to function appropriately (Krystal, 1984).

Post Traumatic Stress Disorder:

The post traumatic stress response was described towards the end of the 19th century, but was defined as a psychiatric disorder only in the 1980s. The DSM IV (APA, 1994) delineates two types of disorders which develop in response to traumatic events: acute stress disorder, which develops immediately and resolves within one month, and Post Traumatic Stress Disorder (PTSD), which is considered a chronic condition. In both disorders the first criteria is exposure to a traumatic event. Both disorders are classified

as anxiety disorders and require three central categories of symptoms: intrusive, avoidant and hyper-arousal. In order to merit a diagnosis the symptoms must cause clinically significant distress or impairment. Acute stress disorder also includes symptoms of dissociation.

We usually live in a kind of narcissistic envelope believing that 'it will never happen to us'. Even if we live in a country where terror attacks happen daily we cannot always stay alert and anxious about the possibility that we will be the next victims. This denial is necessary for normal life. So when something terrible does happen, we are in a state of shock. A person who undergoes a traumatic experience will never forget it. The experience haunts the survivors, enters their dreams, impacts their lives and changes their perception of reality. Some lose their faith in mankind, distance themselves from people and from close connections, and shut themselves off psychologically, sometimes physically.

This is especially true if the traumatic experience was caused by another person or a group of persons, such as in the case of sexual abuse, terror attacks or domestic violence. In such instances the survivors' normal denial of the possibility of human cruelty is fractured, because other human beings inflicted merciless harm upon them. In response, they develop distrust in relationships. They feel helpless and horrified long after the experience has ended, especially if the trauma was continuous and they had no control of its occurrence or recurrence. They develop learned helplessness that occurs whenever organisms learn that their actions have nothing to do with the consequences of their behavior. This helplessness also occurs in cases of natural disaster or other traumas.

Klein and Schermer (2000: 6) summarized the impact of trauma under the following headings:

1. *PTSD Symptoms*: re-experiencing (intrusive recollections, nightmares, distress when exposed to cues of the event), avoidance (of thoughts, feelings or events related to trauma, diminished interest, detachment from others), and hyper-sensitivity (irritability, trouble concentrating, startle responses).
2. Changes in the assumptive world: erosion of trust in significant others, survival as crucial goal, feelings of helplessness, shame and guilt, assuming a 'victim (or perpetrator) role'.

3. Changes in internalized objects and the self: helplessness and entrapped dependency, massive use of dissociation, projective-identification and splitting, regression to 'primitivized' object relations, imposing of a 'false-self', loss of self-cohesion and self-esteem.

When choosing treatment for PTSD, one important consideration is the context within which the trauma occurred. If the traumatic event was a singular experience that a relatively intact person experienced, then the treatment can focus on a resolution of the immediate effects of the trauma. For example, the common intervention model since the First World War in immediate response to trauma was based on the eco-system theory with its principles of continuity, proximity, immediacy and positive expectation (Herman, 1997). This means that the best intervention following a catastrophe is immediate, close to 'home' and contains a message of normality and returning to routine. However, if the trauma was chronic, during significant developmental phases, and involved close intimates of the survivor, then the treatment will also need to address rebuilding the relational fabric and the reworking the developmental deficits. With appropriate consideration of these important differences, group therapy can be a powerful mode of treatment in response to trauma.

Why Psychotherapy Groups for Trauma Survivors?

Group therapy is widely used in treating victims of trauma, whether of an individual trauma such as rape, assault (Lubin and Johnson, 1997) and child abuse (Alexander et al., 1989; Nicholas and Forrester, 1999) or of group trauma, such as natural disasters (Foreman, 1994), war (Goodman and Weiss, 1998; Shatan, 1973), and the Nazi Holocaust and other acts of genocide (Danieli, 1985; Vardi, 1999).

All survivors need a warm and supportive environment after the trauma. They need to restore their belief in humanity, reconstruct positive and close relationships with significant others, and rebuild their feeling of belonging to a community. The psychotherapy group is the best place to achieve these goals. The group can help in reducing psychological reactions to the trauma, gaining an understanding of the effects of the past experience on current life issues, integrating the traumatic experience into their personal history and

learning new ways of coping with interpersonal stress (Barnes et al., 1999; Muller and Barash-Kishon, 1998). Specific advantages of the group for treating trauma are:

1. The group can easily become a substitutional envelope for people whose normal denial of reality dangers is fractured. This envelope is referred to as 'the mother-group' (Foguel, 1994; Kibel, 1991; Scheidlinger, 1974). Within the safety of this metaphorical uterus, participants can restore some of their previous safety and PTSD symptoms can subside. The group atmosphere encourages self-disclosure and the resonance helps people to open up. By discussing the traumatic experience, which has often remained a secret, members normalize their responses to trauma (Yalom, 1995). By telling their stories and finding that they themselves are not seen as 'horrible' and are still safe, their symptoms of intrusion, avoidance and hyper-arousal decrease. They learn from each other how to cope with their difficult symptoms and situations and how to deal with problems and relationships instead of avoiding them.
2. The group can be a corrective experience regarding trust. Trust can be worked through successfully and rebuilt in a group by focusing on the here and now experience, and by mirroring how the participant takes on the survivor role. Gradually group members feel that they are no longer alone and that other people understand them and empathize with them. Feelings of isolation and alienation reduce significantly the more members let themselves belong to the group.
3. Regression to early object representation and the use of archaic defense mechanisms frequently happens in the group (Weinberg, in press), and participants have the opportunity of receiving feedback about their regressive behavior, exploring their defenses and changing them.

Group Models for Treating Trauma

For treatment of trauma survivors, Foy et al. (2001) suggest the following types of groups –

1. *Support Groups*: The most common are support and self-help groups (Amelio, 1993; Hoppmeyer and Werk, 1994; Schwab, 1995), and psycho-educational groups (Janowiak et al., 1995).

Trauma survivors need a lot of support to rebuild their faith in themselves and their environment. This support is invaluable in restoring survivors' self-esteem and sense of belonging to the community. Support groups differ from therapy groups in several important features (Lederberg, 1998): anxiety is defused, regression is discouraged, transference is uninterpreted, and confrontation is minimized. In addition the group leader is more direct and active, uses self-disclosure and encourages a warm and supportive climate among members. Support groups for trauma survivors focus more on the consequences of trauma than on the traumatic experience itself, although they are often composed of people with similar traumatic experiences. Affects such as disappointment, hurt, shame, guilt, rage are expressed and explored, but no connection is made to past and childhood history. Unlike most therapy groups, support groups often encourage outside of group contact as a part of the healing process, helping people to restore a sense of a supportive community network.

2. *Cognitive-Behavior Groups* (Walls and Meyers, 1985) focuses on the individual's distorted cognitions and misperceptions of the world. Cognitive behavior therapy (CBT) helps people change their way of thinking and incorrect assumptions that lead to negative affects (such as depression), low self-esteem and problematic behavior. People listen to one another recounting the traumatic event and help identify the faulty assumptions which developed following these experiences. This challenges the changes in the assumptive world, such as feelings of helplessness, shame and guilt. Listening to each other's stories of trauma brings a healing effect in itself, reducing isolation and increasing understanding of one's faulty perceptions through the mirror brought forth by the other. CBT groups are usually time-limited and usually include a psycho-educational component. The group leader might provide information about normal reactions to trauma, and group members consult with one another and share important educational material. Group boundaries are less strict than in psychodynamic models.
3. *Psychodynamic Groups* (McCallum and Piper, 1990): the psychodynamic approach understands human behavior as stemming from and motivated by dynamic forces. Unconscious drives, anxieties and the defenses against them, inner

object representations, self – self-object relationships, all feature in the complexity of our life. In psychodynamic trauma groups members explore the impact of the trauma on their inner lives. They focus specifically on changes in internalized objects following the traumatic experience, and its influence on the self and self-cohesiveness. Primitive defense mechanisms, such as splitting, projection and projective-identification surface in the group process and can be successfully worked through. Early attachments, deprivations and defects in ego-organization are linked to the members' individual patterns of reaction to stress and trauma. Emotional reactions to the trauma are deliberately explored and when the group is emotionally flooded, the therapist contains the intense feelings and helps the members deal with painful issues and discuss their repetitive behavior, vulnerabilities and self-deficiencies.

While survivors may benefit from any of these groups, generally a phase-related treatment is suggested where immediate support groups are followed by more intensive and in-depth CBT or psychodynamic groups (Nuttman-Shwartz et al., 2002).

In addition Foy et al. (2001) mention psychological debriefing which is used to help people immediately after acute trauma or disaster to unload the emotional and stressful scenes that accompany the event. It is based on the assumption that suppressing painful experiences and emotions contradicts mental health and psychological hygiene. The group facilitator helps participants to tell their traumatic stories in a structured way, allowing the reconstruction of scenes and their accompanying affects. This approach is directed more to prevention of future impact and consequences of the trauma, and is usually done in a single or few sessions. Unfortunately research does not support its effectiveness in reducing distress and preventing future symptoms, and there are even some indications that it may be harmful and increase distress (Bisson et al., 2000).

Evaluation of Groups for Trauma Survivors

While clinical studies report that the trauma survivors feel better with the aid of group therapy, (Alexander et al., 1989; Johnson et

al., 1999; Solomon, 1992; Vardi, 1999), empirical studies do not provide solid evidence of improvement (Johnson et al., 1999; Solomon, 1992). Moreover, even those who do claim improvement observe that many victims continue to feel isolated from society and unable to express their feelings about their injury (Johnson et al., 1999; Nicholas and Forrester, 1999, Vardi, 1999). Chiamonte (1992) found that some patients benefited from supportive group therapy focused on recounting the traumatic events while many veterans found that it stimulated more memories and symptoms. The limited success of these treatments may be attributed to the enormous psychic devastation of traumatic events, which may make the damage essentially irreparable (Nicholas and Forrester, 1999; Solomon, 1992).

A complementary explanation rests on the implications of the homogeneity of most trauma victims' groups. The similarity of homogeneous group members offers each person a mirroring of experience which can be validating and containing (Barnes et al., 1999) and promotes the group cohesion that is essential to the therapeutic work. This cohesive group is accurately perceived as competent, compassionate and safe (Rozytko and Dondershine, 1991). In groups of trauma victims, however, the homogeneity and cohesion which serve to support the victims' weakened egos make it extremely difficult, if not impossible, for the individual group members to go on to the separation-individuation that is essential to working through the traumatic experience. The more homogeneous and cohesive the group is, the less room allowed for individual expression and the more pressure for denial, repression, and projection of anything outside the group consensus. Many authors suggest that the homogeneity and cohesion of the trauma victims' group may serve as a defensive shield which protects the group from outside intrusion, but blocks progress beyond the initial stages of the treatment because it undermines the emotional support and understanding required for the group members to grapple with their individual problems (Berman and Weinberg, 1998; Hazzard et al., 1993; Johnson et al., 1999; Shalev and Toval-Mashiach, 1999). Others suggest that the homogeneity of the victims' group keeps the members from interacting deeply and does not provide the opportunity for them to engage in the intensive reality-testing and transferences that might lead to vital reworking of their fundamental assumptions about self and others (Nicholas and Forrester, 1999).

Unique Phenomena and Processes in Trauma Groups

Trauma groups require the therapist to identify, understand and manage unique transference dynamics. Patients suffering from a traumatic syndrome create an intense and specific transference with unique features. Having felt helpless under traumatic conditions, they make special efforts to gain control over their environment and relationships. This might be perceived as manipulative or controlling when it occurs in the group and can result in group conflicts and emotional turmoil, especially since many members may be using this defense simultaneously. At the same time this helplessness can lead to a desperate need for a savior. Group members look for someone to cling to, which results in idealization of the group leader. They cannot listen to any criticism regarding the therapist and may distort their reality testing in order to feel safe again.

An opposite phenomenon occurs too. Most trauma survivors need to restore their faith in authority and institutions. They feel betrayed by authority figures, either because these figures failed to help them in their difficult times, or were even the ones who tortured and inflicted pain upon them. Suspicion in trauma groups is ubiquitous and the help offered by the group therapist might be rejected. So, besides idealization, there are often attacks on the therapist's authority and overt or covert suspicion about his/her intentions. These attacks can burst forth when idealization breaks down. For example, if the therapist fails to fulfil impossible rescue fantasies of a survivor by 'allowing' members to criticize the patient, rage can erupt towards the therapist.

The traumatic transference/countertransference matrix in groups of traumatized people reflects the trauma and its players. Traumatic situations involve more than a victim and a victimizer, and the intense emotions of the victim are sometimes directed towards the bystander who did nothing to intervene. The group process may include reenactments where members play the roles of victim, perpetrator, rescuer, and bystander – often on a rotating basis. When group members recount the trauma, other members respond in various ways. Some identify with the survivors, others attack or criticize him/her for not being more active, while others are still and passive. They all play a role in the reenactment of the scene, including the therapist. It can be confusing to follow the changes of positions and understand the roles involved, and the group therapist must be aware about possible sources of members' reactions.

People who go through trauma, especially in chronic situations involving an abuser, develop sharp senses: they have had to read the slight cues of the overt and hidden communication of their torturer in order to protect themselves against the coming attack. Their sensitivity to non-verbal and unconscious communication is enormous, and they bring this to the group sessions, carefully observing other members' cues, especially those of the therapist, and responding to these cues before the therapist is aware of their emergence. Their hypervigilance leads to reality distortion, because they relate to unconscious motives as if they were really acted out. Primitive defense mechanisms govern the scene of the group. Massive projections are common, such as ascribing evil intentions to innocent acts. Splitting occurs when members are perceived as either 'good' or 'bad', and the therapist is idealized or devalued. The use of projective-identification is intense when the therapist responds to a role projected by members of the group, entering the position of victim, perpetrator, rescuer, or bystander. Identification with the aggressor can also lead to aggressive behavior by the survivor.

Overall, we can say that transference reactions of trauma survivors are colored by the horror and turmoil of the traumatic experience. That is why their emotional reactions are as intense as if dealing with life and death (Herman, 1997). In the group this tension multiplies as the number of participants in the reenactment of the scenes multiply.

The Group Therapist – Countertransference and Vicarious Traumatization

Considering the carousel-like emotional experience occurring in trauma groups, we can anticipate the therapist to have strong reactions and countertransference. When working in groups where trauma prevails, the position of the observing-analyzing-interpreting therapist is quickly interpreted by the members as the position of the indifferent passive bystander. Group members should experience him/her as empathic, supportive, relating to their stories in an accepting way without seeming to be a judge determined to assess absolute truth, and holding a clear position about who is the victim. In times of crisis, the therapist should be ready to step out of the neutral uninvolved position and find a balance between empathy and respect for the patient's experience without validating that the

experience remembered or reported is absolutely accurate. Different perspectives can change the story and accepting one perspective can handicap the ability to explore any others. (See van der Hart and Nijenhuis (1999) for an important discussion regarding the trauma therapists' development of reflective belief.)

Ziegler and McEvoy (2000) consider the central task of the trauma group therapist as providing a safe holding environment, because this is the main feature lost to the trauma survivor. Maintaining this safe environment is exceptionally difficult in face of the stormy, emotionally laden atmosphere in these groups. The amount of pain the therapist has to face and empathize with is enormous, but there is a therapeutic value in staying with the group's pain. Maintaining contact with the group helps to model that the members are okay even if the trauma may be horrifying, and also helps with working through. The group therapist does not judge or evaluate the member's reactions either to the traumatic event or to the group, but tries to understand and mirror.

In order to maintain empathy, safety and connection, the group therapist must have a deep understanding of the dynamics in trauma groups. S/he might be called upon to play the role of the victim and feel the terror inside, or the role of the victimizer and identify with aggression through attacking the member, or fall into the passive role and become the indifferent bystander. Losing perspective of the trauma group dynamics, the therapist may become reactive and be drawn into one of these roles. The keen awareness as to his/her inner reactions helps in avoiding falling into the pitfalls of reacting out of identification with members' projections. This awareness may also help in identifying the dynamics, since it also must be kept in mind that the only evidence of trauma may be in reenactments and projective identification. Strictly maintaining the boundaries of the group and the therapist is another tool which helps to avoid reenactments.

The affects of trauma can also be projected and introjected into the therapist. Staying connected and open to the experience in the group means that the therapist will feel the horror, the helplessness, the clinging, or any other affect. But along with this possibility of over-identifying with the survivor, it is not surprising that group therapists can go to the other extreme and defend themselves from being flooded with emotions by building a wall and distancing from the group experience, swinging from one extreme to the other, feeling overwhelmed by emotions at one moment and becoming

numb and disconnected the next. One of the main characteristics of PTSD is swinging from dissociation and avoidance to extreme sensitivity and over-reaction (Raphael, 1986). Therapists dealing with trauma and disasters should be able to contain all the projected parts and emotional detritus, elaborate it within themselves, and return these projections to their source in a way that advances group members' development.

There is also the danger of vicarious or secondary trauma for the therapist (Pearlman and Saakvitne, 1995). The trauma narratives and horrible stories that therapists witness in groups become part of their lives, intrude upon their psyches and impact their wellbeing (Goldblatt and Buchbinder, 2003). Vicarious traumatization (VT) differs from countertransference in that it describes the impact on the therapist of vicariously experiencing many instances of trauma rather than a specific countertransference reaction to a specific patient. VT involves how the identity, worldview, spirituality, ego functioning, psychological needs and even sensory system of the therapist are affected by working with trauma, and how their day-to-day lives can become immersed in secondary traumatic experiences such as the nightmares, anxieties for self and loved ones, and hypervigilance of the survivors themselves.

Therapists need to be aware of VT and develop special techniques for prevention and self-care. Techniques for healing the healer (and even better, for preventive care) include the help of supervision, support groups for group trauma therapists, appropriate countertransference disclosure, and stress management techniques varying from mediation to taking the time for relaxation (Dalenberg, 2000, Saakvitne and Pearlman, 1996).

Aftermath

This paper reviews the literature of trauma groups stressing the need for and uniqueness of groups for trauma survivors. Leading groups for trauma survivors is not only more difficult than many other groups, but also different. The intense emotions, the consistently stormy atmosphere, and especially the unique transference and countertransference phenomena make it a challenge for the group therapist to keep a therapeutic stance without deserting an empathic approach. Conversely, the challenge is also to stay in contact with human suffering without losing the therapeutic relationship and becoming overwhelmed with misery and horror.

Group members will project almost any attitude on to the therapist, who might be perceived as too passive and indifferent, not empathic enough, being a savior or an abuser. All these projections have to do with the helpless position of the survivors and the horrors they went through when other people or authorities failed their trust.

Since group therapy for trauma creates such a hazardous climate for group therapists, it is important to consider why such groups are necessary. This is especially true given that, although in most cases group patients report relief and improvement in symptoms, it is still questionable how much they succeed with reintegrating in society, or even whether society sees them as part of the social matrix and is ready to reintegrate them. Perhaps what is also important is what happens *after* the group treatment of trauma survivors. Herman (1997) recommended seeing these trauma groups as only one stage in the treatment of trauma, and referring the patient later to a heterogeneous group where they can lose their special status as victims and work on integrating their traumas into the relational world to which the rest of us belong. Perhaps heterogeneous groups are the bridge to social integration while homogeneous ones alone may become an obstacle for creating a continuous groupal-social matrix. Such a phase-related treatment facilitates the patient rejoining society and forces society to deal with the injured who we would rather forget or deny.

Beyond the challenge of how to integrate between injured individuals and society lies the question of how to encourage a pluralistic social situation that expresses solidarity with the weak and social support for survivors. Society and community has the responsibility not only to prevent traumatic events, but also to help the survivors in the aftermath. The challenge is to create an inclusive society which takes care of the injured not from pity but from an attitude of equality and from openness leading to a dialogue. As group analysts practised to think of the individual as part of the social matrix and texture – this is also our task.

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