

# **GROUP INTERVENTIONS FOR TREATMENT OF PSYCHOLOGICAL TRAUMA**

## **MODULE 4: AN OVERVIEW OF EVIDENCE-BASED GROUP APPROACHES TO TRAUMA WITH ADULTS**

By

David W. Foy, Ph.D.

William S. Unger, Ph.D.

Melissa S. Wattenberg, Ph.D.

## ABOUT THE AUTHORS

**DAVID W. FOY, Ph.D.** is Professor of Psychology, Graduate School of Education and Psychology, Pepperdine University and Adjunct Professor of Psychology, Headington Program in International Trauma, Fuller Theological Seminary. Dr. Foy has many years experience as a group therapist, working first with male veterans in an alcohol treatment program. In the last 15 years he has worked extensively in developing trauma focus group methods for treating PTSD in combat veterans.

**WILLIAM S. UNGER, Ph.D.** is Chief, PTSD Clinic, Providence, VA Medical Center (where he has been for 15 years) and Associate Clinical Professor, Brown University Medical School. He has provided individual psychotherapy for survivors of physical and sexual trauma for 20 years and has conducted Trauma Focused Treatment Groups with veterans for 10 years. He has also been active with training workshops for Trauma Focused Treatment Groups and Present-Centered Treatment Groups for adult trauma survivors and is the author of journal articles and book chapters in the field.

**MELISSA S. WATTENBERG, Ph.D.,** is Director of an intensive group treatment program for veterans with chronic mental illness at VA–Boston Healthcare System. She also coordinates and runs childhood trauma groups in the PTSD clinic within the same system. She is an Instructor at Tufts University Medical School, and Adjunct Clinical Professor at Massachusetts College of Pharmacy and Health Sciences. Dr. Wattenberg was the Senior Clinical Supervisor for Present-Centered Group Therapy in a 10-site VA cooperative study on group treatment of PTSD in Vietnam combat veterans. She helped to develop the International Society of Traumatic Stress Studies' clinical practice guidelines for group therapy. She has published in the area of group therapy for PTSD.

## I. RATIONALE AND OBJECTIVES OF THE PRESENTATION

This module is designed to provide an overview of the principles of two empirically supported, contrasting models of group therapy: (1) trauma-focus (TFGT) and (2) present-centered (PCGT) group therapies, both adapted for adult survivors of terrorist disasters. Narrative descriptions of the two models, companion PowerPoint slide presentations, demonstrations of critical skills, and discussion are the methods to be used in the presentation of each form.

The rationale for using group therapy for survivors of terrorism is based on the need and advantage for survivors to join with others in therapeutic work when coping with victimization consequences such as isolation, alienation, and diminished feelings. Group therapy seems quite appropriate for terrorism survivors, who may feel ostracized from the larger society, or even judged and blamed for their predicament. Bonding with similar others in a supportive environment can be a critical step toward regaining trust. Beyond its obvious cost advantage, group therapy may be particularly useful for those individuals who fail to meet common assumptions (e.g., psychological mindedness and responsibility for life choices and outcomes) thought necessary for individual psychotherapy (Klein & Schermer, 2000).

Group therapies for adult trauma survivors may be distinguished on the basis of their approach to traumatic memories as either “uncovering” or “covering” types, depending upon whether the therapy promotes in-depth trauma processing (uncovering), or discourages references to traumatic memories (covering) in favor of focusing upon issues in the present. This module presents an example of each type: TFGT as an uncovering approach; and PCGT, representing the covering variety. These methods differ in their theoretical models of symptom development and therapeutic intervention, but they share a set of key features that build a therapeutic, safe, and respectful environment. These features include:

- A. Group membership determined by shared type of trauma (e.g., terrorism survivors, combat veterans or adult survivors of child abuse);
- B. Acknowledgment and validation of the traumatic experience;
- C. Normalization of trauma-related responses;
- D. Validation of behaviors required for survival during the time of the trauma; and
- E. Challenge to the idea that the non-traumatized therapist cannot be helpful, through the presence of fellow survivors in the group.

Two other objectives guide the work in this module:

- A. To present the research findings supporting these two prominent models of group intervention with traumatized adults.
- B. To consider the risks and advantages of the two evidence-based group approaches presented here.

## II. FORMAT OF THE MODULE

The materials to be covered in the narrative portions of the module include:

- A. Brief Review of the Outcome Literature
- B. Overview/Description of the Group Therapy Format (Trauma-Focus or Present-Centered)
- C. Rationale For Using This Group Therapy Model With Terrorism Survivors
- D. Goals Guiding The Group Sessions
- E. Leadership Style Issues and Requirements
- F. Member Selection Criteria
- G. Group Composition and Preparation For Entering Group
- H. Group Structure and Phases
- I. Difficult Situations
- J. Variations of the Model

### III. BRIEF REVIEW OF THE OUTCOME LITERATURE ON TFGT, PCGT MODELS OF GROUP THERAPY

A detailed review of the published reports of clinical trials of group psychotherapy for adult trauma survivors (Foy, Glynn, Schnurr, Jankowski, Wattenberg, Weiss, Marmar, & Gusman, 2000) reveals that group therapy was typically conducted over 10–15 weekly sessions (range = six weeks to one year), and session length was usually set at 1 1/2 or 2 hours. Most studies were conducted with female survivors of childhood or adulthood sexual abuse; very few published reports have included male participants.

For trauma focused or “uncovering” forms of group therapies the literature on treatment outcome can be sorted along theoretical lines, cognitive-behavioral and psychodynamic. Each of six studies examining the efficacy of cognitive-behavioral forms of group therapy for trauma survivors demonstrated improvements in group members’ distress at the end of treatment. The groups represented a variety of trauma populations (e.g., sexual assault, adult survivors of abuse, and combat veterans). The variety of cognitive behavioral techniques represented in these groups included the following: exposure therapy, cognitive processing therapy, assertiveness training, stress inoculation, and affect management. The groups met, usually weekly, for a range from 6 to 16 weeks. All six studies assessed PTSD symptoms directly (Foy, et al., 2000).

Five outcome studies of psychodynamic group treatment for adult survivors of child sexual abuse reviewed by Foy and his colleagues (2000) indicate general improvement in group members’ distress. Two studies specifically measured changes in PTSD symptoms; the others measured anxiety and depression. The psychodynamic therapy groups being studied met weekly for a range of 10 weeks to 1 year. Three of the studies reviewed used control groups; one used random assignment. The remaining studies were single group designs.

A review of literature examining five studies on the efficacy of present-centered or supportive group therapy models indicates improvements in symptoms such as depression, anxiety and self-esteem. These groups met weekly with duration of treatment ranging from 6 to 20 weeks. Three studies used control groups; one used random assignment. However, specific post-trauma symptoms, such as PTSD, were not measured in several of these studies (Foy, et al., 2000).

To update the literature on studies of treatment outcome of group therapy, we will examine results of three new studies. First, Morgan & Cummings (1999) used psychodynamic TFGT to treat 40 adult female sexual abuse survivors in a series of 20 weekly group therapy sessions. Compared to no treatment controls, group therapy participants showed significant improvements in trauma-related distress. A second recent study by Classen, Koopman, et al. (2001) featured random assignment of 53 adult female child sexual abuse survivors to either TFGT, PCGT or waitlist groups. Results indicated that both TFGT and PCGT showed significant improvement on trauma-related symptoms, while the waitlist controls did not.

In the most recent study making direct comparisons of TFGT and PCGT (Schnurr, Friedman, Foy, et al., 2004) 360 male veterans with chronic combat-related PTSD were randomly assigned to TFGT or PCGT for a series of 25 weekly therapy sessions. Post-treatment assessments of PTSD severity and other measures were significantly improved from baseline for both TFGT and PCGT. However, rigorous intention-to-treat analyses found no overall differences between the two types of group therapy on any measure of outcome. Analyses of data from participants who received an adequate dose of treatment suggested that TFGT produced better outcomes in reduced PTSD symptoms. However, dropout from treatment was higher among those randomized to TFGT. Average improvement was modest in both treatments, although roughly 40% of subjects showed clinically significant change.

Overall, the current literature provides consistent evidence that group psychotherapy, regardless of the type, is associated with favorable outcomes across a number of symptoms. PTSD and depression are the most commonly targeted, but efficacy has also been demonstrated for a range other symptoms, including global distress, dissociation, self-esteem, and fear. Elsewhere we have delineated a number of significant methodological issues, including random assignment of participants, ensuring adequate statistical power, and use of standardized treatment manuals, that currently constrain the causal inferences that can be drawn about the efficacy of group treatment (Foy, et al., 2000). These limitations are particularly important for informing future research in this area.

#### **IV. TRAUMA FOCUS GROUP THERAPY (TFTG)**

##### **A. Brief Description of TFGT**

TFGT emphasizes two cognitive-behavioral methods, systematic prolonged exposure and cognitive restructuring, to process each group member's trauma experience. Each group member has the opportunity to recount his or her story as others listen. Therefore, group members take part in trauma processing through both direct experience of their own trauma event, as well as vicarious experiences of others'. The TFGT group model encourages both the strength of personal narrative, as well as the power of group support; members "stand together" and hear the experiences of others without judgment. Psychoeducational material regarding normal reactions to trauma and use of key coping skills bolsters the group member's resources for response to current and future trauma-related reminders and symptoms (Foy, et al., 2001).

##### **B. Rationale for Using Trauma Focus Group Therapy for Survivors of Terrorism**

The information presented in the following sections will review the issues and treatment considerations for using Trauma Focus Group Therapy (TFGT) with individuals victimized by

acts of terrorism. The current module is based upon a treatment protocol developed for use with combat veterans (Foy, Gusman, Glynn, Riney, & Ruzek, 1997).

Individuals are often told to forget the traumatic event, to move on with their lives, and to not dwell on the past. However, for many victims of traumatic events, this simple philosophy is not possible. Treatment via therapeutic exposure asks the individual to maintain focus on the events and all the memories, affect and stimuli associated with the incident with the understanding that this may be a painful emotional experience. The symptoms associated with the event are viewed as resulting from the individual's attempts to avoid the painful memories. The group leader and the other group members serve as the guide and support structure to assist the individual in working through the painful memories.

The term therapeutic exposure refers to a focus of treatment, with the client's informed consent, on the memories and experiences associated with the reported traumatic event. Therapeutic exposure will occur with a focus on a single traumatic event of extreme affective intensity. A traumatic event is an incident during which the individual directly experiences a significant threat to their personal safety or the safety of someone else. The individual responds with extreme fear, horror and/or distress. Following the incident, the individual reports recurrent intrusive and distressing memories of the event, recurrent nightmares of the event, increased physiological arousal with the presentation of stimuli associated with the event and/or flashbacks.

Posttraumatic stress reactions involve avoidance of trauma-related memories. However, trauma work directly confronts memories in a therapeutic setting with the support of the facilitators and other group members. This helps group members to integrate their experiences into their present lives and to move forward from the experiences.

Posttraumatic stress is seen as a predictable response to overwhelming, uncontrollable and potentially life-threatening events. It is a normal response to abnormal circumstances including man-made and natural disasters, physical or sexual abuse, and terrible accidents. It is something that can happen to anyone. The survivor experiences fear, helplessness, and terror. The feelings frequently begin immediately after the event, but can occur days, weeks or months after the incident in some cases. The individual may experience sleep disturbance, emotional instability, impaired concentration, and distress.

PTSD may be diagnosed when these symptoms continue to be present beyond one month after the incident and the symptoms significantly disrupt the individual's daily routine and function. The disorder is most often characterized by at least one of the following symptoms: intrusive thoughts or nightmares concerning the incident, flashbacks and physiological arousal at exposure to stimuli that resemble an aspect of the traumatic event. Other symptoms include avoidance behaviors, emotional numbing, an inability to recall important aspects of the event, increased startle, hypervigilance, irritability and outbursts of anger. Problems associated with PTSD may include depression, substance abuse or panic attacks.

The cognitive restructuring component of TFGT focuses on the thoughts, beliefs and attitudes related to the traumatic incident. Changing these thoughts, beliefs and attitudes will lead to a

decrease of distress. Some of the thoughts and interpretations about the traumatic incident may be altered and the client will begin to see what happened differently. The client may see it in a healthier way and develop a new perspective about the experience.

### C. Group Goals

The first goal of treatment is a gradual reduction of emotional reactivity to painful memories. This gradual reduction occurs via extinction of the negative affective drive-state. The process of extinction is facilitated by the repeated exposure to the traumatic memories during the scheduled treatment sessions and the self-exposure home based therapy assignments.

The improvement of group members' abilities to manage symptoms is the second goal. The group will accomplish this goal both during sessions and via home based therapy assignments. The work done during the trauma focused sessions may cause a temporary increase of nightmares, anxiety and other symptoms. This possible increase of symptoms will be addressed during the sessions and group members' use of techniques to manage this stress will be monitored. Group members will need to outline a plan for their recovery.

The third goal for the group will be for members to increase their abilities to tolerate strong negative emotions. Improved tolerance occurs with practice as members learn that they can manage high levels of distress with the use of their new skills. Once again, practice is necessary to ensure the process of extinction and reduction of negative affects.

Lastly, through the course of TFGT sessions, members will also focus on the thoughts associated with the traumatic incident. Trauma survivors often have strong feelings of guilt and negative self-statements associated with guilt, as well as other aversive emotions. Distorted interpretations of the experience based on these feelings may also be present. During TFGT members are asked to review their trauma-related feelings and thoughts. The group as a whole provides corrective feedback to each member. The group members learn that their emotions, feelings and thoughts concerning the incident can be changed.

The following paragraphs outline the goals to be accomplished in the various group meetings. Two of the major goals for the group facilitators during the first two sessions include developing group cohesion and trust. Group members may be initially nervous and uncertain about the group process. The facilitators should be open and supportive of the group members. Establishing a positive therapeutic alliance is paramount to successful treatment outcome.

Trust and group cohesion are also major goals during session two. Providing the group members with effective stress management skills including deep breathing, relaxation and thought stopping will enhance this process. The group facilitators also present the need for the group to improve their ability to manage symptoms more effectively with home based therapy assignments.

The group facilitators have two additional goals during the trauma focus treatment sessions. The first will be to guide group members through a re-experiencing of their traumatic event. The group facilitator helps to direct each group member with the use of the trauma scene outline from

session three. The group members are asked to place themselves back into the event as if it were happening. It may be explained that they are like an actor in a movie scene. Members will provide an elaborate description of the event including their behaviors prior to, during and immediately following the event. The facilitator will prompt the member about feelings and thoughts throughout the scene. The other group members will remain silent and listen to the presentation until the cognitive restructuring portion of the session. The presenter may also require assistance from the facilitators to maintain focus on the trauma scene. This can be accomplished by re-directing them back to the event. It is not unusual that a group member begins to digress to other memories during their trauma scene. It may be necessary to assess these memories at a later time. If the new memories are related to the trauma scene the new information may be used during the second round of scene presentations.

The second focus during trauma focused sessions will be to help group members change faulty cognitions associated with the event. An emphasis is placed on negative self-statements. Assessing these statements helps to clarify the individual's perspective on the event during the trauma focus scene. It is also a focus of the feedback provided to the individual by the other group members during cognitive restructuring. The group members will, each in turn, respond to the scene material. The group facilitators guide and prompt the member's response to key points of the scene. These points often involve feelings of guilt, shame and anger. These emotions are associated with the individual's actions taken or perhaps actions not taken during the traumatic event. A particular emphasis should be on questions to the group members of predictability, controllability and culpability of the tragic outcome of the scene. The emotions of guilt and anger associated with this perspective help to maintain avoidance symptoms, anxiety and depression.

The goals of the final treatment session focus on assisting the group members with termination. Members are asked about how they feel about the termination of the group. Were their expectations met? Did their feelings and thoughts about their traumatic event change? Are there key issues that have not changed? How do they plan to work on these areas? Group members will have to continue their work in these areas. Facilitators may assist them with developing a plan using the skills and techniques learned during the group.

#### D. Leadership Issues

##### 1. Solo or Co-Leadership

The role of the group leader is to support and direct members' work during each session. Group leaders also facilitate group discussion and keep therapy on track in order to cover scheduled material and prevent avoidance behaviors.

The groups require co-leadership. This requirement is best illustrated during the trauma-focus treatment sessions. One of the group leaders will be working with the group member presenting his or her traumatic event, while the second group leader will be observing the remaining group members who may experience an increase of symptoms, suffer a panic attack or dissociate. The second group leader will monitor these clients,

provide support or accompany someone leaving the group room, if this unlikely event should occur.

## 2. Leadership style

The group leaders will generally be directive and didactic in style especially during the first two sessions. During the trauma focused treatment sessions the group leaders should be supportive and assist group members with the therapeutic exposure scene. A confrontational style may also be necessary at certain times. This may be done when clinical judgment suggests that the group member is avoiding memories, cognition, or affect associated with the traumatic event being presented.

## 3. Management of extreme affect

It is expected that some or all group members will also have strong emotional reactions during treatment. The group leaders should be supportive throughout the group process. The Subjective Units of Distress Scale (SUDS) is utilized to assess the level of emotional response of each group member throughout each group session. The group leaders will assist the group members with both staying in the affect and not avoiding the aversive thoughts and feelings. Instruction in the utilization of positive coping skills to more effectively manage symptoms will also be presented. Repetitions of this material during the exposure session will facilitate extinction. It will also benefit the individual if the group facilitators challenge the negative cognition and affects. The other group members may also be prompted to focus on these themes during the cognitive restructuring portion of the trauma focus session. Group leaders may utilize relaxation skills, deep breathing and grounding techniques to assist group members with prolonged episodes of extreme distress at the end of each session.

After a scene presentation, the group facilitators will prompt the group members listening to the scene with questions concerning the predictability of the tragic outcome. Was the event foreseeable? Given the individual's knowledge of the circumstances, could he or she predict what would happen? The controllability of the event is also a factor. Prompts in the form of questions such as "Was the outcome of the traumatic event controllable?" or "Was there anything that anyone could have done at the time to change the outcome?" may be used. These questions are directed at the group members following the scene presentation. Issues concerning self-blame should be challenged by the group.

Following the in-session exposure, each member should be asked to have a coping plan for the remainder of the evening and the time between group sessions. Group members should not review the audiotape for a few days following the group meeting. However, they should review the tape prior to the next trauma focus session. The group member is also asked to write the incident down answering the questions on the form provided as a home therapy assignment.

#### 4. Countertransference pitfalls

The presence of a co-leader is extremely useful concerning the resolution of issues regarding countertransference. Individual clinicians may themselves identify this response. However, the co-leader may be the first to observe the countertransference. Once identified, a clinical resolution will be determined during treatment planning and case review between both co-leaders. The co-leaders must work as a team, providing peer supervision and constructive feedback to each other throughout the treatment protocol. A determination for specific in-session interventions should be made prior to the next scheduled group meeting.

Trauma work often exposes the clinician to profoundly disturbing stories of human suffering and aggression. Much has been written about the necessity of clinician self-care and the need to prevent secondary traumatization (Figley, 1995) in view of this ongoing stress. Similar to natural disasters, terrorist attacks raise the likelihood that clinicians have been exposed to a traumatic event at the same time and in a similar way to the client—that is, both the clinician and the client have undergone recent direct traumatization. Both may still feel at risk.

Although relatively little has been written to date about this phenomenon, the demands of conducting trauma work under these circumstances can probably not be overestimated (Saakvitne, 2002). The clinician is challenged with the task of managing his or her responses to the trauma and to fears about immediate prospective safety, while attending to clients' concerns as well. Complicated issues, such as the clinician's own possible desire to avoid reminders of the trauma and discerning appropriate clinician self-disclosure about the experience and responses to the event, are often confronted. The clinician must have a safe place to deal with his or her own responses to the terrorist act. The clinician must develop plans to maximize personal safety in order not to interfere with the therapeutic work with clients. Contact with a support network and collaborating, consulting or seeking peer supervision with other colleagues can be vital.

Many clinicians find that the work of seeing clients can actually help restore a sense of normalcy and worth in a very disrupted, anxiety-provoking environment. Confronted with high levels of uncertainty, a manualized therapeutic intervention can be especially useful in providing a clear, comprehensible, accessible intervention structure for both the clinician and client.

#### E. Criteria for Selection of Members

##### 1. Evaluation and assessment

Broadly construed, there are three sets of prerequisites for the intensive trauma work that has been outlined in this module: symptoms of PTSD from the terrorist event; stable living circumstances; and toleration of intense affect. Thus, to determine if it is the appropriate time for an individual to be participating in this intervention, all three of these domains must first be assessed. Typically, this assessment can be conducted in a

single meeting with a clinician who provides the rationale for the items being assessed and then conducts a clinical interview, a mental status examination and asks for the completion of the Impact of Events Scale-Revised (IESR; Weiss & Marmar, 1998). The IESR is a paper-pencil measure and can be quickly administered and scored.

Should more extensive documentation of PTSD be required, the Clinician's Administered PTSD Scale (CAPS; Blake et al., 1995) is the recommended assessment tool. This semi-structured interview begins by eliciting exposure to a criterion—the traumatic event—and the requisite diagnostically related responses (e.g. terror, helplessness, horror). Inquires are then made about the intensity and frequency of the 17 PTSD symptoms outlined in the DSM-IV. The manual includes scoring rules to assure that the diagnosis of PTSD has been confirmed, as well as optional questions to elicit other thoughts and emotions typically found in trauma survivors (e.g. survivor guilt). Because interview-based and self-report instruments for PTSD usually have a high rate of concordance, many clinicians prefer to utilize a brief self-report tool as part of the documentation of the presence of PTSD and as a foundation for ongoing symptom assessment. The Los Angeles Symptom Checklist (King, King, Leskin, & Foy, 1995) is an example of a useful self-report instrument that gives severity scores for PTSD and depression. Other similar scales include the Trauma Symptom Inventory (TSI: Briere, Elliot, Harris, & Cotman, 1995), the Posttraumatic Disorder Scale (PDS: Foa, Cashman, Jaycox, & Perry, 1995), and the PTSD Checklist (PCL: Blanchard, Jones-Alexander, Buckley, & Forneris, 1996).

## 2. Inclusion criteria

Clinicians will need to make decisions concerning which individuals to include in the group, by assessing whether potential participants promote appropriate group function and trust. Groups may be comprised of same sex members or a mixture of men and women. However, when multiple members of a family were involved in an incident, we recommend that they be placed into different groups if possible. They may have very different views of the event and may, in fact, have complicated, negative attitudes and feelings about other relative's behavior during the incident. These familial conflicts can play havoc with group dynamics. Individuals must, of course, be agreeable to participation in a group. Group members will require the capacity to participate in treatment objectives and to interact appropriately with other members. Individuals should be able to tolerate high levels of distress and anxiety, be accepting of the rationale for exposure based therapy and have a willingness to share information concerning traumatic experiences. Group members should have stable living arrangement and be able to meet the schedule of treatment sessions.

## 3. Exclusion criteria

Exclusion criteria include, but are not limited to, acute psychosis, homicidal or suicidal tendencies, insufficient command of the common group language, other language difficulties, and heart disease/severe angina, which might preclude intensive trauma work. Some group members may require a referral for additional supportive services during participation in the group. Cross-cultural factors must be considered as relevant

to group participants; the inclusion of a co-facilitator familiar with these differences is recommended. Other criteria include individuals with pending litigation and those that may be compensation seeking.

#### 4. Additional selection considerations

Multiple traumatization over a lifetime is common (Turner & Lloyd, 1995), and thus it can never be inferred that any traumatic incident is the first in any client's life. Any individual exposed to a new traumatic event may already have a diagnosis of PTSD from a prior event. Ascertaining a prior formal diagnosis of PTSD is typically not important in assessing readiness for a group. However, one of the tasks of the clinician's interview is to determine whether the individual has been exposed to prior traumas and then to endeavor, as much as possible, to link current PTSD symptoms with the current terrorist stressor. Exposure to prior traumatic events can be ascertained through questioning (e.g. "Have there been times in your life when you thought your life might be in danger? That you might be hurt or die? Tell me about what happened."). In addition, a questionnaire designed for that purpose may be used. If exposure to a prior trauma has been confirmed, the clinician can then inquire whether there has been an increase in symptoms since the current terrorist event (e.g. nightmares about the current event, more irritability, etc.). This change criterion can be difficult to employ for some chronic symptoms (e.g. emotional numbing).

### F. Composition and Preparation for Entry Into Group

#### 1. Homogeneous characteristics

Once the diagnosis of PTSD has been confirmed, the clinician has two more tasks in ascertaining appropriateness of an exposure-based intervention. First, the clinician must be sure that the client's basic living needs are being met and he/she can make a commitment to regular group attendance. Exposure therapy can be very emotionally demanding. It involves doing out-of-session assignments. Clients usually obtain optimal benefits when their living situations are stable during the time of their participation in the treatment. At a most basic level, this means the client has a safe place to reside that affords him/her some privacy and place for downtime. Thus, this is an intervention that is best deferred if someone is living in a shelter or in temporary housing. Similarly, it is best if the client clears his/her emotional calendar when embarking on this work. That is, if the client anticipates an emotionally charged event that may be highly distressing or impact on attendance during the duration of the group, it is usually optimal to delay the start of the trauma work until this issue has been resolved. This includes surgery or treatment for a serious medical problem, divorce or child custody proceedings, and serious illness or imminent death of a loved one.

Group members will all be instructed with regard to the focus of the group during a discussion prior to individual assessment. The individual will be informed that they will be asked to describe their trauma experience in detail, including the thoughts, feelings and bodily reactions during the event. Each individual will be informed that they may

experience a short-term increase of negative affect and symptoms. This is a normal response but one that they will need to tolerate to benefit from the treatment. The ability of each individual to manage stress and symptoms will vary.

## 2. Heterogeneous characteristics

Group members will vary in a number of ways including degree of psychological-mindedness, adaptational strengths, active-passive response style, capacity to be independent, sexual identity, and symptom presentation. Some members will have experiences with psychotherapy others will be first time consumers. Some group members will be flexible and enthusiastic about engaging in treatment. Other group members may be suspicious and rigid. Some members will be extremely passive and require frequent prompting and repetition of instructions to complete tasks. Group members may also present with different constellations of symptoms. Some may develop severe re-experiencing symptoms. Others may be emotionally numb. Still other individuals may be engaging in extremely disruptive avoidance behaviors. These symptoms are all managed in group and may be a focus of the coping skill interventions.

## 3. Specific member preparation techniques

Trauma work can sometimes lead to short-term exacerbation in PTSD and depressive symptoms. A fundamental principle of the treatment is that by allowing oneself to experience prolonged exposure to previously avoided images and thoughts during a supportive therapy session, anxiety will heighten and then eventually extinguish. Often, this exposure continues after the formal treatment session has concluded for the day. The client may experience residual feelings and thoughts about the therapeutic work, or engage in assigned out-of-session tasks, such as listening to the therapy audiotape or going to a previously avoided location. Group members with a tendency to avoid stressors through use of alcohol or other substances, or who become aggressive towards themselves or others, are generally not good candidates for intensive group trauma treatment without additional support. Some group members may require concurrent individual therapy, as these issues are not directly addressed in the group treatment protocol. It may also be necessary to delay TFGT until these problems are under better control. Thus, during the final phase of the assessment interview, the clinician inquires into current level of substance use, suicidality, and potential for violence. Initial work to reduce substance use or develop better anger management strategies can be critical in preparing someone for the more intense trauma work. Here, a referral for a medication evaluation can also be invaluable.

## G. Group Structure and Phases

### 1. Structural considerations

The trauma focus group will meet for 16 sessions. The group will consist of six group members and two group facilitators. The group is closed after the first session. The sessions will all be of at least 90-minute duration, with the trauma focus sessions lasting

two hours. Each session will have five different components: check in; review of home based therapy assignments; session specific content; presentation of new home-based therapy assignments; and check out. The first two sessions will provide the group members with a description of the treatment and present a number of techniques to manage stress more effectively. Twelve sessions will focus on the traumatic experiences of the group members. Each of the six members will present their own experiences during two separate treatment sessions. The treatment will conclude with one session for treatment review and termination.

In addition to the group exposure work, an important component of TFGT is the use of out-of-session, home-based therapy assignments. Group members must leave each session and take their treatment home for additional work. Repetition of scene material is critical for therapeutic gain and much of the exposure work done by the group members will be via the home based self-exposure assignments. It is essential that group members listen to their audiotapes at home and complete the self-exposure worksheets. Other home-based therapy assignments are given each session and include a weekly journal and a symptom record. These are important to the group facilitators to assist with an evaluation of each group member's progress during the treatment protocol.

The sessions will be scheduled as follows:

- Session 1: Introductions, treatment protocol, group rules and symptom education
- Session 2: Coping skills, deep breathing, relaxation
- Session 3: Trauma scene outline
- Session 4–15: Trauma focus sessions (2 sessions per member)
- Session 16: Treatment summary and termination

## 2. Phases of the model

### a. Beginning Phase (Sessions 1–3)

During Session 1, each group member introduces himself or herself. The treatment protocol is described, behavior guidelines used during groups and symptom education are provided. During Session 2, coping skills, deep breathing and relaxation skills are demonstrated. An outline of the trauma scene to be used during Sessions 4-15 is developed during Session 3.

### b. Middle Phase (Sessions 4–15)

During these 12 weeks, the group sessions will focus on each group member's traumatic experiences. The session duration will increase to two hours to allow for prolonged therapeutic exposure and for corrective feedback from the other group members. Each group member will take a turn for the first six weeks and repeat the scene during the next six weeks. Group members will be informed at the start of each session as to which individual will be asked to present their scene. The order of presentation may be altered during the second 12 weeks. For

example, if Group Member 3 presents during session number four, Group member 3 may not present again until session number 13. The two group facilitators determine the order of presentation each week prior to the session. Group members are not told when they will be asked to take their turn.

c. Termination

This is the final group meeting. The role of the facilitators will be to assist group members with termination and transition. Plans for effective coping should be reviewed with each group member. The continued use of the skills learned and the materials provided during the treatment should be promoted.

The need to continue an exercise routine for emotional and mental well-being is emphasized. It will be the group member's responsibility to manage his/her continued recovery. This will also include continued use of the audiotapes and the self-exposure forms. Many members of the group will feel sad or a sense of loss with the termination of the group. A re-direction to other social supports or additional treatment may be provided if necessary.

3. Development of working alliance

This process begins when the group members take part in a screening/assessment interview. The rationale, nature of the treatment, the roles of the group leaders and the tasks of group members are described. Each group member is instructed in the need to participate in the group process and the benefits of treatment. The group leaders will need to maintain a positive working alliance throughout the treatment protocol. This process is strengthened by the presentation of positive coping and stress management skills during Session 2. Group leaders should also utilize a supportive style whenever possible during each of the 16 treatment sessions.

H. Difficult Situations in Trauma Groups

1. Members found to be difficult for therapist

It is not unusual for a group to include a member that is difficult to manage. The presence of difficult members can disrupt the structure and schedule of treatment. The presentation of a set of guidelines for group behavior during the treatment sessions will assist with the management of difficult group members. These guidelines should include, but may not be limited to:

- a. Must attend each session, on time, or call 24 hours ahead if an emergency occurs;
- b. Missing sessions is grounds for being asked to leave the group;
- c. Must attend clean and sober;

- d. Must not discuss group content outside of group or after meetings;
- e. Must show mutual respect, don't minimize other experience;
- f. No violence or threats of violence;
- g. No touching other group members;
- h. No therapizing other group members;
- i. No leaving the room unless a break is specified by group facilitators;
- j. No politics or religion;
- k. No candy, food or smoking.

Issues may come up that can be difficult for individual members to discuss or hear about. These individuals may engage in disruptive behaviors such as repeatedly interrupting the speaker. Other individuals may repeatedly dissociate, report "no feelings" or scores of "35" on the SUDS Scale. Group cohesion and support are extremely important when discussing such issues. Some topics can interfere with the group function including confidentiality, fear of disclosure, legal concerns and focusing on differences in traumatic experiences.

## 2. Situations experienced as difficult

Group members frequently have present-day stressors affecting their lives. The presence of such stressors may interfere with the individual's ability to focus on the content of the group. These issues can be identified during the check-in with a referral for additional services outside the group if necessary. The identification of these potential distractors remains critical for progress during the group as they may facilitate avoidance and hamper work during therapy sessions. Check-in also prevents such stressors from monopolizing the group session and preventing avoidance of the session protocol. Each group is highly structured, and the completion of required material is a frequent challenge to the group facilitators.

The group members must also understand that, as treatment advances and they expose themselves to traumatic memories, an exacerbation of their PTSD symptoms is likely. Group members will need to use the positive coping skills presented during the group to manage their symptoms. It will be important for the group to prepare a plan for a symptom flare-up. It will be necessary to review with the members the goals of the treatment and the work to be done. The members should have realistic expectations for their progress in therapy. The group members may feel overwhelmed by the tasks presented during this session. It may not be clear to them how these simple sounding skills may help them improve their lives. A simple rationale for proactive symptom

management is necessary to help the group members engage in the home-based therapy assignments.

Some people dislike homework, and a rationale for embracing treatment at home is critical for adequate compliance. It is important to present to group members that progress in treatment requires work, and perhaps the hardest work that they have ever done. It should be made clear that what they will get out of therapy will be directly related to the work done. You may explain that, if they come into group and expect to work for 90 minutes or two hours and go home and forget about the group, they will receive minimal benefit. The group members need to continue to process and not avoid the memories of their trauma. Avoidance is a key aspect of symptom maintenance. Group members will need to continue to work on material covered during treatment sessions each week at home and not continue with the behaviors that have perpetuated the pain.

If group members have strong reactions to the content being presented during the session, they should be asked to use the coping skills practiced during the prior session. This will be an opportunity to assist them with these techniques in the presence of distressing stimuli. Group members may utilize deep breathing or relaxation skills to manage their symptoms. Some individuals may also be anxious about taking their turn to present or be concerned about the type of reactions they may receive from the group and the two facilitators. Others may fear judgment and rejection because of their actions or lack of action during the incident. Taking a final SUDS level at checkout is very important. Review the need to practice positive coping skills. Ask each member for a plan as to how they will take care of themselves the rest of the day.

The selection of a specific group member for the trauma scene presentations should be based on the clinical concerns for the group. Certain individuals may experience extremely high levels of anticipatory anxiety. A significant increase of symptoms, as the therapeutic exposure sessions begin, may be experienced. One way to decrease this anxiety will be to select such individuals to go first or very early in the rotation.

During the trauma-focused sessions, group members are informed on the day of the meeting as to which individual has been selected to present his or her scene. Individuals experiencing extremely high levels of distress and severe symptoms may be selected to present first or very early in the trauma-focused rotation. Therapeutic exposure should lead to an overall decrease of symptom intensity after the first session of trauma exposure. Group members will continue to experience symptoms, but some relief should occur especially with the client's use of home-based therapy assignments during the following week. Another consideration for order selection may be the response of each group member during the outline and scene description from session three. The SUDS scales ratings of the group members during this process and their reactions to the presentations by other group members may provide helpful information. Some group members will present with coherent and well-defined outlines. Others may struggle with the scene outline, provide vague descriptions, and be confused about the procedure and requirements of the task despite repeated clarifications by the group facilitators. These

individuals may benefit from a later position in the rotation. It may be less confusing for them if they are given the opportunity to observe other group members taking their turn first.

Change will be extremely difficult for some group members. Treatment will be difficult and they will not be flexible in their thoughts of self-blame or judgments concerning their behavior. One technique to challenge the member's thoughts is to have him or her give an estimate on the probability that a behavior would lead to a specific outcome. This question may also be directed to the other group members listening to the scene presentation. The group consensus will be that it is impossible to predict with complete certainty that any one action will cause a specific outcome. This exercise helps the individual continue the focus on the emotions and thoughts associated with the event. It provides for additional extinction of the negative affect and an opportunity for the individual to change their perspective concerning the event.

Based upon past experience with TFGT, disclosing who will be asked to present at the beginning of each session resolves many of these issues. First, it helps to decrease anticipatory anxiety. An individual may feel heightened distress and experience an increase of symptoms during the week prior to their scheduled presentation. This may make it more difficult for them during the actual in-session trauma work. Also, individuals may avoid taking their turn by not attending the session during which he or she has been scheduled to present his or her scene. Subsequently, if someone misses his or her scheduled turn, it can create stress within the group as the facilitators will either have to ask someone else to take the missing individual's turn or to add sessions to the treatment protocol to accommodate and maintain the treatment schedule. Adding sessions places a burden on the group facilitators concerning the session content for the group meeting during a group member's absence. It also places a burden on the other group members with regard to time, their emotions and financial concerns.

### 3. Premature terminations

Premature terminations may occur for many reasons. Group members may have significant life events, such as a death in the family, an unexpected illness, or some other unpredictable circumstance take place during treatment. A group member may also leave because he or she no longer wishes to continue with the trauma-focused group.

Following the member's departure, the group leaders should use the check-in time at the start of each session to review the reactions of the remaining group members concerning the departure. Group leaders should be supportive of the group's concerns and the decision to remain in treatment.

After a group member has departed, this individual may also express the wish to return to treatment. The return of a departed member may be very disruptive to the group process and requires careful consideration by the group leaders and the group members. If a group member has missed more than one session, a consideration for participation in a subsequent group is recommended. For individuals having missed only one group

session, the group leaders should first consider and decide on a recommendation for a return to group. Final approval for a return to group must come from the group itself.

Premature termination will also change the flow of the treatment sessions. As an alternative, additional work on coping skills may be scheduled for these meetings. All variations from the original protocol should be reviewed by the co-leaders and agreed upon by the group.

#### I. Variations of the Model

Group members should not be involved in other individual or group psychotherapy services concerning their traumatic experiences during participation in the trauma focus treatment group. Participation in the group is often very demanding of each member's time, resources and energy. Home-based therapy assignments are an essential part of treatment. These assignments include in-home exposure to the trauma scene presented during the group session via an audiotape. Audiotapes are recorded during treatment sessions and require a great deal of effort from each group member.

If necessary, group members may attend peer-led services, such as Alcoholics Anonymous, Narcotics Anonymous, or other 12-step based programs. Marital counseling or other services that do not focus on the trauma history may be considered. Group members may be involved in case management programs for assistance with housing, finances and other personal or family needs.

The group leaders should review medication management. The symptom presentations may change during the course of the treatment protocol. Consultations with the prescribing physician are recommended.

### V. PRESENT-CENTERED SUPPORTIVE GROUP THERAPY FOR SURVIVORS OF TERRORISM

#### A. Brief Description of PCGT

Present-Centered Group Therapy (PCGT) is a form of supportive group therapy that is problem-oriented, providing members with additional social support in the group to improve current coping. While there may be variations among PCGT groups, there are a number of shared characteristic features. PCGT groups typically avoid actual details of members' traumatic experiences, although personal consequences of trauma are acknowledged and validated. Groups are managed so that there is some emotional engagement of members' middle-range affects (e.g., frustration, sadness, happiness, hurt), while rage and terror are diffused. These groups infrequently use structured materials, and expectations for members' participation rarely involve homework or testing for mastery of material. Unlike other types of experiential groups, PCGT groups attempt to maintain a sense of interpersonal comfort and to keep transference at a low to moderate level. Other features include an active, facilitative leadership style, emphasis on members' strengths, process-encouraging interventions, combination of pragmatic and here-and-now focus, low to moderate structure, and view of change as gradual and incremental. Level of confrontation is generally low to moderate.

## B. Rationale for Establishing Present-Centered Group Therapy for Survivors of Terrorism

In the wake of terrorism, survivors must balance two competing tasks: making sense of the trauma, and re-establishing a secure foundation in the present in the face of intrusions that overwhelm the current time frame. PCGT emphasizes the latter, encouraging attention to current feelings, needs, situations and wants, and supporting recalibration of trauma-based symptoms, attitudes, and behaviors. An alternative to exposure-based, uncovering, and skills-building treatments, PCGT bridges the realities of life before and after a terrorist event, legitimizing members' return to non-emergency functioning. This supportive approach provides a context which gently re-orient members toward current coping, with a modicum of structure to maintain the focus on trauma-related symptoms and attitudes (Wattenberg, et al., 2003).

This model relies on the intrinsic therapeutic factors of group psychotherapy (Yalom, 1995) to mobilize strengths and competence in members whose emotional resources have been depleted by trauma. The stable, yet fluid and complex, interpersonal environment provides compelling context cues that compete with intrusions from the encounter with terrorism. These context cues provide a present-oriented foundation from which trauma-based responses can be brought into focus, examined, and gradually restructured. With continued attention and repeated examination, the automatic reactivity of these responses yields to awareness and deliberation. As members come to distinguish more accurately between current environmental cues and intrusions from the traumatic past, they gain mastery over trauma-based concerns, and more readily allocate personal resources to current goals and needs. At the same time, they experience themselves in relation to others, and engage in problem-solving about their current lives, reconnecting with a sense of empowerment that was lacking during the trauma. The group emerges as a corrective context, shifting from trauma orientation to a more balanced perspective that supports current functioning.

The return of attention to the present that this model emphasizes can be understood in terms of schema theory (Neisser, 1976; McCann & Pearlman, 1990). Schemata represent the means by which human beings actively and automatically engage the environment, applying previously learned information, incorporating new information, flexibly recalibrating in response to this new information, and reorienting to the environment. For individuals with PTSD, trauma-based intrusions, affects, and attitudes interfere with this automatic process of digesting and assessing new information. Information from the past is revisited repeatedly, often as though it were occurring in the present, in place of the current environment. At the same time, cues in the present may be overlooked. Trauma-based attitudes are reinforced, and trauma-based behaviors tend to be re-initiated even once the trauma has subsided. The therapy environment afforded by PCGT, by emphasizing consistent access and attention to the current environment, allows an opportunity for the trauma-influenced world-view to gradually readjust, resulting in functioning that more accurately reflects current information.

### C. Group Goals

The overarching objective of PCGT is to support movement from a trauma-based world-view toward a broader perspective that incorporates information from the current environment, and applies it to improving current life functioning. To this end, this group model:

1. Validates the impact of the trauma on the lives of group members, without encouraging reliving.
2. Addresses intrusions, and other PTSD symptoms, as well as symptoms of associated disorders.
3. Addresses trauma-based attitudes, beliefs, and habits.
4. Counteracts alexithymia through repeated attention to emotional experience.
5. Allows a sense of community and common experience to develop, counteracting the isolation, alienation, numbing, and disconnection that trauma survivors often experience.
6. Provides a safe environment in which to begin to feel effective again, counteracting the sense of helplessness from the trauma.
7. Inoculates against potential 'secondary trauma' from other less responsive contexts in the members' lives, following the initial trauma, through providing support.
8. Diffuses the sense of shame that often accompanies traumatic experience.
9. Encourages perspective-taking in relation to other people.

This model is flexible enough to be applied to a variety of settings and purposes. In programs for treatment of psychological trauma, PCGT may serve as the primary therapy modality, as introduction and preparation for further therapy, as support for adjustment after trauma work, or as support for compliance with other concurrent treatment (e.g., individual or group trauma work, or formal skills-building). In intensive outpatient, partial hospitalization, or inpatient programs for PTSD, this modality often provides the sense of cohesion that supports more demanding therapies. PCGT may also be used to address special circumstances, e.g., crisis intervention, adjustment to life transitions (e.g., retirement, marriage, graduation) affected by trauma, stabilization (e.g., following an inpatient hospitalization for PTSD), sobriety maintenance (e.g., during or following substance abuse rehabilitation).

### D. Clinical Considerations For Trauma Group Leaders

## 1. Co-therapy

Co-therapy is highly recommended, given the range of issues that can arise with trauma, the relatively high potential for crises to be raised in the group, and the advantage of co-therapists modeling communication, mutual support, and self-care. Co-therapy provides greater continuity and group stability, so that sessions can continue despite occasional therapist absences. The sharing of responsibility within the co-therapy team also serves as a support for the facilitators in dealing with the trauma-based affects expressed in the group, and for problem-solving regarding potential trauma-related re-enactments. The opportunity for facilitator 'debriefing' afforded by co-therapy reduces the potential for vicarious traumatization in the co-facilitators.

## 2. Leadership style and facilitator roles

PCGT utilizes an active, flexible, facilitative leadership style. Facilitators maintain a well-defined but accessible professional role. They are neither uncommunicative and distant (which can elicit paranoia, confusion, and sense of abandonment), nor over-involved, intrusive, or controlling (which can elicit dependence and passivity). They assume legitimate authority through demonstrating awareness of trauma-related symptoms and attitudes, identifying these phenomena as they occur, and intervening proactively. In doing so, they establish a sense of safety, and illustrate that management of symptoms is feasible. Facilitators neither abdicate authority to the group members, nor exaggerate their own power and authority. Their aim is to encourage members to adopt legitimately powerful roles as the group develops. PCGT interventions emphasize client strengths. The process of change is regarded as gradual and incremental. Level of confrontation is generally low to moderate, and a sense interpersonal comfort is supported.

Facilitator role also includes maintaining ultimate responsibility for violation of group rules and consequences, for emergencies, risk, psychiatric issues, and other treatment issues. In addition, facilitators serve as a bridge to other treaters within the treatment setting, and may perform case management as needed (or may refer for separate case management if available).

## 3. Development of working alliance

The over-riding socio-emotional task of PCGT is to establish an environment in which members can restore awareness of a range of human experience, in place of the sense of endangerment, victimhood, fatalism, and diminution so commonly experienced as sequelae to trauma. Facilitators strive for authenticity within the boundaries of their clinical role, maximizing a sense of connection, and offering clear, reliable interpersonal cues. The aim is to reduce ambiguity for clients whose world-view is already compromised by trauma. Facilitators begin with psychoeducation, establishing that they are both knowledgeable about and interested in the sequelae of trauma. From the viewpoint that knowledge is power, psychoeducation also represents empowerment of the group through demystifying the often-confusing constellation of symptoms. Facilitators use this information to normalize the response to trauma, supporting a sense

of shared humanity that serves to reduce shame and alienation. These efforts help to negotiate an alliance with clients who have difficulty with trust and connection.

Communication from facilitators may be more formally polite in early sessions, in order to clearly establish an authoritative, yet non-authoritarian, stance. As the group continues, communication from facilitators may become more informal, playful, and direct. At the same time, facilitators step back and become less active as the group develops, permitting the group process to expand.

#### 4. Management of extreme affect

Trauma tends to have powerful impact on subsequent perception of emotion. Survivors' inner experience tends toward high-level arousal states such as terror, panic, and rage, and disconcerting absence of affect, as represented by numbing, dissociation, or 'freezing.' Re-experiencing brings up strong affective responses that are more related to the memory of traumatic events than to present-day experience. Mid-range affects associated with every-day life, such as hurt, anger, sadness, happiness, uneasiness, and even milder levels of fear, are diminished or simply dismissed. The result is disconnection from information about the current environment that is normally afforded by affective nuances, and the domination of experience by affects associated with trauma. Alexithymia often develops, in which the trauma survivor has difficulty connecting with inner emotional experience, and/or has difficulty putting feelings into words, most likely secondary to the shutting down of higher cognitive processes due to hyperarousal. Trauma survivors then continue to live in a world dominated by trauma, despite absence of immediate threat.

#### 5. Responding therapeutically to alexithymia

Unlike exposure and uncovering therapies, PCGT focuses away from the details of the terrorist experience, while acknowledging and validating the impact of trauma. Interventions aim at exploring mid-range affects, diffusing more extreme affects related to hyperarousal. PCGT counters trauma-based reactions by encouraging identification of and attention to nuances in emotion. This repeated attention provides successive approximations toward broader emotional awareness, which serves to reduce alexithymia and enhance reconnection to the current environment. Members are also encouraged to identify with feelings in others, starting with a sense of identification with one another. Members may also be enlisted to help others identify affects that are hard to express.

#### 6. Therapeutic responses to re-experiencing and hyperarousal

Members may react to either internal stimuli (e.g., hunger, tiredness, physical pain) or external stimuli (e.g., comments made in group, weather conditions, loud sounds, certain smells) with re-experiencing symptoms. Intrusive memories are likely, and partial or full-blown flashbacks may also occur, leading to distractibility and distress in the group and also hyperarousal. Signs of re-experiencing may be relatively subtle, (e.g., discontinuing

eye contact, intensification of thousand-yard gaze), or dramatic (e.g., when accompanied by strong hyperarousal, indicators may include aggressive or fearful posturing, anxious foot-tapping, loud voice, sudden movement) or panic attack).

When arousal is so high that a member cannot focus, or when he or she is distracted by re-experiencing, facilitators help to diffuse these experiences. Body reflection (Prouty, 1994); verbally describing body postures, gestures, and voice quality, and sometimes physically mirroring these nonverbal behaviors) provides feedback to members, allowing them to observe and share their own inner experience. This technique, developed for working with psychosis, can be applied effectively to functional, non-psychotic clients who are momentarily out of contact with the current environment due to trauma-related intrusions. Facilitators encourage members to self-soothe, using grounding techniques (use of sensory awareness such as feeling feet on the floor, gripping sides of the chair, making eye contact, smelling a neutral olfactory stimulus), breathing techniques, and direction to shift out of arousal-related postures. These interventions help to reduce arousal and interrupt re-experiencing in affected members, and to diffuse likely contagion of fight-or-flight response among members. Once identified, the intrusive memory and/or exacerbated arousal is linked to possible trauma triggers. Techniques for affect management may be discussed, including practice of relaxation techniques to help reduce arousal levels generally. Subsequently, when members experience high-level arousal, the group assists in locating more subtle, antecedent affective states that may have led to the arousal, e.g., an uneasy feeling, a feeling of discomfort, feeling hurt or confused.

#### 7. Responding therapeutically to numbing

When members experience an absence of affect (e.g., psychic numbing), facilitators first determine whether the numbing is reactive or a more consistent state. If the former, the group explores possible triggers for the numbing, and whether any other symptoms, such as re-experiencing or a high level of arousal, led to the numbing. Feelings that may have occurred just prior to the numbing are examined, and grounding techniques may be used. If the numbing has been long-standing, approximations to feelings may be developed, including: what it feels like to be numb inside; what normally expected feeling seems to be missing; what the affected member feels about being numb; whether there is any advantage to the numb state (e.g., is it preferable in some way to what the person might otherwise feel); what other members feel in the room at that moment; what other members might feel if they were in the affected member's shoes.

#### 8. Managing dissociation

Dissociation may lead to loss of interpersonal contact, even without specific trauma-based thoughts or imagery. Signs of dissociation can include: confusion, withdrawal, vagueness, automatic quality, or distracted, aimless behavior. Grounding techniques, as described for re-experiencing, are also useful with dissociation. The affected member is encouraged to discuss her inner experience, and return to contact with the group.

9. Managing shame and losses to self

In addition to trauma-based symptoms, members may experience extremely powerful affects stemming from the helplessness and horror experienced during the trauma. Sources of shame include:

- a. Inability to help others (or help enough) during the trauma;
- b. Confusion during the trauma;
- c. Feeling used in the context of terrorism;
- d. Feeling dehumanized, expendable, devalued during the trauma;
- e. Feeling compromised in terms of basic human needs that were challenged during the trauma;
- f. Being symptomatic after the trauma;
- g. Being poorly received after the trauma.

The impact of trauma on the ordinary needs for safety, control, and predictability creates a sense of fall from grace, as basic expectations are violated. Left with a profound sense of helplessness, group members may be wracked with unreasonable self-blame. They may feel jinxed, as though they are magnets for trouble. This loss in sense of self, combined with actual changes due to PTSD symptoms, may be seen as further evidence of contamination. In addition, to survive when others have died highlights the fragility of life, and engenders loss of meaning. Depending on what survivors witness during the trauma, loss of sense of body integrity may contribute to shame and sense of contamination. These psychological assaults compromise members' capacity to value their own lives, to connect meaningfully with other people, and to invest in significant activities. Group facilitators are likely to see multiple expressions of these affects underlying obstacles to development of a working alliance. Initial psychoeducation can be used to predict and normalize these issues, restoring a sense of safety. Facilitators' awareness and use of these themes to gently interpret interpersonal conflicts and avoidance will help members access group support instead of retreating further into alienation. Facilitators can help members recover from shame issues through re-humanizing outlets such as creative expression, humor, and a sense of belonging and acceptance within the group and other community contacts.

10. Transference and countertransference pitfalls and obstacles to working alliance

- a. Transference

Transference toward facilitators is addressed as it arises, but diffused so as to minimize it as a focus of the group. Transferences commonly revolve around

issues of trust, authority, control, and shame; members may question whether the facilitators are trustworthy, may challenge their authority, may engage them in control struggles, or may deflect shame issues by attributing inadequacy to facilitators. A non-defensive stance on the part of the facilitator, and acknowledgement of imperfections, goes a long way toward diffusing transference.

b. Sense of vigil as transference

Following trauma, a sense of keeping vigil may interfere with return to life as usual. Survivors are often unwilling to allow themselves to let their guard down, hesitating to embrace what seems like a false sense of security. Going on with life may also appear to betray experiences of horror and loss during the trauma. Four major needs that emerge in the aftermath of trauma tend to come into conflict initially with therapy, contributing to transference and countertransference issues in group:

- i. *The need to be prepared for future trauma* reinforces hyperarousal, trust issues, control issues, cynicism, even paranoia. Survivors set their 'signal detection' system to maximize hits on the radar screen, rather than minimizing misses, hyperfocusing on any potential for danger or betrayal. Controlling behavior based on this need takes a number of forms, from 'managing' the facilitators by over-praising them, to creating splits and sub-alliances in order to get around them.
- ii. *The need to protest injustice* creates secondary gain for behaviors such as venting, returning to details of the trauma without attempting resolution, and challenging the authority of facilitators.
- iii. *The need to resist loss of meaning* can kindle existential issues, as survivors represent the trauma, its importance, and its senselessness. Group members may maintain witness for others who died as a result of terrorism. They may also hold a vigil for personal losses of innocence and faith. Members may show a variety of stuck patterns, e.g., a thanks-but-no-thanks attitude regarding suggestions, or repeatedly posing questions that stump the therapist. These patterns serve to underscore the enormity trauma (and the futility of therapeutic efforts). Some members may generate a series of crises that distract from loss of meaning. A crisis also presents a new, urgent situation to which facilitators and the group can respond meaningfully, as a test balloon for the larger trauma. Yet another meaning-related pattern involves assuming a bigger than life' stance, in order to transcend annihilation by trauma. Members with this stance may deny any sense of vulnerability. They may reject help, voicing that other people need help more than they do. Or they may belittle members who do express vulnerability.

They may find ways to discount the facilitators, e.g., treating them as a buddies, or sexualizing them.

iv. *The need to protect others* from contact with trauma can inject the group with irrelevant or even boring material. Despite the present-centered nature of the group, other trauma-survivors can be a trigger. Members may monopolize or filibuster to avoid having to interact at a deeper level with other survivors.

c. Group transference in premature pseudocoheion

While trauma-related issues can be very responsive to group interventions, members may sometimes be motivated to avoid therapeutic change because it means giving up responses initiated in the interest of survival, under conditions of threat and danger. Members may also be motivated, due to shame about the symptoms they are experiencing, to avoid acknowledging disability or vulnerability, or to hide a sense of feeling crazy. Groups of trauma survivors with PTSD sometimes tend to develop a premature, nontherapeutic cohesion that may lead to “therapeutic impasses, intensification of symptoms, acting-out and even the demise of the group.” (Parson, 1985) This premature cohesion represents a form of pseudomutuality that prevents differentiation and avoids true intimacy and sharing of feelings (and so, termed here, “pseudocoheion”). In any group with significant common experiences, a period of over-identification within the group, and alienation from others outside the group, may be natural. However, inflexibility and crystallization of these features may signal the start of pseudocoheion, warranting early intervention.

Pseudocoheion is based on feelings of narcissistic endangerment, paranoid defenses in the group’s social structure and general fragmentation-prone functioning accompanying loss of self-cohesion, which are exacerbated by re-experiencing. This faulty cohesion, in turn, intensifies a variety of trauma-related issues (e.g. loss of trust, authority issues), sending the group members into sub-alliances that often ignore, demote, or co-opt the facilitators. The group develops an us-versus-them mentality which supports the status quo against change, and discourages connection to the world outside the group. The result is typically a loss of trust, avoidance of genuine intimacy, stagnation of the group, and immobilization of therapy within the group, as well as loss of a sense of responsibility in group members.

Scapegoating of a member or group of members is more likely under conditions of pseudocoheion, when distinctions among members appear to threaten the unity of the group. If left without intervention, premature pseudocoheion may precipitate re-enactments of the trauma and entrenched roles.

i. *Re-enactment of the trauma* can threaten the group with overwhelming affects, loss of safety, and potential for secondary trauma. Members may take on roles from the trauma itself and play them out,

resulting in a sense of the enemy entering the group. Without intervention, a member or members may become alienated from the group, creating risk for premature termination. Scapegoating often develops. Facilitators may intervene by noting the re-enactment and reframing the actual roles of group members, identifying the enemy as shared fears, shame, and sense of contamination from the trauma.

ii. *Entrenched roles:* Re-enactments generally involve certain entrenched roles, which become rigid characteristic responses to managing the emotional sequelae of trauma. Group members who experience prominent reliving symptoms will be especially prone to assuming these roles, making re-enactment more likely. Entrenched roles of victim, aggressor, caretaker/protector, challenger/rebel, and cynic/critic may dominate the group process if allowed to proceed without therapeutic intervention. All of the roles can be reframed as stopgap protective responses to the trauma, which may now interfere with recovery. It is often effective to express appreciation for the function of these roles, while encouraging greater role flexibility and authenticity. Interventions for premature pseudocoherence, re-enactments and entrenched roles include: a cautious paradoxical approach; expression of the negative side of the ambivalence by the facilitators; respectful confrontation; and overt limit-setting, with review of group purpose and guidelines. Use of additional structure, whether psychoeducation or skills-building, can be useful in re-establishing a therapeutic orientation.

iii. *Scapegoating* typically represents one form of re-enactment. It is more likely to emerge when there is a sense of loss regarding one of the facilitators, e.g., extended or repeated absence, serious illness, or pending departure that has not been addressed adequately, leading to a sense of shame at being abandoned, or intensifying a sense of contamination (“I must be driving people away from me”). In these latter instances, the group directs anger toward one of its members rather than toward the facilitator in question. When scapegoating is extreme, it can intimidate the out-of-favor member or members to the point of driving them from the group, or at best, silencing them within the group.

A group that threatens expulsions of a member signals an unhealthy group process, warranting quick and direct intervention. This situation also requires re-examination of the co-therapy relationship, and of alliances between members and facilitators. An issue with shame within the group can often be identified, and actively addressed. Attributing difficulties among members to identifiable process factors allows members to rejoin each other in a meaningful way. Facilitator modeling of tolerance and ability to consider a variety of viewpoints also is useful in protecting the group from unnecessary expulsions. Facilitators may intervene by encouraging the group to direct their resentments and fears toward the facilitators. It is important for facilitators to support the targeted

member, and to redirect the attacking members toward their own feelings and behavior. It is helpful to reframe the process in terms of the group as a whole, and not in terms of personalities among the members, as each member has strengths and frailties, either of which could become a target of sustained negative group attention in an unhealthy process. Once the process has been redirected and members have been reassured, the attacking members can be encouraged to take responsibility for hostile statements or actions, while the targeted member can be supported in expressing a reaction to the formerly skewed process. The aim is for a more authentic process that allows honest expression among members without shaming any one person or group.

d. Countertransference

For even experienced therapists, the strong pull of trauma-related affects, and reactions to the traumatic experience itself, present potential pitfalls:

- i. A sense of personal or therapeutic inadequacy, and idealization of group members as strong survivors, may develop. Facilitators may minimize the symptoms and vulnerabilities expressed by group members, and overestimate what they can handle.
- ii. Conversely (and sometimes simultaneously), facilitators may identify with the vulnerability of the members (e.g., “If that had happened to me, I would not have been able to handle it.”), and identify with members’ sense of victimization. Facilitators may then reinforce a sense of entitlement in members, and collude with members in overlooking their own contributions to relationship issues. Facilitators can end up splitting over this issue, with one facilitator allying with members in opposition to the co-therapist, intensifying trust and safety issues in the group.
- iii. Facilitators may respond from their own control issues (e.g., ‘Something that traumatic could never happen to me, because I... [take the subway, drive, know better than to work in that part of the city, always lock my door, etc.]’), leading to blaming the victim and feeding into members’ self-blame.
- iv. Facilitators with similar or related trauma may overlook reactions of members that are different from their own, or may assume common experience and therefore fail to explore important nuances.
- v. The combination of loss of meaning, psychic numbing, and depression in members can lead facilitators to feel overwhelmed, and again, inadequate in the face of the trauma. Facilitators may respond by becoming over-active, trying too hard to supply the missing sense of

meaning, or by yielding to the overwhelming affect, passively sinking into the gloom of a depressed group.

vi. Fight-or-flight response is contagious in groups, and facilitators can expect to feel it. Countertransference in response to hyperarousal ranges from a sense of helplessness to catching the intensity of the moment, possibly playing out in:

- Becoming over-responsible in trying to fix problems, potentially over-protecting and infantilizing a distressed member;
- Becoming underprotective, deferring to the powerful affect;
- Supporting and glorifying anger and rage experienced by group members (and failing to acknowledge the pain and shame involved in loss of control).
- Feeling immobilized, and therefore failing to intervene (freeze response);
- Colluding with intimidation in the group out of unacknowledged fear;
- Becoming disdainful and impatient out of discomfort with strong affect.

Facilitators can rely on the co-therapy team to buffer against acting on countertransference. Consultation, whether with trauma-informed peers, or a more experienced trauma therapist, recommended. Facilitators are also encouraged to inform themselves about potential for vicarious traumatization, in order to prepare for the potential emotional impact of trauma therapy, and strategize self-care.

#### E. Criteria for Selection of Members

Screening and evaluation for supportive groups resembles that for other trauma-related groups. Members are thoroughly interviewed, and a history (including recent and prior trauma (as the survivor's comfort level will allow), neglect in childhood, mood swings, risk to self or others, psychiatric hospitalizations, substance abuse and substance abuse treatment, violence, victimization, structure of current family and family of origin, and parenting issues) is taken. Interview also includes work and educational history, financial issues, and treatment experience to date (including past group experiences). Goals and level of motivation are assessed. Other non-therapy group experiences (e.g., work, family, school) that might affect adjustment to group therapy (including group interactions during the trauma) are examined. Members are additionally assessed for secondary trauma (events occurring immediately after the trauma) that might complicate recovery. Impact of Events Scale-Revised (IES-R) is recommended as an assessment instrument.

## 1. Inclusion criteria

Members are selected for having a significant trauma history, and ability to tolerate a group format. Members must have the cognitive ability to understand the purpose and requirements of the treatment (as well as to tolerate and track a complex interpersonal environment), and to be able to consent for treatment. They must be willing to work within the present-centered format, including accepting feedback from other members and from group leaders, discussing symptoms and affective experience, and accepting redirection away from the details of the terrorism experience. Motivation level at contemplation stage, action stage, or maintenance stage is strongly preferred. Symptoms may be acute or chronic. Members must also be able to contract for safety (especially for outpatient groups), regarding suicide and physical aggression, and to observe the group guidelines (e.g., attending group sober, maintaining respect for other members and group leaders (including no violence, no threats or name-calling, etc.)). Members must also agree to maintain confidentiality of other group members, and to accept legal and administrative limits to confidentiality. Factors for which supportive treatment is particularly indicated include:

- a. Being new to therapy;
- b. Having negative prior treatment experiences;
- c. Having significant history of multiple prior traumatic experiences;
- d. Experiencing current instability;
- e. Having a history of bipolar disorder, significant depression, or other major mental illness;
- f. Experiencing difficulty managing affect;
- g. Experiencing difficulty acknowledging aspects of the trauma;
- h. Experiencing high level of current life stressors (e.g., acute or severe medical problem, legal stressors, housing issues, financial losses, recent death in family, recent or pending divorce, serious illness in immediate family);
- i. Having a preference for current-day focus;
- j. Suffering disabling symptoms to the point of being unable to work;
- k. Having prominent parenting issues;
- l. Having demanding family responsibilities;
- m. Experiencing current high-risk situation, either at work or at home;

- n. Having current or recent unstable family circumstances;
- o. Belong to a high-trauma-risk profession (e.g., paramedic, police officer, fire fighter);
- p. Having already completed trauma-focus work and needing subsequent support;
- q. Being in current trauma-focus individual or group treatment, and need additional support.

2. Exclusion criteria

- a. Substance dependence;
- b. Acute psychosis;
- c. Active mania;
- d. Acute paranoia;
- e. Prominent sociopathy;
- f. Inability to refrain from aggressive behavior, e.g., threats, aggressive gesturing, violence
- g. Unwillingness to adhere to group guidelines and expectations

Criteria may be modified if the group is applied within a diagnostic category (e.g., trauma and substance dependence), or if treatment for a comorbid disorder is available concurrently.

F. Composition and Preparation for Entry into Group

1. Homogeneous and heterogeneous characteristics

Homogeneity is desirable for characteristics affecting ability to participate comparably in the group process. Members should be within a close range regarding ability to interact verbally, respond cognitively and emotionally, and draw on personal resources. They should also be within range regarding level of psychological injury (from trauma, or from prior history) and degree of symptomatology from the trauma.

Extreme disparities in level of functioning can result in unhealthy comparisons among members, exacerbation of a sense of shame among both higher and lower-functioning members, and stalemate in the group process. However, modest differences among members allow distinctions in personal identity to develop within the group, so that

members can more clearly understand the impact of trauma, and distinguish symptoms from defining personal traits.

Distinctness of members also allows greater acknowledgement of the healthy aspects of individuals in the group, as opposed to development of a trauma-based identity among members that can defy differentiation (e.g., “We are all alike...our trauma defines us.”). Heterogeneity regarding personality variables, age, gender, sexual orientation, ethnic and religious background, vocational and educational histories, political beliefs, socioeconomic status, level of intelligence (from low average to very superior) is not only allowable but usually desirable. Members may also vary considerably regarding prior treatment experience, unless the group is provided within a ‘stage of treatment’ model, e.g., the Judith Herman/Victims of Violence model, which suggests a progression from introductory, preparatory work before addressing trauma, and supportive work following trauma work (Herman, 1992). It is workable for some members to be more motivated than others, because more motivated members may model for others; however, any group should have a predominance of motivated members. Even higher levels of divergence are desirable on characteristics that allow members to benefit from diverse perspectives in the group, such as personal style, ethnicity, religion. Such differences enhance the problem-solving function of the group, and encourage flexibility and range in learning and coping.

For dual diagnosis groups, members should have comparable level of the particular comorbid disorder (whether for substance abuse, major mental illness, or other disorder). For members who are court-referred due to concomitant legal issues, level of legal issue should be roughly equated. It is generally inadvisable to include court-referred and voluntary members within the same group.

If groups are provided within a particular organization, members should be of comparable hierarchical status, and supervisor/supervisee pairs should not be in the same group. Employees who work closely together should not be members of the same group.

## 2. Preparation for entry

The assessment includes a modicum of introductory psychoeducation about the impact of trauma, normalizing the experience of trauma survivors and reducing the sense of shame around symptoms and need for treatment. Following assessment, members meet with the facilitators (at least one, preferably both) for an individual pre-group interview (important in establishing the credibility of the facilitators) to discuss the assessment and entry into group (if a client is excluded from group, the interviewer should meet with the client in person to explain the exclusion). In the preparatory pre-group interview, information on group therapy, and expectations for members, are provided (i.e., list of group guidelines, emergency numbers, information on the format and scheduling of groups, confidentiality rules and limits to confidentiality). Facilitators present the present-centered focus and rationale, and establish the member’s ability to accept the

focus and format. If the group is provided within an organization (e.g., by an Employee Assistance Program)), special precautions must be taken regarding confidentiality.

3. Guidelines: Members agree to:

- a. Confidentiality (and information on limits to confidentiality). By participating in this group, each member agrees not to disclose the contents of group discussion or identity of group members outside the group session. Exceptions to confidentiality include of risk of danger to self or others, and risk to a minor child, or to an elderly or handicapped person. Facilitators will also record necessary information in the medical treatment folder, and share relevant information with other members of the group member's treatment team, in the interest coordinating good clinical care.
- b. Come to group free from the influence of nonprescribed psychoactive substances;
- c. Respect the physical and emotional integrity of others (e.g., not smoking in the group, refraining from violence, threats, name-calling, use of demeaning names in reference to any ethnic or cultural groups);
- d. Refrain from business transactions with other members;
- e. Refrain from trying to persuade the group toward a particular political view or religion;
- f. Stay in the room during session if possible (while encouraged to stay, members may be allowed to leave if they are feeling triggered, as long as they let the group know the reason for leaving, and agree to return as soon as possible)
- g. Agree to self-care responsibilities such as medical appointments, taking medication, and refraining from self-destructive behavior (e.g., self-mutilating, suicidal behavior, abuse of medication or recreational drugs/alcohol);
- h. Agree to regular attendance, and notifying facilitators of upcoming absences.
- i. Agree to refrain from eating or drinking in the group. \*
- j. Agree that relationships between members that extend beyond the group will be 'grist for the mill' if issues about the relationship have impact on the group.
- k. Agree to maintain the present-centered format

---

\**optional*, at a minimum, a rule can be made that group members not eat meals or distracting food (tearing packages, opening strong-smelling cartons) in group

---

## G. Group Format and Structure

PCGT includes psychoeducation in early sessions (and additional psychoeducation can be added as needed in later sessions). The format is flexible enough to incorporate some didactic and instructional material; however, the use of this material is adapted to a discussion format and is used to further group process, or to enhance the comfort-level of the group. Demand on members is typically limited, with little or no homework or testing for mastery of material.

Present-centered group therapy is flexible regarding many aspects of format. While this manual suggests 16 sessions, number of sessions may be adapted to as few as six sessions. The model may also be used as long-term treatment, with sessions continuing for five years or more (typically 6 to 18 months). Similarly, while a 90-minute session each week is suggested, it may be scheduled for 50 to 90 minutes; whatever session time is chosen, it should be uniform each week. When terminating, tapering is advisable, e.g., reducing to every other week, then to monthly. This manual prefers a cohort model, although in long-term adaptation of the group, open-ended or periodic admissions may be used.

The format generally proceeds as follows (90 minutes):

1. Opening the group (5 to 10 minutes): includes welcoming members, announcements, and option of grounding exercise;
2. Brief check-in (5 to 10 minutes): Facilitators provide an opportunity for members to reflect on reactions to the previous group, and to report any issues interfering with group participation (note: check-in is not a report on the week from each group member, which would slow the group process). It is not necessary to poll members. Facilitators bring up absences of other members, and any announcements, during check-in.
3. Agenda setting (5 to 10 minutes): Facilitators elicit headlines about any issues members would like to bring up during the discussion section of the group. Agenda setting helps with pacing and obviates monopolizing. Members must stick to a brief summary statement of the issue, holding the discussion of it until the next section of the group. It is usually not necessary to poll the group. Facilitators then ask members to prioritize the issues raised, in order to begin the discussion. Facilitators may add issues to the agenda, e.g., upcoming absence of facilitator, coping with upcoming or recent holiday.
4. Group discussion of issues/group process (50 to 65 minutes): Exploration of issues as suggested by agenda setting. Members may spontaneously bring up issues as well, as the discussion continues. Facilitators may offer informal psychoeducation during some of this time, if needed/desired by group.
5. Review of group (10 minutes): includes summary and feedback regarding session, feelings as members leave the group, any difficulties anticipated, plan for self-

care and for transition to life outside group, and any plans for the subsequent group.  
Exercise: Transition task—members report an activity that will signal their transition into the rest of their day, to contain any intense emotion generated in group.

## H. Phases of Group

### 1. Initial Phase: Group Forming and Norms (Sessions 15)

The initial phase includes enhanced structure and psychoeducation, in contrast with later phases. Emphasis is on shared experience and encouragement of joining among members. Facilitators are especially active during this phase, using the structure to foster discussion, and setting an expectation for active contribution from members. This phase is used to establish a shared knowledge base about trauma and its sequelae, in which the group will draw throughout the life of the group. It also establishes standards for the present-centered orientation. If members begin to discuss details of trauma, they are gently redirected to the present, using reflective techniques and direction, e.g., “You seem to be getting into some major aspects of the trauma here. These are important experiences, but I’m concerned we may be getting beyond your comfort level, and the comfort level of the group. How are you feeling right now? Did something in the group discussion trigger this memory? How are other group members feeling? Can you shift back to the present?”

a. Introduction—Session 1: In this first session, facilitators introduce the group as a collaborative process between facilitators and group members. Group discussion is supported. The purpose of this session content is to help members begin to bond as a group, and as members who have had a shared or related traumatic experience, as well as setting a therapeutic tone for the group and establishing the format.

#### i. Objectives:

- Introduce group members and facilitators;
- Present and discuss rationale for PCGT and enlist members in maintaining the focus;
- Provide and discuss brief, general overview on trauma (history of the field of trauma, and what treatment means generally for trauma survivors);
- Present group format (with handout; see format section above);
- Present of ground rules and expectations for members (with handout; see Preparation for Group’ section, above);

- Encourage motivation and active participation from group members.

- Encourage members to list 'coping strategies' for transitioning from group to life outside group

ii. Introductions: Members introduce themselves by:

- Sharing Name and Identifying information, e.g., where they are from, what they do for a living, and any salient information members choose to briefly disclose about their circumstances;

- Sharing interests/activities not connected with the trauma;

- Sharing brief reference to the nature of the trauma, without specific details;

- Sharing reasons for entering the group

Discussion covers group guidelines, treatment orientation and format, general history of trauma treatment and its implications

iii. Review: Members are asked to identify:

- What they gained from the group;

- Current feelings and reactions to group;

- Any suggestions as to how the group might have worked better;

- Simple plans for coping during the week;

- Strategies for transitioning from group to life outside group, as they leave.

b. Psychoeducation (Sessions 2-3)

Psychoeducation varies between formal and informal, with emphasis on discussion. The purpose of the content in these sessions is to validate members' experience with trauma and trauma-based symptoms, and to provide a sense of common experience among the members, in order to facilitate trust and reduce shame. These sessions also model discussion of inner experience, thoughts, and

feelings, which begins to address alexithymia associated with PTSD. Format is the same as in Session 1.

- i. Objectives:
  - Provide psychoeducational shared knowledge base about trauma, symptoms of Post Traumatic Stress Disorder, common comorbid disorders (e.g., panic, depression, substance abuse), trauma-based attitudes and beliefs, and cognitive and emotional mindset adopted in response to the trauma;
  - Encourage comfort with discussion;
  - Build sense of shared experience;
  - Support expression of inner experience centered around symptoms.
- ii. These sessions include:
  - Check-in, including:
    - Introductions (brief), repeated establish familiarity and bring in any new members starting late (after the third session, group is closed);
    - Reactions or unfinished business from Session 1;
    - Reminder of ground rules and group orientation;
    - Explanation of group topic.
  - Psychoeducation and discussion, with handouts as follows:
    - Session 2: copy of Criteria for PTSD and common comorbid disorders (panic, depression, substance-dependence; see Appendix A).
    - Session 3
      - Themes and issues related to trauma (see Appendix B);

- Core Schemas affected by trauma (McCann & Pearlman, 1990; Appendix C);
- Phenomenology of trauma and its sequelae (see Appendix D)

-- Review of Group, covering:

- Reactions to group, including response to psychoeducation
- Transition plan
- Feedback from facilitators to encourage participation

c. Goal-Setting (Session 4–5)

Facilitators assist members with goal-setting, referring to the handouts from Sessions 2 and 3 for areas for suggested areas of difficulty or desired improvement. Goals set at this early phase may evolve further as group continues, and will need to be revisited periodically. The purpose of the session content is to establish the working atmosphere of the group, and identify individual goals supported by the group. Goal-setting also addresses the sense of helplessness associated with trauma, asserting that change is possible, and that members can be instrumental in their lives. This task can be approached informally, but may also be structured to include recording specific steps for goal achievement, and projected time frame, to be revisited at intervals. Facilitators keep a record of members' goals, to revisit in subsequent groups as needed. Format continues as in previous sessions, including check-in at the beginning of group regarding issues remaining from the prior group, and review at end of group.

i. Objectives:

- Transition to less structured group format;
- Facilitate the identification and discussion of individual members' problems and goals for the group;
- Maintain present-centered orientation of group;
- Facilitate feedback and support among group members;
- Avert pseudocoheion.

ii. Handouts:

Members refer to handouts of symptoms and trauma-related issues from sessions 2 and 3 (facilitators may hand these out again if members don't have them) to help identify problem areas and issues for goal setting and utilize the goals sheets (Appendix E).

2. Phase II: Cohesion and Mutuality (Sessions 6 -9)

As Phase I comes to an end and Phase II begins, there is less formal structure. Members are supported in developing a healthy group bond, and premature pseudocoherence is averted, as therapists intervene actively to support mutuality and authenticity. Facilitators also note any shame-based interactions among members and intervene quickly in any hostile interchanges or shaming which could result in premature termination. Members are helped to both join with, and differentiate from, each other. They also identify healthy coping strategies, and encourage stretching in current coping capacities. Members may work toward using current coping more consistently, or adopt new coping, as group engages in problem-solving around hard-to-manage situations and affects. Facilitators help the group establish a trauma barometer, noting trauma-based reactions both in the group and in members' stories about their lives. In addition, facilitators regularly check in with members about feeling responses, helping the group to develop a shared language around affective experience. Facilitators point out more complex trauma-related patterns of which members may be unaware. They also intervene strongly if the group shows signs of destabilizing in its progress, e.g., becoming polarized, or showing a tendency toward re-enactment of the trauma (which can also result in premature termination).

a. Objectives:

- i. Increase trust and sense of cohesion among group members;
- ii. Facilitate the continued identification and clarification of current life difficulties and their relationship to PTSD;
- iii. Facilitate problem-solving around concrete problems and goals raised by group members;
- iv. Maintain present-centered orientation;
- v. Encourage awareness of affect and verbal expression of inner experience.

b. Transition to Phase II: Facilitators (Sessions 6 -7)

- i. Review the group format, and guide members through the steps.

- ii. Emphasize members' responsibility for agenda-setting and discussion.
- iii. Maintain an active role in directing the group process groups, fostering relationships among group members.
- iv. Informally help members focus on goals.
- v. Actively emphasize and elicit affective experience, particularly mid-range affects (this work can be encouraged informally, or members may use formal exercises, e.g.:
  - Ask members what they feel and, if addressing an unclear feeling;
  - Ask where (in the body, preferably midsection from throat to above navel) they feel the feeling (Gendlin, 1996) ;
  - Encourage reflection on the feeling, with eyes closed if comfortable;
  - Ask again for a label for the feeling and a body location;
  - Ask group members what they experienced when that member was discussing his/her feeling, and where in their bodies they felt it. (Gendlin, 1998).

c. Phase II Continues (Sessions 8–9)

By these sessions, members have evolved a shared set of values, including an identifiable shared sense of humor, and a shared language and style for addressing inner experience and feelings. These developments show a capacity to manage and transcend the initial shame at having symptoms and having been traumatized. A sense of empowerment is derived from the group. Members work more consistently on goals, and engage each other, allowing the facilitators to take a less active role. Members refine their objectives further, and make adjustments in their behavior within the group in a way that is consistent with their goals. They are able to confront each other supportively, and are less apt to shame one another. Facilitators:

- i. Become less active in this phase;
- ii. Support work toward goals;
- iii. Support group process, maintain group orientation;

- iv. Offer additional psychoeducation or informal skills building as needed.

3. Phase III: Differentiation and Authenticity (Sessions 10–13)

As Phase II comes to a close, the group advances and begins to function as a fluid structure. Change may occur more rapidly, especially for the more forward-moving members. Members who move more slowly may feel some pressure. New challenges emerge as members may become more competitive and confrontational. More subtle representations of shame and rigidity may manifest. The group is achieving a new sense of differentiation, and the commonalities of the trauma become a backdrop against which members find acceptance of their experiences and establish paths of recovery. Affective experience is reported more readily and with greater articulation. Goals are revisited, and changes made in group are applied to life outside the group. Facilitators can often defer to the activity of group members, but also need to intervene if members become polarized in this phase, supporting that differences among members are permitted.

a. Objectives:

- i. Support group process by intervening when needed, stepping back when group discussion is open and active;
- ii. Maintain present-centered orientation;
- iii. Promote continued acceptance among members;
- iv. Encourage progress toward goals, including review of goals;
- v. Encourage application of gains to life outside group;
- vi. Encourage more spontaneous awareness of affect, and expression.

b. Transition to Advanced Phase (Sessions 10–11)

In these sessions, members are immersed in the group process, but are also thinking about the upcoming end to the group, which facilitators help them anticipate in terms of continued goals work and plans for the future. Members note their relationship to the goals they have set, and reassess their goals (see Appendix E). Members who have made changes in their group behavior are encouraged to carry those changes into their personal lives. Members who have moved more slowly are encouraged to try out change behaviors in group. By this time in the group, members have most likely had to field difficult situations that challenge their newly developing skills. Facilitators:

- i. Identify gains;

- ii. Identify stress events occurring since group began;
- iii. Address any relapses;
- iv. Encourage re-investment in coping strategies, with support from group;
- v. Encourage development of further coping strategies, with group support.

c. Advance Phase Continues (Sessions 12 –13)

In these sessions, members typically are experiencing a degree of shift from a trauma-based world-view to attending more fully to current life. They develop a greater awareness of trauma themes as they still occur, and make alterations in their responses to them (e.g., planning to deliberately honor trauma anniversaries, instead of reacting helplessly to them). Members must once again make adjustments to each other and the changes they have or have not made, and once again accept each other as legitimate group members, despite further emerging differences. Members may at times have to agree to disagree rather than come to consonant conclusions. Members are likely to find change and improvement in current relationships and work life. Facilitators:

- i. Encourage greater focus on life outside the group, while focusing on identity as group members, and history of group support;
- ii. Encourage negotiation when conflict arises;
- iii. Review goals and progress;
- iv. Continue to pull for affect.

4. Phase IV: Consolidation and Termination (Sessions 14–16 and four Tapering Sessions)

As the advanced stage moves toward termination, greater differentiation and connection are established among members in group. Members become more aware of what they have gained from each other and the group, but also take responsibility for their own efforts. Members may react to the idea of ending with trauma-based responses, and there is an opportunity to handle these responses in a new way. For example, if members had previously avoided speaking with others who were present during the trauma, they can benefit from terminating thoroughly with group members whom they also met in the context of trauma. The enhanced ability to express emotion is applied to the task of termination.

- a. Objectives:
  - i. Consolidate progress members have made;
  - ii. Encourage continued application of therapeutic gains;
  - iii. Plan for tapering Sessions, emphasizing continuity;
  - iv. Begin work on transition, preparing members for change in amount of contact, and emotional reactions to this change;
  - v. Encourage development of coping strategies for maintaining functioning between Tapering Sessions;
  - vi. Continue work on goals;
  - vii. Continue work on affect.
  
- b. Consolidation and Terminating (Sessions 14–15)

In these sessions, members review progress and areas for continued work, putting the group experience into perspective as part of their own life (and treatment) history. They discuss continued application of gains to life outside the group. Facilitators encourage discussion of feelings about the group coming to a close, sense of loss about the ending, feelings about relationships established within the group, goals fulfilled and unfulfilled, and upcoming plans. Members exchange feedback regarding changes they have seen in each other, and experiences they have had together in the group. Facilitators:

- i. Assist members in discussing trauma themes that emerge in the context of termination;
- ii. Encourage members to share feelings about terminating (putting termination on the agenda);
- iii. Model expression of feelings about terminating;
- iv. Help members review progress (refer to goals sheet in Appendix E);
- v. Help members review history of group and development of connection;
- vi. Encourage continued application of goals work to life outside group;

- vii. Assist with consideration of follow-up treatment if needed.

5. Phase V: Termination (Session 16, and four Tapering Sessions—one at two weeks, and three monthly groups thereafter)

Members address the ending of the group during the final sessions and tapering. They discuss future goals and plans for any future treatment. Members support each other in continuing to make changes. They review past experiences in the group, and consider the meaning of both positive and negative interactions in the group. They reflect on a new sense of meaning in terms of the trauma (without discussing trauma details). They explore the meaning of their good-byes. Facilitators:

- a. Help members stay engaged rather than distancing during the good-byes;
- b. Encourage awareness and expression of reactions, even when good-byes evince strong emotions;
- c. Help members separate trauma-related affects connected to good-byes from current attachments and losses;
- d. Model expression of emotion around good-byes;
- e. Help members consolidate gains by reviewing progress of group, and relationships within the group, across the group timeline;
- f. Encourage a sense of gains carrying forward into the future;
- g. Obtain feedback from group members about the group experience, including both positive and negative feelings about the group;
- h. Reinforce plans for coping between sessions;
- i. Reinforce follow-up goals, reviewing goals achieved and goals yet to be achieved.

## I. Difficult Situations in Trauma Groups

### 1. Inconsistent Attendance

It is worthwhile to set limits early about attendance, as a subset of trauma survivors may tend to be irregular in attendance. Members who are depressed, avoidant, unstable, agoraphobic, or inclined toward re-experiencing may absent themselves; yet they stand to gain the most from group if they can commit to being there. Members may need to be educated that it is appropriate to come to group when feeling raw or vulnerable, even though it can be easier to avoid it.

## 2. Trauma Triggers in Group

If graphic trauma references are repeatedly made, contrary to group policy, the group may become preoccupied, overwhelmed, and depressed in response to these repeated segues. Members may become apathetic over time, leading to loss of membership. Grounding techniques are helpful in responding immediately to members' needs, while prevention of over-disclosure through setting appropriate limits around group policy is the most effective long-term solution. Occasional inadvertent shifts into the trauma can be processed in a present-centered fashion, focusing on current affective responses to the disclosure.

- a. Inconsistency in the treatment setting can be difficult for trauma survivors to manage. Yet, because group is a complex environment, some inconsistency is inevitable. For example:
  - i. Facilitator absences: If facilitators are out for extended periods of time, members may tend to discount them, even if there is a legitimate reason for the absence.
  - ii. Member absences: If other members are absent, members may tend to pull back emotionally. Yet, as discussed above, a subset of trauma survivors tend to be inconsistent in attendance.
  - iii. The low to moderate structure leaves a lot of room for both expression and vacillation. For some members, the variability in group topic can be seen as lack of predictability, a concern that is already associated with the terrorist events and with trauma in general. The flexibility that is the hallmark of this approach also is a challenge for members in a vulnerable emotional state, who must negotiate competition for group time, and the group demand for members to be assertive.

Members need support in order to develop the resilience to tolerate a degree of inconsistency. Processing of reactions to inconsistencies can be very helpful, as facilitators reframe trauma-related reactions, and normalize adjustment to the level of inconsistency.

- b. Unaddressed issues can invite transference to the level of stalemate, or impasse, in trauma survivors. These include *secrets among members* that are kept from facilitators, creating an impression that facilitators are either too weak or too untrustworthy to handle the secret information.
- c. A secret between facilitators that will affect the group (e.g., knowing that a facilitator is about to leave employment), although it may occur due to institutional pressures, leaves a sense that the professional role that normally

protects group members may instead be a wall behind which the facilitators hide. The sense of authentic connection is lost, intensifying the sense of alienation that is already part of the trauma survivor's world.

d. Unaddressed violations of guidelines can paralyze group process, leaving members feeling unprotected. It is important to address any such violations, re-establish the guidelines, and discuss members' reactions to the lack of attention to the infringement.

e. Setting of administrative limits concerning a member is part of the facilitators' role, but contrasts starkly with the clinical role with which members are most familiar. Members will be reassured by limit-setting (e.g., involuntary hospitalization of a suicidal or homicidal group member; reporting of child abuse by a group member; requiring that a member detox from substance abuse before returning to group), knowing that facilitators will preserve the safety of group and its members (and even family members) whenever possible. Yet they will also tend to resent the facilitators' authority, and to identify with the member's helplessness and limitation of choice (often a trigger for trauma survivors). Thorough discussion, with attention to trauma-based reactivity and identification of both sides of the ambivalence, can move the group forward through the impasse.

## REFERENCES

- American Psychiatric Association (1994). PTSD Symptoms and Related Disorders. Washington, DC: American Psychiatric Association. p 427-428.
- American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders* (Fourth Edition). Washington, DC: American Psychiatric Association.
- Blake, D., Weathers, F., Nagy, L., Kaloupek, D., et al. (1995). The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress, 8*, 75-90.
- Blanchard, E., Jones-Alexander, J., Buckley, T., & Forneris, C. (1996). Psychometric properties of the PTSD checklist (PCL). *Behaviour Research & Therapy, 34*, 669-673.
- Briere, J., Elliott, D., Harris, K., & Cotman, A. (1995). Trauma symptom inventory: Psychometrics and association with childhood and adult victimization in clinical samples. *Journal of Interpersonal Violence, 10*, 387-401.
- Classen, C., Koopman, C., Nevill-Manning, K. & Spiegel, D. (2001). A preliminary report comparing trauma-focused and present-focused group therapy against a wait-listed condition among childhood sexual abuse survivors with PTSD. *Journal of Aggression, Maltreatment and Trauma, 4*(2), 265-288.
- Figley, C. (Ed.) (1995) *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. Philadelphia, PA: Brunner/Mazel, Inc.
- Foa, E., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The posttraumatic diagnostic scale. *Psychological Assessment, 9*, 445-451.
- Foa, E., & Tolin, D. (2000). Comparison of the PTSD symptom scale-interview version and the clinician-administered PTSD scale. *Journal of Traumatic Stress, 13*, 181-191.
- Foy, D., Glynn S., Schnurr, P., Jankowski, M., Wattenberg, M., Weiss, D., Marmar, C., Gusman, F., (2000). Group Therapy. In E. Foa, T. Keane, & M. Friedman, (Eds.), *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies*. New York: The Guilford Press, pp. 155-175.
- Foy, D., Schnurr, P., Weiss, D., Wattenberg, M., Glynn, S., Marmar, C., & Gusman, F., (2001). Group Psychotherapy for Posttraumatic Stress Disorder. In J. Wilson, M. Friedman & J. Lindy (Eds.), *Treating Psychological Trauma and PTSD*. New York: The Guilford Press, Chapter 8, pp. 183 – 202.
- Gendlin, E., (1981) *Focusing*. New York: Bantam Books.
- Gendlin, E., (1996) *Focusing Oriented Psychotherapy: A Manual of the Experiential Method*, New York: The Guilford Press.
- Herman, J., (1992) *Trauma and Recovery: The Aftermath of Violence from Domestic Abuse to Political Terror*. New York: Basic Books.
- Horowitz, M., Wilner, N., & Alvarez, W. (1979). Impact of Event Scale: A measure of subjective distress. *Psychosomatic Medicine, 41*, 109-218.
- King, L., King, D., Leskin, G., & Foy, D. (1995). The Los Angeles symptom checklist: A self-report measure of posttraumatic stress disorder. *Assessment, 2*, 1-17.
- McCann, I. & Pearlman, L. (1990). *Psychological Trauma and the Adult Survivor: Theory, Therapy, and Transformation*. New York: Brunner/Mazel.
- Neisser, U. (1976). *Cognition and Reality: Principles and Implications of Cognitive Psychology*. New York: W. H. Freeman and Company.
- Parson, E. (1985). Post-traumatic accelerated cohesion: Its recognition and management in group treatment of Vietnam veterans. *Group, 9*(4), 10-23.

- Prouty, G. (1994). *Theoretical Evolutions in Person-Centered Experiential Therapy: Applications to Schizophrenic and Retarded Psychoses*. New York: Praeger.
- Saakvitne, K. (2002). Shared trauma: The therapist's increased vulnerability. *Psychoanalytic Dialogues*, 12, 443-449.
- Schnurr, P., Friedman, M., Foy, D., Shea, M., Hsieh, F., Lavori, P., Glynn, S., Wattenberg, M., & Bernardy, N. (2004). A randomized trial of trauma focus group therapy for posttraumatic stress disorder: Results from a Department of Veterans Affairs Cooperative Study, *Archives of General Psychiatry*.
- Shea, M., Wattenberg, M., & Dolan, R. (1997). *CSP420 Present Centered Group Therapy Manual, Training and Instruction Manual for VA Cooperative Study #420 on Group Treatment of PTSD*.
- Steele, K., van der Hart, O., & Nijenhuis, E. Phase-oriented treatment of complex dissociative disorders: Overcoming trauma-related phobias. In A. Eckhard-Henn & S. Hoffman (Eds.), *Dissociative Disorders of Consciousness*, Germany: Schattauer-Verlag, 2004.
- Turner, R. & Lloyd, D. (1995). Lifetime traumas and mental health: The significance of cumulative adversity. *Journal of Health & Social Behavior*, 36, 360-376.
- Wattenberg, M., Foy, D., Unger, W., & Glynn, S. (2003). Present centered supportive group therapy for survivors of terrorist disasters. In Shein et al. (Eds.) *Group Approaches to Treatment of Survivors of Terrorist Disasters*, 2003.
- Yalom, I. (1985). *The Theory and Practice of Group Psychotherapy*. (3rd edition). New York: Basic Books.

## Comparison of Trauma-Focused and Present-Centered Group Formats

| Criteria for Comparison                             | Trauma-Focused Group Therapy  | Present-Centered Group Therapy  |
|---|---|---|
| I. RATIONALE FOR THE CREATION OF THE SPECIFIC GROUP | (Uncovering trauma memories)<br>TFGT trauma work directly confronts trauma-related memories in a therapeutic setting with the support of the facilitators and other group members. TFGT helps group members to integrate their traumatic experiences into their present lives and to move forward from the experiences.   | (Covering trauma memories)<br>PCGT seeks to re-establish members' secure foundations in the present; PCGT bridges the realities of life before and after a terrorist event, legitimizing members' return to non-emergency functioning.  |
| II. GROUP GOALS                                     | <ol style="list-style-type: none"> <li>1. reduce members' emotional reactivity to painful memories;</li> <li>2. improve members' abilities to manage symptoms;</li> <li>3. increase members' abilities to tolerate strong negative emotions;</li> <li>4. reduce cognitive distortions of predictability and culpability concerning the tragic outcome in the traumatic incident.</li> </ol> | <ol style="list-style-type: none"> <li>1. validate the impact of the trauma on the lives of group members;</li> <li>2. address trauma-based attitudes, beliefs, and habits;</li> <li>3. counteract the isolation, alienation, numbing, and disconnection that trauma survivors often experience;</li> <li>4. diffuse members' sense of shame related to their traumatic experiences;</li> <li>5. encourage perspective-taking in relation to other people.</li> </ol> |
| III. LEADERSHIP ISSUES                              | <ol style="list-style-type: none"> <li>1. Cotherapy needed;</li> <li>2. Style varies; supportive, directive, and confrontational as needed;</li> <li>3. Extreme affect managed by coping skills training, monitoring.</li> </ol>  | <ol style="list-style-type: none"> <li>1. Cotherapy recommended;</li> <li>2. Style is primarily supportive while active and flexible;</li> <li>3. Extreme affect managed primarily by mid-range affects in the group, using grounding and refocusing as needed.</li> </ol>  |

| <b>Criteria for Comparison</b>        | <b>Trauma-Focused Group Therapy</b>  | <b>Present-Centered Group Therapy</b>   |
|---------------------------------------|--|---|
| IV. CRITERIA FOR SELECTION OF MEMBERS | <ol style="list-style-type: none"> <li>1. able to tolerate high levels of distress</li> <li>2. accepts the rationale for exposure based therapy</li> <li>3. is willing to share detailed account of trauma experience</li> <li>4. has stable life situation and living arrangements</li> </ol> | <ol style="list-style-type: none"> <li>1. willing to discuss symptoms and affective experience</li> <li>2. able to accept present-centered focus of the group</li> <li>3. cognitive ability to understand and tolerate a complex interpersonal environment</li> <li>4. able to accept feedback from other members and from group leaders</li> </ol> |
| V. PREPARATION FOR ENTRY INTO GROUP   | Same for both TFGT and PCGT  | <ol style="list-style-type: none"> <li>1. Provide brief psychoeducation about impact of trauma</li> <li>2. Provide information on group therapy</li> <li>3. Provide information re: format, schedule, and contacts (e.g., for emergencies, absences)</li> <li>4. Establish agreement to guidelines</li> </ol>                                       |
| VI. COMPOSITION                       | <ol style="list-style-type: none"> <li>1. Homogeneous re: exposure to same traumatic event or trauma type</li> <li>2. Heterogeneous re: symptom dominance (intrusion vs avoidance vs hyperarousal)</li> </ol>  | <ol style="list-style-type: none"> <li>1. Homogeneous re: ability to participate in group process</li> <li>2. Heterogeneous re: variety of perspectives, including religion, ethnicity, preferences</li> </ol>  |