GROUP INTERVENTIONS FOR TREATMENT OF PSYCHOLOGICAL TRAUMA

MODULE 3:
GROUP INTERVENTIONS FOR TREATMENT OF TRAUMA IN ADOLESCENTS

By

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I.   RATIONALE AND OBJECTIVES

A.   To learn to differentiate normative from problematic responses to trauma in adolescents.

B.   To understand the benefits of group interventions in treating adolescents, specifically adolescents who have suffered trauma.

C.   To learn how to develop a workable group for treating adolescents who have suffered trauma.

II.   FORMAT OF THE MODULE

A.   Didactics

B.   Question-and-Answer Period

C.   Sharing of Work Experiences

D.   Audience Participation

III.   THE DEVELOPMENTAL TASKS OF ADOLESCENCE

Adolescence is a complex developmental period, involving the negotiation of various issues. The adolescent group therapist is faced with the daunting task of helping the group members deal with a traumatizing experience, while negotiating and beginning to resolve these issues.

Although some researchers (Offer & Schonert-Reichl, 1992) feel that for most teenagers, adolescence is not the stormy period it was once thought to be (A. Freud, 1958), there is evidence to counter Offer's claims (Arnett, 1999).

A.   Separation-Individuation

1.   Blos (1967) has described this period as a time of the second separation-individuation period, following the model for toddlerhood outlined by Mahler et al. (1975). As a toddler, the child begins physically separating from the caretaker with the advent of locomotion.

2.   A recapitulation of this thrust towards independence occurs with adolescence, as the teen must separate, not only physically, but also psychologically. Teens must begin to separate from the psychological objects of childhood (e.g., the strong ties to parents and caretakers), relinquish the connections to childhood, and venture into the world of peers, outside the immediate family. The adolescent experiences a push/pull, approach/avoidance stance towards his/her parents.

3. On the one hand, the adolescent seeks more independence and autonomy; on the other, the teen is still dependent on his/her family for food, shelter, clothing, etc. The forces that pull the adolescent towards furthering their independence include increased involvement in school, vocational and educational choices, and burgeoning intimate relationships—all strong motivators and pressures to separate from the family of origin and begin to form a more distinct, separate identity.

4. The paradox of the strong wish for independence coupled with the still-present dependency can cause conflict both in the adolescent and within the family.

B. Creation of Identity

1. The period of adolescence is the formative period for identity formation. (Erikson, 1959)

2. At this time, youth must consider many factors including

a. Gender identity

b. Career goals

c. Sexual orientation

d. Racial, ethnic and religious identity

3. This may be particularly difficult in a world in which roles and boundaries are blurred, stereotypes upended and gender-bending images abound. It is also a time period in which racial and ethnic lines are at once strongly demarcated and blended.

C. Establishment of Intimacy

Sullivan (1953), among others, has described the need for the adolescent to begin to develop intimate relationships. According to Sullivan, the pre-adolescent develops a "chumship" with a best friend who serves as an object of intense attention and focus. It is the first relationship in which the other is valued deeply and care for another is placed above care for one's self. It is also the first relationship in which one's value as a person–one's sense of personal worth–is reflected in the eyes of the other, the chum. This has strong ramifications for the development of a healthy sense of narcissism, as described by Kohut (1971). The chumship, according to Sullivan, becomes the prototype for future intimate relationships.

D. Stabilization of Body Image

The biological changes of adolescence are obvious and undeniable. The onset of puberty brings changes in body, which in turn leads to concerns over body integrity, sexuality, and attractiveness. The rates of change are quite variable, with girls generally maturing faster than

boys. Due to better health care and nutrition, age of onset of puberty has been decreasing gradually so that the beginning of adolescence–if defined by sexual maturity–has become earlier over time. This has led to youth having to grapple with integrating these bodily changes into a self-image at earlier chronological ages. This developmental task–stabilization of a physical sense of self (body image) is an important one and has ramification for social, sexual, and interpersonal interaction.

E.   Maturation of Cognitive Abilities and Structures

During adolescence, the brain undergoes changes and differentiation into various structures (Kandel, et al., 2000). The developing brain organizes in response to the pattern, intensity and nature of sensory, perceptual and affective experience. Thus, the nature of the adolescent's experiences has a profound impact on the development of cognitive structures that will, in turn, influence further development. An environment that offers predictability and control in regulating tension anxiety helps in establishing a neurochemical milieu that helps in the development of neuropsychological structures that mediate object relations, affect regulation and other adaptive personality characteristics.

IV.   **WHAT CONSTITUTES TRAUMA FOR THE ADOLESCENT?**

A.   Definition of Trauma

According to van der Kolk (1997), a noted expert in the field of trauma, trauma "by definition, is the result of exposure to an inescapably stressful event that overwhelms the person's coping mechanisms." For the adolescent, "any experience or event that threatens the [youth's] sense of safety and security to such an extent that it is perceived as unmanageable" may constitute a trauma (Keyser, Seelaus, & Kahn, 2000). Traumas may be acute (a one-time experience, such as being saved from a burning building) or chronic (repeated sexual abuse). Although most writers agree that trauma inherently includes an experience of loss, not all loss is traumatic.

B.   Symptoms of Trauma

        1.   The DSM-IV breaks down the symptoms of a response to trauma into three clusters:

                a.   Re-experiencing

                        i.   Nightmares

                        ii.   Intrusive recollections of the event

                        iii.   Flashbacks

                        iv.   Distress when exposed to cues relating to the traumatic event

b.   Avoidance

i.   Any attempt made to avoid a thought or feeling related to the traumatic event

ii.   Amnesia or dissociation for the event

iii.   Feelings of detachment from others

iv.   Diminished interest in activities, with a subsequent avoidance of activities

v.   Feelings of a foreshortened future

c.   Hyperarousal

i.   Sleep difficulties

ii.   Concentration and attention difficulties

iii.   Hypervigilance to others

iv.   Heightened startle response

2.   Janoff-Bulman (1992) describes changes in the individual's assumptive world as a result of exposure to trauma. This refers to changes in the individual's assumptions about the world and others. There is often an erosion of trust. Relationships become rigid and inflexible, with the traumatized individual often seeing himself/herself as the "victim" and the "other" as an abuser with no means with which to change these roles. The assumptions are such that the traumatized individual sees no way out of his/her predicament and assumes the world and the "other" to be unsafe.

There are also subsequent difficulties and changes in the experience of self and other. An internalized representation of the self as damaged, deficited and prone to annihilation may develop. In order to cope with the overwhelming, painful affect that may accompany such representations, the traumatized individual may engage in dissociation in an effort to keep these aspects of the self from coalescing, leading to great psychic pain. There may be a loss of self-cohesion, so that the adolescent may have difficulty experiencing an ongoing, cohesive sense of self. Less developmentally advanced defenses such as splitting and projective identification may predominate. Such defenses, particularly projective identification, may have a powerful influence on the group later. Thus, the group leader may find him/herself "pushed" into a role that is unfamiliar to him/her. This may be due to the powerful need by the traumatized adolescent and group

to construct the world along certain lines (e.g., all-powerful leader who is harsh and abusive vs. needy, dependent, helpless group members). It is important to recognize the meaning of such countertransferential reactions and what they might convey vis-à-vis the self and other representations of the group members.

C.   What Mitigates Trauma in the Adolescent

Among the factors that will help to mitigate and determine whether an experience becomes traumatic, one must include the adolescent's level of functioning before the traumatic event. Thus, for example, an adolescent with multiple learning disabilities who has difficulties processing, will, more likely, be overwhelmed by a traumatic event, than an adolescent who can perceptually process the event more easily. The adolescent's past experience with crisis (Webb, 1991) also will play a role in how well the adolescent copes with the current crisis. The meaning of the trauma to the adolescent is also important. Does the adolescent feel punished in some way? Does the adolescent see the trauma more as a random event, over which he/she had no control? How well can the adolescent accommodate new information about the traumatic event and thus, begin to make sense of it and the subsequent reaction?

It is important to remember that the adolescent is experiencing the trauma while in the course of development. The adolescent is still growing and developing and needs to harness his resources and energy towards these tasks. However, following a trauma, adolescents may be unable to put energy into present growth, with the result being that development is adversely affected. For example, the traumatized adolescent may be so overcome by exposure to trauma that he/she has little ability to engage with peers, just at a time when peer connections are most valuable. Thus, the adolescent's ability to individuate and separate from the family becomes impaired because he is lacking peer support. Finally, and most importantly, available adults who can be supportive and nurturing following a trauma will also help the adolescent cope. If these adults or family members can re-frame and transform the events into a more manageable, somewhat understandable experience, the adolescent will have an easier time coping. This transformation can make the experience less overwhelming to the adolescent and can allow more freedom for resolution. For the adolescent, such supportive figures may include peers. This is particularly true as response to trauma typically can include isolation. If peers are willing to "hang in" and remain present and available for an adolescent (e.g., following an illness or tragedy), in the long run their support will inevitably help the adolescent more readily cope. Studies (Young-Eisendrath, 1996) have shown that sometimes, all it takes is one such supportive figure to promote resilience in the adolescent.

V.   IMPACT OF TRAUMA UPON ADOLESCENT DEVELOPMENT

A.   Separation

Because adolescents are still in the process of developing, they need to devote their energies towards the tasks of growing emotionally and physically. When trauma disrupts the adolescent's life, the growing process receives an assault, with a resultant arrest or disruption in development.

For the adolescent engaged in the process of separating, re-experiencing the trauma may make the youth much less able physically to leave the house, with a diminished involvement in peer activities. Separation anxiety may develop, with agoraphobic-like symptoms and possible prolonged absence from school. Nightmares and sleep disturbance may also make waking up for school difficult, resulting in lateness and absences. For the adolescent, who relies on the peer group and involvement in activities outside the home, this may seriously thwart efforts toward increased independence. Concerns about safety and trust in the world can also lead to increased sense of dependency and helplessness, further thwarting the normal separation process.

B.   Creation of Identity

Identity formation may also be impacted. A foreshortened sense of the future may contribute to apathy regarding career and educational goals ("Why bother? We're all going to die anyway," said one adolescent following a trauma). The peer group's role in identity formation is critical, but if an adolescent withdraws as a result of trauma, the peer group's important resource for identity formation is lost. Feelings of disconnection and detachment from experience do not further an integration of various selves into a more integrated identity. The role rigidity that follows trauma also does not permit the adolescent to "play" with various identities, towards the establishment of a more consolidated identity.

C.   Establishment of Intimacy

The traumatized adolescent may also experience difficulties in establishing intimacy. Absence from the peer group and school may severely limit the opportunity for peer interaction, which is necessary for involvement in intimate relationships. A consistent negative self-appraisal, or viewing one's self as a passive, helpless victim will not help in increasing the circle of peers with which the adolescent may interact. An adolescent who presents with a limited range of affect or episodes of dissociation and detachment may also experience peer difficulties. Trauma also affects representations of self and other, which affects the adolescent's expectations and interpersonal interactions.

D.   Stabilization of Body Image

The intense fears of annihilation that the traumatized adolescent frequently experiences may impact on the stabilization of body image. A traumatized adolescent may fear bodily injury or disintegration, and develops symptoms aimed at reducing any experience that will remind the adolescent of the traumatic event. The role rigidity (and subsequent defenses) will also impact on integration of body into self. Thus, for example, a sexually traumatized adolescent may dress in baggy clothes in an attempt to hide her body. Alternatively, an adolescent who is the victim of sexual abuse may dress in a provocative fashion, assuming the role of victim (with concomitant shame, blame and guilt) with little awareness of the role the body may play in the interaction. The adolescent who is struggling to achieve some integration of identities (including physical self with psychological self) may be unable to integrate such identities due to pronounced dissociation and lack of self-cohesion.

E.   Maturation of Cognitive Abilities

The maturation of cognitive structures may also be impacted by exposure to trauma. The sense of a foreshortened future that some traumatized adolescents report clearly impacts on the development of judgment and perspective. Neurochemical events as a result of exposure to trauma can lead to hypervigilance, heightened startle response, affective lability, dysphoria and affect memory and learning mechanisms. The literature (Schwartz et al., 1993) describes the development of "malignant memories" as a result of trauma. If triggered by a cue, such memories invade experience with high levels of noxious arousal, leading to cognitive distortions, dissociative and somatic states, affective intensities and either overactivity or numbness, amnesia, and avoidance. Traumatized adolescents, then, may be at risk to develop "traumatized brains" characterized by dysregulated systems that will not serve them well in regard to learning and cognitive development (Perry, 1993).

VI.   BASIC PRINCIPLES AND ISSUES OF SETTING UP A GROUP FOR TRAUMATIZED ADOLESCENTS

A.   Reasons for Utilization of the Group Modality with Traumatized Adolescents

Group therapy is considered by many the treatment modality of choice for adolescents in general and for traumatized adolescents in particular (Scheidlinger, 1985). Most adolescents spend the majority of their time in groups, gravitate toward being with peers, and are more comfortable with peers than with adults. Adolescents need the peer connections in order to accomplish the necessary separation individuation work of this developmental stage. Since one of the symptoms of PTSD (Klein & Schermer, 2000) is a withdrawal from peers, without the benefit of group therapy, the withdrawn traumatized adolescent would not only be dealing with the effects of the trauma, but also with an additional secondary effect of disconnection from peers, thus arresting the developmental advance. Group therapy provides a relief from that isolation and reestablishes connections with peers through the mutual identifications of the group members (Scheidlinger, 1955). The group, which provides a holding and support, comes to be felt as the "mother group" (Scheidlinger, 1974), and becomes a transitional object for the adolescent, allowing the adolescent to proceed along the normal developmental pathways.

Frequently when an adolescent has experienced trauma, the family also either has been traumatized directly from the event or indirectly from the teenager's trauma. The family, which may have been supportive before, often reacts with despair, helplessness and unhelpful symptoms of its own. Adolescents can show amazing resilience if the key elements of social support from significant adults in their environment is in place. Children during the London Blitz who stayed with their parents during the bombing actually fared better than those who were moved to safety but separated from their parents (Freud & Dann, 1951). Traumatized adolescents need a support network to help "reframe and transform the event" (Janoff-Bulman, 1992) so that the teenager can work toward obtaining some resolution. The group therapy experience provides the restoration of an ideal caring "family," consisting of empathic adults and other teenagers who

are supportive, accepting and understanding. The group creates a caring circle of people who will accompany each of them through their suffering, allowing them to verbalize the stories of their experience (Keyser, Seelaus & Kahn, 2000) and help them to regroup psychically.

The group therapy venue is clearly cost-effective. The group situation offers opportunities for acquiring new information and new coping skills that are easier for adolescents to learn and accept from peers.

B. Group Goals in a Group of Traumatized Adolescents

1. Creating safety

a. Because the traumatized individual feels so unsafe, a major goal for a group of traumatized adolescents would be the creation of safety.

b. Safety in an adolescent group is created by clear definition of group rules and boundaries (see Section E) and by careful individual assessment and preparation of each member before entering the group (see Section D).

c. Safety is created by utilizing measures to enhance early group cohesion.

i. First, this is done by assuring a high degree of homogeneity among group members in terms of type of trauma and how recent the trauma, social and cultural groups and age. Teenagers feel much safer in groups of teenagers only.

ii. Second, this is done by the early introduction of "group as a whole 'interventions.'"

iii. Third this is done by requiring a highly structured method of revealing each person's trauma story, for example, reading journals or showing photographs or drawings within a specific time limit can contain and ground the group during the times of traumatic recollections.

2. Reduction of problematic feelings and behaviors

3. Relieving isolation and establishing peer connections: A major goal in the group therapy of traumatized adolescents is to reduce the feelings of isolation and to reestablish the connections with peers for support and feedback inside and outside the group.

4. Addressing the changes in the assumptive world that occurred as the result of the trauma

a.   Trauma often creates a further response, deeper than behavioral symptoms, reaching into the core beliefs and assumptions about the world.

b.   These changes often occur in the areas of interpersonal relations and in a damaged sense of mastery and empowerment (Janoff-Bulman, 1992).

c.   Thus a major goal for the group therapy is to address these changes in the assumptive world which occurred as the result of the trauma.

C.   Leadership Issues

1.   Co-leadership

The non-trauma oriented co-therapy literature is unresolved as to the benefits of co-leadership. However, literature describing trauma group work assumes the necessity of co-leadership (Ziegler & McEvoy, 2000), because the dynamics in trauma groups are simply too complex for one therapist to manage alone. However, successful co-therapy depends upon a significant commitment to open communication in resolving disagreements and accommodating differences. Courtois (1988) suggests that "Co-therapists should function as a team to guard against being split into good and bad parents, but their individuality should come through as they engage with the group and its members."

Although co-therapy is more costly, it does offer various benefits in that it provides the therapists with assistance with countertransference reactions and burnout as well as providing the group members with potential parental transference figures and minimizes the disruptions centering around one of the therapist's absence or vacation.

2.   The role of the adolescent group therapist

Adolescents are notorious for inducting their therapist into a variety of roles. Phelan's (1974) article, entitled "The adolescent group therapist's trilemma: parent, teacher, or analyst?" is particularly telling: the leader wears many hats, as it were, such as parental, model for identification, limit-setter, educative and resource of information, container and creator of a safe environment, and always, therapeutic.

It is extremely important to adopt an active therapeutic stance. Leading an adolescent group is quite different from leading an adult group, which might require a more passive, non-directive stance. The adolescent group leader needs to speak plainly and authentically. Use of jargon will be experienced as intimidating, off-putting and indicative of yet another adult who does not "get" where the adolescent is coming from. On the other hand, too much slang may reflect an underlying over-identification with the group and a blurring of boundaries, rather than being a leader who will provide safety

for the traumatized adolescents. Excessive use of slang may be seen as indicative of a group leader who cannot maintain limits and appropriate boundaries—all critical to leading a group for traumatized adolescents.

The adolescent group leader must also have a fair degree of tolerance for anger and frustration. Adolescents can be masters at testing the limits and provocative baiting of the leader. Personal questions may be asked of the leader. It is important to remember that some of these questions are efforts to get to know (and trust) the leader. Thus, in a group for traumatized, bereaved adolescents, the members' asking the leader if he/she has experienced loss may not be a provocative effort toward forcing the leader into self-disclosure, but rather may be an attempt to see if the leader can understand the members' experience of trauma and loss.

The role of leader as container is of particular importance for leading groups for traumatized adolescents. Bion's (1957) ideas are of note here. Traumatized individuals are often filled with almost unbearable feelings and memories, many of which they cannot put into words, and remain unprocessed and undigested, as it were. The leader must demonstrate a willingness to be open and listen to the experience, at times, giving words to the traumatic experiences. Such an acceptance of the full range of emotions connected with the trauma and transformation of the (at times) overwhelming affect into feelings and experiences that can be processed and understood can be extremely therapeutic.

3.   Vicarious traumatization

Pearlman & Saakvitne (1995) describe vicarious traumatization as "the transformation of the inner experience of the therapist that comes about as a result of empathic engagement with the clients' trauma material." (p. 31) The concept has also been called "contact victimization" (Courtois, 1988) and "secondary post-traumatic stress disorder" and "compassion fatigue" (Figley, 1995). Most countertransference concepts do not address the specific impact of traumatic material on the therapist. In trauma work with an adolescent group, it is essential that the group therapist monitor his/her responses to the clients, to their stories and to their behavior, as well as stay alert to the conscious and unconscious defenses that are mobilized to protect the therapist from these reactions. Co-therapy, supervision, consultation, and "helping the helpers" peer groups are all extremely important for the group therapist working with traumatized adolescents.

4.   Holding

Ziegler & McEvoy (2000) define the central task of the trauma group therapist to be the creation of a safe "holding environment" (Winnicott, 1965) in which group members can recover from traumatic injury and regain a connection to life. The group therapist working with traumatized adolescents has not only to tolerate and contain the traumatized individual's negative projections of either victim, victimizer, or noninvolved

bystander, but also the variety of projections usually felt by adolescents toward an adult leader. Adolescents frequently have a reluctance to depend upon adults and a fear of attachment to adults. Devaluation of parents and other adult authority figures, as well as open defiant conflict with them, is common (Scheidlinger, 1982). In the adolescent group, the group therapist is often the recipient of these projections and needs to maintain a neutral observing ego that sees, but doesn't judge or evaluate. However, adolescents will not open up to a neutral, passive authority figure. The adolescent group therapist best functions by incorporating and moving within the tripartite roles of therapist, parent, or teacher, emphasizing whichever role is needed. The teacher role can be called upon for didactic explanations, e.g., preventing an adolescent from premature disclosure by saying, "It's great that you are so eager to open up to people, but it's better to wait to talk about painful things until the group has met a few times and people can feel more trusting of each other and of the rules we'll use to tell about these issues." The parent role can be utilized to set appropriate limits of behavior in the group, e.g., not permitting a teenager to throw objects at another group member. The therapist part needs to observe what is happening in the group and request that the group members examine their experience in the present moment.

If the adolescent group therapist is to provide a safe holding environment for the traumatized adolescent, there must be an understanding of the adolescent's cognitive development. Since the prefrontal cortex is not fully developed until age eighteen or nineteen (Kandel et al., 2000), the adolescent's executive functions are immature and still need the life jacket provided by adult guidance. This lack of executive functioning can be seen in a number of areas, including the following:

> a. Difficulty seeing the future; e.g., why go to school to learn when I might be dead tomorrow;
>
> b. Difficulty realizing consequences; e.g., nobody will notice that the lipsticks were missing;
>
> c. Preoccupation in the here and now; e.g., I need to get a date for Saturday night, not think about these things that happened last month;
>
> d. Omnipotence; e.g., I can drive while drunk and not get hurt.

Trauma often causes a regression in executive functioning. The difference between the cognitive effects of trauma on an adult or on an adolescent is that the adolescent's cognitive functioning has yet to grow to a more mature level. The adult might regress for a time and then with treatment regain his original position, whereas the traumatized adolescent remains stuck at his adolescent development level. Group therapy under the leadership of a skilled leader can provide a nonjudgmental voice of reason, consequences and safety, which can help the traumatized adolescent to begin to move forward again in his cognitive functioning.

5.   Over-identification and avoidance

The over-identified adolescent therapist is at risk for empathic enmeshment leading to boundary violations, e.g., the therapist feeling so sad about the lack of adult interest in the teenager's life that the therapist regularly attends the teenager's games. The over-identified therapist frequently has problems with time limits, letting sessions run late. Over-identification can result in inappropriate therapist self-disclosure, which has no benefit to the adolescent. Over-identification can lead to an unspoken collusion to avoid discussing difficult subjects (Courtois, 1988). Ganzarain & Buchele (1986) discuss the urge to rescue and re-parent, which is particularly an issue with adolescent trauma groups if the therapist becomes over-identified with the traumatized adolescent. The over-identified therapist, furious with the adolescent's inadequate or perverted or absent parent, joins the adolescent in his blaming of the parent, rather than helping him to grow responsibly and become self-empowered. It is essential that the adolescent group therapist understand the need for self-determination in an adolescent and that the therapist encourage the adolescent in the development of autonomy (Rachman, 1975). On the other hand, the leader may (unconsciously) avoid discussion of the trauma. Denial, minimalization, dissociation may cause the leader to collude with group members into not discussing the trauma. The unfortunate effect of this is to indicate to the group that the leader, too, is overwhelmed by the trauma event, and cannot contain, and help, the members with their experiences. Adopting a rigid, professional stance may be a way to avoid empathic engagement with group members. Leaders who themselves are survivors of trauma may avoid delving into discussions for fear of awakening their own experiences and memories. Once again, supervision and consultation can be useful in this area.

6.   Managing anger

Adolescents characteristically have a hard time managing their anger and are affectively labile. Adolescent therapy groups stimulate countertransference reactions in the group therapist in any unresolved area of the therapist's own personality (Rachman, 1975). The adolescent group therapist needs to constantly evaluate his/her own issues in order to present himself/herself as a meaningful identity model. In the therapy group, all feelings are encouraged to be verbalized, but careful limits are set on any acting out. Yet even the adolescent's verbal expression of rejecting and aggressive feelings can create feelings of fear, helplessness and inadequacy in the therapist unless that therapist is able to see the rejection and aggression as a distorted attempt to connect and unless that therapist is able to maintain his centeredness, holding firm to decisive limit setting (Rachman, 1975).

The adolescent group therapist is dealing with a room full of egos in the process of developing a sense of identity. The therapist's techniques and responses on every issue need to be used in ways that will aid the ego in accomplishing mastery, e.g., a group member trying to talk should usually take precedence over the therapist. When an adolescent is in the throes of an intense negative transference to the therapist or has

severe difficulties with authority, it is wise to encourage other group members to give the interpretive interaction. If a group member is feeling injured by the therapist, this must be validated by the therapist and necessary effort spent helping to lessen the effects of the bruising. Adolescents tend to band together against any authority seen as having hurt one of their own. An emotional contagion of collective hostility can then rapidly grow in the group to attack back at the therapist (Rachman, 1975). The peer group support can encourage the adolescent to be hostile and aggressive to the therapist. Therapists who have difficulty tolerating their own aggressive urges or anger in others may try to engage in stifling behaviors. They may join with group members, trying to focus the aggression in the group on perpetrators. Therapists need to manage their own anger at perpetrators and at injustice, and also contain, hold and check their own impulses. In addition, in adolescent groups, the adolescent's basic feelings of powerlessness, helplessness and resignation can activate countertransference feelings of depression, frustration, resentment, aggression or withdrawal in the therapist. Careful monitoring of the therapist's issues using supervision, consultation and his own analysis is important for successful dealing with these complex forces.

7.   Managing affection and sexuality

There are also usually positive feelings toward the therapist in a well-functioning adolescent group. Adolescents can develop strong positive feelings toward the group therapist, which is usually demonstrated by subtle modeling of the therapist in terms of mannerisms, dress, speech or interests. Adolescents can also develop strong positive emotional reactions (crushes) on adults. The adolescent therapist needs to feel comfortable and accepting of these powerful feelings, being careful not to view the feelings as neurotic or undesirable. In trauma groups, and especially where sexual trauma has occurred, it is of utmost importance that the therapist is resolved and comfortable with his/her own sexuality and sexual feelings and is able to distinguish for himself and teach the adolescents the difference between lust and affection. The adolescent group therapist working with sexually traumatized adolescents is given a unique opportunity to teach, by example, the setting of appropriate limits on lustful acting out or on fulfillment of erotic needs. The adolescent group therapist needs to give the adolescents support, understanding and acceptance of all their sexual feelings (not of all actions, but of all feelings.)

Sexuality is an area in which the therapist frequently needs to be specifically educative, sometimes didactic, because many adolescents are filled with misinformation. It is helpful to facilitate talking between the girls and the boys about sexual differences to help the adolescents learn about what the other sex is feeling and assuming and what drives their behaviors. Adolescents who have been sexually exploited or traumatized need to learn reasonable expectations for themselves and others. Adolescents need to be taught that what feels good isn't necessarily good for you; e.g., sex without a condom feels good, but isn't good for you. Also, what feels good for you might not feel good to

the other; e.g., intercourse might feel great to a 15-year-old boy, but not to a 15-year-old girl who isn't as hormonally developed. The rule needs to be "only do what feels good to both at the same time."

8.   Managing induced feelings of being the victimizer

Survivors of trauma may develop representations of themselves as victims and representations of others as victimizers. Such relational configurations may, inevitably, be enacted in group. One avenue for such enactments is through the experience of anger. Trauma groups inevitably raise issues of anger about the event, towards perpetrators, and at other group members and the leader. In particular, the adolescent group therapist will experience the expression of anger in groups, at times due to transferential reactions and efforts by the adolescents to separate and reject the adult. The leader may join the group by focusing the anger at the perpetrators, parents—anyone outside the group—in an effort to keep the strong affect out of the group. Or, the leader may respond with a harsh, critical, condemnatory attitude towards such expression of anger. Such a response may be an unconscious enactment of the leader in the role of victimizer and the members as victims, a common relational configuration for survivors of trauma. This may occur in adolescent groups when the members provoke and exasperate the leader to the point of losing control. If the therapist becomes angry and critical, a recapitulation occurs, providing fuel for the traumatized adolescents' negative self-images as victims.

Others (Kantor, 1995; Briggs, 2002) have described the experience of countertransference with adolescents as an important and rich source of information about the adolescent. The discovery and understanding of the leader's responses to the interactional patterns can lead to important insights into the adolescent's experience and lead to growth and change.

D.   Criteria for Selection of Group Members

In leading groups for adolescents, a careful screening is important to determine if a teen can benefit from the group experience.

1.   Group balance

Slavson (1950) emphasized a balancing of the group, which is accomplished via the screening process. Balancing entails planning for an optimal degree of heterogeneity. Such heterogeneity should not compromise the integrity, cohesion and functioning of the group. Factors such as age, sex, educational level, level of sophistication, co-morbidity are also important. For example, to introduce a 13-year-old boy (who may also have a history of sexual abuse) into a group for 12-14-year-old adolescent girls who have been sexually abused, will almost inevitably upset the balance and silence the girls. Or, having a 14-year-old girl with cognitive limitations in a group for 16-18-year-old traumatized adolescents could lead to the girl's being scapegoated as a result of both her age and cognitive difficulties.

2.	Screening process

In the screening interview for the group, the leader can gather information about the prospective group member.

a.	Ego strengths, level of sophistication, and character defenses can be ascertained. In choosing members for the group, the leader should take care that there be enough commonality between members so as to promote some group cohesion and attraction to the group and its goals. During the screening process, the leader can also outline and establish preliminary treatment goals. By taking an active role in this aspect of his/her treatment, the traumatized adolescent's sense of helplessness can be directly confronted and addressed. Another important aim of the screening process is to develop a connection with the adolescent's family. Without cooperation on the part of the family, the group treatment will not succeed. Questions can be fielded and education can be provided so as to demystify the group's workings and the therapeutic process. However, the confidentiality of the group must be stressed to both the adolescent and the family.

b.	There are several important components to the screening process and assessment for the traumatized adolescent. The nature of the traumatic event must be ascertained, i.e., was it acute, chronic. Reports of preceding, concurrent stressors should be obtained. These might include child abuse or neglect, family deaths, conflict, moves, exposure to violence at home or in the neighborhood, among others. The symptom picture should be obtained (Are the symptoms predominantly re-experiencing, avoidant or hyperarousal?). The clinician should look for co-morbidity with depression, including self-injurious behaviors and suicidal ideation, ADHD, conduct disorders and substance abuse. Such co-morbid symptoms may rule out a particular adolescent from group work. For example, the adolescent's substance use may be such that he/she is unable to benefit from a group until the substance use is first addressed. Or, the self-injurious behavior may be so severe that group alone will not be sufficient to provide a safe enough holding environment for that adolescent.

c.	The family's response to the trauma is important to obtain as well. It is critical that the traumatized adolescent have support in the family environment. At times, family members may be so traumatized themselves that they are unable to provide such care and support. Appropriate referrals for other family members may need to be made. Family history, in terms of medical/psychiatric history and previous traumas in the life of the family, is also important to obtain.

d.	Reports of the adolescent's previous history of psychiatric treatment, medical history and a developmental history (with emphasis on reactions to

normal stressors such as entry to school, birth of siblings, etc.) should be obtained.

e.   School history should be discussed (and a release of information obtained), with emphasis on ability to focus and concentrate, and performance since the traumatic stressor.

f.   Standard mental status exam should be conducted. The adolescent should be asked for his/her description of the traumatic event, including who or what he/she believes to be responsible for the traumatic event. Further questions might include: Does the adolescent believe if he/she had behaved differently, the event would not have occurred? Does the adolescent feel ostracized, singled out as a result? How much support does the adolescent feel he/she has received? Does he/she see his/her symptoms as a "normal" response? What is his/her understanding of his/her symptoms? Observations should be made regarding the adolescent's affect, presence of startle response, absence/presence of dissociation, concentration difficulties, etc. Some clinicians advocate use of standardized scales to obtain a symptom picture. These might include self-reports such as the Kiddie-SADS, PTSD Reaction Index, Trauma Symptom Checklist, or Impact of Events scale.

g.   At the end of the screening process, the clinician should have a differential diagnosis. It is important to recognize that the following disorders may be co-morbid with or misdiagnosed as PTSD.

> i.   Acute Stress Disorder
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> ii.   Adjustment Disorder
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> iii.   Panic Disorder
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> iv.   Generalized Anxiety Disorder
>
> v.   Major Depressive Disorder
>
> vi.   ADHD
>
> vii.   Substance Abuse Disorders
>
> viii.   Conduct Disorder
>
> ix.   Dissociative Disorders
>
> x.   Personality Disorders

xi.   Psychotic Disorders

xii.   Factitious Disorder

It is also important to ascertain which subtype of PTSD is present—acute, chronic, or delayed onset. Once this is done, a treatment plan for the adolescent in group can be established based on the symptom picture, history and clinical presentation. The need for medication must also be determined at this juncture, if not earlier, should the need be more pressing.

E.   Practical Considerations

1.   Time frame

A time-limited group serves to focus the members and is generally more structured, whereas an open-ended group is usually geared towards longer-term exploration of issues and includes higher-functioning adolescents. The length of treatment depends on the goals and objectives of the group; i.e., immediate symptom reduction for short-term, time-limited groups vs. in-depth exploration of issues in a long-term, open-ended group.

2.   Group size

In the group psychotherapy literature, eight members is considered an optional number (Yalom, 1985). This allows for the possibility of two members being absent without disrupting a sense of group.

3.   Open versus closed groups

A consideration for the group leader is whether or not to permit new members to join a group in progress. Obviously, closed enrollment is less disruptive to the group's process and cohesion, but many groups successfully add new members midstream. Again, considerations of time-limited versus long-term groups are relevant; it is much more difficult to add new members at Session 5 of a ten-week group than at Session 5 of a long-term, open-ended group.

4.   Group rules

Of utmost importance is that all group rules are thoroughly discussed with each person before entering the group. Having the rules written and giving each a copy to read and then sign is helpful in sealing the agreement. The following items need to be included in the contract:

a.   Confidentiality: It is agreed that everything that is said in the group is confidential forever and that the names of the other group members are confidential forever and will not be shared with family or friends. However,

themes, where no names are used, may be shared. The therapist is allowed to share what happens in the group with the members' individual therapists or with their psychopharmacologists. The therapist will not share anything the members say in the group with their parents or teachers or anyone but their individual therapists or psychopharmacologists, except if the person is talking about any of the following: engaging in self-injury; engaging in other activities dangerous to themselves or others; threatening self or is being abused. In those situations it is understood that the therapist is legally bound to report the danger or possible danger or the abuse to the proper authorities.

b.   Attendance: It is agreed that each member of the group will attend every session. Each calendar year, three absences from the group will be excused without charge. All other group sessions will be charged.

c.   Outside Contact: It is agreed that contact outside of the group will be for a therapeutic purpose only (Stone & Rutan, 1993). Therapeutic purpose means a healthy, constructive purpose. To get together with another group member to stop loneliness or sadness or just to talk or laugh is healthy.

        i.   Many group theorists have warned against out-of-group socializing as acting out or as undermining group process (Stone & Rutan, 1993). However, with adolescent groups, the adult who sets rules that work against the peer connections will be seen as a policeman or authority figure to be rebelled against. It is better to assume that some out-of-group connections will be made and help the teenagers to keep those connections as constructive as possible.

        ii.   Part of the outside contact rule is that all relationships will be platonic only. If guys and girls in the group start to date, they won't be able to use the group to talk about their real feelings and the group will lose its feeling of safety.

        iii.   It is agreed that any interactions that occur outside of the group will not be kept secret from the group and will be shared with the group. If two members have conversations or meetings unknown to the others, it causes cliques to form and creates divisions in the group.

        iv.   Out-of-group contact takes on additional positive force for the adolescent who has suffered trauma. Most of these teenagers present with the symptom of isolation from peers. If they start to use the group as a vehicle for tentative reconnection, it is seen as especially therapeutic and helpful.

d.   Termination: The following item is for an open-ended group, where the number of sessions are unlimited. It is agreed that a person will stay in the group

until the goals they have set for themselves are completed. It is also agreed that when a person feels the need to leave the group, they will first complete a three-step process:

      i.   The person will have an individual session in person with the group therapist.

      ii.   Then after that session, the person will discuss their exit feelings in the next group session.

      iii.   The person will attend three more group sessions after they have told the group that they are leaving, so that the group members and the person can adjust to the termination and leave feeling comfortable and with a sense of closure.

The careful steps of the leaving process have been established because many of these people have been traumatized by sudden loss and the group process needs to provide a safety against any retraumatization.

In groups that are time-specific, the issues about termination need to be discussed and agreed upon as well, so that the members agree to stay in the group for the duration of the group and not jump ship in an untimely manner.

e.   Behavior: In a teenage group, there are group orientation needs to specify that there will be respectful behavior toward each other, with no violent behavior. It also needs to be agreed that participants will, to the best of their ability, be active verbally in the group. It is agreed that all verbal interactions will be honest and respectful of others in the group.

F.   Phases of the Group

1.   The Beginning Phase

The beginning of the group is the time of learning how the group works, building group cohesion, providing psychoeducation regarding trauma and loss, normalizing members' distress reactions and developing specific skills to cope with trauma-related distress (Saltzman et al., 2001). During this time, which is usually from Sessions 1-4, there is a danger of excessive early disclosure by one or more group members. The leader "might be pleased that the group is getting off to such a rich start because one or more members seem so easily able to talk about deeply personal material that is clearly resonating with other members (and often us as well). The problem can be that early disclosers sometimes get overwhelmed with feelings of shame and embarrassment after the fact, and in fact may feel unable to face those to whom they have disclosed so much. Containing those we feel at risk for such a response is difficult but very important to the extent that we can find a way to do so." (Bernard, 2002)

During this initial period, systematic relaxation is taught and then utilized along with guided imagery during each session. Members are also asked to come to each session with one "brag," something that they are proud of that they did for themselves in the previous week.

The beginning phase of the group is the time of learning what to expect and to become familiar with the structure of the group.

The structure of the group has a tripartite composition: check-in, discussion of issues, wrap-up. In the first 20 minutes of each group there is a check-in, where each member is requested to participate by telling any or all of the following: what they were feeling this past week; anything good or bad that happened to them in the week; what they accomplished or didn't accomplish in the week; if they had a dream they remembered; if there was unfinished business from last week's group or a group issue they want to bring up. Each person is given three minutes on a timer for this part of the session. The check-in is felt to be enormously important because it provides an opportunity for the shy or withdrawn adolescent to speak about his/her life. Also, given the enormous mood swings of adolescents, it's important to learn how they felt yesterday because today they might be feeling differently. With the instability of adolescent emotions, the check-in provides the opportunity to hear about the whole week and get a more complete picture of their functioning.

After each has had a turn, the issues are discussed in the following order: group issues have first priority; dreams with their connection to the unconscious are next; then the group selects which themes that were first presented they will discuss next, depending on urgency, popular interest, or concern that a member didn't have their issue discussed in a few weeks.

The middle time in the session, usually an hour, is spent discussing the themes that were brought up in the check-in, and also in teaching coping strategies, in doing creative exercises, and in the middle phase (the fifth session through the third session before termination) in telling of the trauma and in working it through.

The last ten minutes of each session is spent in wrap-up, where each member will say three words describing how they felt in the session that day. The wrap-up helps teach the use of feeling language, helps teach each member to pay attention to their feelings because they are going to have to describe them later, and also provides the leader with a barometer reading of the group members' emotional state at the end of that day's group. A list of possible words for wrap-up was compiled by one group to provide assistance to members (usually male) who had difficulty "languaging" feelings. The list, which later came to be known as the "cheat sheet," is attached.

The wrap-up exercise provides a major benefit in an adolescent trauma group because the feelings described would indicate the need for immediate follow-up with an individual session or phone call.

2.   The Middle Phase

The middle phase of group encompasses weeks five through 17 (if the group is time-limited), or week five until the three sessions before termination (if the group is open-ended).

Weekly journaling is encouraged in order to create a memory book, which will eventually allow the adolescent to weave the narrative of the trauma. This method is particularly encouraged because it helps the adolescent to process the unbearable aspects of the trauma. Members are also encouraged to bring in songs or poems that express some of their feelings about the event. These songs and poems as well as the journal entries can be used as the basis of discussion in the group.

The therapeutic focus of this phase is on processing of the members' traumatic experiences. This may include conducting trauma narrative exposure work, exploring the worst moments to increase tolerance, and identifying and restructuring maladaptive cognitions associated with extreme negative emotions. This work can be accomplished through hypnosis, systematic desensitization and the use of guided imagery.

Another focus of the middle phase of the trauma group needs to be the therapeutic management of the connections between trauma and bereavement (Saltzman et al., 2001). The leader provides psychoeducation about grief, bereavement and anger. To promote healthy grieving, the leader encourages the members to construct a representation or image that is reframed to become more positive and growth-promoting. In a bereavement group, this focus might include bringing in photographs or "linking objects" (Volkan, 1982) to expand and amplify the positive restructuring.

3.   Termination Phase

The termination phase of the group needs to be worked through in the last three sessions. During that time, progress of each member is reviewed and members tell their plans for the future. Each member who is leaving has a turn at being in the spotlight while the other members, one by one, tell the member who is leaving what positive thing he/she will remember about that member, what he/she has learned from knowing that person, and what characteristic of that person he/she will try to make a part of him/herself. After each of the members has had a turn expressing his/her appreciation to the member who is leaving, the group leader reviews the member's progress and gives him/her a sense of what the leader feels are his/her gains and suggests positive areas for future work. At this session, special foods are also brought to mark the occasion. This part of the session is taped (with the permission of the group members) and later transcribed and given to each group member.

VII.   CONCLUDING REMARKS

The need for addressing the adolescent's grief and trauma is vital. The group for an adolescent should be only one of many positive forces in his/her environment helping toward his/her recovery. Whenever possible, families, school staff, clergy, pediatricians and other community members should be helped in understanding the adolescent's grief and trauma so that they can make appropriate referrals for help and can participate properly in the healing process. Because adolescents are still in developmental flux, the right intervention at the right time has a powerful impact. In our experience, adolescent group therapy for grief and trauma can be a most impactful experience with far-reaching, deep effects for both members and leader.

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