GROUP INTERVENTIONS FOR TREATMENT OF PSYCHOLOGICAL TRAUMA

MODULE 9:
IDENTIFICATION AND MANAGEMENT OF MASKED TRAUMA REACTIONS IN GROUPS

By

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PART I: THE NATURE AND IDENTIFICATION OF MASKED TRAUMA

I.   RATIONALE AND OBJECTIVES

A.   This module is one of a series on group treatment of psychological trauma.

B.   It will focus on assessment and management of clients, psychiatric populations, and group treatment situations where masked trauma plays a role. Masked trauma are those traumatic events, histories, and symptoms which are hidden, i.e. not clearly evident to clients, providers/caregivers, and/or significant others.

C.   It is important for clinicians to understand and address masked trauma. Here is why:

1.   Masked traumas occur more frequently than realized in the general population and in psychiatric populations in particular.

a.   As the events of September 11, 2001 and its aftermath suggest, many individuals who were emotionally impacted by these events went unnoticed or sought help many months after the trauma itself.

b.   Trauma is often overlooked as a factor in a variety of conditions other than Post Traumatic Stress Disorder.

c.   Even when individuals receive treatment for trauma, previous traumas are often overlooked as exacerbating factors.

2.   When not recognized, masked trauma may either remain untreated or result in costly, extended treatments with questionable outcomes

a.   Patients may be given an incorrect diagnosis. (Research shows, for example, that trauma victims have been incorrectly diagnosed with borderline personality organization, other personality disorders, clinical depression, panic disorder, etc.)

b.   Patients may themselves remain in denial of the impact of trauma. (Individuals frequently forget the traumatic events, or minimize their importance).

c.   Patients may undergo extensive treatment without resolving the underlying traumatic stress, resulting in recidivism and recurrence of symptoms.

3.   Practitioners therefore need to learn how to recognize and treat masked trauma in order to provide effective care.

D.   Masked trauma can refer to any or all of the following conditions, in which the trauma

and its effects are:

     1.   Unknown to the therapist and/or the patient;

     2.   Disguised, avoided, or otherwise defended against in a way, which is difficult to uncover or resolve;

     3.   Known, but lacking in clear-cut symptoms of DSM-IV Acute Stress Disorder or Post Traumatic Stress Disorder; and/or

     4.   Complicated and/or confounded with other factors such as unresolved grief, co-morbid mental illness, personality disorders, and/or substance abuse.

II.   OVERVIEW OF THE WORKSHOP

A.   To review the nature of trauma and Post Traumatic Stress Disorder (PTSD)

B.   To explore the anatomy of masked trauma, specifically how trauma may occur within other disorders and symptoms, such as depression, bereavement, and problems in relationships

C.   To discuss how group therapists can identify and assess masked trauma in the screening process and in their groups.

D.   To examine how therapists can best manage and treat masked trauma in group contexts to the benefit of the identified patient(s) and the group as a whole, emphasizing the "seven tasks."

E.   To consider issues such as group-as-a-whole dynamics, risk management, countertransference, confidentiality, and supervision as they relate to masked trauma.

F.   To conclude with a question and answer period, debriefing of feelings

III.   FORMAT OF THE MODULE

A.   The leader will primarily use a didactic/lecture format.

B.   Illustrative slides and handouts will accompany the talk.

C.   (S)he will answer questions and lead discussions.

D.   (S)he will give individual and group case examples and elicit clinical examples from the participants (sharing of work experience).

E.   During the debriefing period, participants will have an opportunity to share feelings, including those related to the workshop's group process (experiential component.)

IV.   A REVIEW OF PSYCHOLOGICAL TRAUMA AND PTSD

A.   Definition of Psychological Trauma

1.   DSM-IV definition of trauma as "exposure to an extreme traumatic stressor involving death, injury, or a threat to the physical integrity of oneself [or] another person, or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate."

2.   "The person's response to the event must involve intense fear, helplessness, or horror."

3.   van der Kolk (1997) adds that the traumatic exposure is inescapable.

4.   The stressor may be single, repeated, or cumulative.

5.   It may be experienced vicariously as a witness to another person's trauma story.

6.   In addition, any situation that involves extreme shame, boundary violations, or loss of identity and meaning can be experienced as a symbolic death of self, hence constitute a traumatic event.

B.   Definition and Symptom Clusters of PTSD: Seventeen primary symptoms of PTSD are divided into three general categories

1.   Re-experiencing cluster

a.   Intrusive recollections

b.   Distressing dreams

c.   Flashbacks

d.   Psychological distress

2.   Physiological reactivity in response to reminders of the traumatic event

2.   Avoidance cluster

a.   Efforts to avoid thoughts or feelings related to the trauma

b.   Efforts to avoid activities or situations that arouse recollections of the trauma

        c.   Amnesia for important aspects of the trauma

        d.   Diminished interest in significant activities

        e.   Feelings of detachment from others

        f.   Restricted range of affect

        g.   Sense of a foreshortened future

3.   Hyperarousal cluster

        a.   Sleep difficulties

        b.   Irritability

        c.   Difficulty concentrating

        C.   Hypervigilance

        C.   Exaggerated startle response

C.   Approaches to treating PTSD (Wilson, et al., 2001, pp. 159-182)

1.   Cognitive-Behavioral Therapies (CBT) These treatment modalities are aimed primarily at alleviation of PTSD symptoms as such.

        a.   Prolonged exposure (PE) therapy—A time-limited behavioral therapy that involves repeated exposure to the traumatic memories, stimuli, and situations at tolerable levels with the aim of reducing and desensitizing PTSD responses to these triggers.

        b.   Stress inoculation training (SIT)—This is a stress management approach that uses education, cognitive-behavioral techniques, and stress reduction methods such as deep inhalation.

        c.   Cognitive processing therapy (CPT)—This approach emphasizes structured tasks to attach words, narrative, and cognition to the traumatic experience, thus cognitively processing and attenuating the traumatic responses and emotions

        d.   Eye Movement Desensitization and Reprocessing (EMDR)—EMDR is a more controversial method which uses induced lateral eye movements and/or shifts of attention from left hand to right hand to desensitize the traumatic memories.

e.   These evidence-based methods are usually employed to treat diagnosed Post-Traumatic Stress Disorder. However:

    i.   Masked trauma reactions are more complex and affect the whole personality.

    ii.   Cognitive-behavioral approaches may be useful in treating masked trauma but only as part of an holistic, organismic, and multi-modal treatment plan, which we will discuss later.

2.   Short-Term dynamic psychotherapy (STDP) employs psychoanalytic principle and techniques in a time-limited framework to:

    a.   Support and strengthen healthy defenses;

    b.   Restore ego functioning;

    c.   Focus on trauma-related issues;

    d.   Acknowledge and cope with trauma related realities;

    e.   Incorporate object relations, self psychological, and ego psychological principles when applicable.

    f.   Work through guilt (e.g. survivor guilt), shame, and grief.

3.   Short-Term group psychotherapy

    a.   Short-term groups are perhaps the most commonly used setting for treating PTSD.

    b.   They employ diverse treatment models: cognitive-behavioral, interpersonal, and psychodynamic.

    c.   They are time limited.

    d.   They are ego supportive.

    e.   They are comprised of a homogeneous group population.

    f.   They are highly structured to limit regression and contagion.

    g.   They emphasize the narrative of the trauma.

4.   Medication Management

       a.   Use of medication is an important adjunct in treatment of Post-traumatic stress but that trauma is complex and requires multi-modal treatment, including medication, stress management, psychotherapy, and community supports.

       b.   Some specifics of medication management will be covered later in the workshop.

V.   THE ANATOMY OF MASKED TRAUMA

A.   A significant incidence of masked trauma can be found in most clinical settings and populations, including therapy groups.

    1.   Psychological trauma is a factor underlying many mental health and stress related conditions other than PTSD.

    2.   Previous trauma may lurk under recent trauma and exacerbate the patient's current conditions.

B.   Therefore, it is judicious to consider and rule in or rule out masked trauma when screening and treating patients in any setting and situation.

C.   Masked trauma may be the result of a variety of circumstances and situations, including any or all of the following:

    1.   Memories of the trauma were repressed;

    2.   The patient does not consider the event traumatic when in fact it was;

    3.   The patient does not think the trauma is significant in the present context;

    4.   The symptomatic outcome was other than Post-Traumatic Stress Disorder;

    5.   Social norms (such as male dominance, punitiveness towards children, etc.) may make the traumatic action seem innocent or non-impactful;

    6.   Caregivers, including the therapist, may deny the trauma;

    7.   The patient presents with a high degree of coping ability and practical success, while the trauma appears in subtle, easily overlooked symptomatology;

D.   In some cases, PTSD is present but not disclosed or else misdiagnosed. Examples include:

1.   A patient has repressed the traumatic memory and presents the symptoms of PTSD but not the cause. The clinician then may diagnose depression or anxiety.

2.   A patient is "biting the bullet" and "in denial," and so minimizes the symptoms.

3.   A patient self-medicates with drugs and alcohol or addictive behaviors such as gambling or overeating, so the symptoms don't appear until the self-medication is stopped.

4.   The physician or therapist is not sufficiently trained in trauma and doesn't recognize the condition.

5.   A physician, patient, and/or family may be in an unconscious collusive cover-up of the trauma.

E.   Sometimes the client manifests co-morbid responses to trauma in addition to or other than PTSD. These may occur:

1.   Prior to the trauma (i.e, a pre-morbid and/or pre-disposing condition)

2.   As a consequence of trauma (as part of complex Post Traumatic Stress Disorder)

3.   Examples include:

a.   Clinical depression;

b.   Bipolar disorder;

c.   Panic attacks;

d.   Substance abuse;

e.   Hallucinations and delusions (occasional) ;

f.   Dissociation and dissociative disorders;

g.   Psychosomatic disorders;

F.   Complex PTSD may develop from prolonged and/or repeated exposure to traumatic situations

1.   Herman (1997) proposed a new diagnosis (not in the DSM-IV) of Complex Post-Traumatic Stress Disorder

a. Other, similar diagnostic entities regarding the long-term consequences of post-traumatic stress have been proposed world-wide.

b. Herman emphasizes a prolonged period of trauma ("months to years") as a criterion for complex PTSD

c. She accentuates "totalitarian control" as an interpersonal factor in trauma, whether a hostage, prisoner of war, or person subject to abuse.

d. Complex PTSD consists of a constellation of symptoms that develop and persist over an extended time period, often throughout life.

e. Complex PTSD is often masked and thus diagnosed as major depression, borderline personality organization, and so on, because it includes symptoms from any or all of these categories.

2. According to Herman (1997), symptoms of Complex PTSD include marked alterations in the following areas of the personality

a. Affect regulation, for example, dysphoria (lack of pleasure), self-injury, explosive or extremely inhibited anger

b. Consciousness, including amnesia, dissociative episodes, depersonalization

c. Self-perception, including helplessness, shame and guilt, sense of stigma, sense of being different

d. Perception of the perpetrator, such as preoccupation, revenge wishes, paradoxical over-idealization

e. Relations with others, such as isolation and withdrawal, disruption of intimacy, persistent mistrust

f. Systems of meaning, including loss of faith, sense of despair

G. Other symptoms and signs of masked trauma include:

1. Inappropriate lack of emotional response to trauma, signaling a risk for later PTSD.

a. Individuals often activate coping mechanisms to deal with the immediate threat of trauma.

b. Subsequently, when safe, they may continue to show a lack of any strong emotions about the episode.

c. This lack of responsiveness may suggest a pervasive denial or dissociation of the traumatic experience

2. Anniversary reactions.

a. Key dates and anniversaries of traumatic events can serve as useful times to remember and rework traumas.

b. Sometimes, however, emotions and actions take the place of memories, and without awareness of the cause, the individual may

i. Become depressed

ii. Act out in a self-hurting or inappropriate way

3. Attachment disturbances and relationship difficulties.

a. There is evidence that psychological trauma disrupts basic mechanisms of attachment and bonding that were established early in life

b. Mistrust, social withdrawal, prolonged grief, and a shift in attitudes towards loved ones may be manifestations of disturbance in attachment behaviors.

4. Traumatic loss and complicated bereavement. Rando (1993) and Figley (1985) have studied loss that occurs under traumatic circumstances.

a. All grief is traumatic, and all trauma involves loss.

b. The combination of severe traumatic impingement or disruption with a major loss is called traumatic loss.

c. For example, family members of those who lost their lives in the terrorist attacks experienced traumatic loss. Because the loss was so sudden, the result of malevolent intent, and so many lives were lost.

d. Traumatic loss often results in prolonged reactions lasting many years, with a variety of symptoms including but not exclusively PTSD.

e. This complicated mourning may not be recognized as such and hence constitute a masked trauma.

VI.   DETECTION, EVALUATION, AND SCREENING OF MASKED TRAUMA

A.   Intake screening and assessment (Goodman & Weiss, 2000)

1.   On account of the possibility of masked trauma, all medical mental health assessments and screening should always include a trauma evaluation component, even if no trauma is evident or disclosed.

2.   In addition to a standard mental status examination, trauma detection and assessment should especially include:

a.   Detailed developmental history from pre-natal and birth factors to the present;

b.   Family history of abuse, substance dependence, and psychological trauma;

c.   Specific empathic inquiry about any history of sexual or physical abuse or severe deprivation, rejection, abandonment, or punishment.

i.   Questions should be sensitively phrased and focus on behavior patterns rather than placing blame

d.   Have there been any periods of memory loss (amnesia; blackout) or gaps in memory of the past?

e.   Do a PTSD symptom checklist

3.   The clinician should especially observe:

a.   Dissociation and trancelike states during the interview;

b.   Labile emotionality;

c.   Countertransference feelings of being a victim or perpetrator vis-à-vis the patient.

4.   The evaluating clinician should be aware of the importance of:

a.   Establishing trust and rapport;

b.   Maintaining an objective, non-judgmental stance;

c.   Avoiding premature closure.

            i.   The nature of the traumatic situation may be uncertain for an extended period of time

            ii.   Patients may hesitate to disclose certain facts, and this needs to be respected

            iii.   It is often difficult to distinguish between valid recollections and "false memories" and fantasies.

5.   When trauma is unmasked, screening and matching patient to group should take into account:

        a.   The patient's ego strength and resilience;

            i.   Higher level patients and those with prior trauma treatment can usually tolerate unstructured, psychodynamic, and heterogenous groups better than

            ii.   Those with severe personality disorder, poor defenses, or victims of very recent trauma or re-traumatization.

        b.   Availability of community and treatment supports from self-help groups to family availability to individual psychotherapy and medication;

        c.   The particular group's potential ability to identify with and support the patient and his/ her trauma needs;

        d.   Risk factors;

        e.   Confidentiality issues.

B.   Sometimes, the masked trauma emerges after a person is already a group member. It is important to observe and note client behavior, interactions, transference and re-enactments in and outside of the group. Signs of possible masked trauma include:

1.   Seductive behaviors and erotic fantasies;

2.   Extreme emotions vs. emotional numbing (affect dysregulation) ;

3.   Excessive attempts to control others' behavior;

4.   Violations of group boundaries and rules;

5.   Difficulty bonding with the group such as:

a. Severe mistrust;

b. Emotional withdrawal;

c. Becoming depressed, anxious, or avoidant when experiencing intimacy and closeness;

d. Scapegoat role;

e. Extreme clinging and overdependence on the therapist.

C. Importantly, these observations are merely suggestive of possible trauma history. The therapist should keep in mind that:

1. Behavior is multi-determined;

2. The above signs are not diagnostic criteria, but rather are red flags for the clinician to consider further inquiry.

D. Following up with group members who become aware of trauma in mid-treatment

1. Awareness and/or disclosure of trauma by a group member will affect the member and the entire group.

2. When trauma disclosure or responses occur in group, it is important to

a. Provide support to the identified patient.

b. Assure that the other group members understand and empathize with the trauma and its impact.

c. Help resolve the group members' tendency to treat the identified patient either overprotectively or with special status.

d. Work out confidentiality issues, since some trauma disclosures in group settings may impact negatively on the patient and/or significant others.

i. Disclosing some facts to peers may evoke more shame and anxiety than disclosing the same information to a professional.

ii. Group members are not bound by the same laws that prohibit therapists from disclosing information without written consent.

e. When safe, encourage further exploration within the context of the group interaction.

f.   Meet with the patient individually to further evaluate and to review treatment needs.

    i.   When a trauma is unmasked, the treatment plan may need to be revised in significant ways

    ii.   Risk factors may increase when a trauma is recalled or disclosed

PART II: GROUP TREATMENT FOR MASKED TRAUMA

VII.   BASIC TREATMENT CONSIDERATIONS FOR MASKED TRAUMA

A.   Establishing treatment goals and objectives

1.   Masked trauma entails treatment of multiple levels of disorder and dysfunction:

2.   Masked trauma treatment, in contrast to symptomatic treatment of Post-Traumatic Stress Disorder, requires a multi-level, multi-modal treatment approach that addresses the whole person.

a.   A useful model for such treatment is the Holistic/Organismic Approach (Wilson, Freeman, & Lindy, 2001)

i.   This model emphasizes allostatic adjustment to trauma.

ii.   When traumatic stress occurs, the normative levels of organismic functioning are permanently altered. These permanentized changes are termed "allostasis."

iii.   This may include changes in neurotransmitter and endocrine levels, as well as changes in psychosocial functioning such as arousal, interpersonal trust, and basic beliefs and meanings.

iv.   To restore normative, non-traumatic functioning, treatment must address the whole self: biological, psychological, social, and spiritual.

b.   The holistic model advocates multiple levels of treatment, including:

i.   Symptomatic relief;

ii.   Stress management;

iii.   Addressing relational/interpersonal issues;

iv.   Re-integration with the community;

v.   Restoring meaning and spirituality.

c.   Treatment must be multi-modal, combining as needed:

i.   Individual therapy

ii.   Family counseling

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iii.   Group therapy

iv.   Medication management

v.   Community support and interventions

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3.   On account of the potential for re-traumatization, trauma treatment requires special respect for defenses; the Hippocratic Oath: "Above all, do no harm."

VIII.   THE "SEVEN TASKS" OF WORKING WITH MASKED TRAUMA IN GROUP PSYCHOTHERAPY

A.   Task I: Unmasking the Trauma

1.   Initial indications of masked trauma in the group

a.   The therapist watches and listens for individual disturbances and shifts enumerated in VI-B, above. Especially, one should note that:

i.   The group-as-a-whole may manifest extremes of merger versus individual isolation (Hopper's 4th basic assumption: see below)

ii.   Narcissistic vulnerability and shame-based behavior in a member may signal re-experience of a trauma.

iii.   A member may be scapegoated or, conversely, overprotected by other group members

iv.   The group members may act out in surprising ways, such as attacking each other or the therapist, or meeting secretively outside the sessions.

b.   These manifestations may represent symbolic re-enactments of boundary violations experienced in the past by a member or members.

c.   The therapist's countertransference when encountering masked trauma may include his/her own traumatic recollections, or finding him/herself playing an uncomfortable role w/ a group member, such as being unusually critical, feeling hypnotized, etc.

2.   Discovery and "Un-covery:" As the trauma aspect unfolds:

a.   A group member may experience intense emotions or difficult interactions with others in or external to the group;

b.   Exploring the sources of these feelings and conflicts may lead to memories, which include traumatic experiences;

c.   In an atmosphere of empathy and support, these experiences may be further elaborated in detail;

d.   The therapist should inquire whether the other members of the group "resonate" with these experiences, so that the individual becomes a "voice for the group;" (Agazarian & Peters, 1981)

e.   The therapist may want to meet individually with the patient to do further assessment and re-negotiate the treatment plan, if needed.

3.   Working with the impact of member disclosure on other members and the group: Restoring safe space in the group:

a.   Member recall and disclosure of traumatic experience can have a profound impact on the group.

b.   It is important that the therapist attend to the impact of the trauma disclosures on the other group members.

i.   Members may experience vicarious traumatization from hearing about the trauma, especially if presented in graphic detal.

ii.   Members may re-experience traumas of their own and become anxious or guarded.

iii.   Members may become alienated from the patient, feeling that he or she is receiving special treatment and/or becoming perpetrating scapegoaters in relation to someone they now perceive as a helpless victim.

c.   The therapist works to restore an atmosphere of empathic and authentic inquiry, a safe space for every group member.

B.   Task II: Developing a Group Base for Trauma Work

1.   Establishing trust

a.   One of the main sets of forces that maintains the mask over trauma are feelings of interpersonal mistrust that were established at the time of the trauma and may persist long after the trauma is dissociated or forgotten.

b.   Trust issues are therefore intensified in a group marked by traumatic experience.

c.   Trust is necessary for the group to do the healing work.

d.   Trust is gradually re-established by:

i.   The leader's role modeling of merited trust (Boszormenyi-Nagy, 1984) through consistently ethical behaviors, good boundaries, and staying in role;

ii.   The leader's ability to contain and interpret the intense traumatic affects and re-enactments that occur;

iii.   The group establishing norms that are safe for and preserve the dignity of each member;

iv.   The empathic awareness and working through of emotional wounds and narcissistic injuries that inevitably occur in the group interaction.

2.   The need for a holding environment

a.   Winnicott (1951) defined the holding environment as the mother's attuned good enough ministrations to the infant, which the infant experiences as a safe, secure context in which to go on being.

b.   The "group as mother" (Scheidlinger, 1955) serves as such a context for the group members.

c.   The group holds each member by providing a supportive context for working through difficult issues and emotions.

d.   In homogeneous groups of members with a common trauma (e.g. incest survivor groups; post-9/11 groups; etc.), the holding environment is initially supplied by:

i.   Protective rules and structure;

ii.   Strong identifications with each other and with members' mutual understanding of the trauma.

e.   In heterogeneous, unstructured groups, the holding environment is strengthened by:

i.   The merited idealization of the leader as a skillful professional and empathic human being;

ii.   Surviving and working through difficult issues together.

iii.   Addressing the negative transference.

     a.   Traumatized individuals often project their angry feelings of victimization and betrayal into authority figures such as the group therapist.

     b.   Unless interpreted and worked through, such angry feelings can interfere with the treatment process and the holding group.

     c.   The therapist must be able to contain the negative feelings and help resolve them in a way that restores the safety and holding of the group.

C.   Task III: Healing the Wounded Self Beneath the Mask

1.   To some extent, the mask that covered over the trauma can be thought of as a false self (Winnicott, 1965), which protects the especially vulnerable true self of the trauma victim from further intrusion and fragmentation.

2.   Healing the traumatized self consists in gradually restoring the safe functioning of the true, authentic self, which has become dissociated from its interpersonal meaning context.

3.   There are several steps in this process:

     a.   Witnessing the trauma

         i.   The patient's disclosure and exploration of the traumatic events in the context of group support provides validation of the patient's perceptions and emotions, and a social context which affirms the patient's need for fairness, reparation, and justice.

         ii.   The telling of the story provides structure and self-soothing which helps modulate the intense emotions associated with the trauma.

     b.   Re-integrating dissociated parts of self (Hegeman & Wohl, 2000). The dissociation from trauma results in a compartmentalizing of self-experience. Behavior, emotions, sensations, and cognitions associated with the trauma are

often kept apart, limiting the capacity for integrative insight, change, and growth.

      i.   This dissociative pattern is conceptualized in the acronym: BASK: Behavior/Affect/Sensation/Knowledge (Chu, 1998)

      ii.   Group therapy, through the interaction, feedback, and mirroring of the membership, offers multiple opportunities to re-integrate these components of the self into a unified whole, capable of agency and mastery.

   c.   Reworking interpersonal relations

      i.   Traumatic interpersonal relations tend to be governed by the repetition compulsion (Freud, 1920), in which the disturbed relationship with the perpetrator is replayed over and over again (often in different variations), leaving the individual further abandoned, abused, and victimized or engaging in self-destructive behaviors.

      ii.   Members tend initially to re-enact these recurrent traumatic patterns with each other and the therapist.

      iii.   By identifying and reflecting on such patterns, and contracting for change, the group members can gradually re-work these repetitive patterns and achieve healthier interactions with less tendency to play the role of either victim or perpetrator.

   d.   Resolving grief and loss

      i.   All trauma involves loss:

         --   Loss of parts of self

         --   Loss of loved ones

         --   Loss of possessions

         --   Loss of meaning and loss of the assumptive world (Janoff-Bulman, 1992)

      ii.   Rando (1993) and Figley (1985) have pioneered in the field of traumatic loss, the study and treatment of grief that is complicated by traumatic stress.

-- After the shock of trauma is resolved, a period of grief may naturally occur.

-- Groups are a natural context for working through the stages of grief.

-- Mourning losses help the members to move beyond absorption with the trauma to live in the here and now.

-- Resilience and transcendence facilitate and result from working through grief.

    e. Re-writing the relational biography and narrative

        i. Trauma is always filtered through the perceptions, cognition, and social relations of the traumatized person, resulting in a narrative that reflects the sense of damage and victimization.

        ii. As the group evolves, this relational biography is gradually re-written to reflect the healthier norms of the group.

-- Foulkes said that "Together, we constitute the norm from which individually we deviate." (1983)

-- The therapeutic norms established in the group provide a context in which the individual can reframe the relational biography into one with a hopeful future, the possibility of choice, and a sense of universality and belonging.

D. Task IV: Managing Trauma-based Responses in the Group, for example:

    1. Vicarious traumatization

        a. Both members and therapists may experience varying degrees of traumatic response to re-enactments and recollections of trauma by other participants. (Pearlman & Saakvitne, 1995 ; Ziegler & McEvoy, 2000)

        b. Vicarious trauma may overstimulate the group members and also lead to contagion of unmanageably overwhelming affects

        c. Therapists must manage their own vicarious traumatizations on a regular basis through supervision, co-therapy, stress management, and their own prophylactic therapy.

    2. Rescuing, victimization and scapegoating

3.   Dissociative states

   a.   Dissociation commonly occurs as a result of trauma and often goes unrecognized.

   b.   In groups, it is often manifest in various disconnects of members from the group interaction.

      i.   Members may appear to be distracted, withdrawn, or inattentive.

      ii.   Members may not hear specific members or information.

      iii.   Members may recall events without experiencing the feelings that are connected with them.

      iv.   Members may have intense emotions that seem to come from nowhere, without obvious linking to the group interactions.

   c.   An important task of the group therapist is to identify these disconnects and help weave together the fragments into a coherent whole.

4.   Deficits, cognitive distortions, and traumatic affect resulting from the neurophysiological encoding of traumatic experiences.

   a.   Traumatic experiences are often encoded differently than normal experiences. For example, they may be permanentized as a vivid and immediate experience rather than being attenuated and modified with the passage of time.

   b.   Changes in the limbic system and neurotransmitters are especially implicated in the neurophysiology of trauma. (van der Kolk, 1991)

      i.   The limbic system plays a role in regulating sensation, memory, emotion, and behavior.

      ii.   Research (van der Kolk, 1989) suggests that endorphin levels are temporarily increased by trauma, possibly accounting for the tendency to repeat trauma in order to get a hit of this neurotransmitter.

   c.   Traumatized patients often benefit from therapist- and group-feedback to help correct thought distortions such as magnification, overgeneralization, and thinking in extremes.

d.   In general, it is important in addressing trauma deficits to avoid the two opposite pitfalls of

      i.   Psychologizing neurophysiological deficits as defense mechanisms and, conversely,

      ii.   Rescuing patients from developing needed coping skills, making healthy changes, and giving up the victim role.

5.   Differences in managing trauma responses in trauma versus non-trauma groups.

a.   Trauma-focused groups are generally homogeneous, highly structured, and time-limited, while non-trauma groups in outpatient settings are often heterogeneous, relatively unstructured, and open-ended.

      i.   In trauma focused groups, trauma responses are confronted, minimized, and/or extinguished.

      ii.   In heterogenous groups, trauma responses are allowed to develop sufficiently that they can be pointed out and worked through in the group setting.

         --   The group therapist must exercise good clinical judgement in deciding whether this process is manageable at any particular time in the group.

         --   Sometimes structure and limits rather than interpretation and working through are needed to contain the powerful emotions.

b.   Traumatic responses in trauma groups are best managed by remaining goal-directed, providing boundaries and structure, and encouraging cognitive processing.

c.   In trauma groups, at least the one trauma has been identified and unmasked.

      i.   However, members may be masking trauma histories that are not the focus of the group.

      ii.   Trauma victims are often re-traumatized by later trauma, and their responses to catastrophic events are often more severe than those with no trauma history.

E.   Task V: Managing the Group-as-a-Whole

1. Managing splitting and projective identification

   a. Trauma fosters regression to the paranoid-schizoid position (Klein, 1977; Ganzarain & Buchele, 1988)

   b. The negative half of the split is often projected into the therapist or other group members.

   c. This may result in aggressive group relations.

   d. Helping the members to own their projections facilitates group development and promotes integration of self.

2. Managing contagion effects

   a. The overwhelming emotions of trauma can lead to emotional contagion in group, with many of the members feeling overwhelmed, grieving, helpless, angry, and so on.

   b. The therapist needs to help the group manage these labile affects by:

      i. Pointing it out to the group and exploring the underlying sources of the emotions;

      ii. Interpreting the underlying object relations and/or narcissistic injuries that evoked the powerful affect;

      iii. Providing additional structure;

      iv. Interrupting the affect with a time out;

      v. Using educational, cognitive, and behavioral contracting strategies to attenuate the emotionality and provide a learning experience.

3. Group cultures/basic assumptions

   a. Groups evolve distinctive group cultures or climates that change over time.

   b. Bion (1959) called such group-as-a-whole climates "basic assumptions." He identified three "Ba's:"

i.   BaD: Dependency, where the group members look to the leader to magically solve their problems and provide a cure;

ii.   BaF/F: Fight/Flight, where the group imagines the presence of danger from within and outside, and shows either aggression or anxiety in response;

iii.   BaP: Pairing, where the group puts its hope in a couple and emphasizes utopian ideals.

c.   All three basic assumptions occur in groups with traumatized individuals (Ganzarain & Buchele, 1988)

d.   Each basic assumption provides an opportunity to:

i.   Help the members understand their unrealistic and maladaptive thinking, defenses, and behavior as impacted by traumatic experience;

ii.   Work with themes of dependency, aggression, and relationship in ways that are manifest in the whole group;

iii.   Restore realistic, constructive thinking and therapeutic alliance that Bion called the "Work group (BaW)."

e.   Hopper (1997) has found that, in addition, the presence of psychological trauma in the group induces a fourth basic assumption, I/AM (Incohesion: Aggregation/Massification)

i.   In this group culture, members alternate between feelings of sameness and fusion (massification) versus feelings of isolation and apartness (aggregation) (Hopper, 1997)

ii.   These states could also be understood as manifestations of the emotional contagion and lability (massification) and dissociation (aggregation) that characterize trauma (Schermer, 2001)

F.   Task VI: Managing Risks of Masked Trauma, Including Complex PTSD and Comorbid Diagnoses

1.   Patients with masked trauma may be at heightened or undetected risk for:

a.   Suicide

i.   Suicide has many causes, of which trauma is only one factor.

ii.   Covering over and masking the trauma often causes the patient to conceal his feelings, thoughts, and motives from others, leading to a pattern of isolation and withdrawal that increases suicidal risk.

iii.   The feelings of shame and guilt that are evoked when the trauma is unmasked may temporarily increase suicidal risk.

iv.   Feelings of hopelessness and depression resulting from prolonged, unremitting depression or PTSD may increase suicidal risk. (Wilson, Freeman & Lindy, 2001)

v.   All therapists who work with trauma should receive risk management training.

b.   Less commonly, homicide

i.   The masking of trauma may include suppressed rage and resentment, especially against the perpetrator, but also at significant others.

ii.   The risk of homicide increases when:

--   The patient has ongoing proximity to the target individual;

--   The patient has psychotic features, especially delusions, paranoia, and/or command hallucinatory voices;

--   The patient does not contract for safety and has no strong belief system or rationale for not harming others.

c.   Abuse, whether physical, sexual, or mental, whether spousal, child, relationship, or work harassment

i.   Both victim and perpetrator roles can result from trauma

ii.   Ongoing abuse tends to increase denial of current and past trauma and vice-versa;

iii.   Current abuse must be curtailed in order to provide effective psychotherapeutic care.

d.   Lowered levels of functioning: job loss, social withdrawal, etc.

i.   Patients with masked trauma often function at levels much lower than they are normally capable, whether at work, interpersonally, or in activities of daily living

ii.   The causes of such lowered functioning range from anxiety attacks to avoidant behavior to loss of interest to shame and self-blame.

e.   Substance abuse

i.   Traumatized individuals may turn to drugs and alcohol for self-medication of the emotional pain, setting off the addictive cycle.

ii.   Substance abuse can be an indicator of masked trauma and vice-versa.

2.   Risk levels may increase:

a.   When the trauma is first uncovered;

b.   When the trauma is re-lived and re-enacted in treatment;

c.   As a result of reminders (e.g., anniversary dates) and triggers;

d.   During stressful times in the patient's life;

e.   If co-morbid conditions emerge;

f.   If the patient isolates, withdraws, or shows significant behavior changes.

3.   Important risk management procedures include:

a.   Active and periodic assessment of risk with patient;

b.   Behavioral contracting and contract for safety;

c.   Involvement of significant others;

d.   Ready availability of crisis resources to patient and family.

4.   All therapists should be trained in risk management

G.   Task VII: Managing the Therapist: Countertransference To Complex and Masked Trauma Reactions

1.	Therapists who work with trauma are subject to powerful emotional pressures from:

	a.	Exposure to trauma narratives;

	b.	Interpersonal scenarios (transference/countertransference) that develop with traumatized patients;

	c.	Retraumatization stemming from the therapist's own trauma history.

2.	These pressures and stressors can lead to:

	a.	Inappropriate acting out with patients;

	b.	Ignoring important therapy issues;

	c.	Work stress, dissatisfaction, and burnout.

3.	When trauma are masked, the therapist may have such reactions without being aware of the source of the problem.

4.	For all these reasons, trauma therapists must be especially vigilant about countertransference reactions. (Ziegler & McEvoy, 2000; Pearlman & Saakvitne, 1995)

5.	Definitions and understandings of countertransference:

	a.	Psychodynamically-based

		i.	Freud and his followers have emphasized the negative aspects of countertransference as an unconscious reaction to the patient that interferes with treatment.

		ii.	The therapist must become aware of the sources of the countertransference in his/her own personality and resolve it so as to reduce its impact on the role of the therapist.

	b.	Intersubjective-relational-based

		i.	Interpersonal theorists regard countertransference as inevitable and a potentially useful tool in treatment.

		ii.	They see it as an ongoing part of the relationship between therapist and patient or group.

iii.   In their view, the therapist strives to understand and clarify the reciprocal relationship and its sources in him/herself and the patient or group.

iv.   The intersubjective/relational therapist may sometimes disclose his/her here and now feelings to the patient if he/she feels it would help the therapy process to do so.

c.   Trauma-based

i.   Therapists who specialize in treatment of trauma emphasize the potential in the therapist for vicarious traumatization and re-traumatization.

ii.   They also emphasize the countertransference tendency of therapists to adopt three inappropriate roles with patients—victim, perpetrator, or unresponsive bystander.

iii.   They point out the importance of ongoing supervision, stress management, and burnout prevention for therapists who work with trauma.

6.   Particular countertransference issues in response to masked trauma

a.   Strong internal reactions in the therapist may be the first clue to the presence of masked trauma in a patient.

i.   The therapist should be alert to tendencies to be pulled into victim, perpetrator, or bystander roles with a patient.

ii.   The therapist should notice discrepancies between clinical assessment of the patient and how he/she feels when working with that individual.

iii.   Similarly, strong, unexpected reactions in group members may indicate a masked trauma.

b.   When trauma is masked and hidden, therapists may become frustrated about patients' lack of responsiveness to themselves and the treatment process.

c.   When trauma is masked and hidden, therapists may unconsciously re-enact the traumatic situation with the patient or group.

d.   When trauma is masked and hidden, therapists may become overly confrontive with patients and/or frequently change the treatment plan, adding to the patient's sense of shame and failure.

H.   Special Problems and Issues

1.   Confidentiality issues, especially when trauma is spontaneously disclosed in a non-trauma group.

a.   Confidentiality among the group members is not legally binding as it is in individual therapy vis-à-vis the therapist.

i.   The therapist is legally bound to maintain confidentiality, while group members are not.

ii.   Group members maintain confidentiality by mutual agreement, but may unwittingly share information outside the group that can negatively affect patients and significant others.

b.   In some contexts, the therapist him/herself gives up the legal privilege of confidentiality when others, such as the group members, are privy to the disclosure. (This may vary according to state regulations.)

c.   Group members should be made aware of this difference.

d.   Some disclosures by group members are best made in individual sessions, where the therapist and patient can discuss the potential positive and negative consequences of disclosing to the group.

e.   Traumatic material can often be worked through without revealing potentially damaging details.

f.   Confidentiality is best preserved in the group through a strong therapeutic alliance and ethical group norms.

2.   Psychopharmacology: Medications are helpful but not sufficient in treating PTSD

a.   PTSD and, especially, masked trauma are biochemically and psychosocially complex phenomena.

i.   Medications help, but do not cure.

ii.   Multi-modal treatment is indicated for trauma-related conditions.

b.   Medications can significantly alleviate anxiety, insomnia, depression, and psychotic symptoms.

c.   Effective medication can overcome helplessness and restore initiative.

d.   There is sometimes a risk of substance dependence when trauma and anti-anxiety medications are mixed.

e.   The physician should always assess for comorbid disorders such as Bipolar disorder.

f.   Medication without relationship can re-traumatize.

3.   Need for acquiring specialized training and/or supervision.

a.   Trauma treatment requires specialized skills and knowledge.

b.   We can easily and incorrectly assume that our generalist therapy training and experience qualifies us to treat, train, and supervise trauma-related psychopathology.

c.   In reality, relatively few practitioners and supervisors have had significant training and supervision in trauma treatment

d.   Within the manifestations of trauma, additional specializations may be necessary: e.g. substance abuse treatment, perpetrator issues, risk management, bereavement counseling;

e.   How to access proper training and supervision.

IX.   QUESTION-AND-ANSWER PERIOD; DEBRIEFING; RESOURCES FOR THERAPISTS

A.   Participants are encouraged to ask questions to clarify any aspect of the workshop.

B.   Participants are encouraged to verbalize the feelings evoked during the workshop.

C.   The leader will make suggestions regarding follow-up, both regarding future learning and resolving open-ended feelings and issues.

REFERENCES

Agazarian, Y. & Peters, R. (1981). *The Visible and Invisible Group*. London: Routelege.

American Psychiatric Association (1994), *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition, Washington, DC: American Psychiatric Association.

Aron, L. & Harris, A. (1993) *The Legacy of Sandor Ferenczi*. New Jersey: The Analytic Press.

Ashbach, C. & Schermer, V. (1987) *Object Relations, the Self, and the Group: A Conceptual Paradigm*. London: Routledge and Kegan Paul.

Bion, W.R. (1959) *Experiences in Groups*. New York: Ballantine.

Bowlby, J. (1960). Grief and mourning in infancy and early childhood. *Psychoanalytic Study of the Child*, 15, 9-52.

Bryer, J., Nelson, B., Miller, J., & Krol, P. (1987) Childhood sexual and physical abuse as factors in adult psychiatric illness. *American Journal of Psychiatry*, 144: 1426-30.

Buchele, B. (1994). Group psychotherapy for persons with multiple personality disorder and dissociative disorders. *Bulletin of the Menninger Clinic*, 57, 362-370.

Burton, J. & Marshall, R. (1999) Categorizing fear: The role of trauma in a formulation. *The American Journal of Psychiatry*, Vol. 156 No. 5: 761ff.

Chu, J. (1998). *Rebuilding Shattered Lives: the Responsible Treatment of Complex Post-Traumatic and Dissociative Disorders*. New York: John Wiley & Sons.

Durkin, H. (1964) *The Group in Depth*. New York: International Universities Press.

Fairbairn, R. (1943) The repression and the return of bad objects. *British Journal of Medical Psychology*, 19: 327-341.

Ferenczi, S. (1932) The Confusion of tongues between adults and children: The language of tenderness and passion. In M. *Balint (*Ed.) (trans. E. Mosbacher). *Final Contributions to the Problems and Methods of Psychoanalysis*, London: Karnac Books, 1980, pp 156-167. Re-published as Confusion of tongues between adults and the child. In *Contemporary Psychoanalysis*, 24 (1988):196-206.

Figley, C., Ed. (1985). *Trauma and Its Wake: The study and treatment of post-traumatic stress disorder*. New York: Brunner/Mazel.

Fine, C. & Kluft, R. (1993) *Clinical Perspectives on Multiple Personality Disorder*. Washington, DC: American Psychiatric Press.

Fish-Murray, C., Koby, E., & van der Kolk, B. (1987) Evolving ideas: The effect of abuse on children's thought. In van der Kolk, B. (Ed) *Psychological Trauma*. Washington, DC: American Psychiatric Press.

Freud, S. (1920). Beyond the pleasure principle. In *the Standard Edition of the Complete Psychological Works of Sigmund Freud*, London: Hogarth Press, 1975.

Foulkes, S. (1983). *Introduction to Group-Analytic Psychotherapy*. London: Karnac.

Gallagher, R. (1994). Stages of group psychotherapy supervision: a model for supervising beginning trainees of dynamic group therapy. *International Journal of Group Psychotherapy*, 44(2), 171-185.

Ganzarian, R. (2000). Group-as-a-whole dynamics in work with traumatized patients. In R. Klein & V. Schermer (Eds.) *Group Psychotherapy for Psychological Trauma*. New York: Guilford Press, pp. 89–115.

Ganzarain, R. & Buchele, B. (1988). *Fugitives of incest*. Madison, CT: International Universities Press.

Gelinas, D. (1983) The persistent negative effects of incest. *Psychiatry*, 46: 312-32.

Hazard, A., Roger, J., & Angert, L. (1993). Factors affecting group therapy outcome for adult sexual abuse survivors. *International Journal of Group Psychotherapy*, 43, 453-466.

Hegeman, E. & Wohl, A. (2000). Management of Trauma-related Affect Defenses and Dissociation. In R. Klein & V. Schermer (Eds.), *Group Psychotherapy for Psychological Trauma*. New York: Guilford Press, pp. 47-63

Herman, J. (1997) *Trauma and Recovery*. New York: Basic Books.

Herman, J., Perry, J. & van der Kolk, B. (1989). Childhood trauma in borderline personality disorder. *American Journal of Psychiatry*, 146, 490-495.

Hopper, E. (1997). Traumatic experience in the unconscious life of groups: a 4th basic assumption. *Group Analysis*, 30, 439–470.

Janoff-Bulman, R. (1992) *Shattered assumptions: Towards a new psychology of trauma*. New York: Free Press.

Klein, M. (1977). *Love, Guilt, and Reparation and Other Works: 1921–1945*. New York: Delta.

Klein, R. & Schermer, V. (2001) *Group Psychotherapy for Psychological Trauma*. New York: Guilford Press.

Kohut, H. (1977) *Restoration of the Self.* New York: International Universities Press.

Kramer, S. & Akhtar, S., Eds. (1991) *The Trauma of Transgression: Psychotherapy of Incest Victims*. Northvale, NJ: Jason Aronson.

Lindemann, E. (1944) Symptomatology and management of acute grief. *American Journal of Psychiatry*, 101:141-148.

Loewenstein, R. (1991). An office mental status examination for chronic complex dissociative symptoms and multiple personality disorder. *Psychiatric Clinics of North America*, 14, 567-604.

Myers, D. (1994). *Disaster Response and Recovery: A handbook for mental health professionals.* DHHS Publication No.(SMA) 94-3010. Washington, DC: Substance Abuse and Mental Health Services Administration.

Nicholas, M. & Forrester, A. (1999). Advantages of heterogeneous therapy groups in the psychotherapy of the traumatically abused: treating the problem as well as the person. *International Journal of Group sychotherapy*, 49, 323-342.

Pearlman, L., & Saakvitne, K. (1995). *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy with Incest Survivors*. New York: W.W. Norton.

Piper, W. & Perrault, F. (1989). Pretherapy preparation for group members. *International Journal of Group Psychotherapy*, 39(1), 17-34.

Resick, P. & Schnicke, M. (1993). *Cognitive Processing Therapy for Rape Victims.* Newbury Park, CA: Sage Publications.

Rando, T. (1993) *Treatment of Complicated Mourning*. Chicago: Research Press.

Scharff, J. & Scharff, D. (1994) *Object Relations Therapy of Physical and Sexual Trauma*. Northvale, NJ: Jason Aronson.

Scheidlinger, S. (1955) The concept of identification in group psychotherapy. *American Journal of Group Psychotherapy*, 9, 661-672.

Schermer, V. (2001). From I: A/M to "Who am I?" Aggregation/massification and trauma-based affects and object relations in groups: A response to Earl Hopper. *Group: The Journal of the Eastern Group Psychotherapy Society*. 25 (3), September, pp. 215–223.

Shengold, L. (1989) *Soul Murder: The Effects of Childhood Abuse and Deprivation*. New Haven: Yale University Press.

Stamm, B. (Ed.), *Secondary Traumatic Stress: Self care issues for clinicians, researchers and educators*. Lutherville, Maryland: Sidran Press. pp.3-28.

Tedeschi, R., Park, C., & Calhoun, L., Eds. (1998) *Posttraumatic Growth: Positive Changes in the Aftermath of Crisis*. Hillsdale, NJ: Lawrence Erlbaum Associates.

van der Kolk, B. (1987) The separation cry and the trauma response: Developmental issues in the psychobiology of attachment and separation. In van der Kolk, B., (Ed.) *Psychological Trauma*. Washington, DC: American Psychiatric Press, pp. 31-62.

van der Kolk, B., Ed. (1987) *Psychological Trauma*. Washington, DC: American Psychiatric Press.

van der Kolk, B. (1987). The role of the group in the origin and the resolution of the trauma response. B. van der Kolk (Ed.). *Psychological Trauma*. (p 153-171). Washington, DC: American Psychiatric Press.

van der Kolk, B. (1989). The compulsion to repeat the trauma, reenactment, revictimization and masochism. *Psychiatric Clinics of North America*, 12, pp. 389–430.

van der Kolk, B. (1997) Post-traumatic Stress Disorder and Memory. *Psychiatric Times*, XIV: Issue 3, March, 1997.

van der Kolk, B. & Saporta, J. (1991). The biological response to psychic trauma; mechanisms and treatment of intrusion and numbing. *Anxiety Research*, 4, 199-212.

Wilson, J., Freeman, M., & Lindy, J., Eds. (2001) *Treating Psychological Trauma and PTSD*. New York: Guilford Press.

Winnicott, D. (1951) Transitional objects and transitional phenomena. In *Playing and Reality*, New York: Basic Books, 1971, pp.1–25.

Winnicott, D. (1965). Ego distortion in terms of true and false self. In *The Maturational Processes and the Facilitating Environment*. New York: International Universities Press.

Wolf, E. (1988) *Treating the Self: Elements of Clinical Self Psychology*. New York: Guilford.

Yalom, I. (1995). *The Theory and Practice of Group Psychotherapy* (4th ed.). New York: Basic Books.

Ziegler, M. & McEvoy, M. (2000). Hazardous Terrain: countertransference reactions in trauma groups. In R. Klein & V. Schermer (Eds.) *Group Psychotherapy for Psychological Trauma*. New York: Guilford Press, pp. 116–140.