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25

Group Interventions Following Trauma and Disaster

Suzanne B. Phillips and Robert H. Klein

The solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience. (Herman, 1997: p. 214)

The goal of this chapter will be to examine and demonstrate the suitability and efficacy of multiple different group interventions in the aftermath of trauma and disaster. Toward this end, the authors will address the nature and impact of traumatic events, common reactions, mediating variables and stages of recovery. They will develop the rationale for group interventions after trauma, delineate the specific core principles that underlie such interventions and provide a set of guidelines for conducting group interventions. The role of the leader, as well as a comparison of the salient differences between a trauma group and a psychotherapy group, will be highlighted. The proposed guidelines will be illustrated by examining evidenced-based group intervention models best suited to address the needs of diverse populations as those unfold across the time spectrum of trauma and recovery. Finally, the chapter will conclude with a consideration of the countertransference issues stirred in trauma group leaders and the necessary tenets of self-care needed to counteract secondary post-traumatic stress and vicarious traumatization.

Introduction

Traumatic events, be they natural disasters or man-made atrocities, push us to our limits. By definition, they overwhelm our usual abilities to cope and adjust, and call into question the basic assumptions that organize our experiences of self, relationships, the world and the human condition. In the case of disasters, the destruction that unfolds is thought to exceed the coping capacity of the affected community.

Traumatic events generally involve threats to life and bodily integrity; a close personal encounter with violence and death; witnessing an event that involves death, injury or threat to the physical integrity of another; or learning of the death, serious harm or injury of a family member. According to the *Diagnostic and Statistical Manual of Mental Disorders* (4th Ed.) 1994, the criteria for psychological trauma include the experience of intense fear, helplessness and horror. These most certainly are salient features in the definition of what is traumatic for many trauma survivors. However, intervention with uniformed personnel or combat veterans, suggests that while they may be quite traumatized in the aftermath of a critical incident or combat, their mission focus and battlefield mentality often overrides the experience of fear, helplessness or horror at the time the event occurs.

In this vein, some trauma experts (Shalev and Ursano, 2003) underscore the importance of broadening the dimensions of "trauma" to include the experiencing of other feelings including profound loss, be it concrete or symbolic; isolation like that experienced with captivity or kidnapping; dehumanization and degradation as in prisoners of war or rape victims; uncertainty as experienced by those waiting on rooftops during Hurricane Katrina; and a sense of incongruity with the assumptive world as rescue workers handling children's body parts. Shalev and Ursano suggest such incongruity to be at the core of mental traumatization.

Common Reactions to Trauma

The human response to trauma is a complex, integrated system of physical, psychological and neurophysiological reactions. These reactions manifest in symptom clusters in three categories: hyperarousal; intrusion or re-experiencing; constriction and avoidance. Hyperarousal, as described by Judith Herman (1997), is the persistent expectation of danger. It is reflected in an intense startle response, sleep difficulties, agitation, irritability, and anger common after experiencing a traumatic event. Intrusion involves the re-experiencing of the trauma in the form of intrusive and disruptive recollections, flashbacks, nightmares and traumatic memories. Traumatic memories, neurologically imprinted in the right brain as sensation during a state of hyperarousal to danger, are different from conscious narrative memory. The intrusive re-experiencing of trauma represents the continued attempt to assimilate the "imprint" of trauma. It most often persists longer than the symptoms of hyperarousal. The constriction or numbing that is frequently a response to trauma can constitute an escape from the traumatic situation by an altered state of consciousness. Manifested as the detached calm in the face of terror, rage or pain, this dissociative response is, as Herman suggests, "one of nature's small mercies, a protection against unbearable pain" (Herman, 1997: p. 43).

According to van der Kolk and McFarlane (1996), avoidance in the aftermath of trauma may take many different forms, including keeping away from reminders, ingesting drugs or alcohol in order to numb awareness of distressing emotional states, as well as the unconscious use of dissociation to keep unbearable aspects of experiences from consciousness. Avoidance differs from dissociative symptoms as it involves a more conscious withdrawal and detachment from everyday activities. It is frequently one of the most tenacious symptoms as a person feels relieved by putting constraints

on daily life to avoid re-experiencing the traumatic symptoms (Herman, 1997: p. 49).

It is important to recognize that most survivors experience these symptom clusters in the immediate aftermath of trauma. They appear to be "normal" reactions to an abnormal, terrifying and overwhelming situation. Such early symptoms tend to subside over time, usually within a matter of weeks for most survivors. Responses from the majority of individuals exposed to a traumatic event fail to meet criteria for a diagnosable mental disorder and will not need formal psychological intervention (McFarlane and Girolamo, 1996).

Accordingly, it is not the initial presence of such symptom clusters that mark any individual's responses to trauma as pathologic. Rather, it is their persistence, intensity, and disruptive impact on overall level of pre-morbid functioning that is critical to evaluate. If such symptoms do not begin to dissipate or resolve and cannot be overcome through the normal range of available personal, family and community supports, but instead continue to interfere with and disrupt more adaptive functioning, then careful professional assessment and treatment may be required.

Furthermore, because of the nature of the particular symptom clusters aroused in response to trauma and the social stigma that can be associated with the trauma and/or help-seeking behavior, the survivor may not come forward requesting help. Often it is those who know him/her who first recognize that the survivor is not doing well and does indeed need professional assistance. Similarly, there may be individuals suffering from lingering sub-clinical and/or delayed or disguised reactions that may require formal intervention to resolve.

Mediating Factors

The reaction to traumatic events and the persistence of post-traumatic stress cluster symptoms are a function of a number of factors that can exacerbate or mediate their impact. These factors include the nature of the event, meaning of the event, individual crisis experience variables, personal resiliency or vulnerability, and the networks of available social support.

Nature of the event

There is evidence that a man-made trauma, like rape or a terrorist attack, escalates more extreme responses than the pain and suffering caused by an accident or natural disaster (Herman, 1997). An event that involves unanticipated traumatic loss of life tends to be complicated as one is first assaulted with trauma and then expected to deal with loss (Rando, 1993). Events of catastrophic proportion like 9/11 which involve the elements of a man-made atrocity assaulting safety, the death of thousands and the loss of social networks, community structures, financial and personal resources spare no one in their impact. Similarly, wars like those waged in Iraq and Afghanistan involving multiple deployments, a different type of warfare, the lack of safe zones, the use of improvised explosive devices (IED's), and the risk of extensive injuries, escalate combat stress and post-traumatic stress disorder (PTSD).

Meaning of the event

According to van der Kolk, McFarlane, and Weisaeth, (1996) the critical element that makes an event traumatic for a survivor is the meaning s/he attributes to it. The survivor's assessment of it in terms of threat, helplessness, and overall impact on body, mind, spirit and future is more fundamental in terms of response than the event itself. Hence, what may be traumatic for one individual, need not be for another.

Individual crisis experience variables

The meaning and impact of a traumatic event is quite often a function of individual crisis experience variables such as degree of exposure, duration, proximity to the danger and/or relationship to the victim(s). For example, the location of children on a playground versus in the school when a sniper shoots other children, the amount of time someone is trapped in a vehicle after an accident, or witnessing the explosion of your friend in the vehicle immediately ahead of you all weigh into the meaning and impact of the event.

Personal vulnerability and resiliency

Children, the elderly, those who have a prior psychiatric diagnosis as well as physically ill or infirm are at higher risk for suffering from the impact of traumatic events. Similarly, factors such as culture, job, or gender may significantly affect the impact of trauma. Personal resiliency traits such as intelligence, problem-solving, spirituality, physical mastery, independence, social skills, artistic ability, and creativity have all been shown to offset the impact of trauma and foster recovery (Boss, 2006; Norman, 2000).

Available social support networks

The presence and connection to familiar networks of care and support have also proven to be a crucial variable in mediating responses during the acute stage of trauma (Ørner and Schnyder, 2003) Similarly, the unavailability of such support networks evident in the form of negative social appraisal can have an adverse impact as can be seen when a rape victim is blamed for her assault or when Vietnam Veterans suffer social stigmatization.

The time-line of trauma

Another factor that bears on the experience and impact of traumatic events is its phase-specific nature. Trauma unfolds across a time spectrum. Interventions, therefore, must be designed to address different needs at different points in time. The stages of trauma include:

1. The Acute Stage usually extends from the time of impact to the first four weeks;
2. The Post-Acute Stage, usually identified as the time when rescue is complete and recovery begins, may span from one to several months after the traumatic

event. This stage is often extended by additional unrecognized traumatic events like the impact of injury, loss of resources, relocation etc.;

3. The Long-term Stage is often considered to begin six months or more past the event. As seen after 9/11, with the closing of Ground Zero almost 9 months later, or the multiple deployments and combat stress experienced by those serving in the military, the long-term impact from trauma may unfold for many years thereafter.

A Rationale for Using Group Interventions to Address Trauma

How, then, might group interventions (either alone or in combination with other interventions) be useful in addressing responses to disaster and trauma? The rationale for the use of groups in such circumstances is based upon multiple considerations. To begin with, group psychotherapy has been a widely accepted treatment option for more than 50 years. Substantial evidence has been compiled attesting to the empirical effectiveness and cost-efficiency of group psychotherapy for the treatment of a variety of psychological as well as physical problems (Bergin and Garfield, 1990; Burlingame, MacKenzie, and Strauss, 2003; Burlingame, Fuhriman, & Mosier, 2003; Garfield & Bergin, 1994; Lambert, 2003).

Specifically with regard to the treatment of trauma, the current literature provides consistent evidence that group psychotherapy, regardless of type, is associated with favorable outcomes across a number of symptoms. PTSD and depression are the most commonly targeted symptoms, but efficacy has been demonstrated for a range of other symptoms as well including global distress, dissociation, low self-esteem and fear (Foy, Glynn, Schnurr, Janowski, Wattenberg, Marmar, and Gusman, 2000).

A critical component of group efficacy rests upon the notion that groups can provide a safe, nurturing, non-judgmental environments where participants can feel accepted and emotionally supported (Klein and Schermer, 2000; Klein and Phillips, 2008; Buchele and Spitz; 2004). This is especially valuable because groups can offer relief from the aloneness, isolation and disconnectedness that disaster survivors frequently feel. Group participants meet together with others who have endured similar frightening, overwhelming and deeply disturbing experiences. Such experiences are difficult to put into words and difficult to talk about with others.

A holding container can be established that enables group members to find their voices, share their experiences, disclose painful feelings, and find words for the unspeakable. The dreadful nature of such experiences, along with the accompanying feelings of shame, loss, rage and anguish, often interfere with and sometimes totally preclude broaching these concerns anywhere else, with anyone else, particularly in an on-going fashion. In fact, many trauma survivors find it difficult to seek help. Participating in a group with other survivors rather than seeking individual attention, can relieve the social stigma and cultural barriers that often impede help-seeking and enable emotionally isolated survivors to recognize that they are not alone.

Furthermore, the presence of other people in the group generates opportunities to reveal, validate and to bear witness to what has happened. In the process of so doing, members begin to restore their disrupted external connections with others as well as begin to repair the often profound rifts in their internal assumptive worlds

about themselves, relationships, life and the way the world usually works (Klein and Schermer, 2000; Kauffman, 2002). In the early stages, the very act of sharing information about what happened can quell misinformation and upsetting rumors. The group can provide a context for education and the proper dispersal of information, especially with regard to needed available resources and how to secure them. The courage, strength, compassion and resilience displayed by group members often serve to inspire participants and to stimulate a renewed sense of hope about the future.

By helping other group members, individual participants can both augment their own damaged sense of self-esteem and relieve the collective sense of helplessness survivors experience. In addition, groups enable members to share and learn new ways of self-care and new strategies for coping. The acquisition of such tools can promote healing and restore more effective levels of functioning. Finally, by providing opportunities for sharing, emotional support and new learning in a safe environment, groups can help disaster survivors to begin to repair their disrupted sense of trust in their leaders, the world around them, and other people (Schein, Spitz, Burlingame, Muskin, and Vargo, 2006; Klein and Schermer, 2000).

Core Principles: A Comparison of Trauma Groups and Psychotherapy Groups

Psychotherapy groups come in different sizes and shapes. So, too, do time-sensitive intervention groups following disaster and trauma. Different theoretical orientations have given rise to a host of different approaches, including psychodynamic, cognitive-behavioral and supportive models. The specific nature of the disaster situation has contributed to the development and implementation of a variety of group interventions. In the aftermath of 9/11 for example, the American Group Psychotherapy Association pioneered a series of group interventions that included both large and small groups, with different selection and composition criteria, and various leadership structures that met for varying lengths of time. These groups adopted different formats in pursuit of a variety of goals at different points in time following the disaster (Buchele and Spitz, 2004; Klein, Bernard, Thomas, Block, and Feirman, 2007; Klein and Thomas, 2003, 2005; Klein and Phillips, 2008). It is, therefore, an oversimplification to speak about a single type of group intervention for disaster.

Differences between trauma groups and psychotherapy groups

An important consideration in understanding group intervention for trauma and disaster is a clarification of the similarities and differences between trauma group interventions and psychotherapy groups in terms of therapeutic factors, group goals, the nature of the participants, leader roles and techniques.

Therapeutic factors

In terms of similarities, both types of groups clearly rely upon common therapeutic factors that underlie the efficacy of all groups (e.g., Yalom and Leszcz, 2005; Bernard et al., 2008). This is especially the case with regard to factors such as acceptance,

support, belonging, universalization, and establishing a sense of cohesion and trust in a safe environment. Both types of groups encourage self-expression, the sharing of information and emotional ventilation/catharsis. Each provides opportunities for new interpersonal learning to occur.

Goals

Decisions regarding the specific nature and form of any group intervention ideally should be based upon the overall purpose of the group, that is, what is it that one wishes to accomplish. Depending on the time and stage unfolding after trauma and disaster, we believe that the goals for group intervention would include safety, support of feelings, assessment, triage, normalization of responses, acceptance, development and facilitation of coping skills, recognition of resiliency traits, connection and restoration of functioning. The unspeakable is contained and defenses are supported.

These are different from the goals of most on-going outpatient psychotherapy groups. Regardless of the model, on-going outpatient psychotherapy groups work toward relief of anxiety, depression, interpersonal problems, discontent with life by facilitating change or development of existing personality structures over time. Toward this goal, the group is utilized to uncover or confront unconscious conflict, resistance, defense, and transference. The here-and-now in the group serves as an important new experience as well as a reference point toward examining historical patterns and transference reactions.

Participants

This fundamental difference in goals follows on from the fact that participants enter post-disaster groups under different circumstances, in a different state of mind and with different expectations compared to those who enter psychotherapy groups. More specifically, something unexpected and tragic has occurred which has left survivors feeling frightened and overwhelmed. Post-disaster group participants do not identify themselves as patients intent upon resolving conflicts in their own personal histories. They do not come into the group seeking treatment or psychotherapy. Rather, they see themselves as survivors, people who have experienced and emerged from a deeply disturbing situation. They are struggling to understand what has happened, to examine their own responses to the situation and to learn how to go on being. Frequently what is most helpful is psycho-education and emotional acceptance. In addition, participants may not wish to see the group leader as a psychotherapist with expertise in treating psychopathology. Rather, they want to view the leader as someone with expertise in dealing with trauma who can guide them through their terrible ordeal.

Role of leader

The goal of a group has a direct bearing on the role of the leader in the group. Specifically, s/he must make differential use of the available therapeutic factors, emphasizing the development of certain factors, that is, cohesion, while limiting the

operation of others, such as, transference analysis and insight. Working successfully with a group of disaster and trauma survivors requires that the group leader always remain aware that the group goal is to facilitate re-integration and recovery, not to uncover and work through unconscious material to promote personality change.

The traditionally more neutral and detached stance of the leader in the psycho-therapy group must give way to one that can be best described as more emotionally-near and available. Skillful interpretations need to be replaced by modeling a compassionate presence. Because the sense of trust in self and other is often assaulted by trauma, the leader must be more attentive to providing clear structure, limiting disruptive anxiety, and carefully titrating emotional expression and exposure. S/he must help the group to make sense of what has happened, and what needs to occur for them to be able to cope more successfully.

With this in mind, the leader must be especially patient in post-disaster and trauma groups. S/he must allow the group to develop at its own pace, not push individual members to do more than they are capable of doing, and respect the fact that the group, as a whole, will need to go slowly. The typical stages of group development (MacKenzie, 1994, 1997; Brabender and Fallon, 2009) may at times seem delayed. However, it is important for the leader to recognize that re-establishing a sense of trust and re-connecting with others are core components at the heart of what is helpful in such groups. It is well worth spending additional group time and energy to ensure that participants feel heard and accepted, gain relief from isolation, learn about and normalize responses to disaster, and begin to re-discover their own voices.

Dealing with the here-and-now of the group is important in both psychotherapy and post-disaster groups. However, examination of the deeper, unconscious inter-personal patterns that are being replicated between members in the group does not constitute a primary focus for post-disaster groups. Emphasis is placed instead on helping participants to cope with their current life situations, normalizing their responses, and aiding them to assist and learn from one another in order to strengthen and support more adaptive functioning and thereby promote recovery. These efforts can best be served by making use of conscious and pre-conscious mental content, not probing for unconscious material.

Technique

Disaster intervention group leaders frequently make use of a variety of other tech-niques that they may not ordinarily use during their more traditional psychotherapy groups. These may include, for example, the use of mini-lectures, structured exercises, written materials, specific suggestions and guidance, homework assignments, etc. Many of the principles underlying the operation of short-term or time-limited groups are also relevant in this regard (MacKenzie, 1996; Klein, 1985).

In the aftermath of disaster, technique is often driven by circumstances. As described by Kauff and Kleinberg (2008), post-disaster groups are often conducted on site in the community, not in the safety and security of the mental health profes-sional's office. The surrounding situation may still remain frightening and chaotic. It is often the case that group service has been described and presented by someone other than the group leader, thus making it more difficult to establish a realistic and coherent group contract with the group participants. Furthermore, it may not be

possible for the group leader to attend to issues of group selection and composition, or to prepare members for what to expect and how best to make use of the group. In addition, many post-disaster groups are conducted in schools, community centers and organizations where group participants will continue to work with each other during and after the group. Determining what is safe to express in the group and what are the boundaries surrounding confidentiality may well take on additional meaning and importance.

General Guidelines for Group Intervention after Trauma and Disaster

The following is a list of general guidelines for group leaders who choose to utilize group interventions in the aftermath of trauma and disaster. They essentially reflect the core principles of response discussed above that should underscore group intervention regardless of the type of model being used. These guidelines are consistent with those endorsed by the American Group Psychotherapy Association (AGPA website; Bernard et al., 2008; Klein & Phillips, 2008).

- Try to restore, promote and ensure safety in the group. This is essential for any group treating trauma survivors, many of whom are stunned and dazed.
- Establish initial safety and mitigate anxiety levels by introduction of the leaders, and clarification of time, place and purpose of the group.
- Go slowly; it will take time to develop a climate of safety and trust in the group. Encourage members to join the group in their own ways and at their own pace. Let members know they can listen and participate as they wish.
- Remember that fears of stigma and cultural barriers may impede help-seeking and interfere with becoming a group member. Participants in such groups often enter burdened with deeper feelings of shame that may well be stimulated during the joining process.
- Utilize opportunities to normalize responses and provide information that legitimizes feelings, fears and physical symptoms in the aftermath of trauma. It is often useful to incorporate a psycho-educational component into the group.
- Model support, acceptance and active, non-judgmental listening.
- Try to remain experience-near, emotionally attuned and soothing to counter members, feelings of aloneness and isolation and to pave the way for subsequent interpersonal reconnection
- Highlight similarities/commonalities/universalities to relieve aloneness and to promote group cohesion.
- Pay careful attention to basics, especially with regard to establishing and examining boundaries and boundary violations (task boundaries; time boundaries; role boundaries; confidentiality boundaries).
- Recognize that the frame may be different in a trauma group. For example, outside social support and networking by members may be encouraged in the trauma group but not the typical outpatient psychotherapy group.
- Give members the opportunity to find their voices; to share/discuss accurate information about unfolding events and disclose their experiences.

- Remember that "emotional avoidance" may be an important and necessary defense for some in the early aftermath of trauma; trauma groups do not confront or challenge defenses, they support existing healthier structures.
- Contain/control the level of emotional stimulation and the anxiety level of the group; titrate stories of trauma so that group members can take in what is being said without becoming overwhelmed and re-traumatized.
- Assess in an on-going way and verbally check how speakers and listeners are doing with the material shared or feelings expressed. A critical aspect of the group as a container is its capacity to assist members to detoxify and metabolize what has happened and their roles in it.
- Attempt to re-establish trust; remember that this is a core issue and that members are likely to feel severely shaken, distrustful and suspicious.
- Encourage members to help one another, especially in terms of sharing coping strategies and self-care activities. Such activity enables individual members to experience increased self-esteem and relieves the collective sense of helplessness in the group.
- Facilitate members' use of existing family and social networks as well as fostering new networks of support. Promote the use of available resources both inside and outside the group.
- Look for opportunities to identify and support resiliency traits, such as: creativity, intelligence, spirituality, interpersonal strength, art, athletic ability, sense of humor, etc.
- Avoid making interpretations; stick with conscious material. Focus primarily on the current life situations, the here-and-now of the group, and what lies ahead.
- Make provisions prior to the group for managing referrals and emergency interventions, for those in need of immediate individual assessment, medications, or hospitalization.
- Be alert to members who manifest persistent, intense or incapacitating symptoms of anxiety, depression, and PTSD. Be aware that such responses may be triggered during group sessions; think through ahead of time interventions that could be used to deal with emotional over-arousal, re-experiencing, withdrawal or dissociation.
- Work with a co-leader, if possible. Co-leadership facilitates on-going assessment and individual member attention, if needed. It also affords support for the leaders in terms of containment of traumatic material, physical and emotional fatigue, processing of countertransference issues, and reducing vicarious traumatization.
- Establish an on-going relationship with a supervisor/consultant. It is especially important to be able to process leader responses outside of the immediate, often intense, emotional line of fire.
- If possible, participate in a support group for leaders where you can examine your own reactions.
- Monitor your countertransference responses; be alert to signs of vicarious traumatization in yourself, especially the cumulative effects of prolonged exposure.
- Be sure to take proper care of yourself; leaders who are emotionally overburdened, overworked and unsupported are more vulnerable and less effective.

Trauma Group Interventions

The following section contains examples of endorsed and evidenced-based group interventions applicable across the time spectrum of trauma and disaster. More detailed comprehensive discussions of time and population-specific group interventions can be found elsewhere (e.g., Klein and Phillips, 2008; Schein et al., 2003)

Acute stage

There is ample evidence that early psychosocial intervention is a crucial dimension to a comprehensive response to trauma and disaster (Ørner and Schnyder, 2003; Schein, Spitz, Burlingame, Muskin and Vargo, 2006). The most widely endorsed response in the acute stage of trauma is Psychological First Aid (PFA) (US Department of Health and Human Services, 2001). Psychological First Aid is defined as "a supportive and compassionate presence designed to reduce acute psychological distress and/or facilitate continued support, if necessary" (Everly and Flynn, 2005). The Core Actions of Psychological First Aid (Uhernik and Husson, 2009) include:

- Establish a human connection: non-intrusive, compassionate manner.
- Enhance immediate and on-going safety: physical and emotional comfort.
- Help survivors to articulate immediate needs and concerns.
- Connect survivors to social support networks, including family members, friends, and community helping resources.
- Support positive coping, acknowledge coping efforts and strengths.
- Offer practical assistance and information.
- Provide psycho-education.
- Refer to higher levels of care.

Given that trauma and disaster most often impact natural groupings, be they a family, community, corporation or school, it is important to note that these Core Actions can be effectively implemented in a group context. Group Psychological First Aid (GPF) was developed by Everly, Phillips, Kane, and Feldman (2006) for homogeneous cohorts who have experienced a traumatic event, such as a school team who has lost a member to a tragic accident, a bank staff who has faced a robbery, or uniformed service personnel (fire, police, emergency medical services and military) who have suffered a traumatic incident.

Group Psychological First Aid draws upon the pre-existing cohesion of the existing group as a protective factor and aims to reduce distress, assist with current needs, and promote adaptive functioning by active listening, normalizing, identifying coping skills, supporting and providing opportunities for higher levels of care. Unlike former debriefing models (Everly and Mitchell, 1999), this is a consensus model that does not elicit details of traumatic experiences and losses.

The Core Actions of Psychological First Aid can also be invaluable components of broader community, corporate or school programs that seek to restore the social networks of connection and care necessary for recovery after a traumatic event.

Post-acute stage interventions

As noted earlier, a number of group treatment interventions have proven effective in response to the diagnosis of PTSD or the prolonged presence of sub-clinical levels of symptom clusters of intrusion, hyperarousal, numbing and constriction, as well as anxiety, depression and substance abuse (Foy et al., 2000).

Two programs that have statistically demonstrated reduction of symptoms with adults include Trauma-Focus Group Therapy (TFGP) (Unger, Wattenberg, Foy, and Glynn, 2006) and Present Centered Supportive Group (PCGT) therapy for adult trauma survivors (Wattenberg, Unger, Foy, and Glynn, 2006). Both are time-limited programs that include a specific pre-determined number (often sixteen) of sessions.

TFGP draws upon the cognitive behavioral techniques of systematic prolonged exposure and cognitive restructuring to process each group member's trauma experience. More specifically, each member works at describing a personal narrative of trauma experiences in the context of non-judgmental group support. In addition, this model makes use of psycho-educational material for normalizing trauma reactions and supporting coping skills when dealing with trauma-related reminders and symptoms.

PCGT is based on the finding that inherent in the suffering of trauma survivors is the inability to observe themselves in relation to their current physical and interpersonal situation because trauma-based intrusions, affects and attitudes interfere with their daily and automatic processing of new information. The dual focus of PCGT includes Symptoms That Diminish Attention to Everyday Life and Trauma-Based Alteration in Beliefs, Attitudes, Habits and Behaviors. The main objective is to support movement from a trauma-based worldview to a broader perspective that includes the present environment.

Less structured than TFGP, this model involves an active leader working to facilitate client strengths, process encouraging interventions and keep the here-and-now focus. Interpersonal comfort is supported. The flexibility of this model has proven effective as an adjunctive intervention to other types of intervention. Both TFGP and PCGT have been used effectively with civilian and veteran populations.

Long-term intervention

Regardless of the model used, an understanding of the issues related to the longer-term impact of trauma or disaster are crucial for effective intervention (Cecil Rice, 2004). It is worth recognizing, for example, that the unconscious is not bound by literal time. Traumatic memory and intrusions can haunt survivors for years. It is often the avoidance of such triggers that causes a survivor to withdraw from life and remain locked in the past.

Traumatic intrusions whether manifested as feelings and sensations on anniversary events or in traumatic memories and on-going nightmares can be contained, understood, normalized, and addressed in group treatment. With intervention, they can become opportunities for healing and integration.

Long-term trauma centered group therapy

An excellent example of a long-term group intervention for trauma is the model described in *Trauma Centered Group Psychotherapy for Women* by Lubin and Johnson (2008). This model addresses the historical, chronic, childhood and adult trauma of women in a way that integrates cognitive behavior, exposure, supportive and psychodynamic perspectives and techniques. Accordingly, it accomplishes two tasks rarely found together in most models. It uses a manualized protocol that enhances the possibility of quality control and assessment, and it recognizes the power of group dynamics and the *group process* as a crucial component and therapeutic change agent for addressing the interpersonal ramifications of traumatic experience.

Care of the Trauma Group Leader

It almost goes without saying that the trauma group leader must be willing to enter into and contain the feelings, words and protective patterns ancillary to the insult of childhood or adult trauma, natural disaster, war and catastrophic violence. To do so, one must put himself/herself in harm's way (Stamm, 1999). As such, there will be inevitable countertransference reactions which can include feelings of helplessness, anger, empathy, fear, and over identification, etc. (Phillips, 2004; Klein and Phillips, 2008; Pearlman and Saakvitne, 1995). There are times when a trauma group leader may actually experience Secondary Posttraumatic Stress (SPTSD), that is, the same cluster of PTSD symptoms of hyperarousal (cannot relax, sleep, concentrate), intrusion (nightmares, traumatic memories, intrusive thoughts), numbing (protection by not feeling) and avoidance (personally and professionally) suffered by those with whom he/she is working.

As identified by Pearlman and Saakvitne (1995) it is not uncommon for those working with trauma to suffer vicarious traumatization in addition to SPTSD. Vicarious Traumatization includes an altered and negative view of self, the world, and one's capacity to access joy, hope and maintain connection with others. Pearlman and Saakvitne offer guidelines for ameliorating Vicarious Traumatization which include the ABC's of self care: *Assessment* of needs and limitations, *Balance* of personal and professional life; and *Connection* to others professionally and personally (Saakvitne and Pearlman, 1995; Pearlman, 1999; Stamm, 1999).

Group programs for leader self-care

It has been the experience of the authors and other AGPA colleagues who have offered "Care of the Caregiver" programs both nationally and internationally that the use of a group venue to address the impact of trauma on caregivers is invaluable (Andronico, Cleary, Einhorn, Miller, Shapiro, Spitz, and Ulman, 2008; Phillips, 2004). The group provides its members with opportunities to arrive at a deeper, more personal understanding of the potency and emotional impact of the psychoeducational material, specifically information on countertransference, SPTSD and vicarious traumatization.

It is the nature of caregivers whether civilian, uniformed service or military to prefer to be "trained rather than treated." A group venue that offers caregivers, in some cases, the first "safe" opportunity to hear about the impact of trauma on other caregivers and to disclose and bear witness to the unspeakable pain and suffering that they have held alone for others is therapeutic for all involved. A group program for caregivers offers an opportunity "to actually experience in the group context" the ABC's of caregiver care being recommended.

Summary and Conclusions

In this chapter we have described typical and pathologic responses to trauma and provided a rationale for the use of group interventions in the treatment of trauma. We have examined the phase-specific nature of responses to trauma, have identified a core set of principles that underlie group interventions by contrasting trauma and more traditional psychotherapy groups, and have provided a set of guidelines for the trauma group leader. Examples of evidenced-based trauma group intervention strategies and programs have been highlighted along with the role and techniques of the trauma group leader and the importance of self-care activities.

Our experience suggests that in order to work effectively with trauma survivors group leaders require special preparation and training. Such training, we would argue, must include not only increased intellectual understanding but opportunities for emotional exposure, sharing, support, inspiration and learning that can be best accomplished through the use of the group. Joining a network of trauma group leaders who meet in a group on a regular basis and are committed to self-scrutiny, new learning and mutual support can be invaluable.

We want to conclude by emphasizing that the world of trauma is dangerous territory to venture into alone. This is equally apt for both survivors and caretakers. Judith Herman, commenting upon the value of group for trauma survivors, states:

> Trauma isolates; the group re-creates a sense of belonging. Trauma shames and stigmatizes; the group bears witness and affirms. Trauma degrades the victim; the group exalts her. Trauma dehumanizes the victim; the group restores her humanity. (Herman, 1997: p. 214)

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