Introduction to Group Interventions for Trauma Survivors

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Abstract

Group interventions for trauma survivors offer cost-efficient opportunities for members to join "fellow strugglers" in coping with trauma-related feelings of alienation and mistrust. For adults, supportive, psychodynamic, and cognitive-behavioral models have been described in the literature, each offering common as well as unique group therapy features. For older children and adolescents, "integrated" and cognitive-behavioral models are available, and there is general empirical support for the use of group therapy regardless of the model chosen. Group psychological debriefing immediately following trauma exposure may be useful for normalizing reactions, but evidence for its effectiveness in preventing trauma-related psychopathology is lacking.

In this introductory article we present a rationale for group treatment of trauma-related distress and an overview of several models of group intervention for individuals exposed to life-threatening violence: 1) supportive, 2) psychodynamic, and 3) cognitive-behavioral groups for adults; 4) groups for children and adolescents; and 5) psychological debriefing. For adult survivors of trauma, supportive, psychodynamic, and cognitive behavioral models of group therapy that are represented in the literature are described here. Two types of adaptations of group therapies for use with children and adolescents, "integrated" and cognitive-behavioral models, are then discussed. We also provide a brief description of psychological debriefing as it is currently represented in the literature. First, we present a brief review of several advantages offered by group therapy. Next, for each type of group intervention a brief description of typical procedures is presented, along with a review of its demonstrated effectiveness. Finally, we discuss current limitations in our knowledge of group interventions, and identify areas that require further investigation and development.

Relevance of group therapy to trauma treatment

By their very nature, many traumatic experiences involve interpersonal violence (e.g. rape, physical assault, domestic violence, torture, or combat) and vividly illustrate how humans are capable of inflicting terrible harm on others. Other traumas, especially those resulting from natural disasters or accidents, may not involve interpersonal violence per se, but they do evoke individual reactions of fear, helplessness, or horror. These emotions may cause survivors to question whether others are really available to assist and support them in times of extreme need, and may result in a subsequent disruption of trust.

The disruption in interpersonal trust seen so frequently in trauma survivors is reflected in the classic posttrauma avoidance reaction, the feeling of profound detachment or estrangement from others.

The appeal of group interventions for trauma survivors rests, to a large extent, on the clear relevance of joining with others in therapeutic work when coping with victimization consequences such as isolation, alienation, and diminished feelings. A group intervention seems even more suitable for populations such as Vietnam veterans or sexual assault survivors, who often feel ostracized from the larger society, or even judged and blamed for their predicament. Bonding with similar others in a supportive environment can be a critical step toward regaining trust. Beyond its obvious cost advantage, group therapy may be particularly useful for those individuals who fail to meet common assumptions (e.g., psychological mindedness and responsibility for life choices and outcomes) thought necessary for individual psychotherapy (Klein & Schermer, 2000).

Group therapies for adults with PTSD may be sorted into three approaches: "supportive", "psychodynamic", or "cognitive-behavioral". These methods differ in their theoretical models of symptom development and therapeutic intervention, but they share a set of key features that build a therapeutic, safe, and respectful environment. These features include: 1) group membership determined by shared type of trauma (e.g., combat veterans or adult survivors of child abuse); 2) disclosure and validation of the traumatic experience; 3) normalization of trauma-related responses; 4) validation of behaviors required for survival during the time of the trauma; and 5) challenge to the idea that the non-traumatized therapist cannot be helpful through the presence of fellow survivors in the group.

Group treatments for trauma-related distress do not use a “process-oriented” approach to treatment; the key therapeutic ingredient is not the recreation and processing of family of origin dynamics within the group relationships. Instead, the three approaches take one of two directions for addressing the members’ traumatic experiences: covering or uncovering. Supportive group therapies “cover” the trauma event by maintaining attention to daily coping and adaptation, whereas psychodynamic or cognitive-behavioral therapies “uncover” the experience by focusing intentionally on discussion of the event and members’ memories of their experiences.

Supportive Group Therapy

The term "supportive" includes a variety of modified process group interventions that attend to current life issues and coping. These groups capitalize on the intrinsic therapeutic qualities of groups (e.g., normalization and cohesion; Yalom, 1995) and enhance the strengths of group members to cope with post-trauma symptoms (e.g., intrusions, avoidance/numbing, and hyperarousal) that can interfere with tasks of daily living. Supportive group therapy places little attention on the details of traumatic events; instead, the focus lies on group validation of the impact of trauma experience. Group leaders encourage exploration of affects such as hurt, disappointment, frustration, or happiness. The supportive group is also useful in diffusing extreme affects (e.g., terror, rage) associated with physiological hyperarousal. There are restricted demands on group members in supportive approaches: transference is downplayed, homework and challenging skill building are limited, and the group environment generally remains comfortable.

Supportive groups may be conducted in clinical or community settings, and they are amenable to an "open" format, which allows for new members to be added during the life of the group. Groups often meet weekly, and number of sessions recorded in the treatment literature range from 10 to 15 (Foy, et al., 2000). Supportive groups often provide the key opportunity for developing positive cohort relationships in PTSD treatment programs. This modality may be used as the primary method of treatment, as preparation for additional therapy, or as an adjunctive treatment to individual therapy or trauma-focused group therapy. A review of literature examining the efficacy of supportive group therapy models indicates improvements in symptoms such as depression, anxiety and self-esteem. However, specific post-trauma symptoms, such as PTSD, were not measured in these studies (Foy, et al., 2000).

Psychodynamic Focus Group Therapy

Psychodynamic group treatments for trauma-related distress uncover the experience of trauma and the meaning attached to reactions and continued symptoms. In a psychodynamic perspective, the key ingredient of successful treatment is clarification of the internalized model of self and relationships to others surrounding the experience and aftermath of the trauma. During psychodynamic group treatment, group members consider their conscious and unconscious self-concepts that reflect feelings of weakness and strength evoked by the trauma. Treatment examines these self-representations as they are related to current conflicted views of the self and to self-representations from early attachment.

The group provides a safe context to disclose the experience of the event, as well as to explore potentially harmful implicit assumptions about the meaning of the trauma. In effective treatment, group members are able to create an accurate narrative of their trauma experience that includes important pre and post-event interactions. During the retelling of their trauma stories, members may experience affective reactions that move from anxiety about disclosure, to fear and intense hurt during the description of the trauma event, to a later sense of relief or calm as the safety of telling the story in the group is internalized. Affective responses to the stories are monitored by the group leaders, to help prevent members from being emotionally overwhelmed or having dissociative reactions triggered. The affective reactions to the trauma material may be associated with views of self and other, which often represent irrational assumptions of blame, need for control, or a so-called "rational" world-view.

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

Cognitive Behavioral Focus Group Therapy

In cognitive-behavioral group treatment effective therapy reduces current trauma-related symptoms, and provides members with skills to cope successfully with

exacerbations of chronic symptoms. Cognitive-behavioral focus group therapy uses systematic prolonged exposure and cognitive restructuring techniques to process each group member's trauma experience (Foy, et al., 1997). Each group member has the opportunity to recount his or her story as others listen. Therefore, group members take part in trauma processing through both direct experience of their own trauma event, as well as vicarious experiences of others'. Cognitive-behavioral group models encourage both the strength of personal narrative, as well as the power of group support; members "stand together" and hear the experiences of others without judgment.

Psychoeducational material regarding relapse prevention and coping skills bolsters the group member's resources for response to current and future PTSD symptoms (Foy, et al., 1997). Acknowledging the need for support in chronic distress takes into account the frequently intractable nature of chronic PTSD, as symptom exacerbation (or "relapse") remains an ongoing challenge for group members.

Each of six studies examining the efficacy of cognitive-behavioral group treatment demonstrated improvements in group members' distress at the end of treatment. The groups represented a variety of trauma populations (e.g., sexual assault, adult survivors of abuse, and combat veterans). The variety of cognitive behavioral techniques represented in these groups included the following: cognitive processing therapy, assertiveness training, stress inoculation, and affect management. The groups met, usually weekly, for a range from 6 to 16 weeks. All six studies assessed PTSD symptoms directly (Foy, et al., 2000).

Two recent group treatment outcome studies represent a specialized subset of cognitive-behavioral approaches (Morgan & Cummings, 1999; Stalker & Fry, 1999).

Both studies used a feminist approach to address the recovery needs of adult female survivors of child sexual abuse. These treatment models capitalized on group cohesion and mutual respect as members processed their trauma experiences, challenged self-blame, and uncovered relational disturbances created by the trauma. Psychoeducational resources were used to increase knowledge of societal influences on sexual abuse, posttraumatic stress symptoms, and effective coping strategies. Morgan and Cummings (1999) reported that members of a 20-week group treatment following this feminist empowerment model demonstrated a significant decrease in depression, social maladjustment, self-blame, and posttraumatic stress symptoms, as compared with a community control sample. Participants in a 10-week, short-term group model based on a feminist approach also showed a decrease in symptoms; however, this improvement was not significantly different from a comparison group receiving 10 weeks of individual treatment based on the same model. In addition, almost 50% of the women in this short-term treatment sought further treatment during the follow-up period (Stalker & Fry, 1999).

Group therapy for children and adolescents exposed to trauma

The rationale for using group therapy methods with children and adolescents is much the same as for adults: it offers advantages over individual therapy in providing a safe, shared therapeutic environment where children who have survived terrible experiences can normalize their reactions and provide support for each other while processing their traumas. A recent review of group therapy studies on child and adolescent trauma (Reeker, Ensing, & Elliott, 1997) revealed that two theoretically

different models, “integrated” and cognitive-behavioral, were predominant among the 15 studies meeting empirical selection criteria for the review.

Integrated group therapy for children and adolescents usually involves a collection of techniques (e.g., exploration of feelings, art therapy, play therapy, puppet work, prevention of future sexual abuse) drawn from several theoretical traditions, including cognitive-behavioral. Conversely, cognitive-behavioral group therapy (e.g. Stauffer& Deblinger, 1996) includes the familiar elements of psychoeducation, coping skills training, exposure therapy, and cognitive restructuring. Groups of both types typically include a series of 8-24 weekly sessions. Most often, groups are composed of same gender members, although mixed groups have been reported, especially for younger children (Reeker, et al., 1997). Similarly, groups have most frequently been composed of children within the same developmental stage, although a few reports have included members whose ages range across the developmental spectrum from early childhood through late adolescence.

Although there is ample evidence that children may be even more at risk for exposure to both family and community sources of violence than adults (e.g. Kilpatrick, et al., 2000), the empirical literature on group therapy for children exposed to trauma is sparse and almost exclusively concerned with child sexual abuse survivors. Furthermore, there are no randomized controlled trials reported to date; most studies have presented results from single group pre-post designs where comparison groups were not included. As is true of the adult group therapy literature, there are many more child studies with female participants; thus, males are underrepresented in the empirical base of our current knowledge about group therapy treatment effects. However, positive treatment effect

sizes for group therapy with traumatized children reported by Reeker, et al. (1997) compare favorably to effect sizes for general group and individual psychotherapy for children reported by Weisz, Weiss, Han, Granger, and Morton (1995).

Psychological Debriefing following disaster

In the immediate wake of trauma, psychological debriefing (PD) is increasingly offered as a preventative and inclusive intervention. >From a historical perspective, the U.S. military's recognition of the need to care for traumatized WWII soldiers led to the development of so-called "stress debriefing" more than 50 years ago (Shalev & Ursano, 1990). Since then, a number of brief psychological crisis interventions have emerged, including models primarily for emergency service personnel described by Mitchell (1983), Raphael (1986), and Dyregrov (1989). These have since evolved and have served as prototypes for other derivative approaches. Similar models of PD have been applied to groups of children and adolescents (c.f. Wraith, 2000). PD includes many of the key features of group therapies, including disclosure, validation, and normalization of reactions. It is not a standardized intervention; the term "debriefing" is applied to a variety of similar and dissimilar models.

Bisson, McFarlane, and Rose (2000) have defined PD as "a single-session semistructured crisis intervention designed to reduce and prevent unwanted psychological sequelae following traumatic events by promoting emotional processing through the ventilation and normalization of reactions and preparation for future experiences" (p. 555). Debriefing is usually an early (e.g. 1-3 days post-trauma) group intervention, facilitated by mental health professionals or trained peers. Usually, PD includes some or

all of the following: 1) an introduction to the rationale and methods of PD to group members; 2) explanation of confidentiality; 3) time to describe traumatic events and discuss initial reactions; 4) time for describing emotional responses to the experience; 5) discussion of the recognition, normalization, and management of symptoms; 6) discussion of implementing knowledge and coping strategies; and 7) identification of internal and external sources of support. The aforementioned draws attention to a critical issue in evaluating the effectiveness of PD- i.e. the lack of clarity regarding what actually constitutes PD.

Although PD is widely used and is often described as helpful by recipients, it's effectiveness is hotly debated. Relatively current, comprehensive reviews of the efficacy research on PD are available in Neria & Solomon (2000) and Bisson, McFarland, & Rose (2000). While proponents argue for its effectiveness in reducing trauma distress, opponents argue that PD is ineffective, and perhaps even harmful. When examined critically, it is clear that most of the PD studies are plagued by methodological problems, the first of which is the lack of standardization across interventions noted above. Inconsistencies are found in method, timing, duration, trauma type, recipients, and facilitator training. In addition, few of the studies include appropriate control groups. The lack of randomized control groups, baseline data on symptom type and duration, and limited statistical power, as well as apparent self-selection of participants, are also problematic.

Although there is little evidence to suggest that PD reduces or prevents unwanted psychological sequelae, studies suggesting that it is ineffective or harmful are also limited and inconclusive. Bisson et al. (2000) concluded that "overall, the impact of early PD

was neutral when all the identified studies were considered collectively" (p. 556). What emerges from our brief review is the need for randomized controlled studies, designed to address the concern of delaying or limiting access to PD when it is thought to be helpful.

Final Summary

Taken together, articles on the various forms of group therapies for trauma survivors present an impressive array of available interventions. Furthermore, the literature shows that considerable progress has been made toward building a firm base of empirical support for using group interventions. Studies of group psychotherapy for adults, children, and adolescents consistently report positive treatment effects. At present, however, there is no evidence of the superiority of one particular model of group therapy over another. In this early stage of empirical evaluation of group therapies, only one recent study (Schnurr, et al, 2001), for which final results are not yet available, has directly compared efficacies of two types of group therapy (cognitive-behavioral trauma focus vs supportive). In addition to the limited comparisons, current group therapy outcome studies are over-represented by female (vs male or mixed) samples and by childhood sexual abuse survivors as the trauma population studied.

Empirical support for PD, perhaps the most commonly used form of group trauma intervention, is less consistent. Although there is support for selective use of debriefing for education and normalization of trauma reactions, there is no clear evidence that the intervention reduces or prevents trauma-related psychopathology. Future studies on debriefing, as well as studies on group psychotherapy, need to incorporate control groups and uniformity in treatment components in their designs.

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