CHAPTER 2

Overview of the Trauma Recovery Group

THEORETICAL INFLUENCES ON THE TRG

As we noted in Chapter 1, the TRG is based on a feminist analysis of interpersonal violence and a stage-based model of trauma recovery. In regard to its theoretical orientation, the TRG integrates various treatment approaches but is most strongly influenced by psychodynamic and cognitive-behavioral traditions. The development of the TRG was informed by James Mann's (1973/1996, p. 74) psychoanalytically based model of time-limited psychotherapy, which was "designed to take advantage of, to utilize constructively in the service of the patient, the element of time that . . . is so steadfastly avoided in the mental lives of both patients and therapists." The TRG is insight-oriented in its emphasis on the value of making conscious connections between past experiences (particularly past trauma) and present behavior. The group is based on a psychodynamic understanding of self in relation. The TRG recognizes the impact of early experiences and relationships with caregivers in shaping individuals' development and expectations of self and others. It assumes that "individuals repeat emotional and behavioral patterns that were of value to them when they attempted to solve difficulties in the past. . . . Interactions in the interpersonal field of a group often evoke these repetitious patterns, which are the essence of transference" (Rutan, Stone, & Shay, 2007, p. 81). Through exposure to a myriad of possible interactions, group psychotherapy provides unparalleled opportunities for "working through" these interpersonal patterns. In the TRG, this "working through" is focused on patterns and behaviors relevant to the member's trauma-related goal.

The TRG also incorporates several important aspects of CBT. The ultimate purpose of treatment is to effect behavioral change in the present in a domain of functioning that has been impacted by trauma. It also shares with CBT an emphasis on setting and tracking concrete and achievable goals. In its focus on retelling aspects of the trauma, the model recognizes the role of exposure and habituation in reducing the emotional valence of traumatic memories. Where faulty beliefs related to the experience of trauma are identified in the retelling, these are respectfully and empathically challenged by group members and leaders. Group leaders provide psychoeducation when appropriate, which is another feature shared with CBT approaches. Using Foy et al.'s (2001) formulation, detailed in the preceding chapter, the TRG can thus best be described as an "uncovering" rather than a "covering" approach to group trauma treatment.

GENERAL GOALS

The TRG has a number of overriding goals that resemble Yalom and Leszcz's (2005) description of curative factors in group therapy (but which are particularly salient for trauma survivors at the second stage of recovery) in addressing the negative impact of trauma on perceptions of self and others, an effect that frequently endures even after safety is established and symptoms have stabilized. The accomplishment of these general goals both facilitates and is promoted by participants' work on their individualized goals, which are described later in this chapter.

Relieving Shame

Shame is one of the enduring effects of chronic interpersonal trauma. Fonagy, Target, Gergely, Allen, and Bateman (2003, p. 445) describe the shame of the abused child as "an intense and destructive sense of self-disgust, verging on self-hatred." Participating in a group with fellow survivors can provide a powerful antidote to the shame and stigma often associated with traumas such as sexual abuse and domestic violence. The simple process of relating one's story in a safe and structured setting and recognizing one's commonalities with others who have been traumatized can be a tremendous relief for survivors who have borne the burden of silence for many years. Experiencing the acceptance of group members who have heard the survivor's story counteracts this impaired self-reference. The feminist orientation of the group also expands the reference frame for understanding experiences of violation from one of personal responsibility to one recognizing the broader societal problem.

Reducing Isolation

After experiencing trauma, it is common for survivors to feel an overwhelming sense of being alone and disconnected from others. Feelings of shame, trust difficulties, and trauma-related symptoms can all contribute to social withdrawal and impairments in interpersonal functioning. The experience of connecting with other group members who have had similar

experiences and difficulties is a powerful vehicle for combating these feelings of isolation as well as laying a foundation for enabling the survivor to connect or reconnect with safe others in their outside lives, which is one of the ultimate goals of the recovery process.

Promoting Mastery

Extreme feelings of helplessness are frequently a core component of the experience of trauma. Prolonged and repeated trauma can result in a pervasive sense of powerlessness, a phenomenon known in the psychological literature as "learned helplessness" (Seligman, 1972) and associated with depression and other ill effects on mental health. Furthermore, survivors often come to treatment with low self-esteem and a limited sense of personal agency. Through the process of choosing, pursuing, and then achieving a goal, group members discover that their intentions and actions can effectuate change. The mastery experience that the group celebrates is a powerful antidote to the feelings of helplessness attendant to victimization. It is for this reason that a lot of time and care is taken in defining a suitable goal, one that is both psychologically meaningful and realistically achievable. It has been our observation that, regardless of the nature of the individual goal pursued by members, the experience of doing so successfully promotes fundamental shifts in their sense of control and self-efficacy. It is hoped that survivors will leave the group not only with a sense of pride derived from this particular accomplishment but also with the skills and confidence to set and accomplish goals in other areas of their lives.

Promoting Empowerment

As noted in Chapter 1, the feminist vision of empowerment is a guiding philosophical underpinning of the TRG. The group promotes empowerment in a number of ways:

1. It brings survivors out of isolation and into connection with one another.
2. It counters the enforced passivity of social subordination with the psychological experiences of initiative and agency involved in accomplishing a goal.
3. It provides members with choice and control over the content of their therapeutic work.
4. It structures interactions in a way that conveys the notion that everyone is equal and deserves to be heard.
5. It gives the member opportunities to contribute to the goal accomplishment and healing of other survivors.
6. By providing a social and ecological analysis of interpersonal violence (Harvey, 1996), the group assists members in enlarging their understanding of what has happened to them so that they gain both an emotional and intellectual experience of solidarity.

By taking the initiative to participate in a group of this nature, the client is making a choice to take action on behalf of her own healing.

During the course of the group, participants will frequently evolve from feeling like victims to feeling like survivors. As Herman (1992b) notes in regard to the work of the second stage of recovery:

> Though the survivor is not responsible for the injury that was done to her, she is responsible for her recovery. Paradoxically, acceptance of this apparent injustice is the beginning of empowerment. The only way that the survivor can take full control of her recovery is to take responsibility for it. The only way she can discover her undestroyed strengths is to use them to their fullest. (p. 192)

Modeling Healthy Relationships

As was noted in Chapter 1, disruption in relational capacities is one of the hallmark effects of chronic interpersonal trauma. As Pearlman and Courtois (2005) observe, many symptoms of PTSD are interpersonal in nature (e.g., avoidance of people that trigger recollection of the trauma, feelings of detachment or alienation, irritability). At the same time, these problems make it hard for others to relate to traumatized individuals, compounding their isolation and cutting them off from the social support that has been found to buffer the effects of trauma. These problems are even more complicated for survivors who have experienced severe cumulative trauma and/or were harmed or abandoned by primary care givers or attachment figures. Adult survivors of childhood abuse frequently experience sensitivity to rejection, abandonment fears, unstable and chaotic relationships, problems in trusting others, and ambivalence regarding intimacy (Briere & Jordan, 2009). Survivor relationships often consist of victim–perpetrator bonds and dynamics that may be expressed in repeated abusive relationships and high rates of revictimization (Cloitre et al., 2006).

Safe attachment has been identified as an important indicator of recovery status among abuse survivors (Tummala-Narra, Liang, & Harvey, 2007). The highly structured format for peer interaction in the group allows for individuals to form safe connections and attachments with one another that are based on mutual support and reciprocity. Furthermore, the co-leaders, in their interactions with each other and with group members, provide an experience of caring and respectful authority figures collaborating to promote the safety and growth of all participants. In this way, the group experience is designed to provide an alternative "template" that can be used by members to identify and cultivate safe and mutually supportive relationships outside of the group.

Integrating Past and Present, Memory and Affect

Courtois et al. (2009) describe the primary accomplishment of Stage 2 of recovery as the development of a progressively elaborated and coherent autobiographical narrative based on safe, self-reflective disclosure of traumatic memories and associated reactions. Harvey (1996, p. 12) notes that "in recovery, memory and affect are joined. The past is remembered with feeling. Cognitive recollections of traumatic events include some remembrance and incorporate some re-experiencing of the affects and bodily states that initially accompa-

nied those events." She adds that memories are also interwoven with new feelings born of remembering and reflecting on the past. In the TRG, the focus on a goal that is related to each client's trauma history and relevant to her present life provides a context for disclosure and making connections between past and present. Integration of memory and affect is promoted as members gradually share relevant traumatic memories, and they are assisted by the group leaders and other members in noticing and differentiating feelings associated both with remembering these experiences and sharing them in the group. Where necessary, group leaders intervene either to deepen the connection between memory and affect or to promote affective modulation so that the client's information-processing capacity is preserved. Group leaders also help members to integrate the feedback they receive from the group into their stories, often resulting in dramatic shifts in members' understanding of their experiences. Techniques for facilitating such integration are examined and exemplified in Chapters 4–6, which cover the implementation of the TRG approach.

Providing a Future Orientation

One of the hallmark effects of psychological trauma is a foreshortened sense of the future. Survivors are frequently preoccupied by past events and may feel hopeless about the possibility of change. The act of planning a goal and taking action toward that goal can be extremely helpful in fostering a newfound sense of hope for the future. Also, because survivors are often at different points even within this second stage of recovery, participating in a group with others who may be earlier or further along in the recovery process can promote both a sense of accomplishment and hopefulness for what lies ahead.

KEY ELEMENTS

The TRG has six key elements that define its structure and make it unique relative to other group models. The TRG is *trauma-focused*. It is *time-limited* and *goal-oriented*. It is structured by the technique of *time sharing*, which ensures equal participation. Its *process is supportive*, with emphasis on learning to give and receive empathic feedback. Finally, we strongly recommend *co-leadership* of the group as the ideal model, with the understanding that many circumstances may make this ideal impossible to realize. These basic characteristics are described in detail below.

Focus on Trauma

As a Stage 2 group, the TRG is trauma-focused in that it involves the exploration and processing of relevant traumatic memories as members work on their present-oriented goals. As Herman (1992b) notes, work at this stage of recovery involves reconstructing the story, transforming traumatic memories, and mourning losses associated with the trauma. During the early sessions of the group, members tell the group their story as a means of contextualizing their goal and its relation to their trauma. In doing so, participants also place

their trauma in the context of their life and developmental history. In this process, it is not uncommon for members to broaden their perspective on the aspects of their history that they perceive as contributing to their current difficulties. For example, a member who came to the group reporting a history of physically abusive adult relationships realized how her family environment of emotional neglect and verbal abuse predisposed her to becoming involved in violent relationships in her teen years. She understood for the first time that she longed for attention and was not able to heed the warning signs that her partners would become physically violent, as she was so accustomed to the verbal abuse that preceded the physical violence.

For some clients, transformation of a traumatic memory may be the explicit goal of their group participation, for example, in the case of a survivor who indicated that she wants to be able to recall her abuse experience without experiencing a primary reaction of shame and self-blame. This client delayed the telling of the narrative, taking time to develop trust and to let herself and the group know what meaningful support might look like in response to her disclosure. She also made sure that she had several weeks after the telling to experience herself as part of a group that knew what happened and expressed respect and caring for her. This powerful experience of safe self-disclosure in the supportive relational context of the group environment had the power to enable her to transform her own self-loathing and shame. For others, transformation of memory may be incidental to their goal but also nonetheless an important aspect of their group participation. Members are most helpful in supporting one another deal with present-day issues if they understand what happened in the past. For example, a participant who worried that the perpetrator might abuse other young family members and wanted guidance on what to do now was asked about her past abuse experiences. What happened? Did she think anyone knew? If she told no adults, was it because she feared no one would believe her, and did she fear that would happen now with her young relative? Did she worry that the child would be further hurt by disclosure, and, if so, what steps could she take to prevent unnecessary harm? Looking back now as an adult, who might she have enlisted as a potential ally?

Another aspect of sharing the trauma narrative has to do with members who have already disclosed their story to family members and realize in the group that they did so without sharing any details of what happened to them or what the impact has been on them as adults (Schatzow & Herman, 1989). Although this more detailed disclosure may be met with a reaction similar to the original one, it creates a real opportunity for the survivor to give voice to the experience and hand the shame back to the perpetrators and bystanders. This type of disclosure can be enormously empowering so long as the client is not looking for acknowledgment but rather a chance to speak her truth. The goal for this member could be to prepare for this event, determining the best process for accomplishing it (e.g., a meeting in her therapist's office, a letter, or a phone call) and clarifying what she wants to say. It would be ideal if this event occurred over the course of the group sessions, but even if this were not possible, planning for such an event would be a very worthy goal. This type of work would not be possible in a Stage 1 group (where safety and self-care are not yet firmly established) because the process described above can be destabilizing for clients in early recovery.

Although formalized exposure procedures are not part of this group model, exposure and habituation take place as members revisit their trauma histories and retell their stories either as a means of contextualizing their goals or as part of their goal work. Group leaders assist members in working within the "therapeutic window" (Briere, 1996) in the ways we describe in subsequent chapters so that they are connected with affect but not overwhelmed by it. Questions asked and observations offered by group leaders and members facilitate the integration of thoughts and feelings associated with the trauma. We do not view exposure as sufficient in transforming the distortions in perceptions of self and others experienced by survivors of chronic and prolonged interpersonal trauma. In this regard, the experience of retelling the trauma story or parts of it in the relational context of the group is crucial. In response to the caring and empathetic feedback from other members who "bear witness" to the member's story, the client's negative views of herself are challenged and ultimately give way to a more compassionate stance toward her own behavior and increased self-worth. Expectations that others in the wider community will be disapproving or abusive are also countered by the respectful and supportive reactions of group members. When such support is offered by respected group members with whom the client identifies and who have made themselves equally vulnerable within the group, this "corrective" feedback is much harder to dismiss than when it is provided by the client's individual therapist or the group leader. The individual therapist may be regarded as someone who is well meaning but could be "lying" about the supportive feedback because he or she just wants the client to feel better. In addition to receiving compassionate responses to her own story, each group member feels compassion for others. Often it is the authenticity of her own deeply felt experience that convinces a group member of the genuineness of others' compassion.

The third major task of the second stage of recovery involves mourning the losses associated with the trauma. As Herman (1992b) notes, coming to terms with these losses can be an extremely difficult and painful process. These losses may involve actual physical integrity as well as "internal psychological structures of a self securely attached to others" (p. 188). In addition, clients frequently mourn the loss of "possible futures" as they reflect on the ways in which their lives might have been different had the trauma not occurred. In the supportive context of the TRG, members inevitably grieve painful losses related to their histories. With the help of the group leaders where needed, the group is challenged to allow this grieving to occur without prematurely intervening to shut it down. Other members are usually an important source of encouragement and inspiration to clients in the midst of grieving, reminding them that grief does not last forever and that acknowledging and processing losses is an essential step before one can move on with life. This is a key component because many trauma survivors believe that effective coping means *never* mourning the losses. A common fear is "If I were to allow myself to feel the sadness, I would never, ever stop crying."

An important aspect of this mourning process frequently involves taking responsibility for behaviors and choices that the survivor ultimately regrets as well as finding ways to "put things right" in the present whenever possible. For example, Anna's group goal involved preparing herself to attend her son's college graduation. Anna reported a strained and distant relationship with her son, based on her guilt at not having protected him adequately

from his violent father and her awareness that he was angry toward her for this neglect. In preparing herself emotionally for this event, Anna expressed a lot of remorse for not being more protective. The group listened empathetically to her tearful confessions about the ways in which she perceived herself as having failed him. In the feedback, members who had themselves had a nonprotective parent appreciated the step that Anna had taken in assuming responsibility for her behavior, something their parents had never done. Group members also noted how Anna's real fear for her own safety had kept her paralyzed. Anna decided that she wanted to have a conversation with her son prior to his graduation expressing her feelings about not having intervened sufficiently and letting him know that she wanted to play a more active and supportive role in his life going forward if he were willing. Anna used her group time to rehearse what she would say and anticipate possible reactions from her son. Toward the end of the group sessions and prior to his graduation, Anna spoke with him. Although he continued to express hurt and anger, he also indicated that he was willing to work on improving their relationship. Anna concluded her time in group treatment saying that she felt more compassionate toward herself and more hopeful about the future of her relationship with her son.

Time Limit

The TRG is not an open-ended psychotherapy group but rather one deliberately designed to provide clients with a limited amount of time to accomplish their goals. This time limit encourages trauma survivors to engage in emotionally intense work that might not be possible for them in a more open-ended format. It also helps preserve the focus on goals as opposed to interpersonal process. Although we do not claim that all the work of recovery is completed within the time limit, we are teaching group members an important recovery skill: they learn that they can accomplish a piece of work by focusing in on a specific behavioral outcome and that this approach can be applied to other goals of recovery. Not everything has to be done at once. It is possible for a client to repeat the TRG group with a different goal. However, we generally recommend that clients take a break between groups in order to consolidate what they have achieved and have time to practice applying it in their daily lives.

Goal Orientation

A key component of the TRG is the selection by each client of a personally meaningful goal that is related to her trauma history and its present consequences. Individualized goals allow for specificity in tackling what each group member feels is particularly challenging about her trauma history. Given the range of tasks that survivors may face in this mid-stage of recovery, it makes sense to employ a model that allows each member to achieve mastery over the issue that she finds most salient. For some clients, this goal relates to residual trauma-related symptoms; for others, it pertains to the impact of trauma on their sense of self, relationships, or ability to participate in the wider world. As has been noted, the purpose of the individual goal is both to provide a structure and focus for the client's group

participation and to promote a sense of mastery and self-efficacy. The process of defining a goal begins in the initial intake interview and continues through the early stages of the group. Once the group member has defined a goal, the group tracks her progress, helps her to redefine her goal if necessary, and celebrates her success. During the concluding phase, members take stock of what they have achieved relative to their goals and consider their next therapeutic steps in light of their accomplishments.

The client's goal also provides a starting point and organizing framework for disclosing her trauma history and processing salient memories. During the early stage of the group treatment once goals have been identified, members talk about how those goals came to be important in their life. This process inevitably involves reviewing aspects of their trauma history and honing in on particular memories that were most influential. For some members, detailed retelling *is* their goal work—for example, in the case of a member who wants to be able to remain present in her body while recalling the trauma, or one who is preparing to disclose to a family member or significant other that she is an incest survivor. For others, retelling is undertaken with the purpose of separating fears and assumptions from the past from the reality of present situations relevant to their identified goals so that they are empowered to make choices rather than replay old trauma-based scripts.

When thinking about how to help members formulate useful goals, the leaders should be thinking about the particular tasks that members of their targeted population are facing. How might these tasks be accomplished in small steps? What are the psychological, socioeconomic, and political impediments to achieving these tasks? The process of taking large recovery issues, analyzing them, and breaking them down into concrete achievable goals may be a new skill for some therapists. Several guidelines for assisting clients in arriving at the goals that are most beneficial in counteracting the effects of trauma and promoting healing are detailed below:

- *The goal should be trauma-related.* Although this statement may sound self-evident given the nature of the group, it is important that all clients work on goals that are in some way related to their trauma history. While many clients may be simultaneously dealing with problems that are clearly not related to their histories of trauma, these should not be the focus of their work in the group.

- *The goal should be present-oriented.* Goals should relate to the impact of the client's trauma history on relevant aspects of her present functioning. It is important to explore which areas of her life continue to be affected by the trauma. Once she has identified some core areas, a common theme may emerge that can be honed into a goal for the group treatment. Alternatively, a particular area may stand out as most pressing in regard to the need for intervention.

- *The goal should be realistic and achievable.* Goals should be realistically achievable within the time span of the group treatment. If a goal seems too large or overly ambitious, it is crucial to reassess and modify it so that the client can ultimately experience a sense of mastery. For example, a client whose symptoms have interfered with her ability to maintain employment may come with a goal of getting back to work in her chosen profession. Apart

from any practical considerations involved in finding a suitable job, for someone who has not worked for some time it may be more realistic to start by finding and maintaining a volunteer job several hours per week. The client could use her group time to reflect on some of the challenges she confronts in doing so and how these relate to her trauma memories, and work on overcoming them as a step toward seeking paid employment.

- *The goal should be concrete.* It is important that the goal be adequately detailed and concretely defined that the client is able to recognize when it has been accomplished or how much progress she has made in doing so. The more measurable the goal, the better. For example, many clients come to the group with the somewhat vague goal of "feeling better about myself." For a particular client, this goal may be operationalized as "taking better care of myself," which may then be further developed and made more substantive as "engaging in at least one self-care activity each day." The client's group time could be spent reflecting on her reactions to engaging in self-care and the obstacles to doing so.

- *The goal should be specific.* Many clients come to the group with a goal that is overly broad. It is the task of the group leaders to help the client specify it sufficiently so that it can be accomplished while still retaining its significance to the client. For example, a client may enter the group with general goal of wanting to feel less isolated, whereupon this goal may be usefully recast as joining one or more social groups.

- *The goal setting should be collaborative.* While goals should be personally relevant and ultimately originate with the client, developing and refining the goals should be a collaborative process that is part of the work of the group. Although it is beneficial for clients to have some sense of a potential goal at the start of the group, it is expected that their goal may be transformed during the first few sessions. Even when one comes to the group with a relatively clear and well-defined goal, it is helpful to receive and incorporate feedback from the group leaders and the other members before committing oneself to its precise expression. It is also helpful for clients to share in developing their goal with their individual therapist to gain additional feedback from a person who is likely to have a more extensive knowledge of their history and abilities.

- *Goals can be renegotiated.* Members' goals are not "set in stone" for the duration of the group sessions; indeed, they often evolve over time as it becomes clearer what is and is not achievable during the time frame of the group. For example, a client may begin the group therapy with the goal of confronting a nonprotective parent. Over the course of the group sessions, she may decide that she is not emotionally ready to do so and may choose instead to have a conversation about her abuse with a sibling. Less frequently, after a few sessions a member may find that she has achieved her goal (e.g., telling the group about an episode of abuse without dissociating); in this case, she may choose to extend her goal, for example, to disclosing the abuse to her significant other in a connected way. Renegotiation of goals should be treated as an integral part of the therapeutic process so as to promote a sense of mastery and success and to discourage feelings of shame and failure.

- *Clients may have in-group or out-of-group goals.* Some clients select in-group goals that involve working directly on their goal during their group time. These goals often involve

disclosing a piece of the trauma narrative with affect and remaining present in the group while doing so. It is important that this retelling have relevance to a present-day difficulty. Alternatively, a client who struggles with trust difficulties related to her trauma may choose to work on the goal of allowing other members to know her better over the course of the therapy. Her work may involve sharing aspects of herself that she usually conceals and reflecting on her experience of doing so in the interpersonal context of the group. Other clients may work on out-of-group goals. For example, a client who experiences anxiety in social interactions with men may seek out such situations incrementally and use her group time to explore further her emotional and cognitive reactions and their connections to her trauma history. Alternatively, a group member may choose the goal of disclosing her abuse to members of her family and may use her group time to prepare herself for this disclosure. It has been our experience that out-of-group goals are generally easier to plan, recognize, and report back on, with attendant celebratory feedback. In considering the group as a whole, generally we recommend that members have a mix of in-group and out-of-group goals. When all or most members focus on in-group goals, this emphasis can create too much interpersonal intensity. It may also contribute to a feeling of not having sufficient time, since members' work is centered around what they are doing in the group rather than what other steps they may be taking outside the group.

The following illustration is offered of how a client's goal is first identified, refined, and then pursued over the course of the therapy. In the screening interview, "Cathy" stated that she would like her goal for the group to involve becoming less isolated. The group leaders encouraged her to think about ways to make this goal more specific and break it down into concrete steps in order to identify something that could be accomplished within the time frame of a 4-month treatment. At the start of the group, Cathy indicated that she had been talking about this goal with her therapist and had realized that she found it difficult to pursue new relationships because she worried about being perceived as needy or flawed. A group leader asked if there was anyone in her current life who she would like to know better, and she reported that there was someone at work who might be a potential friend, as they shared common interests. Her goal evolved into being able to ask her coworker to join her for lunch or coffee. In preparing to take this step, during the group's earliest sessions Cathy used some of her time to speak about her fears of being judged and their origin in her childhood environment, which was characterized by physical and verbal abuse. During succeeding sessions, Cathy described her experience of having been repeatedly humiliated by her father and brothers (and later by peers at school) when she made her needs and wishes known. She recalled painful feelings of shame associated with these experiences and reflected on how they ultimately led her to avoid initiating interpersonal relationships. Through empathic questioning and comments from group members, Cathy was able to recognize the ways in which her fears had kept her removed from the feedback that might normally counter the negative messages she had received in childhood. She was also reminded that she had no reason to expect that this particular coworker would reject her. Strengthened by this new perspective on her behavior and its consequences and encouraged by the acceptance she experienced from the group, Cathy indicated a readiness to act

on her goal. Group members shared examples of ways in which they had approached people that they had wanted to know better, helping Cathy decide how to approach her coworker. She also used her group time to speak about how she would manage feelings of disappointment if the advance were rebuffed and how, in reaching out, she would consider the goal accomplished irrespective of the recipient's response. Cathy approached her coworker and suggested that they meet for coffee one day after work. Her coworker responded positively, they met, and Cathy felt that they both enjoyed the interaction. The following week, her coworker invited her to see a movie together. During the next group session, Cathy shared these developments with the group, inciting both applause and other positive reinforcement. She was asked to reflect on the impact of this experience on her beliefs about others' negative perceptions about herself.

Time Sharing

During each session, usually about three members volunteer to work on their respective goals, and each member's "turn" is divided between sharing their perspectives and receiving feedback from others. This time-sharing approach enables members to work on their various goals without having to actively compete for time. It ensures that no single person will dominate the group, nor will anyone be overlooked or allowed to avoid participating. With its insistence on equal time sharing, the group models a community based on equal participation. This approach facilitates moving from the work of one person to the next. Dividing time between sharing and feedback recognizes the importance of reciprocity, empathy, and mutuality in relationships, concepts that are emphasized in feminist psychology (Surrey, Stiver, Miller, Kaplan, & Jordan, 1991). In taking responsibility for time keeping, the group leaders remove one of the most potentially contentious group process issues from the arena of conflict. How specifically to implement time sharing is described later (in the section on "Individual Session Format"). It is important to note here that, unlike the situation in process-oriented psychotherapy groups, structured time sharing requires that group leaders assume a very active and directive role in managing time and controlling group interactions. Co-leaders have to interrupt members to let them know when it is time to shift from sharing to feedback and when a member's "turn" is almost done. Especially during the early stages of the therapy, when members are becoming oriented to the group's procedures, leaders also sometimes need to intervene when a member strays off the topic or gives inappropriate feedback. Technical considerations in doing so are reviewed in Chapters 4–6 of this volume, on implementation of TRG therapy.

Supportive Process

Therapy groups for trauma survivors in the second stage of recovery generally manifest high cohesion and low conflict tolerance among members (Herman, 1992b). The TRG is intentionally structured to create an atmosphere of mutual support and interpersonal safety as members work on their goals. These supportive connections both sustain the member while she processes painful material from the past and also provide her with a new rela-

tional experience of safe attachment. This favorable environment is fostered in several ways. As noted above, providing for time sharing means that members do not have to actively vie for time within the group. Allocating a portion of time to the process of receiving feedback means that members who have volunteered to share in a session also have the experience of others attending and responding to them. They hear other members identifying with their experiences, offering empathy and compassion, expressing respectful curiosity, and sharing suggestions. This group model requires that members be attentive and engaged in the group even when it is not their turn to share. The group leaders model thoughtful and supportive feedback by making observations about what the member has shared and asking relevant questions, encouraging group members to do the same and thereby become active agents in one another's recovery. If a member is particularly withdrawn or dissociated, group leaders should notice and gently intervene to assist her in becoming more present and engaged by exploring with her what might help to facilitate her participation. Group leaders also check in with members often on how they are receiving the feedback that has been offered. If feedback is offered or heard with a critical tone, group leaders will intervene quickly to provide the speaker with an opportunity to reword her thoughts or reframe what she has said. Group leaders will also take careful note of how a member is responding to *positive* feedback, as this is often hard to take in fully. If needed, the leaders may deliberately slow down this process to help the member identify what gets in the way of internalizing feedback and find ways of making herself more receptive to listeners' feedback. For example, they may ask the sharing member what she is thinking or notices feeling in her body as she hears the feedback. If it appears that there are distortions in her understanding of the feedback, the group members providing it may be asked to reword what they have said or clarify their intentions and meaning.

As in any group situation, group members may feel a variety of negative feelings toward one another such as anger, dislike, and envy and competition based both on real interactions in the present group situation and projections from past relationships. Similarly, interpersonal conflicts are bound to arise. In process-oriented psychotherapy groups, the exploration of such reactions and conflicts is usually encouraged and ultimately facilitates members' "working through" the interpersonal problems that brought them to the group. In the TRG, these reactions and conflicts are typically *not* explored—for two reasons: (1) to maintain the focus on members' individual goals and (2) to preserve interpersonal safety and cohesiveness in the time-limited group. Usually, when such situations arise, the co-leaders may intervene by acknowledging the feelings or conflict being expressed and explaining that these feelings should be explored further in members' individual therapy (for the reasons mentioned above). An exception may be made when a process issue is clearly relevant to a member's individualized goal. In this case, group leaders may frame the situation as an opportunity for the member to take steps toward her goal, either through increased understanding of self and other or through trying out a new interpersonal behavior. The example of Kate and Rose, below, may help to differentiate how interpersonal conflict is dealt with in the TRG as compared with a process-oriented group.

In her therapy group, Kate gives other members a lot of advice while sharing little of her own vulnerability. After this pattern occurred numerous times, Rose had an outburst

of frustration, accusing Kate of "acting like you're better than all of us." What should the group leaders do? The answer depends on the kind of group involved. In a process-oriented group, this kind of confrontation may present an opportunity for Kate to explore her feelings about being criticized in this manner, the ways in which her behavior may contribute to this perception, and the purpose that it serves. Rose might explore her feelings of anger and shame at Kate's perceived condescension and how this reaction relates to the interpersonal conflicts she experiences outside the group. The group leader would also likely elicit other group members' reactions to this situation if these were not readily expressed.

In contrast, in the TRG, the group leaders would intervene quickly to deescalate conflict and try to repair group cohesion. After briefly checking in with Kate about how she is feeling, the leaders would acknowledge that members may be having a variety of emotional reactions to the interpersonal conflict, reiterate the importance of mutual respect, and perhaps offer some psychoeducational comments about different interpersonal styles that members bring to a group. They might then provide Rose an opportunity to reword her feedback in a way that could be more helpful to Kate. If the interpersonal conflict is not relevant to the goals of either Kate or Rose, the group leaders would likely point to the goal focus and time limit of the group and encourage Kate and Rose to process their feelings further in individual therapy. In the rare case where this solution might not be sufficient, the group leaders could also meet with Kate and/or Rose outside of session (the group will always be informed of such a meeting) to help them find a way to manage their reactions sufficiently well to them to continue to participate in the group. These interventions would not occur in a process group, where there is an emphasis on keeping group interactions and process in the group.

If it were determined that the conflict was relevant to Kate's and/or Rose's goals, the leaders would solicit their agreement to continue processing this interaction during the member's respective turn. However, the processing would focus on the aspects of the interaction directly relevant to each one's goal rather than involve open-ended exploration about members' feelings about the conflict. For instance, if Rose's goal in group was to respond less reactively to certain interpersonal triggers, during her turn her reaction in this situation and its impact on Kate and the group could be explored, and Rose could be helped to identify more appropriate ways of managing and expressing her frustration. Similarly, if Kate's goal involved allowing herself to feel "known" by the group by sharing her feelings associated with her past trauma, her tendency to take on the "co-therapist" role could be understood as a way of avoiding this intimacy. During her turn, her fears of allowing herself to be vulnerable in the group could be explored, and the function of her behavior in keeping others at a distance could be better elucidated and understood. As part of her goal work, Kate might be specifically challenged to "step out of this role and experiment" by allowing herself to be a group member. The group might then be enlisted to help Kate monitor this behavior in a gentle and empathic manner.

Co-leadership

Co-leadership (i.e., two leaders conducting the group together) serves a number of specific purposes in the TRG. For the group members, effective co-leadership sets an example of

a relationship of mutuality and collaboration—in contrast to the relationships of domination and subordination that characterize the histories of so many clients. It provides an alternative experience of adult care taking in which power is shared and not abused. It models a cooperative and collective approach to solving problems and handling differences. It minimizes the ready attribution of power and control to a single person. It also communicates the idea that one person cannot "do it all" without support. Co-leadership also has important benefits for the group leaders. The logistics of managing the group from session to session (e.g., contacting others involved in members' care, following up clients who miss sessions) can be shared between two people. Within each session, therapists can share the tasks of attending to the overall group process and tracking individual clients and their goal-related progress. Last but not least, the co-leadership model provides therapists with peer support and feedback that are essential in preventing vicarious traumatization and burnout. Co-leadership is thus highly recommended despite the financial and human resource constraints that can complicate this arrangement.

It is important, however, that group leaders be also aware of the dynamics and complexities involved in co-leadership (for a review, see Delucia-Waack & Fauth, 2004). These dynamics are different for dyads involving dual leadership where one therapist has more experience and power than the other (e.g., in a training situation) versus co-therapy where two leaders are similar in experience and power (Rutan et al., 2007). For trauma survivors in particular, whenever such differences exist, it is crucial that the dynamic of domination and subordination not be reenacted in the leadership pairing (Herman, 1992b). Rutan et al. (2007) note that, irrespective of the specific circumstances of the shared leadership arrangement, several important principles apply: (1) leaders must have fundamental respect for each other, even when considerable differences in experience and skill exist; (2) leaders must allow for sufficient time to explore group process, members' relationships, and their own relationship; and (3) leaders should share a similar theoretical stance.

Having discussed the theoretical underpinnings of the TRG, its overall goals, and its six key features, we now provide an overview of the group. We review the requirements for group leaders and members before describing the details of the group framework and session structure. We conclude by describing some ways in which the work of the group can be reinforced and expanded between sessions.

OVERVIEW OF THE TRG

It is useful to conceptualize the TRG as beginning with a phase of preparation and screening that precedes the group sessions, which in turn unfold over three distinct stages or phases.

Preparation and Screening

Preparation for the TRG entails both establishing logistic arrangements for running the group (e.g., identifying the venue, the preferred time period, and the co-leaders) and ensur-

ing that co-leaders have sufficient familiarity with the treatment model as well as the requisite background and skills to conduct the group properly. A clinical interview with the group leader is considered the primary basis for determining each client's capacity to enter and participate in the psychotherapy group (Rutan et al., 2007). In the TRG, owing to the requirement that safety and stability be established prior to engaging clients in the trauma-focused work of a Stage 2 group as well as the importance of maximizing interpersonal safety in the group, thorough pregroup screening is of utmost importance. The screening process involves a detailed interview that evaluates clients' interest in group therapy, current symptoms, treatment history, coping skills and supports, and risk factors. The co-leaders provide clients with an overview of the group and its purpose and also begin a discussion about possible goals in the event that the client joins the group. With the client's consent, the group leaders also make collateral contacts with any others treating her to assess their support for the client's group participation, providing them with information about the group's structure and function and eliciting their assistance with goal definition. Through these screening procedures, the co-leaders determine whether the group is a good fit with the client's current treatment needs.

Introductory Sessions

The beginning sessions are focused on establishing a sense of safety, structure, and trust within the group as well as formulating individual participants' goals. After initial parameters are established through discussion of the group's purpose, structure, and guidelines, members gradually share information about their lives as they work to provide a context for their individual goals. In this process, members also begin to share their trauma history and its relationship to their goals, initially providing only limited details. Feedback from the group leaders and other members is an integral part of helping clients to define and then refine appropriate goals.

Goal-Work Sessions

As the group becomes more cohesive and members' goals become more clearly defined, the focus normally shifts from providing background context to actively taking steps toward concretely defining the goals that have been identified. As a Stage 2 group, the goal-work stage of the TRG involves some degree of affective sharing of trauma memories in the service of members' goals. Members share their unique traumatic experiences and associated feelings that are related to some ongoing life difficulty or challenge. This phase of the treatment process is charged with strong emotion as members confront painful memories, risk sharing them with others, and begin reaping the benefits of feeling understood and supported by the group. Once these affective and cognitive connections between past and present are made, members may use their group time to try some new behavior, or process more completely something they have done or realized, or reflect on obstacles to doing something that is needed. Feedback may be geared toward supplying support and encouragement, providing a different perspective, and/or making connections that the client had

not previously considered. About midway through the treatment, one or more members usually take significant steps toward accomplishing their goals, which provides impetus for others to do likewise.

Concluding Sessions

During the closing sessions, the group reviews the progress that everyone has made in achieving their goals and considers possible next steps and future wishes for each individual. Members reflect on their own progress during the treatment and hopefully they are able to feel a sense of mastery and accomplishment. The leaders provide feedback based on their observations and make recommendations regarding future areas of work for each member.

REQUIREMENTS FOR GROUP LEADERS

Unlike many other groups for trauma survivors, apart from some guidelines for the initial orientation to the group model, the TRG does not have an externally defined curriculum; rather, it is organized around each group member's individual goal work. The group leaders provide structure by taking responsibility for time sharing, ensuring that members' contributions and interactions are directed toward their goals, assisting members in modulating their emotional arousal during trauma processing, monitoring and containing group process, and providing psychoeducation as needed by the group. The specific themes arising in each TRG and the interventions required of leaders will differ, depending on the goals of group members and the specific composition of the group. Owing to this inherent variability, group leaders must be able to draw on a comprehensive understanding of the impact of trauma effects as well as diverse practical skills in working with traumatized clients, as detailed below. Their own access to consultation or supervision, in turn, is a key factor in supporting group leaders' active multifaceted role in successfully implementing TRG therapy.

Relevant Background, Knowledge, and Skills

The leaders of any TRG should be appropriately trained and qualified mental health professionals (e.g., psychologists, social workers, psychiatrists, psychiatric nurses) with experience in working with traumatized clients and facilitating therapy groups. They should be familiar with the clinical literature pertaining to the treatment of adult survivors of childhood abuse and other forms of complex trauma. They should also have a good understanding of group process and treatment. These areas of knowledge and skill are outlined in Table 2.1, with references to key sources containing this information. We suggest that co-leaders review these topics in order to facilitate self-assessment of readiness to conduct the TRG as well as to provide opportunities to acquire or strengthen needed skills. The risks of attempting to run this group without adequate educational background and prior experience include the possibility of retraumatizing members, which may result in compounded pain and the

TABLE 2.1. Required Group Leader Knowledge Base

Topic	Key references
Complex trauma and recovery	
Complex trauma • Characteristics of complex trauma • PTSD, dissociation, and other trauma-related disorders • Impact of trauma on developmental capacities and attachment • Neurobiological consequences of chronic trauma	• Briere & Scott (2006) • Courtois & Ford (2009) • Harvey & Tummala-Narra (2007) • Herman (1992b) • *Journal of Traumatic Stress* (2005) • Wilson, Friedman, & Lindy (2001)
The recovery process • Stages of recovery • Psychotherapy with trauma survivors ▪ Addressing trauma-related symptoms ▪ Enhancing affect modulation and interpersonal functioning ▪ Countertransference and vicarious traumatization • The role of group therapy in the recovery process	
Societal perspectives • Ecological model of trauma and recovery • Sociopolitical roots of interpersonal violence • Multicultural perspectives on trauma and recovery	
Group therapy	
Group therapy basics • Curative factors in group therapy • Stages of group development • Group dynamics • Preparing patients for group therapy • Change process in group psychotherapy	• Bernard & Mackenzie (1994) • Delucia-Waack, Gerrity, Kalodner, & Riva (2004) • Kaplan & Sadock (1994) • Klein & Schermer (2000) • Rutan, Stone, & Shay (2007) • Yalom & Leszcz (2005) • Young & Blake (1999)
Special considerations • Characteristics and types of groups • Special issues in time-limited group therapy • Group therapy with trauma survivors	

likelihood of avoiding future treatment. We strongly urge those considering co-leading a TRG to assess their own readiness objectively and to take sufficient time to acquire the knowledge base and skills we recommend.

The TRG treatment model requires active and responsive co-leaders who intervene readily to promote a sense of safety, maintain the group structure, and model empathetic feedback, particularly during the early stages of the group. Clinicians leading this type of group have to draw on a variety of clinical skills ranging from providing psychoeducation about the impact of trauma, to supporting the development of new interpersonal coping skills, to facilitating the exploration and processing of painful memories. This regimen requires that leaders have the ability to remain flexible and be able to apply whatever interventions are needed during the course of the group sessions. Although significant overlap and integration exist among the functions of the various cognitive-behavioral and dynamically based skills that are employed, a broad overview may help differentiate them, aided

by a close review of the case examples provided in the text. In general, such cognitive-behavioral skills as goal setting and tracking, directness in managing time and maintaining focus, containment, and psychoeducation are typically most useful in maintaining the structure of the group, focusing mindfully during periods of individual work, and providing ample opportunities for relevant learning experiences. More dynamically oriented skills are typically utilized to deepen the insights derived from individuals' goal work and include both interpretation and putting one's current behaviors into a developmental perspective. Leaders should also have a repertoire of skills gained from trauma-informed treatments upon which to draw, especially ones that involve modulating affective arousal to an optimal level, including exposure and grounding techniques.

Psychoeducation

Although the TRG is not a psychoeducational group where group leaders have a primarily didactic role, psychoeducational interventions are often indicated in the group and therefore deserve special mention. The use of psychoeducation begins in the screening interview, where group leaders explain the purpose and format of the group and the importance and characteristics of goals. Psychoeducation about group guidelines, structure, and procedures is provided during the early sessions, as described in detail in Chapter 4, and in the concluding phase, described in Chapter 6. In other instances, psychoeducation is provided as the need arises based on members' goal work or experiences in the context of the group. The group leaders therefore need to be able to determine when such a need is present and must be capable of explaining key concepts and processes relevant to trauma and recovery in a brief and comprehensible manner. Psychoeducation may be useful in the following instances: (1) to "depersonalize" a member's experience by putting it in a broader context when she feels alienated and/or different or expresses shame or self-blame; (2) to reinforce a commonality when several group members identify with a particular symptom or experience, especially while cohesion is still building; (3) to minimize or contain group process or conflict that might distract members from their goal-focused work; and (4) to provide a cognitive frame for grounding a member who is overwhelmed by affect. However, leaders should take special care not to use psychoeducation prematurely to shut down affect that might be hard for the group to tolerate but might also be important for a member's goal work.

Psychoeducational input should be both brief and to the point and be used very selectively so as to keep the key focus on members' individual goal work and facilitate their empowerment by making members rather than leaders the central agents in one another's recovery. Psychoeducational comments are usually integrated into the feedback provided by group leaders to individual members, although occasionally (when a psychoeducational issue is salient for many group members and/or addressing it may prevent or diffuse group conflict) group leaders may claim time in the session before or after turn taking to address this issue. Psychoeducational topics that emerge frequently include PTSD, the recovery process, self-care, trust difficulties, anger, shame and guilt, dissociation, the intergenerational impact of trauma, trauma and sexuality, the impact of developmental trauma, and

the societal problem of gender-based violence. Table 2.2 lists some frequently occurring psychoeducational topics and directs the reader to examples contained in this treatment guide.

Group leadership skills relevant to short-term groups are also essential and include an awareness of group dynamics and familiarity with techniques for building cohesion and diffusing potential conflict. As already noted, even if they bring different skills to the group, co-leaders should understand the benefits and challenges involved in co-leadership, like and respect each other, and have a shared understanding of trauma and the recovery process. They should also have the willingness and time to collaborate with other treatment professionals (e.g., the client's individual therapist, psychopharmacologist), as this is an important component of this group model (and is also generally good practice).

Because the TRG is a group therapy for survivors of interpersonal violence, issues of power and its possible abuses frequently arise from the outset. Survivors naturally want assurances that the therapist will use power in a benign and constructive manner and will be willing both to witness their trauma stories and to denounce the violence. For example, in a group for survivors of political violence, one could well expect, at a minimum, that the group leaders would have no affiliation with the perpetrator group and preferably that the leaders would have even demonstrated engagement in human rights advocacy. Similarly, in a group for combat veterans, one would naturally expect that the leaders have no affiliation

TABLE 2.2. Common Psychoeducational Topics with Text Examples of Their Use

Topic	Page number(s)
Group structure and process	68–71, 73–75, 77–78, 110–111
Effective feedback/interpersonal skills	77–79, 87–88
Establishing effective interpersonal boundaries	71–72, 111–112
Trauma and self-care	76, 88–89
Differentiating shame and guilt, introducing self-compassion	74–75, 93–94
Confusing being misunderstood with being mistreated	98
Dissociation and grounding	106
Impact of trauma on abilities to trust and form relationships	78, 80–81
Impact of trauma on self-perception	83, 93–94
Sociocultural influences on understanding of trauma and its impact	101
Trauma and sexual responses	94
Impact of trauma on parenting	95

with hostile forces and preferably that they have some firsthand understanding of the soldier's life. In a group for survivors of gender-based violence, the situation is more complex. In general, it would seem preferable for women's groups to be led by women and men's groups to be led by men. However, this arrangement might create a complicated power dynamic—particularly for male survivors, the majority of whom have been abused by men, but also for female survivors who have been abused by women. It is all the more important, therefore, for TRG leaders to understand and be able to communicate their understanding of interpersonal violence as an abuse of power and to anticipate the emotionally fraught reactions that their gender will inevitably inspire. Co-leaders should also be open to exploring and addressing power dynamics within the co-leadership dyad.

In addition to recommending these specific areas of knowledge and skill, we consider it essential that clinicians intending to conduct TRG therapy read this treatment guide thoroughly from start to finish *before* actually organizing such a group. Co-leaders should thoroughly understand the six key elements of the TRG. They should then familiarize themselves with each chapter of this volume so that they have a clear overview of the screening process and each phase of the group process. The flexibility of content in this type of therapy does not lend itself well to a manual that prescribes word for word what clinicians should say. This treatment guide includes many verbatim examples of group leaders' explanations and interventions, but these are offered as examples only; clinicians new to the model are encouraged to find their own words as they assume the leadership role. We strongly advise group leaders not to bring the treatment guide into sessions or read from it verbatim, as this is disruptive to the development of the relational connections among participants that the group strives to foster. For the same reasons, group leaders are discouraged from taking notes during sessions. However, it is well worth the effort to take detailed notes following each session, recording the progress in each member's goal work as well as important group process developments.

Supervision

Regardless of their level of expertise, group leaders must have regular access to supervision or consultation with a clinician who is experienced in conducting and supervising trauma treatment and group therapy, is familiar with this treatment approach, and has read the manual thoroughly. Supervision is an *essential* component of all clinical work, since it both assists clinicians in learning from their experiences and progressing in their expertise as well as helps to ensure good service to the client. In group therapy, supervision helps group leaders to understand their groups' participants, adopt a group-oriented perspective, monitor and regulate emotion within their groups, deal with the range of feelings induced in them by their groups, and become more familiar with the relevant treatment principles and techniques (Rosenthal, 2005). Lansen and Haans (2004) identify three categories of issues most frequently addressed in the clinical supervision of trauma therapists, namely, case conceptualization, the emotional impact of the work on the therapists, and miscellaneous problems related to the management of specific situations. Regular supervision or consultation has been identified as a key element in preventing secondary or vicarious trau-

matization among therapists (McCann & Pearlman, 1990; Salston & Figley, 2003). Therapeutic work with trauma survivors often poses unique challenges in regard to the therapist's countertransference (see Chu, 1988, for a review). Supervision provides therapists with an opportunity to understand these reactions so that they are not enacted to the detriment of the client or the therapist. Walker (2004) points out that when two therapists co-lead a group of abuse survivors the possibility of multiple projections, transferences, and countertransferences is dramatically increased. If these issues are not recognized and addressed in supervision, they can become unmanageable and potentially destructive to the group.

The role of the supervisor for TRG is both demanding and multifaceted. The supervisor should support group leaders in implementing the key features of the treatment model in a manner that fits with their respective therapeutic styles. Perhaps most important, he or she should help the co-leaders maintain the goal focus and trauma frame that define the model and enable members to do the work of the group. Part of the supervisor's role is to keep the "big picture" in view, reminding group leaders of where they are in the overall trajectory of the group and of the work that should be taking place in each phase. The supervisor helps co-leaders attend to the progress of each member in relation to her chosen goal as well as group process issues that may enhance or hinder therapeutic work or need to be otherwise addressed. Supervision provides a forum for "troubleshooting"—addressing specific problems that may arise over the course of the group sessions (e.g., difficulty in containing a particular member, out-of-group contacts between two group members). The supervisor also plays a key role in attending to dynamics that may arise between co-leaders based on differences in power, leadership styles, or other factors. The supervisor should be actively checking in with co-leaders about these issues for the entirety of the therapy. As has already been mentioned, supervision also has an important function in reducing secondary traumatization by enabling group leaders to be "debriefed" about what members have shared and their personal reactions in a safe and confidential setting. This function is especially critical for this type of group, owing to the intensity fostered by the time limit, the typically high level of affective and interpersonal engagement that occurs within the group, and the focus on members sharing their trauma narrative in the service of a goal. The importance of having a supervisory relationship in which these issues can be processed cannot be overemphasized, regardless of the co-leaders' level of experience. It is the supervisor's responsibility to create an environment in which co-leaders feel safe to discuss their respective clinical difficulties and personal reactions as well as any conflict that arises in the dyad over the course of the sessions. Supervision is regarded as sufficiently important that it is the sole subject of a separate chapter (Chapter 7) of this treatment guide.

CRITERIA FOR GROUP MEMBERS

Although this manual describes a women-only trauma recovery group, it can easily be adapted for both co-ed and men's trauma recovery groups. Members of this group should have achieved some stability and control over trauma-related symptoms. They should have

no suicidal or self-harming behavior, hospitalizations, or substance abuse for at least the preceding year. They should have some healthy coping behaviors and at least a few established social connections. They should have done some prior trauma work and ideally should be engaged in stable concurrent individual therapy (or, at the very least, have access to a previous therapist to whom they can return if needed during the group). Their current living situation should be safe, and they should not be anticipating any major life changes or crises over the course of the therapy. Furthermore, potential members should have an interest in group therapy, be able to commit to regular and punctual attendance, and be able also to articulate at least a vague goal for the group. These criteria are described in detail in the Chapter 3, on "Initial Preparations and Member Screening."

It is important that group leaders pay attention to the *overall composition* of the group. While the TRG initially began as a group for incest survivors, we have that these groups were able to tolerate a fair amount of heterogeneity in terms of trauma history (e.g., one group might include survivors whose primary traumas involve childhood sexual abuse, intimate partner violence, and adult sexual assault). Similarly, diversity among members in regard to race, ethnicity, religious background, age, and sexual orientation tends to enrich the group and underline the commonalities experienced among survivors despite their apparent differences. It is often helpful if each member has at least one other person with whom he or she can identify relatively easily, although this is not always possible. As will be discussed further in the next chapter, it is very important that a member know if she will be the only representative of a particular social group (e.g., person of color, lesbian, person with a disability) so that she can make an informed choice about her own participation.

GROUP FRAMEWORK

Group Size

Based on our experience, five to eight group members seems to be the ideal size for the typical TRG in order for participants to have the appropriate amount of sharing and feedback time to accomplish their goals. With more than eight members, it becomes very difficult to devote sufficient time to each member's therapeutic work. When there are fewer than five members, the unique benefits of a group intervention are reduced, particularly if a member is absent or drops out of treatment.

Group Length

This manual is based on a typical TRG that meets once a week for 90 minutes for 16 weeks. The length and frequency of meetings is well suited to the emotional intensity of the work. Although the duration of the therapy is flexible (ranging in our experience anywhere from 10 weeks to 8 months), it is vital to choose a specific duration and subsequently comply with that time frame. Also, it is important to be aware of the advantages and disadvantages to different therapy durations. A shorter time frame provides more focus and impetus to

members' actively pursuing their goals; however, it may limit the depth of this work and often does not allow much room for processing in-group interpersonal experiences that may be relevant to members' identified goals. A longer time frame may enable members to accomplish more extended goals that may involve processing both out-of-group and in-group experiences; however, there is also the risk that members may stray unduly from their goals or procrastinate in regard to pursuing them. In order prevent this situation, staged goals (i.e., goals that are deliberately "broken down" into several increments) can be helpful in providing members with multiple motivating experiences of success. If at all possible, the group should be scheduled so as to avoid frequent or prolonged disruptions attributable to holidays or therapist vacations. Co-leaders should also be aware that holidays (e.g., Mother's Day, Thanksgiving, Valentine's Day) will inevitably introduce particular dynamics and content into the group that will need to be addressed in relation to members' treatment goals.

Group Guidelines

In order for members to work productively toward their goals, it is crucial that the group environment be experienced as a safe and containing setting. It is important for group leaders to understand (and be able to help members understand) the sometimes hazy distinction between feeling unsafe in the group and feeling challenged by the therapeutic work. Behaviors that may be experienced as abusive or as causing other members to feel unsafe to participate in the group should not be tolerated, and it is the leaders' responsibility to ensure that these boundaries are maintained and intervene promptly if they are violated. However, there are times when a client may reexperience feelings of anxiety and fear or other intense affects from the past and attribute them to the group's feeling unsafe in the present. In this instance, the leaders' role is to help the member name and explore her feelings in an effort to differentiate between past and present.

It is essential to establish and uphold a clear set of guidelines for participation in order to provide a sense of safety for group members. Some guidelines that we have found to be central to maintaining a safe and productive setting for members' therapeutic work include confidentiality, mutual respect, no out-of-group contacts with other members, no touching, no food, and advance warning about any anticipated lateness or absences. These guidelines are discussed in detail in Chapter 4.

INDIVIDUAL SESSION FORMAT

Check-In

At the start of each session, there is an opening round or group check-in that should last approximately 5–7 minutes. During check-in, clients are asked to state as briefly as possible how they are doing or feeling as they start the group. This check-in is important because it gives each group member an opportunity to have her voice heard in the room, and this in turn often inclines members to talk more freely throughout the session. During the check-in, members may also claim time to share their goal-related work.

Sharing and Feedback

The majority of the session time is divided among clients sharing and receiving feedback from other group members. In a 90-minute group with an opening and closing "round," typically three group members will be able to "claim time," with approximately 25 minutes devoted to each person for sharing her goal work and receiving feedback. It is the responsibility of group leaders to structure the sharing and feedback within each session so that each contributor has roughly an equal amount of time (unless a group member specifically states that she needs less time). Approximately halfway through each member's allotted sharing time, co-leaders should check in with her about whether it would be all right to pause in her narrative to receive feedback from other group members.

Sharing

During their allotted time for sharing, group members may talk about the painful details of their trauma histories. For some, speaking about these experiences may in itself be the focus of their therapeutic work in the group; for others, it may be a necessary part of identifying, defining, and/or contextualizing an appropriate out-of-group goal. The commonalities that emerge in regard to survivors' experiences of trauma and its impact create strong affective connections among group members and decrease feelings of isolation and shame. It is important to note, however, that disclosure should be carefully paced and guided by an awareness of each member's needs in regard to the development and pursuit of her goal.

At the start of each session, it is helpful to ask each group member to start her time taking/sharing by stating her goal insofar as it has been formulated. This approach not only helps the group member focus her sharing on matters pertinent to her goal but also assists other members of the group in providing relevant feedback.

Since most participants lead very complex lives, it is understandable that a group member might get off track and share other pressing issues that do not necessarily relate to her goal. When this situation occurs, group leaders should gently and respectfully intervene to guide the group member back to her goal work (and encourage her to address the extraneous content in individual therapy, if appropriate). This reminder is intended to be containing and instructive to the member concerned and reassuring to other members.

Group members should be encouraged to monitor their affective reactions while sharing and be attentive to cues that may lead them to start dissociating. Whenever dissociation occurs, they should utilize their coping skills to reorient themselves to the present, with support from the co-leaders and other members as needed.

Feedback

The most important guidelines for providing efficacious feedback are that it should be goal-relevant and focused on the group member who is sharing. As group members share their past experiences, there are likely to be many points of commonality that may stimulate the fresh recall of similar memories for everyone in the group. As they listen, group members

will have a natural tendency to compare mentally their own experiences with those of the person who is sharing. Although having had similar experiences may help a group member to relate to the person sharing, it is crucial that any feedback remain focused on the needs and experiences of *that* person. In this regard, it is often helpful to remind group members to focus on the empathic message that they wish to convey to the person sharing rather than getting involved in describing the details of their own experiences.

It is often helpful to remind group members that making an observation or asking a question of the person who is sharing is usually more helpful than stating an opinion or giving advice. No one in the group should give feedback as an authority; rather, everyone should share their perspectives as individuals with varying experiences that can aid one another toward healing. Since learning to give helpful feedback is frequently a difficult and anxiety-provoking task for group members, it is especially essential that group leaders continuously model appropriate feedback strategies.

Usually members claim time on a *rotating basis* so that they take a turn every other session to share their goal-related work. However, it is important to have some flexibility in this regard to accommodate needs that might arise related to the work of individual members. For example, a member who uses her time one week to prepare for a disclosure or confrontation may request some time the following week to process what occurred. Alternatively, a member who is struggling emotionally during a particular session may ask for time to share when she is not scheduled to do so or may offer her time to others and participate instead in providing feedback. However, it is important that group leaders assure that time is shared roughly equally overall, that no member goes without sharing for more than two consecutive sessions, and that members who are not claiming time are still actively engaged in the group.

Closing Round

Comparable to the check-in, in reverse, the closing round provides an opportunity for everyone to say how she is feeling as she leaves the group. The closing round provides group members with an opportunity to notify the leaders if they are feeling unsafe or worried about themselves in any way. Equally as important, the closing round allows time for members to share the positive self-care strategies that they plan to engage in following the session. Group members find this exercise useful, both to remind themselves of their own resourcefulness and to give others new ideas for their self-care. Because clients are doing such intense work during the group sessions, it is important to encourage them to pay extra attention to taking care of themselves and to acknowledge and reward their hard work.

CONTINUING GROUP WORK BETWEEN SESSIONS

Structured homework exercises are not a part of TRG. However, there are several ways in which each member's goal-related work will carry over into their treatment and life outside of the group.

Out-of-Group Goals

It is often the case that group members need to complete some of their goal work outside of the group sessions. Many group members will have out-of-group goals (e.g., disclosing their abuse to a family member, setting limits in a significant relationship) and use their time in group sessions to prepare for this work, report back on their progress, and obtain feedback and support.

Self-Care

Establishing routines of self-care is a major focus of Stage 1 trauma groups. Among participants in Stage 2 groups these routines should already be reliably established, and the continuing focus should be on enhanced self-nurturing to ameliorate the emotional strain of trauma-focused work for the duration of the therapy. This requirement may involve taking extra steps to keep physically and emotionally healthy by eating well and exercising, engaging in stress-relieving activities such as yoga or meditation, making more extensive use of existing social supports, and planning enjoyable and relaxing activities such as watching a movie or taking a long bath.

Individual Therapy

Individual therapy should be used concurrently with the TRG to address issues that may arise for the client over the course of the therapy. The client's individual therapist can be an important ally in honing and specifying goals as well as processing goal-related material at a depth not possible within the framework of a time-limited group. It is important to ascertain whether the therapist will use the individual sessions to support the client's group work during the course of the group sessions—otherwise, the client may feel torn between the two processes. It may be necessary to initiate a discussion with the individual therapist on how best to work together. Individual therapy is a helpful venue for processing reactions that may be evoked by participating in the group. If these concerns are relevant to the client's selected goal, the individual therapist can assist the member in finding ways to bring them back to the group during her sharing time.

CONCLUSION

This chapter has reviewed key issues related to the purposes, key features, structure, and format of the TRG. The subsequent chapters consider their practical implementation as the reader is guided from preparation and screening, through the introductory phase and goal work, to goal completion and finally to the conclusion of the group treatment.