CHAPTER 1

Group Treatment for Interpersonal Violence

In the 26 years since the publication of the classic text *Trauma and Recovery* (Herman, 1992/2015), a collective understanding of the impact of traumatic and violent events—on the brain, on children, on attachment, on health, on society—has expanded. The Adverse Childhood Experiences studies (Felitti et al., 1998) conducted at Kaiser–Permanente and in collaboration with the Centers for Disease Control and Prevention have moved the recognition of the impact of interpersonal trauma out of the cloistered realm of psychiatry into medicine, public health, and the public sphere. Reports from our returning veterans and from college campuses have made us grapple with the pervasiveness of interpersonal violence, while also illuminating the institutional failures that perpetuate it (Armeni, 2014; Sinozich & Langton, 2014).

Trauma and Recovery framed the concept of complex posttraumatic stress disorder (PTSD) as an adaptation to prolonged and repeated abuses, especially those that begin in childhood. Complex PTSD, with its symptom triad of somatization, dissociation, and emotional dysregulation (van der Kolk et al., 1996), is chronic, is often refractory to treatment, and results in significant functional impairment (Courtois & Ford, 2009). The impact of prolonged interpersonal trauma on the lives of its victims is particularly destructive in its social disruption and alienation (Sewell & Williams, 2001). The relational difficulties that plague chronically traumatized people—such as volatile relationships, disordered attachments, and vulnerability to repeated victimization—are well demonstrated in the research (Brown, 2009; Brown, Kallivayalil, & Harvey, 2012; Classen, Palesh, & Aggarwal, 2005; Liotti, 2004). Prolonged trauma simultaneously evokes emotional distress and undermines the capacity to regulate it. Interpersonal violence compromises the victim's access to social support by engendering distrust of others and by shattering assumptions about the safety of the world (Charuvastra & Cloitre, 2008). In addition, the classic symptoms of posttraumatic

disorder, such as avoidance and irritability, make it difficult for survivors to build new mutually sustaining relationships (Briere & Rickards, 2007; Cloitre, Miranda, Stovall-McClough, & Han, 2005; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005).

Psychotherapy, a potentially reparative experience, is the treatment of choice for severe and complex trauma (Cloitre et al., 2012). Recovery requires not only the reduction of symptoms, but also an improvement in the capacity for self-regulation and strengthening of interpersonal relationships. While long-term individual psychotherapy is the foundation of treatment, the unequal power dynamics between patient and therapist can create certain limitations. The experience of being subordinated and humiliated by a more powerful person profoundly affects all future relationships, including the therapy relationship. Group therapy, in contrast, can provide survivors of violence an exceptional opportunity to counteract the experience of subordination by joining with peers on a plane of equality to combat social isolation and fear, to relieve shame, to cultivate a sense of belonging, to connect with sources of resilience and self-esteem, and to rebuild the relational capacities shattered by traumatic experience.

There is now considerable evidence that group therapy can also help address an array of posttraumatic symptoms that affect the survivor's sense of self, mood, and daily functioning (e.g., Foy et al., 2000; Shea, McDevitt-Murphy, Ready, & Schnurr, 2009). The importance of group therapy is recognized in the expert consensus guidelines of the International Society for Traumatic Stress Studies (ISTSS). In fact, six of the nine studies cited in the ISTSS best-practice guidelines for complex PTSD used group treatment models (one used group plus individual treatment and another group plus case management; Cloitre et al., 2012).

This treatment guide describes a time-limited approach to group treatment called the Trauma Information Group (TIG). This group model was developed in the early 1990s at the Victims of Violence (VOV) Program, a hospital-based outpatient program serving survivors of complex trauma at Cambridge Health Alliance. Since that time, over 60 groups have been conducted, with more than 500 trauma survivors. In studies conducted at our clinic, most participants in the TIG made significant improvements in measures of depression, posttraumatic stress, dissociation, and self-esteem (Mendelsohn et al., 2011).

The TIG model has also been used in multiple other treatment settings. It has proved to be a very durable and adaptable group model for trauma survivors in an early stage of recovery. The group is unique in that it *combines a grounding, psychoeducational, and cognitive framework with a carefully constructed supportive relational group process* that is particularly well suited to early-stage trauma treatment. Like some other group models, it utilizes educational worksheets that provide information about trauma and recovery to structure the group and homework handouts to help patients deepen their understanding of trauma and build new coping skills. Unlike other existing models, however, the TIG manual also includes specific instructions for group leaders on how to build on the unique therapeutic potential of a group by developing an interpersonal process that relieves shame and fosters a sense of belonging. For these reasons, we believe that this treatment guide for the TIG will constitute an original and useful contribution to the field and a unique, accessible, and adaptable model for trauma clinicians in a multitude of settings.

THE TRAUMA INFORMATION GROUP

The conceptual framework for this group is derived from the stage model of treatment for complex trauma outlined in *Trauma and Recovery* (Herman, 1992/2015). The stage model, a widely accepted and adopted metamodel of trauma treatment, is recommended by the expert consensus guidelines of the ISTSS (Cloitre et al., 2012). In contrast with trauma treatments that begin at once to focus on telling the trauma story, in a staged model of recovery, the initial focus of treatment in the *first stage* of recovery involves the establishment of *safety*. Both individual and group treatment interventions at this stage are focused on symptom mastery, stabilization, and the basic routines of self-care. Therapy focuses on the body (establishing daily rhythms of sleeping and eating, managing intrusive PTSD symptoms, and reducing self-harming behaviors), on the environment (establishing a secure living situation and having steady work and financial stability), and on safe interpersonal relations (building a trustworthy social support system with mutual, nonexploitative relationships). This early stage of treatment is often the most demanding and prolonged.

The rationale for a staged model of recovery is that without establishing safety in the present, exploration of the traumatic past simply becomes another experience of trauma. Once safety is established in the present, it becomes possible for the survivor to revisit the horrors of the past, rather than simply to relive them. The therapeutic task of the *second stage* of treatment involves a carefully paced, in-depth *exploration and processing* of the traumatic memories so that they can be integrated into a coherent and nuanced life narrative. Once this stage is completed, it becomes possible for the survivor to envision a future, and preoccupation with the past gives way naturally to a focus on rebuilding a life. The *third stage* of recovery therefore involves *reconnecting* with the survivor's larger community (Herman, 1992/2015).

Stage 1 groups are designed to meet the goals of safety, stability, and self-care. They are present focused, they generally have a didactic component, and they usually discourage detailed trauma disclosure to prevent group members from becoming overwhelmed (Harney & Harvey, 1999). The TIG is conceptualized as a Stage 1 group. Its tasks include increasing the capacity for modulating extreme arousal states, reducing trauma-related avoidance, deepening understanding of the impact of trauma, and developing both a sense of basic agency and a sense of peer support (Courtois, Ford, & Cloitre, 2009). The focus of the TIG on early recovery issues; its relatively brief time frame (usually 10–14 sessions); and its combination of a structured, educational, and cognitive framework and a supportive, relational group process make it well suited as a "beginners" group for patients who have only recently started treatment.

Though the combination of individual and group therapy is often highly effective, we have found that individual therapy is not a necessary prerequisite for this group. Over the years, the TIG has been adapted for use in many different settings, including an inpatient unit, a gay and lesbian counseling program, a rape crisis center, and a Latino mental health program where worksheets were translated into Spanish and modified to include the impact of political trauma and issues of acculturation. Most recently, the TIG has been adapted

for rural Native Canadian trauma survivors, for mostly undocumented immigrant workers who retrieved the remains of the dead from Ground Zero, and for women with HIV/AIDS, many of whom have histories of severe trauma. The worksheets can be expanded or shortened, and clinicians can develop additional worksheets for the populations they serve (see Chapter 6).

The TIG is designed for patients who may have little understanding of how traumatic events have affected their lives. Survivors who are just beginning to explore the relationship between their traumatic past and their current life patterns are appropriate candidates for this group, as are those whose lives are marked by social isolation. Many patients who participate in this group have never spoken about their traumatic experiences to anyone or have shared it only with significant others who have minimized, denied, or invalidated the significance of the trauma. This group, for many, is their first experience meeting others who recognize that the trauma has had a significant and harmful impact and who understand that they are not responsible for the abuse they suffered.

The TIG has a deceptively simple structure, which in practice serves multiple complex functions. Many Stage 1 group treatments have a cognitive and psychoeducation orientation, as the TIG does; however, in the TIG the *interpersonal* or relational nature of the group context ("the groupness of the group") is emphasized; it is not simply a class on trauma and recovery, nor is it cognitive-behavioral therapy done in a group context. Patients are encouraged to share the relational impact of trauma, and this kind of sharing allows them to develop a sense of belonging and to be relieved of shame. The structure is designed to facilitate interpersonal exchange, while minimizing disclosure and maximizing affiliation and mastery. In this way, the group provides an opportunity to begin the recovery process while adhering to the principle of safety.

Each group usually contains 6 to 10 members and ideally should be co-led by two therapists. The usual length of group sessions is 10–14 weeks. Each group session usually lasts 1 hour. The treatment model lends itself to this relatively short group session, as it is designed to be containing rather than exploratory. The structure of the group is discussed in greater detail in Chapter 2. Modifications of the usual structure are reviewed in Chapter 6.

Each group session focuses on a topic related to the impact of trauma; examples include Safety and Self-Care, Trust, Anger, Remembering, and Shame. Topical worksheets help group members to develop a cognitive framework for understanding the impact of trauma on their current lives. Each week the worksheets build on each other, starting with the topics that most easily facilitate bonding and progressing to more challenging topics.

Most of the patients seen at the VOV Program are survivors of childhood trauma. Therefore, our standard worksheets begin by explaining what would be the optimal developmental process for children in a safe and supportive environment. They then go on to describe how childhood trauma can affect this process. Each worksheet outlines the many emotional, cognitive, and behavioral ways trauma survivors cope that may have been adaptive at the time, but that may cause considerable suffering later on. For example, in the Trust session, a number of people might share how from a very early age they learned not to trust. Someone might share a story of how she assumed throughout her life that people were

going to hurt her and how she never let anyone in. She may then discuss her contemporary struggles in the trust arena and connect the past and present, leading group members to reflect on how hard it is to let go of the past.

The worksheets are read aloud in the group, one or two paragraphs at a time, and members comment on them and share relevant stories from their own life experiences. Group leaders model empathic feedback and encourage group members to offer compassion and understanding to one another. Group members frequently comment on how relieving this framework is because it makes many of the experiences they find particularly distressing comprehensible to them as consequences of trauma, rather than as a sign of personal defectiveness.

The focus of the group on the *impact* of trauma, rather than on details of the trauma history, helps members titrate and regulate affect, so as to make addressing trauma-related issues manageable. It also provides an experience in which group members can learn to reference and discuss their trauma histories without disclosing every detail in an unmodulated way. This in itself is often a vastly important interpersonal skill for survivors, who may feel that their only options are either to hide their trauma histories from others or to disclose indiscriminately.

By witnessing both the struggles and the strengths of other trauma survivors, group members often come to feel markedly less alone. Discovering that they can be helpful to others, group members develop a sense of competence and pride. In offering compassion and empathy to others, group members are often enabled to develop increased compassion and empathy for themselves.

THE "EVIDENCE BASE"

Outcome research generally supports group therapy for patients with PTSD, but does not favor one type of group over another. Foy and colleagues (2000), who conducted a comprehensive review of empirical studies, found that group psychotherapy was associated with positive outcomes in a range of symptoms, regardless of treatment approach or model; improvements in PTSD symptoms, dissociation, global distress, and self-esteem were all noted. More recently, Fritch and Lynch (2008), in a similar review, found that many studies reported improvement on measures of interpersonal functioning, as well as symptom reduction. The range of group treatment approaches included affect management (Zlotnick et al., 1997), dialectical behavior therapy (DBT) skills plus writing-based exposure (Bradley & Follingstad, 2003), psychoeducation (Lubin, Loris, Burt, & Johnson, 1998), cognitive processing therapy (Chard, 2005), trauma-focused therapy (Classen, Koopman, Nevill-Manning, & Spiegel, 2001), interpersonal therapy (Cloitre & Koenen, 2001; Ray & Webster, 2010), and process groups (Hazzard, Rogers, & Angert, 1993).

There is no evidence supporting the superiority of one group model of treatment over another (Sloan, Feinstein, Gallagher, Beck, & Keane, 2013). In fact, very few studies have directly compared the effectiveness of two different types of group therapy for interpersonal

trauma survivors. Dunn and colleagues (2007) compared the efficacy of a self-management group versus psychoeducation for a cohort of veterans with comorbid PTSD and depression. The self-management intervention appeared to show initial gains for depression symptoms, but this difference did not persist at follow-up. A randomized controlled study by Classen and colleagues (2001) with adult female childhood sexual abuse survivors assigned participants to either trauma-focused group therapy, person-centered group therapy, or a wait-list group. Participants in both treatment conditions showed significant improvement on trauma-related symptoms, while the wait-list controls did not. Finally, 360 male veterans with chronic combat-related PTSD were randomly assigned to trauma-focused or person-centered group therapy for 25 weekly therapy sessions (Schnurr et al., 2003). PTSD and other symptoms were significantly improved for both conditions, but there were no overall differences between the two types of group therapy on any outcome measure.

We wonder whether it would have been possible to discriminate between the effectiveness of these two types of group therapy if the authors of these randomized controlled trials had taken account of the stages of recovery. We suspect that patients in Stage 1 would have done better in the person-centered group, while patients who were ready for Stage 2 work would have done better in the trauma-focused group. It is worth noting that treatment dropout was higher among those assigned to the trauma-focused group. This outcome is just what one would expect if patients in early recovery were assigned to a type of group for which they were not ready.

Comparable Group Manuals

Very few group models for trauma survivors in early recovery have been developed into published treatment manuals. With one exception, existing manuals are designed either for individual or for group psychotherapy, with little if any discussion of either the potential power or the particular demands of group treatment. The three that most closely resemble the TIG are called Trauma Recovery and Empowerment (TREM), Seeking Safety (SS), and Trauma-Centered Group Psychotherapy (TCGP). The TREM model (Fallot & Harris, 2002; Harris, 1998) was originally designed to serve impoverished women with histories of childhood abuse living with the cumulative effects of poverty and stigma. It is based on the principles of cognitive restructuring, skills development, and psychoeducation and has three major sections: empowerment for women, trauma education, and skills building. The group model has been implemented in a wide range of agencies, including residential and nonresidential substance abuse and mental health programs, correctional facilities, health clinics, and welfare-to-work programs, among others, particularly in urban areas. Twenty-four to 29 topics are covered in weekly 75-minute meetings; each topic is introduced with a brief clinical rationale, a set of goals, questions to be posed to the group, and an experiential exercise. An adaptation for Latina women has been developed and published in a separate manual. One outcome study has shown promising results for reducing trauma symptoms, improving coping, and reducing general substance abuse (Fallot, McHugo, Harris, & Xie, 2011); another study showed that women who participated in TREM had significantly

better outcomes for trauma-related symptoms than those who received treatment as usual, but better outcomes were not found for alcohol or drug use.

The SS model was developed by Najavits (2002) for clients with dual diagnoses of PTSD and substance abuse. It is conceptualized as a cognitive-behavioral treatment with influences from 12-step programs and other self-help traditions. SS does not include discussion of specific trauma memories and is best conceptualized as a Stage 1 treatment. It can be offered as either an individual or a group treatment. Twenty-five topics are discussed, and clients are asked to identify a safe coping skill. More than 80 "safe coping" skills are taught in a curriculum that has defined topics and structured exercises. Various studies have shown the effectiveness of SS in reducing PTSD and substance abuse (Desai, Harpaz-Rotem, Najavits, & Rosenheck, 2008; Hien, Cohen, Miele, Litt, & Capstick, 2004; Najavits, Weiss, Shaw, & Muenz, 1998). A recent summary of the evidence, however, argues that SS is not superior to other active treatments, such as psychoeducation (Sloan & Beck, 2016).

TCGP (Lubin & Johnson, 2008) was created specifically to address the interpersonal effects of psychological trauma. The group has both a didactic component and an exposure element and therefore is somewhat of a hybrid between a Stage 1 and Stage 2 group. There are 16 weekly sessions, with a lecture topic, handouts and homework assignments, and a "graduation ceremony" at the end of the group. The group was originally developed for women, but it has since been adapted for men, veterans, and women with concurrent PTSD and substance abuse. A nonrandomized outcome study showed that the model is effective in reducing PTSD and depression symptoms, and gains were maintained at a 6-month follow-up (Lubin et al., 1998), but we could not find more recent studies of this treatment method.

Other manualized therapies are comparable to some degree. The most well known, DBT, is a cognitive-behavioral treatment consisting of behavioral skills training originally developed for chronically suicidal individuals with borderline personality disorder, which is now used for a wide range of disorders in which emotional dysregulation is a core feature (see Lynch, Trost, Salsman, & Linehan, 2007, for a review; Salsman & Linehan, 2006). Given the high prevalence of childhood abuse among individuals with borderline personality disorder (upward of 75% have experienced childhood abuse [Herman, Perry, & van der Kolk, 1989; Zanarini, Williams, Lewis, & Reich, 1997] and up to 90% have experienced adult trauma [Zanarini, Frankenburg, Reich, Hennen, & Silk, 2005]), DBT groups are frequently used with trauma survivors, even though there is no explicit recognition of the impact of trauma in the model. The behavioral analysis and skills work that are the cornerstones of DBT can be helpful in addressing the various deficits in self-care and self-soothing that are features of complex traumatic stress disorders. There is a growing attempt to integrate and build a bridge to complex trauma applications among DBT scholars and practitioners (Harned & Linehan, 2008; Swenson, 2000; Wagner, Rizvi, & Harned, 2007). DBT can be implemented in either an individual or group format or with a combination of the two.

TARGET (Ford & Russo, 2006) is another cognitive-behavioral treatment designed to enhance affect regulation without trauma memory processing. It provides psychoeducation that explains PTSD symptoms and affect dysregulation as the results of biological adaptations to survive trauma. Like all the other models we have discussed (with the one exception

of TCGP), TARGET can be offered either individually or in a group setting. Restoring affect regulation is described as requiring seven practical steps, or skills, summarized by the acronym "FREEDOM" (where F = Focus the mind on one thought at a time, R = Recognize specific stress triggers, E = Emotion self-check and Evaluate thoughts, D = Define goals, O = Options, and M = Make a contribution). Each chapter of TARGET describes the key points of the lesson, teaching examples, session scripts, and activities, and it can be offered in 12 weeks or adapted for longer treatment trajectories. Studies have shown promise for the TARGET treatment model in various settings in both individual and group therapy contexts (Ford, Steinberg, & Zhang, 2011; Frisman, Ford, Lin, Mallon, & Chang, 2008).

Special Features of the Trauma Information Group

The TIG has a number of features in common with the manualized models described previously; it was originally developed mainly for women survivors of childhood abuse and has since been adapted for many other populations, it is time limited, and it is most appropriate for survivors in early recovery. It uses a didactic format with weekly topics and worksheets. However, it also differs from these models in a number of ways. As compared to SS and TREM, the TIG has a shorter time frame (10–14 weeks), in part to make the group tolerable to members so early in recovery. A shorter time frame also makes groups relatively easy to implement and to offer frequently.

TIG also explicitly draws on the therapeutic action of the group context. Caring interaction and witnessing among group members are powerful mechanisms for normalizing traumatic experience, reducing shame and isolation, and building self-compassion. The TIG manual offers group leaders specific instructions on how to manage potentially disruptive interactions among group members and how to model empathic but containing feedback. Surprisingly, the other existing manuals offer little direction on how to foster a therapeutic interpersonal climate. For those manualized treatments that can be offered either in a group or individually, little attention is given to the ways in which group therapy differs from individual therapy. The therapeutic potential of the bonds that develop between group members is not discussed. By contrast, the TIG manual contains clear instructions for group leaders to maximize the power of this therapeutic modality.

A note about the pronouns used in this treatment guide: Our collective experience with implementing this group treatment approach has primarily been with women survivors of interpersonal trauma. Therefore, this book is based on a women's group, and female pronouns are used to refer to group members and leaders. However, as is discussed in Chapters 2, 4, and 6, the TIG model has also been successfully applied in mixed-gender and men's groups and on occasion with transgender clients.

An additional note about the clinical examples in the book: The clinical material includes case descriptions and modified transcripts from actual clients, as well as composite examples based on the notes of group leaders. We have changed demographic information and other identifying details to preserve anonymity. All the names used are pseudonyms. Clients who participated in the observation groups consented to having their sessions observed.

CONCLUSION

We believe this versatile group model will be suitable for many different populations, as it has already been adapted and used in various settings and with a wide range of patients. The worksheets alone can serve as a comprehensive educational tool, summarizing basic knowledge on many aspects of trauma and trauma recovery. They can be a useful guide to the many aspects of recovery for patients and therapists alike. The group has utility and practicality in numerous clinical settings. The manual has specific instructions about how to run the group, attend to problems, and screen patients, directly addressing the training that therapists need to facilitate the group successfully. The model is unique in that it understands complex PTSD as the consequence of relational harm that needs to be repaired in a relational manner. As an early recovery group that is both educational and relational, we believe the TIG has stood the test of time.

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