

Group Therapy for Survivors of Childhood Abuse

PT 007 - Professional Training

By

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Introduction

The frame of mind with which a clinician approaches a patient largely determines the nature and outcome of therapy. Successful treatment of victims of childhood abuse and other forms of trauma presents us with special challenges. This manual represents our efforts to more effectively respond to the needs of this population in the context of a limited service delivery system.

There are four parts to this manual:

- A. Theory and knowledge base of treatment model
 - 1. Nature of chronic trauma experience
 - 2. Characteristics of Post Traumatic Stress Disorder
 - 3. Co-morbidity factors.
- B. Three-step stages of recovery — a developmental model for treatment
- C. Group therapy guidelines
- D. Appendix and Bibliography

Theory and Knowledge Base of Treatment Model

Nature of Chronic Trauma Experience

Chronic trauma occurs under conditions of captivity, where there is interference with the victim's ability to escape, and the victim is faced with the fundamental choice between exploitation or abandonment/annihilation. The core emotional state is one of unspeakable terror. The psychological state is one of complete disconnection and disempowerment. In cases of childhood trauma, where the perpetrators are parents or other family members, the trauma is exacerbated by feelings of profound betrayal and confusion. Earliest and most damaging psychological trauma is the loss of a secure base when caregivers who are supposed to become the main source of protection and nurturance become, instead, the main source of danger.

Since human life seems to be incompatible with a sense of meaninglessness and loss of control, victims will attempt to avoid this experience at nearly any price, from grovelling dependency to psychosis. In the neurotic realm the most common and most tenacious form of regaining or holding onto this sense of meaning and control is through self-blame.

Effective treatment must center on helping the victim with the task of re-empowerment, re-connection, and release of self blame. It is our current thinking that an understanding of Post Traumatic Stress Disorder is a major factor in effective treatment.

Post Traumatic Stress Disorder

Trauma victims are those who have experienced: war, rape, cults, incest and abuse as children, neglect, witnesses of abuse, and survivors of civilian disasters. Until recently, little attention has been given to the impact of overwhelming life experience on both the soma and the psyche. It is in The Post Traumatic Stress Disorder (PTSD) more than any other disorder that we

see the close interdependence of psychological and physiological reactions — a human being is a biological organism embedded in a social environment. It is in this paradigm that we acknowledge the impact of life experiences

PTSD syndrome earned its way into the DSM III in the 1960's. Curious that it took so long, since it was defined in World War I period. During the 1960's, the myth of war and the myth of the family were challenged. Until that time the family had to be viewed as safe and there could be no acknowledgement of the damage and cost of war. The forces of the loss of the Vietnam war and the rise of the women's movement combined to seriously challenge these myths.

The syndrome has two major features:

1. Long latency period — it is also described as a disorder of memory where a painful memory is "sealed off" from conscious access.
2. Biphasic nature — hyperarousal or intrusion alternating with numbing or constricting.

The trauma response although it can vary greatly in intensity, is remarkably consistent across trauma experiences. The PTSD syndrome has five principle features:

1. Persistent startle response or irritability and a low tolerance for physical and emotional arousal
2. Proclivity to explosive outbursts of aggression on self or others often exhibiting an absence of inner mediators resulting in an all or nothing response
3. Fixation on the trauma by retelling or reliving
4. Constriction of general level of personality functioning
5. Atypical dream life —intrusive nightmares

Remember that the syndrome is likely to appear when clients are in the intrusive stage of remembering. Often the trauma response will surface just prior to a painful memory.

The following information on co-morbidity factors underscores the importance of informed sensitivity to identifying abuse victims since in our experience few patients seek help with any awareness that the trauma history is the source of their pain.

Co-morbidity Factors

A 1986 study of 100 cases of multiple personality disorder and borderline personality disorder showed the following:

- 90% were sexually abused;
- 85% were physically abused;
- 80% were both physically and sexually abused;
- 70% suffered from severe neglect;
- 70% were witnesses to all or some of the above.

It is estimated that at least 50% of female psychotherapy patients and 25% of male patients have a history of incest. That figure does not include other forms of trauma. In our experience every type of symptom can be part of the presentation. The following mnemonic helps us to remember the major problems that trauma victims present:

- F** fugue state, dissociation
- E** ego fragmentation, overwhelmed by present experience
- A** antisocial history - avoidant, isolated, history of crime, theft, prostitution
- R** reenactment, repetition, selfdestructive behavior or abusive relationships
- S** sleep disturbances, sadness, somatization, suicide attempts (the depressive cluster).

At times, it is very difficult to distinguish between Borderline and Multiple Personality Disorders (BPD and MPD, respectively) those who are suffering from PTSD. The following factors have been identified to help distinguish the difference.

Non-MPD, non-BPD trauma victims:

1. Clients' moods are not unstable nor is intense anger a predominant mood or affect.
2. Immediate transference does not occur - they tend to be wary of closeness.
3. Intense unstable relationships will be lacking, particularly, the rapid shifts in attitude between idealization and devaluation.
4. Acting out tends to occur in spouses or significant others, with the victims as caretakers.

5. Profound identity disturbances are lacking; gender identity, values, loyalties, and self-image are stable.
6. Show no intolerance for being alone, and crave time alone to get away from demands.
7. They do not have marked problems with chronic boredom or emptiness.
8. Under stress or treatment, they tend to not have psychotic episodes but instead dramatically recount original traumatic events.

In addition to the presentations listed, there is what I call the “abnormal copers.” These are clients who are often high achievers and who can convince themselves, and you, that they are fine. They are the successful minimizers and deniers of their own pain. Also, do not be deceived by those clients who exhibit such low-level, chronic despair that they no longer register pain. The most serious clients are those who have lost the capacity to feel.

Three Stages of Recovery

This model, developed by Dr. Judith Herman as part of her seminar on "Psychological Effects of Sexual and Domestic Violence," looks at the client as a trauma victim. It is important to understand that this is not a linear model, although it is developmental in character. Most clients will continue to recycle through the three stages throughout treatment and perhaps throughout life.

The first stage is a very helpful assessment tool when clients enter therapy and also provides a necessary guideline for group therapy criteria. The guiding principles of all three stages of recovery are safety and integration.

Stage I Concrete Care of Self

1. Care and control of body—food, sleep, drugs, alcohol, medical history, assessment and treatment of co-morbidity issues, especially monitoring and treatment of depression
2. Creation of safe environment —living, work, school, finances, physical self-protection
3. Replacement of self-harming with self-soothing protection; music, reading, reliable attachments
4. Social support systems—self-help, church, AA, Alanon, Weight Watchers, and so on

(The importance of careful assessment for substance abuse cannot be over-emphasized. Therapy for resolving past trauma can only take place under conditions of sobriety.)

Stage II Reconstruction of Trauma

Anticipate some regression and resurfacing of PTSD during this period.

1. Locus of control remains with patient.

2. Uncovering proceeds in small steps. Patient often wants to "get it over." Slowing down is often important to keep patient safe and not overwhelmed by intrusive thoughts and feelings.
3. Process involves intense grief and mourning.
4. Integration of affect, memory, and cognition is important.
5. Create new meaning as resolution to existential despair of Why me? and the existence of existential cruelty.
6. Often most completely done in group therapy.
7. Triggers of memory are identified.
8. Discovery of connections between current experiences with trauma response and trauma history are important.
9. It is very common for new memories to surface during this period.

Stage III Reconnection

1. Decreasing isolation, shame, stigma - special role of group
2. Renegotiations of relationships with family
3. Developing peer relationships
4. Developing intimate and sexual relationships
5. Social action - giving to others
6. Integration at successive stages of life cycle

Conventional notions of therapy as a discreet process with beginning, middle, and ending in termination is meaningless with victims who have been traumatized by childhood abuse. The more successfully the clients move through the three stages of recovery, the safer they will feel. This safe feeling can set the stage for re-emergence of unacknowledged trauma. It is important to explain this process to clients to enhance their sense of control and predictability of their feelings. Without an understanding of this process, clients often feel they are not getting better and get discouraged about their progress. Clients are well on the road to recovery when they can acknowledge that they involved in a life-long process of exploration.

Group Therapy Discussion

We assume that abuse victims begin therapy by working with an individual therapist and that access to an individual therapist is part of the group therapy experience.

It is important to make explicit the special benefits of group treatment for trauma victims at certain stages of treatment. One-on-one therapy has limits in helping the client overcome the profound sense of disconnection they feel. Even if the secrets of abuse are fully revealed in the dyad, the confidentiality of the dyad is a repeated action with only one individual, rather than a widening of connections and re-connections.

Breaking the secrecy and overcoming the stigma and shame is especially effective in the group context. The experience of sharing and reliving common experiences powerfully facilitates entrance into the world of adult relationships. It is in the group interaction that members can learn to modulate their responses to others in the here and now as well as in terms of the demands of the past trauma.

There is an inherent inequality in the dyadic relationship. Even in the most skillful hands there can be a fantasy of new strength in the client which is difficult to test. If the fantasy of strength is too far from the reality, growth at later stages can be inhibited. The group is a major testing ground for this process. The amount of support demanded of an individual therapist in the initial stages of therapy can evoke or reinforce passivity in the client. There is evidence in the stress management literature that those people who have good social support combined with an external locus of control are least capable of effective stress management. The group, by providing good social support balanced with feedback, is most effective in counteracting the development of passivity and more likely to reinforce an *internal* locus of control in the individual.

The group situation most nearly approximates the family setting and, through that similarity, serves to stimulate difficult-to-access feelings and memories. Another important factor in group treatment relates to the early and often ongoing emotional deprivation in which the victims have learned to live.

Studies on overcoming trauma continue to prove that *peer* relationships and support are the most important factors in recovery from the damage of early deprivation.

Active strategies and support by group members in matters of family disclosure and confrontation can facilitate this painful, often frightening process. Participation in group therapy provides members with a mirror of their own progress that is often easy for them to minimize or forget.

And finally, the group can contribute to recovery by being a place where members can speak out and share feelings and, by doing so, find ways to take action for themselves and others.

Group Characteristics

- Population: Female university students 19 - 40 years of age who report history of childhood abuse. Specific nature of abuse—physical, sexual, psychological—is not important, provided there is one other member with similar history.
- Size of group: 8 optimum, 10 maximum, 6 minimum
- Time: Weekly 2-hour sessions; 12 week units, ongoing sessions
- Leadership: Preferably two female co-leaders (When leaders are of both genders, it is important that a high status male not be paired with a low status female.) There is some indication that female leaders result in easier self-disclosure in initial stages of group treatment. It is also important to be aware that with some clients males may not be tolerated at all.

Criteria for membership

Rigorous assessment is the most important part of a successful therapy group for trauma victims. These are 6 important guidelines.

1. Has the person completed stage I of recovery and, especially, is she free of substance abuse?

2. Has she been able to form some trusting relationship? (Assessment of stability of marital relationship is especially important.)
3. Does she have access to an individual therapist?
4. Does she have access to medication, if needed? (Careful assessment of co-morbidity issues, especially of depression or self-abuse is important.)
5. Does she feel, for the most part, ready for the group?
6. Remember that even if people meet the criteria, they may not be ready for group, but may not realize that until they are in it. Remember Bruno Bettelheim's adage that the patient is always right. In our experience, many members make two or three attempts before committing to a group. If they do not stay, it would be helpful to them if they could identify which part of Stage I they have to go back to in individual therapy. Unacknowledged substance abuse is very often a major factor.

Guidelines for Therapy Group

Therapy groups for trauma victims differ from classic therapy groups in many ways; one of the most pervasive being the more active stance required of the leaders throughout the life of the group. Leaders actively prepare group members for treatment in the beginning sessions. This process could take 1 - 3 sessions depending on the demands of the group. Below are fourteen guidelines helpful to leaders of such groups.

- Inform group members of the trauma syndrome, particularly the importance of re-empowerment and reconnection as central to their recovery.
- Warn them that old symptoms may come back and new memories and feelings are likely to surface. Emphasize the importance of sharing all of this with the group. Be as matter-of-fact as possible about this point.
- Let them know that the goal of the group is *safety* and you are there to keep them safe. In addition, all of you will be working to express thoughts and feelings as freely as possible without hurting one another.
- Suggest they define a goal or series of goals for themselves that they feel they can accomplish.
- Make explicit all guidelines for meeting times and attendance.
- Be prepared for high emotional intensity. Sometimes it is necessary to modulate intensity and slow group down.

- Remind members that when they speak out for the first time they might have a strong reaction, and it is important for them to come back and tell the group about it.
- Active solicitation of input from each member is necessary each meeting time by the leaders.
- Each session should begin and end with a go-around for each member to report in and out of the group. How they are or have been feeling, etc. Control of time lies with the leaders.
- Group process comments are minimal and often non-existent. Anxiety level should be kept as low as possible.
- After the check-in of each member, the topic of discussion is in the control of the group.
- Be sure to prepare for holidays or any interruption of group meetings, and focus on that as a topic of discussion. What are they feeling? What plans do they have for getting support through these periods?
- Acting out behavior must be dealt with matter of factly and openly. Remember that most of these clients do not feel they are worth loving and tend to act unlovingly.
- Outside relationships between group members is officially approved. However, initiation for outside contact must remain with members. Members must not feel coerced into signing a list and exchanging telephone numbers must be handled sensitively. Members must be free to be different and to take that step only when they are ready.

Some Do's and Don'ts for Leaders

- You must feel safe and know what you need to do to protect yourself.
- Exploration and exposure to often sexually explicit material demands you must do what is necessary to confront your own moralistic, judgmental self.
- You cannot be neutral. The client needs to hear you say: "What happened to you was wrong and was not your fault."
- Abuse victims are equisitely sensitive to demeaning statements and you must be prepared to have your own genuineness and honesty challenged.
- Some statements to avoid:
 - a. "Your parents did the best they could." If that line is appropriate, it is theirs, not yours.
 - b. "How could your Mother protect you when she didn't know?" Volumes could be written on this one. The appropriate response is that which validates the client's expectation that a mother's proper role is one of protector.
 - c. "Most parents who abuse their children have been abused." Again often irrelevant to the therapeutic task and supports guilt, hopelessness, self-blame, and helplessness in the client.
 - d. "You must forgive your parents." Again, each client will come to a different resolution. If forgiveness is appropriate, the statement will come from the client. Premature forgiveness is often an obstacle to healing.
- Things that are important to say:
"It was not your fault."
"What happened to you was wrong."
"Your caretakers did not uphold their responsibility to you" or

"The adults entrusted with your care let you down."

"It was not your fault."

"It was not your fault."

- Reaffirm that the adult is always responsible.
- Speak to the survival value of the defense mechanism.
- Avoid attributional statements such as "You have a problem with trust." It is more therapeutic to reframe trust issues in terms of their understandable fears of vulnerability.
- All memories do not have to be uncovered. Remember the process is slow and besides, it may not be possible.

Goals of Therapy

1. Acknowledgement of trauma
2. Improved locus of control
3. Importance of self-protection and safety as a priority
4. Identification of triggers of trauma syndrome
5. Reattachment and reconnection - there is no cure in isolation
6. Acknowledgement of life-long integration
7. Freedom to play

Appendix

(The following article was placed in the student newspaper to advertise our group treatment for victims of abuse.)

As early as 1953, the results of the Kinsey Report revealed that of the women surveyed 20 - 24% reported being sexually abused. It is now estimated that 100,000 children are sexually abused each year, over half by parents or caretakers. Seventy-five percent of all cases reported involve natural and step fathers and daughters. At least 1 of 4 female university students and 1 out of 7 male university students has been sexually abused as a child. In addition, there are those who suffer from the trauma of emotional and/or physical abuse.

A high percentage of victims struggle with the effects of this experience well into their adult years, most often in painful isolation.

This isolation begins when the child victim is caught in a conspiracy of silence in the family. The child is often not believed or supported by other family members and feels tremendous guilt and shame. Fear of breaking up the family is a major factor in maintaining the painful silence.

Society's response is often no different than the family's in providing a helpful response to the victim. There are several myths surrounding the subject of incest which reinforce the conspiracy of silence.

The first is the unfortunate human propensity to blame the victim. The second is that it does not occur in "respectable" families. The third is that it only occurs in lower socio-economic groups. In addition, the incestuous father is generally thought to be degenerate or psychopathic.

In fact, incest occurs in all classes and ethnic groups, and most offenders have no measurable distinguishing characteristics. There are, however, some common family characteristics of this group.

The fact that incest occurs in the context of a caring relationship results in abuse of power and betrayal of trust that can have harmful consequences for the victim. Long-term consequences include depression, negative self-image, mistrust of men, feelings of isolation, bitterness toward mother and sexual dysfunction. Difficulty in maintaining close peer relationships is an additional problem for the victims; this is often a carryover from the isolation from other family siblings.

Victims of incest can be helped with this problem, and many successful programs exist throughout the country to help both the victims and the families. Successful treatment usually begins with help and encouragement for the victim to express and explore reactions to current feelings concerning the incest experience. The group setting has been a very effective part of treatment to help the victim break out of the common painful isolation and help overcome life-long feelings of guilt and shame.

The CMHC will be offering a group for victims of incest. The group will be confidential.

All those interested are encouraged to call the Counseling Center at 471-3515 for further information.

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