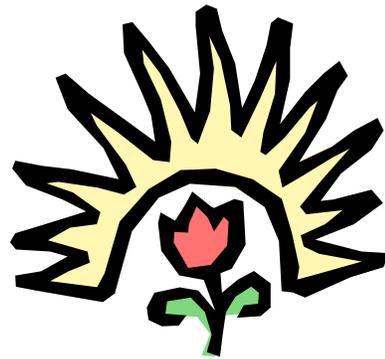


A Treatment Manual for  
Present-Focused and Trauma-Focused Group Therapies  
for Sexual Abuse Survivors at Risk for HIV Infection



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# Chapter 1

## INTRODUCTION

Sexual abuse in childhood, particularly repeated sexual abuse, can have a profound and devastating impact on the victim. Usually the abuse involves the betrayal of a trusted adult, often a father or father figure. Typically at first, the experience goes against all that the child has come to expect from her elders. The child has learned to rely on her caregivers for love and protection. At the very least, the child must rely on her caregivers to feed, clothe, and provide a home for her. Along with this comes a certain sense of predictability in her environment. With the abuse her world suddenly becomes unpredictable and dangerous. The younger she is and the more prolonged the abuse, the greater the damage to her. The experience of the world as a chaotic and dangerous place plays an integral role in her psychological development. In order to simulate some sense of safety and predictability in the world, she may use her experience as a reflection of her own badness. Thus, it is not the world that is unsafe, that causes bad things to happen to her; it is she, herself, that is the cause. Another method of coping with the danger is to dissociate each time she is abused. These split off aspects of her experience then result in the development of a personality structure that is profoundly influenced by the abuse although the person has little or no recognition of the abuse having taken place.

The consequences of these traumatic childhood experiences can be devastating, pervasive, and long-lived. In addition to the long-term psychological effects that include trauma symptoms, anxiety, and depression, adult survivors are also at increased risk being sexually revictimized, engaging in unsafe sexual practices, and abusing substances, all of which may increase their risk for exposure to HIV infection.

The best means for therapeutically addressing these ill effects is still a matter of scientific investigation. Indeed, the impetus for this study comes from a friendly disagreement between Irvin Yalom and David Spiegel, two master therapists, regarding the most effective approach to treating adult female survivors of childhood sexual abuse. Yalom's view is that, although the survivor's abuse history may explain much of why the survivor has adapted as she has, examining and understanding that history is not necessary to her recovery. Instead the therapeutic focus is on examining current functioning, illuminating in the here-and-now (i.e., in the group process) maladaptive expectations and behaviors that undermine current functioning, and beginning to learn new ways of interacting and experiencing. In contrast, Spiegel's view is that successful treatment requires activation of the traumatic material, exploration of the memories and their associated affects and meanings, investigation of the links between early experiences and current difficulties, and a restructuring of the survivor's understanding of these events so that they no longer distort her current experience and functioning.

In this manual we outline two very different group therapy interventions for adult female survivors of childhood sexual abuse (CSA) that capture the essential differences between

these therapeutic points of view: *present-focused group therapy* and *trauma-focused group therapy*. These two interventions are described together in one manual because: (1) in defining each intervention we believe it is important and necessary to describe what each entails and what each does not include (but the other intervention does); and, (2) there are many aspects of conducting groups in general, and in treating adults CSA survivors specifically, that are common to both types of groups.

The fundamental assumption underlying *present-focused group therapy* for sexual abuse is that the traumatic experiences are bound to influence the survivor throughout her life, both consciously and unconsciously. One important goal of present-focused therapy is that the survivor develop an awareness of current maladaptive interaction styles that may have originated with the abuse, although it is not necessary that she be conscious of that fact. By learning how to interact in a more adaptive way, she will feel less controlled by her past. Of equal importance is that she begin the process of changing her sense of herself with others and in the world. This involves looking closely at the participant's subjective experience during her interactions with others in the group process. This will include not only how she views herself and others, but also the measures she takes to protect herself from perceived threat. In a *present-focused* group, the actual abuse may never be mentioned, but the participant will feel less alone or abnormal, perhaps for the first time sharing her inner experience with others.

The fundamental assumption underlying *trauma-focused group therapy* is that it is vital for successful treatment that the adult survivor explore and restructure her memories of the abuse. These traumatic experiences are bound to influence her throughout her life, whether or not she is aware of them, and so one important goal of trauma-focused therapy is that she develop a sense of control over her memories. By learning how to access and control her own memories, she will feel less controlled by her past. Of equal importance is that she begin to examine how the abuse influences her current functioning. This involves looking closely at the traumatic events in her life and identifying how she came to cope with those experiences, including not only the concrete measures she took to protect herself, but also how it shaped the way she viewed herself and the way she interacts with the world now. Exploring her memories of abuse in the presence of others also provides an opportunity to have her traumatic experiences validated and to feel less alone or abnormal. Coming to understand her childhood experiences from the vantage point of an adult may allow her to find new meaning in those experiences and their impacts on her current life allowing her more freedom in her adult interactions and choices.

The present manual has been adapted from earlier editions that were originally developed from the extensive clinical experience of the authors regarding both group therapy and treating CSA survivors. These treatments have also been extensively pilot-tested. The present study builds on these past efforts. In addition to examining whether these therapies can reduce symptoms and enhance current functioning for group members, the present study has an additional goal: the reduction of HIV risk behaviors. In short, the purpose of the present study is to address the question: Is it important to focus on survivors' memories of CSA in order to reduce distress, improve functioning, and decrease HIV risk?

## **PARTICIPANT POPULATION**

### **Inclusion Criteria**

The following are the criteria that the women must meet to be eligible for the current study, regardless of which treatment group they are randomly assigned to.

- Female.
- 18 years of age or older.
- English-speaking.
- Have at least one explicit memory of sexual abuse that involved genital contact.
- At least one sexual abuse event occurred when the survivor was between 4 and 17 years of age.
- The perpetrator was at least 5 years older than the survivor was.
- The survivor must agree that she feels capable of talking about the abuse in a group therapy situation.
- Provides informed consent
- Is at risk for HIV infection, defined as meeting at least one of the following:
  - Has been sexually revictimized within the previous year; and/or
  - Has engaged in risky sexual behavior in the previous year; and/or
  - Meets DSM-IV criteria for substance abuse or dependence within the previous year.

We have selected stringent criteria because, as mentioned, this manual has been written for a study designed to compare *present-focused* group therapy with *trauma-focused* group therapy for women sexually abused in childhood who are currently at risk for HIV infection. Sexual abuse has been strictly defined for determining eligibility because answering the major question of this study will require that the participants' histories be highly credible. Clear memories of sexual abuse are important for this approach in that *trauma-focused* group therapy requires that group members be able to access memories. It is also important that members feel able to talk about the abuse. Sharing and working through memories of abuse in group therapy is difficult and so it is important that participants feel that they would be able to do this work. This also frees up more time and energy for everyone to focus on the difficult task of exploring and working through their traumatic pasts.

### **Exclusion Criteria**

The exclusion criteria are designed to screen out participants who have severe psychiatric disorders or other conditions that might impair their response to treatment and/or

interfere with the treatment provided to others. Criteria for exclusion include any of the following:

- Diagnosed as meeting any of the following diagnostic categories: schizophrenia or other psychotic disorders; dementia; delirium; amnesic or other cognitive disorders.
- Reports ritual abuse.
- Is currently receiving psychotherapy (including individual or group).
- Is currently suicidal (i.e., within the past month).
- Is judged as unable to utilize the group therapy offered in this study (i.e., those who are behaviorally or verbally threatening, hostile, or intoxicated at the time of screening or baseline assessment).

The first criterion (the psychiatric restriction) is included to eliminate those few individuals with severe cognitive or psychotic disorders and who thereby would lack the cognitive resources or reality testing necessary to do the work. The second criterion excludes individuals reporting the unusual experience (or belief) that their abuse involved ritual elements. This exclusion is necessary because these issues can be difficult to address in a group format with a heterogeneous sample and/or these reports may signal other severe psychopathology or memory disturbance. The third and fourth criteria are necessary so that study participation not interfere with other treatments already in progress or that are more clearly indicated. The final criterion excludes those who are unlikely to be able to take advantage of treatment and it is also necessary to ensure the psychological safety and integrity of the groups for other participants.

#### OUTLINE OF PARTICIPANTS' INVOLVEMENT

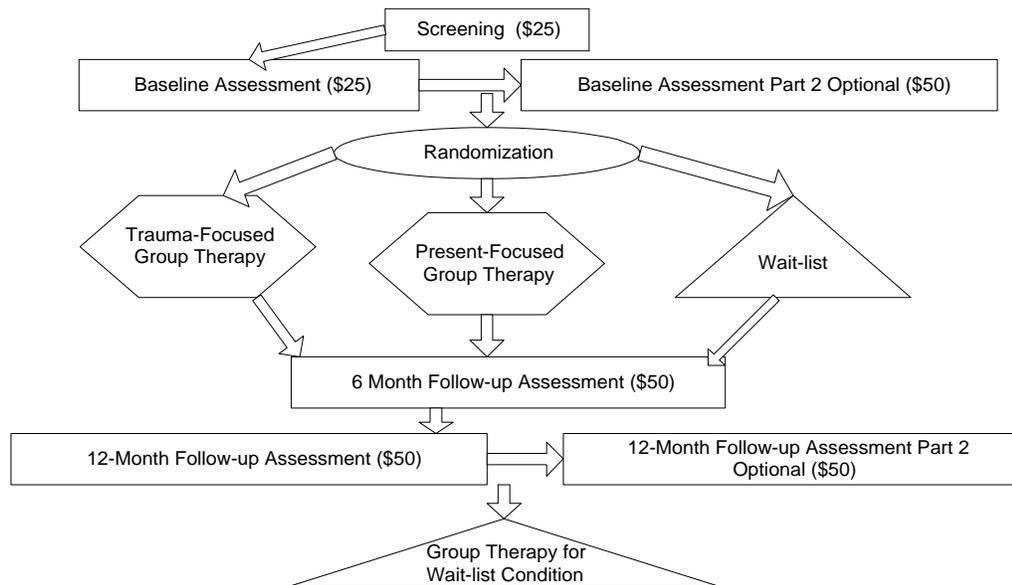


Figure 1: Flow chart describing participants' involvement

Figure 1 describes the various phases of involvement for the participants in each cohort. Once a cohort of 24 women has been found to be eligible for the study in a given location, they are given the baseline assessment. Participants are assessed at baseline, 6 months (i.e. after the first wave of groups have ended) and at 12 months (i.e. 6 months after the first wave of groups have ended). Upon completion of the 12-month follow-up assessment, participants who were randomized to the immediate group treatment condition will have completed their involvement in the study. For those participants who were randomized to the wait-list condition, their participation will continue for an additional 6 months during which time they will receive group psychotherapy. At both the baseline assessment and the 12-month follow-up assessment, participants are given the option of completing an additional packet of questionnaires. Completing these additional questionnaires is optional.

## **THERAPIST QUALIFICATIONS**

Two therapists who have group psychotherapy training and/or experience in working with survivors of CSA lead each group. Each therapist should have completed a masters or doctoral level training in a program offering training in psychotherapy. This includes psychologists, psychiatrists, social workers, MFT's, or MFCC's. Both co-leaders will be female. Although this requirement is not strictly necessary for group therapy with adult survivors of CSA, the traumatic (and other) transference issues that are invariably pulled for by male therapists necessitate that for methodological reasons (such as comparability of the groups) either all groups include a male co-therapist or none of them do. In the present study, we have chosen the latter option.

Given that childhood sexual abuse is by definition relational in nature and thus typically leads to relational difficulties, the relationship of the therapists with the group members is of paramount importance. Perhaps the most important qualifications, but yet the most difficult to operationalize, are the personal qualities of the potential therapists. A potential group leader should be someone who has the ability to establish rapport, instill confidence in her ability, and display warmth and caring. She must be comfortable working with intense emotion and should be a thoughtful listener. The group leaders should be able to work with strong transference and be aware of their own countertransference, for this is a population where problems with authority figures are common and traumatic transference is virtually inevitable (Pearlman & Saakvitne, 1995).

## **THERAPIST TRAINING**

Therapists will read the treatment manual and attend an all-day workshop. Through reading the manual and attending the workshop, therapists will learn how to provide psycho-education on the sequelae of CSA including but not limited to trauma symptoms and HIV risk factors. Therapists will learn general treatment issues and strategies for leading groups with CSA survivors, as well as specific treatment strategies for the *present-focused* and *trauma-focused* groups. The workshop will involve didactic instruction, observation of videotaped groups, and allow therapists to clarify their observations, ask questions, and practice techniques they will be using in the groups.

Once the therapists have successfully completed the training program, they will lead their first group. Each co-leading team will receive weekly supervision by an expert clinician. Videotapes of the groups will be randomly selected and observed by trained personnel to assess treatment compliance. Feedback and recommendations will be provided to the supervisor to aid in the supervision of the group. Thus, the supervisor's role is to help the group leaders both adhere to the treatment model as well as providing clinical guidance as needed.

## **PARTICIPANT MANAGER**

The participant manager (PM) is a licensed clinician and her role is to help participants identify and problem-solve anything that might be obstacles to their participating in the study. Once a woman is deemed eligible for the study, pertinent information is given to the PM so that she can contact the participant. Ideally, the PM will set up an initial interview during which time she will describe her role to the participant, gather information about her current psychosocial status (including current life situation, stressors or problems, and sources of support), and discuss the participant's participation in the study (e.g., her reasons for participating, reactions to the study, and her hopes/expectations, and concerns/fears regarding participation.) Thereafter, the PM will contact the participant by telephone every month or two and conduct a brief assessment over the phone. The participants will also be told that they can contact the PM if they need some assistance. Forms of assistance include: crisis intervention (see below for elaboration), supportive interventions, locating/making referrals if necessary, education, problem solving, assessing mental status, assessing suitability for study and following up with participant dilemmas and concerns.

The PM's role is to maintain a relationship with the participant through the course of a participant's involvement in the study (approximately 14-18 months). However, when the participant is in the intervention phase of the study the PM will no longer have primary responsibility for the participant. Thus, when the participant is receiving group therapy, the group leaders should be who the participants go to regarding any concerns or issues they have. In fact, if the participant contacts the PM during the treatment phase, the PM will steer the participant back to the group. The PM will inform the group leaders about any significant contact she has had with the participants during the group treatment phase (except for contact initiated by the PM during her routine bimonthly check-in). Limiting the role of the PM during this time is important to curtail the potential for splitting.

Regarding crises, the PM will be the person participants are instructed to contact **when they are not in the treatment phase** of the study (i.e., during the waiting period if they are in the waitlist condition or for the 6 month follow-up period after group therapy has ended). If the crisis is limited in scope and the PM can manage it then the crisis intervention will be completed by her. If the crisis is such that it requires crisis intervention counseling of 1 up to no more than 5 sessions, then the PM will refer the participant to our crisis counselor.

Participant Manager: Helen Marlo, Ph.D.  
(650) 579-4499

## CRISIS COUNSELOR

A crisis counselor is available to provide from 1-5 sessions of counseling depending upon the nature of the crisis. Participants should be referred to the crisis counselor through either the PM (i.e. when they are not in group therapy) or the group therapists (when they are in group therapy). That is, the PM or group leaders should make an assessment about whether crisis counseling is needed and then make the referral. A referral for crisis counseling is appropriate in situations where the participant feels like she is in a state of crisis and in the group therapists judgment she requires more attention than is possible to provide in the context of group therapy. This should be a fairly circumscribed situation that can be dealt with in a limited number of sessions. If the participant has recurring crises that cannot be managed by either the group treatment or a limited number of crisis counseling sessions, it may be appropriate to refer the participant for individual therapy. Please discuss these situations with the Project Director.

Note that the crisis counselor is not intended to be the person to whom a participant should call if they are suicidal. In those situations the group members should be instructed to call 919, go to the emergency department, or call a hotline. In a true emergency, they should call 919.

Crisis Counselors:     Bita Nouriani, MFCC  
                              (650) 723-8479  
                              hf.bxn@forsythe.stanford.edu  
                              Stanford University

                              Lisa Nave-Newell, MA, MFT  
                              (415) 272-4472  
                              [lisa.nave-newell@mhn.com](mailto:lisa.nave-newell@mhn.com)  
                              San Francisco

## OBJECTIVES OF THE MANUAL

The main objective of this manual is to provide concise and comprehensive guidelines for conducting *present-focused* and *trauma-focused* therapy groups for women who have been sexually abused in childhood and who are at risk for HIV. The overall goals for each type of treatment are presented in Chapter 2. These outcome goals represent the ideal outcome for these groups. It is not expected that all goals will be accomplished for all members. Chapter 3 presents a discussion of themes that commonly emerge in these groups. In the next three chapters we present the general principles that are applicable for any therapy group and those that are specific to this population. General guidelines for leading therapy groups are presented in Chapter 4, and the specific principles and guidelines for each type of group are presented in Chapters 5 (*present-focused*) and Chapter 6 (*trauma-focused*). In Chapter 7 the general and specific treatment strategies and process goals are presented. These involve a basic outline for approaching the beginning, middle and end of each type of group. In the final chapter, guidelines are presented for working with a variety of group problems,

particularly those that involve therapist interventions related to maintaining a here-and-now experiential focus.

# Chapter 2

## GOALS OF TREATMENT

Below we discuss the goals of treatment; those that are common to both treatment modalities in this study and those that are specific to each type of treatment.

In general, the *present-focused* group treatment approach is one commonly used in group therapy with many different populations (Yalom, 1995) and one that is appropriate for survivors of abuse, particularly when their current functioning is problematic. If the dysfunction is severe enough, a present-focused approach may be the treatment of choice (Herman, 1997). Survivors of childhood sexual abuse are often acutely aware of how they struggle in their daily lives. In fact, it is usually the difficulties in their daily lives that bring them to psychotherapy. The aim of the *present-focused* approach is to help survivors identify and modify the maladaptive patterns of behavior that have developed as a result of their traumatic past, without having to examine the abuse events directly. In the *present-focused* treatment the assumption is that by focusing on the here-and-now survivors can alter their current functioning and thereby address the impact of their abuse history.

In the *trauma-focused* approach the emphasis is on the examination and integration of the survivors' traumatic memories of their abuse. This is often accomplished through successive examinations of detailed accounts of specific abuse experiences that allow for an evolution in understanding of the meaning and impact of the event, and its ultimate integration into the survivors' understanding of their lives. It is important to note, however, that in a *trauma-focused* group it is often necessary to work with *present-focused* material. This may take a number of forms. (1) Group members will, at times, come to group with pressing issues from their present day lives (such as anticipated interactions with family members or recent revictimizations) that obviously need to be addressed in the treatment. (2) As traumatic material is examined by *trauma-focused* group members, it necessary to check in with group members in the here-and-now to ascertain their reactions to and associations with this material. This is done to assess the members' feelings of safety and it allows for the discussion of related traumatic memories. In addition, (3) the nature of being in a group necessitates that the group members be able to examine their interactions with and reactions to other group members and group leaders. Finally, (4) helping survivors recognize the link between their traumatic experiences and their current lives is a necessary component of *trauma-focused* therapy, for example, identifying situations in their current lives that trigger flashbacks or noting how some of their behaviors are reenactments of their childhood trauma.

So in some sense in the present study we are comparing the effects of a *present-focused* group treatment to a *trauma-focused* group treatment that also includes present-focused elements (when and where necessary). However, there is a critical difference in emphasis between the present-focused approach and dealing with present-focused material in

**Comment [RWG1]:** Lisa, I made this all caps to draw your attention to the fact that this passage describes *present focused* treatment and not treatment generally. I added the bits from the article that you left out. My guess is that you will want to move it.

a trauma-focused group. In the *present-focused* group, focusing on issues in the members' lives and in the here-and-now is the essence of the group; while in the *trauma-focused* approach, even when dealing with present material, connections will always be made (where possible) to how the matter at hand is related to the past trauma in general and to specific memories of events (where possible).

The goals described in this chapter can be thought of primarily as outcome goals. In addition to outcome goals, there are also process goals in the treatments, which are described in Chapter 7.

## **OUTCOME GOAL SPECIFIC TO THE PRESENT-FOCUSED GROUP THERAPY**

In *present-focused* treatment the goal is to help survivors identify and modify the maladaptive patterns of behavior *in their current lives* that have arisen as a result of their traumatic past (including behaviors that may be related to sexual revictimization, risky sexual behavior, and substance abuse), and to restructure their damaged view of self and others. By focusing on the here-and-now, survivors can alter their current functioning and thereby address the impact of their abuse history.

### **Identifying and Modifying Maladaptive Patterns and Restructuring Views of Self and Others**

Sexual abuse in childhood, particularly if it is repetitive, brings a serious threat to the child's development. Because it occurs at a time when the victim is in the process of establishing a sense of self, and usually involves trusted adults, the child runs the risk of incorporating the bad feelings it raises for her into her sense of self. The traumatic experiences often elicit feelings of unsafety. In order to recover some semblance of safety the child will often attribute the bad events to herself, concluding that she deserved or asked for what she got. Rather than viewing the world as unpredictable and dangerous, it is far easier to locate the badness in herself, thereby making it seem controllable.

A primary goal of *present-focused* group therapy is to help the survivor reconstruct her concept of herself by working through the self-distortions expressed in relationships. Within the context of a supportive and nonjudgmental environment, the survivor may begin to recognize the ways in which she distorts her experience and her sense of self. As trauma-related thoughts and emotions are evoked in group interaction, the survivor is able to reflect on her experience from a developmentally more mature perspective. She may become aware of the strategies she uses to protect herself; for example, how she assumes responsibility for circumstances beyond her control, or inflicts self-blame for victimization. By recognizing her real feelings and the coping mechanisms she utilizes to protect herself from painful emotions, she will be reconstructing her self-concept, integrating the impacts of the trauma into a more coherent sense of self. This may involve recognition of a loss of innocence or of a basic sense of trust. The process of restructuring her experience and her sense of herself probably will not be completed in time-limited group therapy. For some, particularly those who have a history of severe and repetitive sexual abuse, it may be a lifelong journey.

## **OUTCOME GOAL SPECIFIC TO THE TRAUMA-FOCUSED GROUP THERAPY**

In *trauma-focused* treatment the goal is to help survivors work through and integrate their traumatic abuse experiences into their sense of self. This involves helping them examine their traumatic experiences, integrate the affect associated with the trauma, reconstruct their traumatic experiences in a more differentiated (e.g., a more complex and accurate) fashion, modify the negative views of the self that arose because of the abuse, and integrate their traumatic history into their conscious awareness of self and others.

### **Restructuring, Working Through, and Integrating the Traumatic Memories**

As mentioned, sexual abuse in childhood, particularly if it is repetitive, brings a serious threat to the child's development, particularly her evolving view of self. A primary goal of *trauma-focused* group therapy, therefore, is to help the survivor reconstruct and work through her abuse memories and examine the meanings she took away from these events, so that they will not longer so negatively affect her self-concept. The survivor is encouraged to tell her story of abuse. It is by the telling and retelling of the story, in the context of a supportive and nonjudgmental environment, that the survivor may recognize the ways in which she came to distort the experience and her sense of self in order to survive. As the traumatic memories are re-evoked, the survivor is able to consider these events and the context of these events from a more developmentally mature perspective. She may discover the strategies she used to protect herself, how she may have blamed herself for what happened and why, or the many ways in which she was victimized. She may be able to access her previously warded off affective response to the abuse along with its associated cognitions. This may lead to a discovery of the unconscious meaning she attributed to the experience. She may be able to recognize and possibly even reconcile the incompatible representations she has of her abuser as both perpetrator and loving parent (Davies & Frawley, 1994). By developing a more differentiated understanding of her victimization and that she was not responsible for the abuse, she will be reconstructing her experience and integrating the trauma into a more coherent sense of self. This will also involve a recognition of what was lost because of the abuse, be it the innocence of childhood or the comforting presence of a protective and caring parent or a basic sense of trust. The process of restructuring and working through the abuse experience might not be completed in a time-limited group therapy. However, she will have made some important steps along the path to healing.

## **OUTCOME GOALS COMMON TO BOTH INTERVENTIONS**

The outcome goals common to both interventions include: 1) enhancing self esteem, 2) reconnection, 3) improving interpersonal relationships, 4) improving coping strategies, 5) reducing symptoms, and 6) reducing HIV risk behaviors.

Each of these goals is briefly outlined below. However, often the overarching outcome goals of each intervention necessitate that these common issues be dealt with differently in the different groups. Where this is the case, we have noted these differences in approach.

## Enhanced Self Esteem

Low self-esteem is a common affliction for women who have been sexually abused in childhood. Childhood sexual abuse is not just an assault on the child's physical integrity, but also on her psychological and emotional well-being. Almost inevitably the abuse damages the victim's sense of self and leads to a lowered self esteem. The precise impact of the sexual abuse, however, depends upon the age at which the abuse occurred, the frequency of abuse, the relationship of the perpetrator to the victim, the support system available to the child, as well as the victim's own resiliency. Nevertheless, it is not unusual for the survivor to suffer from feelings of guilt, shame, helplessness, rage, fear or loss (Roth and Newman, 1991). One participant spoke about the abuse as though she was buried beneath rubble. About her feeling that she is responsible for what happened to her she said, "When you are in the rubble it feels as though you are the rubble. You are a part of the rubble. It becomes hard to discern what is what." Low self-esteem can arise directly from the abuse experiences or from the effect that the abuse has on later functioning. For instance, the survivor may have difficulty in forming lasting relationships or may struggle with poor impulse control.

In the *present-focused* group, the emergence and development of the survivor's social microcosm within the group will help her relinquish the excessive feelings of guilt and shame that result from the abuse and surface in the group process. A sense of responsibility for the abuse is a way of managing the helplessness the survivor felt during the abuse. The price she pays for the illusion of control, however, is guilt, shame, and low self-esteem. Instead, the survivor is helped to recognize the ways in which she may feel helpless in the present and, in the face of that helplessness, use her own resources to survive in a way that may no longer be necessary. She is helped to look at problems in her current functioning from this vantage point. Guilt and shame may not be expressed directly and may be difficult to detect by the therapists and other group members. These affects may assume the form of defensiveness and/or anger at the facilitators when a shame response has inadvertently been triggered by interpersonal feedback, or by a question about an experience that feels too painful to share. There may be a sense that the survivor assumes more responsibility for others than for her own needs. As these experiences are explored, and as a result of the acceptance and support she receives from the group, the survivor's self esteem is likely to be enhanced.

In the *trauma-focused* group, while exploring the abuse, it is also important to help the survivor relinquish any responsibility she may feel about her abuse. As mentioned, a sense of responsibility for the abuse is a way of managing the helplessness the survivor felt during the abuse. In the *trauma-focused* group, the survivor is helped to recognize the ways in which she was indeed helpless at the time of the abuse and, in the face of that helplessness, used her own resources to survive. Similarly, the survivor is helped to look at problems in her current functioning from this vantage point. As a result of the abuse she may have learned ways to protect herself that she has carried with her throughout her life, and the group member needs to be helped to make these connections. Although the strategies she developed to cope with the abuse may have eventually become more problematic than helpful, they were her best form of defense at the time. By recognizing how they were once adaptive, it can help the survivor be less critical of herself now as she struggles to learn new, more adaptive coping strategies.

## **Reconnection**

Sexual abuse in childhood typically involves the betrayal of a trusted adult (Finkelhor & Brown, 1985; Freyd, 1996). This experience profoundly disrupts the child's sense of safety and trust in relationships. As a result of being harmed by a trusted adult (often the father) and unprotected by others (usually the mother) the child learns to withdraw and isolate herself. If those who had been the most trusted people in the child's life are not trustworthy, the child is likely to find it difficult to trust elsewhere. Naturally the more severe the abuse, the more difficult it will be to trust.

The traumatized person then proceeds through life without the usual signposts for assessing trustworthiness in others. Often this leads to a pervasive tendency to distrust, thereby seriously impairing her ability to form intimate relationships. Sometimes the survivor errs in her choices of trustworthy others, leading to revictimization. An atmosphere of threat may seem familiar rather than novel and dangerous. The revictimization eventually adds to the feeling that trust is too risky.

Problems with trust will manifest itself in the group. The survivor may have difficulty trusting the group members and/or the group leaders. Because of their position of authority, group leaders play critical roles and are often experienced as figures either real or imagined from their past, such as the perpetrator, the parent who didn't protect, or the omnipotent rescuer (Davies & Frawley, 1994). Early on in the life of the group, there may exist a false sense of trust, and it is only over time that the true level of trust becomes apparent. Helping group members develop a sense of trust and safety is a primary goal in the early stage of any group.

Because CSA survivors often have an especially difficult time trusting others, participating in group therapy with other survivors of sexual abuse provides a unique opportunity to form significant relationships with others. Because their histories are so similar, there is a natural understanding and acceptance that exists among them even when their memories are not explored explicitly. Through sharing their experiences in the group process (which happens in both the *present-* and *trauma-focused* groups) or their common histories (as in the *trauma-focused* groups), deep and significant bonds are formed. For some survivors the relationships in the group may be the most open and real relationships they have. Forming these social bonds and attachments in the group is an important step on their road to recovery (Herman, 1997).

## **Improved Interpersonal Relationships**

As previously stated, survivors of child sexual abuse often have grave difficulties in forming intimate relationships or they have interpersonal relationships that are problematic.

Researchers David Finkelhor and Angela Browne (1985) have examined how sexual abuse affects interpersonal relationships and have identified four "traumagenic" factors that seem to be the most damaging. (1) Traumatic sexualization, which refers to the fact that the child becomes sexualized before she is physically or emotionally mature. The child learns that her sexuality is subject to the desires of the abuser, along with the other dysfunctional aspects of such a relationship. (2) Betrayal, which is a consequence of being exploited and harmed by one who is supposed to protect and act in the interests of the child. Betrayal is particularly traumatic for those who are sexually abused by a parent. (3) Powerlessness, which

refers to the helpless state the child finds herself in when she cannot do anything to protect herself or stop the abuse. (4) Stigmatization, which refers to the negative meanings the child internalizes about herself from the experience of being abused – the feelings of badness, shame, guilt, self-blame, and self-hatred.

As a result of the abuse and the interpersonal trauma it entails, the survivor often develops maladaptive interpersonal strategies to somehow resolve the pain that has been experienced at the hand of others. This can result in the indiscriminate use of strategies designed to protect the self and distance the survivor from others. Or, it can involve the reenactment of abusive experiences through one's interpersonal relationships in the unconscious wish of either undoing or somehow resolving the now intrapsychic problem. These maladaptive interpersonal behaviors result in interpersonal problems in the survivor's current life.

One goal of *present-focused* group therapy is to help the survivor recognize the maladaptive interpersonal strategies she employs. Sometimes members have enough insight that they can report on their use of these strategies in their everyday lives. However, usually these strategies also emerge in the survivor's interactions with other group members and so they can be directly examined in the group process. The group setting then provides an opportunity to try out new and more adaptive ways of relating. In the *trauma-focused group*, attention is also paid to drawing connections between the trust issues and other interpersonal challenges that the survivor currently faces, and the childhood experiences that may be their origin.

Reenactments of the childhood trauma in the survivor's current life or in the group are particularly rich material for the *trauma-focused* groups. When reenactments occur (and they are often readily observed in the here-and-now interaction of the group) in *trauma-focused* groups, it is a prime opportunity to help the survivor bring to conscious awareness the traumatic memory that is provoking the reenactment along with the accompanying affect, cognitions, self-representations, and fantasies. In *present-focused* groups, when reenactments are reported (e.g., a survivor describes repeatedly placing herself in a dangerous situation) or when they occur in the group (e.g., a survivor experiences the group leader as being sadistic), this is an opportunity to help the survivor examine her behavior, cognitions and affect in light of the reality of the situation. For example, for the survivor who repeatedly places herself in dangerous situation, the aim would be to help her recognize the danger she has put herself in and to become aware of the circumstances and the state of mind she is in when she is most prone to engaging in such behavior.

The relationship with the group leaders is another area in which the survivor will manifest maladaptive strategies developed to protect herself, in this case, from authority figures. It is almost inevitable that at some point the group leaders will be experienced as the perpetrator or the adult who stood by and said nothing. These traumatic transference distortions of authority figures are bound to exist outside the group as well, where they can cause real problems. The group process, in contrast, is a safe interactional environment in which to examine these distortions and correct them.

Another area in which relationships are often seriously affected, even for those who have been able to develop and sustain relationships, is the interpersonal domain of intimacy and sexuality. Survivors may have difficulties feeling comfortable and open sexually. They may have difficulties asserting themselves, for instance, requiring that the partner use condoms for their protection. They might believe that their only value is as a sexual object.

Although the group is not a place where sexual relationships can be worked on directly, the *present-focused* group provides a safe environment in which to explore difficulties with intimacy and to learn to share one's real self with others rather than the self that must conform or control. Group members and facilitators can reflect on here-and-now process, instilling hope as survivors learn how to express and cope with the consequences of their abuse. In addition, group members can help "normalize" some of the survivor's experiences and reduce shame, and psycho-education regarding posttraumatic elements that may figure in their sexual reactions and responsiveness can be very useful. For those in the *trauma-focused* group, the group also provides a safe environment in which to discuss these difficulties and understand their origins. This is particularly true when sexual difficulties may be connected to posttraumatic stress symptomatology, such as general numbing of sexual responsiveness, intrusive images that erupt during sexual encounters, erotic preoccupations of which the survivor is ashamed, and unbidden physiological reactivity to intimate gestures or sexual contact that undermines her current sexual relationships. The emphasis on describing the abuse and making connections to sexual functioning can often facilitate understanding of current sexual difficulties. In both groups, members can often learn from one another, as well as instill hope as they learn how others worked through their difficulties.

### **Improved Coping Strategies**

Much of what transpires in *present-focused* groups is the learning of new and more adaptive coping strategies that affirm the survivor's strengths and self-esteem. Coping strategies are learned through exposure to those of others in the group and through practicing new behaviors in the group context. For example, a participant may become emotionally numb during an intense group session and cope with the experience by withdrawing. If the participant's state goes unnoticed by the group therapists she may leave and find herself intensely anxious hours later, thereby replicating the sense of isolation and abandonment during emotional pain and turmoil that she experienced earlier in life. If the therapist notices the state of the survivor then the survivor may have the opportunity to say that she feels numb or "out of touch". At that point she may be helped to become more aware of her experience and more able to ask for emotional support from the group and for help in sorting out her turmoil. In addition, identifying patterns of reactions (such as withdrawal or compensation) within the group can be used to illuminate behavior outside the group. Drawing these connections can be a powerful *present-focused* intervention.

In the *trauma-focused* approach, the emphasis is on understanding how maladaptive coping strategies originated as adaptations to the unusual events of members' early lives. As in the *present-focused* group, the group process may also be used to identify these coping strategies, investigate their origins as well as their current precipitants, and learn more adaptive coping responses. The power of psycho-education to teach survivors to examine some of their maladaptive reactions, understand how they developed, and give them the power to make new conscious choices, cannot be overstated.

### **Symptom Reduction**

There are a variety of posttraumatic symptoms that survivors of sexual abuse may suffer. These include, but are not limited to, trauma-related guilt and shame, dissociative

symptoms, psychological and physiological reactivity to things that remind them of the abuse, flashbacks, nightmares, or intrusive recollections of the abuse, and numbing. There can be an enormous pay-off in taking advantage of opportunities to educate group members about their symptoms, particularly posttraumatic stress disorder symptoms, which virtually all group members will experience. In addition, for the survivor who feels emotionally numb because of her experiences, a safe and supportive environment such as she experiences in the group should enable her to slowly give life to her frozen feelings. The first step in this is to educate group members about the specific types of trauma symptoms (all the different types of intrusion, avoidance, hyperarousal symptoms), and provide examples of how they might be experienced (e.g., fear upon seeing an adult male with a small child; not being able to return to one's childhood neighborhood; feeling physically sick upon smelling certain aftershave) and how they may interact (intrusive thoughts may, for example, invoke avoidance behaviors) or lead to maladaptive coping strategies (e.g., substance use in order to numb the pain that was activated by the intrusive thought). Indeed, in describing various symptoms, some group members may also be able to provide their own examples of specific symptoms, which may help others to correctly identify their own.

In a *present-focused* group the focus should be on identifying these reactions and their triggers, and developing strategies for symptom management. As the survivor explores maladaptive reactions and examines the ways in which she continues to feel the effects of the trauma in her current life, again without focusing on memories but staying in the present and dealing with interpersonal issues among the group members, the spontaneous occurrence of posttraumatic symptoms often decreases. Reductions in symptoms should arise out of the exploration of current experiences (in and outside of the group) related to the abuse in the context of a safe environment. She will recognize the triggers that evoke memories of the trauma or simply notice maladaptive reactions and learn new ways of managing her feelings and behavior. She will naturally begin to anticipate reactions to emotional triggers so that she can either avoid or alter them. As she recognizes the universal aspects of her experience (Yalom, 1985), feelings of guilt, shame and isolation gradually disappear.

In the *trauma-focused* group, psycho-education is also enormously helpful. By describing the range of posttraumatic reactions and discussing the circumstances in which they originate, the survivor will have much of her experience normalized and explained. Reductions in symptoms should arise out of the exploration of abusive experiences in the context of a safe environment. As the survivor explores her traumatic experiences and examines the ways in which she continues to feel the effects in her current life, the spontaneous occurrence of post-traumatic symptoms often decreases (although, in our experience, symptoms – particularly dissociative symptoms -- are sometimes exacerbated in the short-term). As in the present-focused group, she will recognize the triggers that evoke memories of the trauma and learn new ways of managing them when they arise or of anticipating what will serve as a trigger so that she can either avoid or alter it. As she explores the abuse and recognizes the universal aspects of her experience (Yalom, 1985), her feelings of guilt, shame and isolation should also gradually disappear.

### **Reduction of HIV Risk Behaviors**

It is well established that along with the many potentially dire psychological consequences of childhood sexual abuse, women with CSA histories are also at increased risk

of sexual revictimization (Neumann, et al., 1996), sexual risk behaviors (Herman & Schatzow, 1987; Conte & Berliner, 1988; Edwall & Hoffman, 1988; Briere, 1989), and substance abuse and dependence in adulthood (Herman & Schatzow, 1987; Conte & Berliner, 1988; Edwall & Hoffman, 1988; Briere, 1989 – experiences that all increase the survivor’s risk of exposure to HIV. Sexual and drug use risk behaviors are the major routes for transmission of HIV infection, and they tend to co-occur.

The present study was developed to treat adult female survivors who have been determined to be at risk for HIV infection because they have already displayed some of these behaviors. As mentioned previously, Finkelhor and Brown (1985) described sexualization, betrayal, powerlessness, and stigmatization as four of the most traumagenic dynamics that occur in child sexual abuse (and in revictimization). Each of these factors can increase the tendency to engage in high-risk behaviors and the potential for revictimization through their effects the survivor’s interpersonal relations. For example, traumatic sexualization can lead to having many sexual partners and compulsive behaviors or, conversely, to an aversion towards sex and intimacy. Betrayal can lead to faulty judgment regarding the trustworthiness of others or a profound need for a compensatory relationship. Both outcomes can result in a vulnerability to being exploited. Powerlessness can lead to a failure to prevent others from taking advantage of oneself or from harming oneself. Stigmatization can lead to low self-esteem, guilt and shame and a consequent tendency to isolate oneself and to seek maladaptive methods to self-sooth.

#### ***Revictimization.***

Women who have been sexually abused in childhood are at a greater risk for sexual revictimization as adults, including rape and attempted rape, compared to those without a CSA history (Mayall & Gold, 1995; Stevenson & Gajarsky, 1991). A number of explanations have been proposed to account for this association. It may be that the abuse experiences have compromised the survivor’s danger detection system, and this failure to be able to detect and signal danger means that the system will also fail to protect the individual from putting herself in harm’s way. Similarly, dissociative symptomatology triggered by situations that are reminiscent of the trauma may obscure the degree of risk that is perceived in a given situation thereby increasing risk. In addition, a psychodynamic view might suggest that the survivor may seek out potentially dangerous situations as a means to re-enact and attempt to master the abuse experience. Generally, these explanations are based on clinical speculation rather than definitive empirical findings; however, our own research has shown that CSA survivors most likely to be revictimized are women with the interpersonal problems of being socially inhibited, nonassertive, self-sacrificing and emotionally needy (Classen, et al., in press). Increasing the awareness of group members about how they may be putting themselves as risk for revictimization is important to examine in both types of groups.

#### ***Risky sexual behavior.***

The sexual behaviors that put people at particularly high risk of becoming HIV infected include unprotected vaginal, anal, and oral sex, particularly with multiple partners. Again, reasons for the increased rates of such behaviors in CSA survivor populations are not clear, although clinical observation and our research suggests that in some cases they are associated with a general tendency to not adequately protect oneself; failures to be assertive, especially with respect to a partner’s sexual demands; a tendency to be self-sacrificing or

emotionally needy; and/or dissociative symptomatology during sexual encounters. All these possibilities and others that group members may propose are important to explore in the group.

***Substance use and abuse.***

It has long been known that traumatized populations tend to be at much higher risk for substance use and abuse than nontraumatized populations. It is thought substance use may serve a self-medicating function, particularly in those with depression or PTSD, whereby intoxication reduces physiological reactivity, behavioral avoidance, negative affect, and cognitive symptoms. Generally speaking, the use of drugs and alcohol is thought to numb the pain arising from CSA, and some reports suggest that substance abuse can start in childhood (Walker, 1994).

There are two routes by which substance use can result in HIV infection. One is through disinhibition and diminished control over one's person that comes from intoxication, potentially resulting in risky sexual behavior or sexual revictimization (including during periods of alcohol-related blackouts). The other is intravenous drug use that involves sharing of needles or hypodermic syringes.

As described previously, a *present-focused* psychotherapy emphasizes learning about the link between one's symptomatology and the immediate environment; whereas the *trauma-focused* approach emphasizes learning about the link between one's symptomatology and one's past environment. Therefore, from a *present-focused* point of view, HIV risk behavior and distress symptoms can be lessened by making different choices based on newfound awareness. From a *trauma-focused* viewpoint, HIV risk behavior and distress symptoms can be lessened by retrieving and integrating memories of events that led to the development of these behaviors, symptoms and self-structure.

# Chapter 3

## COMMON THEMES

This chapter describes the themes that typically emerge in group therapy for women who have been sexually abused in childhood. Each of these themes addresses issues that are of central importance for survivors of child sexual abuse. Some of these themes emerge in the form of topics that the members spontaneously raise and discuss; other themes unfold and become enacted in the group dynamics, often involving the group leaders. The task of the group leaders in the *present-focused* groups is to help the group make these themes explicit *without* linking the emergence of these themes to their particular abuse histories. The therapists will base their inferential comments on the abuse histories, but the group leaders should avoid stating what he or she views as the specific links to individual abuse histories. In contrast, the task of the group leaders in the *trauma-focused* groups is to help the group make these themes explicit and to explicitly link the emergence of these themes to their abuse histories.

### SAFETY AND ACCEPTANCE

The first theme that is likely to emerge in groups of women who have been sexually abused is the need for safety. Given their abuse histories, it is a virtual certainty that one of the first and primary concerns of the group members will be whether the group is a place where they can feel safe. The concern for safety can take a variety of forms.

#### Self-Revelation

One component is likely to involve concerns about self-revelation. In the *present-focused* groups this will take the form of reluctance to engage in the intimacy required to reveal aspects of themselves and of their internal experience, and also to admit to the damage that the abuse still wreaks in their lives. In the *trauma-focused* groups, group members will have many of the same concerns but they may also be reluctant to reveal the details of their abuse histories – histories that they may imbue with a great deal of shame. In both groups, painful feelings of shame and guilt, and a sense of inner badness, are likely to make members fear that others will judge and criticize them as they criticize themselves. Thus the question becomes, can they expose themselves to the group without risking judgment and rejection? Can they trust that they will be found acceptable?

## Trust

Another aspect of the concern for safety has to do with whether they can trust that the group and the therapists will not abuse them. This concern applies especially to the group leaders who are in the roles of authority. What are the motivations of the leaders? Are they getting some vicarious pleasure out of the pain and suffering of others? Are the group leaders there in the best interests of the members? Can the leaders be trusted not to exploit them, as they have been exploited in the past by authority figures? Are the leaders reliable and predictable figures? Will they maintain appropriate boundaries? Will they ensure that the group does not become an abusive setting? Will the leaders care for them and protect them? Some of these concerns may be conscious; others may not. However, any lapses on the part of the therapists in relation to these issues will be felt by the members and contribute to feelings of unsafety.

The concerns about safety will not be enacted in the same manner for all members of a group. An example of this occurred in a group in relation to the issue of a group leader's history of sexual abuse. In response to a direct question a group therapist revealed to a prospective group member, during an initial interview, that she herself had been sexually abused in childhood. Several weeks into the group, this member raised the issue of the group leader's sexual abuse, asking that the leader reveal what had happened to her. Rather than answering the question directly, the leader asked the member to speak about why she wanted this information shared and asked the group members to express their thoughts and feelings about the request. There were two basic reactions to the issue. Some of the members felt that it was important to know the leader's history, although they were not able to articulate why. Others felt very strongly that they did not want to know the leader's history. The concerns they raised included wanting clear boundaries between the therapists and the group members, and fearing that they would have to assume the caregiver position and look after the therapist. After some discussion the leader told the group that she felt it would not be helpful to reveal her history. The issue was not laid to rest at that point, but would emerge occasionally in later sessions from the member who had requested the information. For this particular member, her stated reason for wanting the disclosure from the therapist was to know that the leader had worked through her own issues, which the group member felt necessary in order to establish trust. In the course of the therapy this member discovered that she had problems with boundaries, originating out of her relationship with her abused and abusive mother. It is likely that having a stable and clearly defined relationship with her group leaders enabled her to see the extent to which she attempted to blur the boundaries in relationships.

It is important that participants and therapists work together to establish an environment in which taking risks is encouraged and rewarded, vulnerability acknowledged, and self-disclosure encouraged. Because of the history of damage by caregivers and the sense of shame that results from victimization, participants in the group expect injury rather than support, and are initially quite reluctant to disclose themselves. Allowing themselves to be vulnerable involves becoming less vigilant and therefore may feel like an invitation to further hurt. Consequently, an atmosphere of safety, free of criticism or judgment, is extremely important to establishing a sense of safety.

## ANGER

Anger at one's perpetrators is inevitable; although awareness of that anger is less certain. Whether the survivor is conscious of her anger or not, it is likely to have an observable impact on her and frequently upon others. Some survivors may be very clear that they are angry with their perpetrators for the injury inflicted. Others may be filled with anger but it is misdirected. Still others may suppress their anger. These women may have no conscious awareness of being angry, although they may admit to difficulty expressing anger. In these situations group members can be extremely helpful to each other, sometimes finding it easier to recognize and express rage on behalf of each other rather than on their own behalf.

Some women report interpersonal difficulties due to their rage. Sometimes it may take the form of anger that seems out of proportion to what was warranted by the circumstances. It may be directed at partners, children, friends, co-workers, strangers, and frequently therapists. It is also not uncommon for survivors to state that they don't want to access their anger, particularly anger that would be directed at their mothers, because of the consequences it might have for their current lives and the shaky truces they have managed to forge with specific members of their families of origin. In addition, some women report in the abstract that they know they are (or must be) angry, but that they fear being overwhelmed and incapacitated by their anger should they truly connect with it.

One type of situation that can elicit anger is a situation that arouses the survivor's need for control. An abused child is typically a child who, when faced with an abusive situation, had very little control over the events that took place. Given no control over the behavior of her abuser, she may have sought to find control by some other means. This can take the form of dissociating, numbing her feelings, appeasing her abuser, or withdrawing into herself.

Anger at the group leaders is common and to be expected. The leaders are authority figures, usually placed in a parental role by the group members. Given that the perpetrators of the abuse are frequently parents or parental figures, they will have been perceived as authority figures, and the group leaders are likely to present a certain degree of threat. Not uncommonly, female leaders may be experienced as the unprotective mother or bystander to the abuse. Alternatively, there may be a diffuse anger towards the leaders with no clear transference role that each leader represents. Dalenberg (1999) has noted that, unfortunately, it is common for therapists to respond to hostility, anger, and aggression from clients with counterhostility, and this type of interaction has been found to be a major predictor of poor outcome in psychotherapy studies. Indeed, the member's ability to express or resolve her own anger in psychotherapy may be hindered by therapists' angry countertransference reactions. So it is critical that the therapists keep track of their own internal process in the group and seek supervision if necessary.

An issue that arises most often in *trauma-focused* groups when memories are being described is important to mention. Very commonly horrendous stories of abuse will be told in which the victims have considerable contempt for themselves and surprisingly little anger at their abusers. They either focus solely on their experience of the abuse rather than what the abuser did to them, or make excuses for the abuser -- he was sick, he was drunk, at least he paid attention to me, etc. In these situations other members of the group can be extremely helpful, finding it easier to express rage at someone else's abuser than at their own. One woman, for example, finally had the courage to look in her imagination at her father's face as

he was raping her. She began to shake as she said, "Shame on you." She said, "I realize that when he did that to me, I lost a father."

## **CONTROL**

Sexually abused children are faced with situations in which they have little or no control. Not only are they being abused, but often their abusers are people on whom they have come to depend for love and care. Faced with a situation that may seem wholly unpredictable and frightening, the victim may develop a profound need for control in her life. Not surprisingly, the need for control may be expressed during the actual abuse. Finding herself in a situation that is frightening and in which she is helpless, the victim may find ways to feel "as if" she had control. This can take the form of dissociating from the experience---just because her body has to be there, it does not mean that "she" has to. Other ways of experiencing some control during the abuse can include withdrawing emotionally or numbing her feelings. Another means is to attempt to appease her abuser in the hope that somehow the abuse can be curtailed.

Living in an abusive environment the child will learn to "read" her abuser's every emotional expression and behavior in an attempt to predict when the next onslaught of violence might occur (Herman, 1997). This strategy may provide a means of protecting herself or, at least, the illusion of control---if she can predict it, then at least she can brace herself for it. Bringing this excessive need for control into her adult life, the survivor will find herself constrained by it. It will affect her ability to form satisfying relationships or to relate to others in an open and healthy way. One woman in a *trauma-focused* group confessed that she occasionally flies into a rage with her young children. When asked whether these experiences remind her of her abuse history in some way, she began to speak about her mother's boyfriend abusing her in her mother's distracted presence. She spoke about how she used to count every tile in the kitchen when he was there. "The kids make me feel out of control sometimes," she realized. The rage, she later discovered, really belonged to her mother.

The need for control can interfere with the development of intimate relationships. By learning to "read" her abusers, particularly when her abusers were also her caregivers, a woman may have established a unique and highly idiosyncratic set of rules to govern her relationships with important others. These rules will be transferred onto her current relationships and undermine open communication. These rules may be understandable given her psychic life, but will be destructive to potential relationships. Alternatively, the survivor may have so struggled between her need for love and her loathing for the abuser and herself, that she is unable to determine whether it is love she receives or abuse.

Survivors may bring in stories illustrating their need for control or they may enact the need in the group. Frequently, enactment takes the form of struggle with the leaders for control. One woman continually engaged in a dialogue with her therapists whereby she corrected or rejected all attempts to be empathic. In addition, she criticized their techniques; while she reported she believed her therapists were well-intentioned, they were also ineffectual and occasionally harmful. What she later discovered was that when she allowed herself to experience their empathy she felt as though she were defenseless and at their mercy. Attempts to control the interactions with her therapists allowed her to feel that she could protect her deep sense of vulnerability.

## **DISTRUST**

The tendency to distrust is common among abuse survivors. This is due to the betrayal of their trust by people in whom they believed, often above all others. That fundamental betrayal makes it difficult subsequently to trust others. One woman, in a childlike voice, asked her male therapist if he were "lascivious" or "getting turned on" by her self-exposure and pain. She was not satisfied until he denied a litany of ways in which she thought he might be getting his "kicks" from her. Evidence of distrust suggests that there is something occurring in the moment that is reminiscent of abuse. This woman spontaneously recalled how, as a young woman, she confided in her boyfriend about being raped by her stepfather. He became "turned on" by her story and proceeded to rape her. Establishing safety and trust is one of the main goals in the initial stages of group therapy, and in groups for survivors particular attention needs to be paid to issues of trust and exploitation. For some individuals, there may remain a basic level of mistrust that is never surmounted. For others, the mistrust may emerge from time to time as events occur in the group that are reminiscent of earlier trauma.

## **SHAME AND GUILT**

Shame is another feeling that is common among survivors. They feel humiliated by their victimization and soiled by their victimizers. They frequently carry an unconscious belief that they elicited and could have controlled the trauma. These issues can best be addressed by attention to events and interactions in the group that are likely to elicit shame, although its expression may be indirect. For instance, the survivor may attempt to shame and humiliate the therapists in an effort to have them experience the shame that she has experienced and may experience by assuming the role of a patient in treatment or, for those in the *trauma-focused* group, the experience of facing and recounting one's abuse history. Indeed, telling their story may feel like moving toward and choosing the trauma, a re-enactment of their unconscious belief that they elicited and chose (and therefore had the ability to control) the trauma.

Some survivors may be aware of having experienced pleasure during the abuse and suffer deep feelings of shame as a result. This can pose particular problems in the *trauma-focused* group, with the shame sometimes preventing the survivor from working on her memories. Group leaders should pay special attention to this issue. Efforts should be made to normalize the experience by providing psychoeducation about the natural physiological response of pleasure when there is sexual contact. There may also be psychodynamic reasons for experiencing pleasure, for example, getting the attention one craves. Therapists in the *trauma-focused* group should be alert to this issue and make special efforts to help members who may have had this experience. Otherwise, these individuals are unlikely to talk about their abuse histories.

In the *trauma-focused* group, these issues can best be addressed by pursuing them to their source, helping them to understand their conscious and unconscious response to what was done to them, the context in which the abuse occurred, and then helping redirect the source of the shame toward the abuser.

Guilt may be more specific and focused, but may also be unconscious and diffuse. Survivors may experience deep remorse about thoughts, feelings, or behavior previous to, or

during, the trauma. The presumed willingness to go along with certain kinds of abusive behavior is a frequent source of guilt. The guilty member lacks perspective regarding her actual situation. For instance, her "willingness" to endure it may have been due to the lack of other perceived options. Although the survivor may lack perspective about situations past or present that cause her to feel guilty, other group members may be quite helpful. They can often perceive the obvious helplessness of another group member far more easily than their own.

The tendency toward self-blame is characteristic of survivors suffering from shame and/or guilt. Self-blame may take the form of self-punishment for participating in the original abusive situation, based upon the survivor's need to believe she had control. In the *present-focused* group it can be fruitful to explore how she fears a lack of control currently, particularly when she encounters situations that trigger feelings of devaluation or exploitation. This tendency may come up in relation to many areas of victims' lives, including transactions in the group. In working through a misunderstanding with her group therapist, Wendy remarked that "it was probably my fault anyway." This elicited a cry from another member, Elaine, "It really hurts me to see you blame yourself". Elaine realized that she did not want Wendy to blame herself because, she, herself was struggling with the tendency to believe that any incident that triggered a sense of abuse was her fault. In the *trauma-focused* group, the survivor's tendency towards self-blame may be readily apparent when she discusses her past abuse experiences; this is based on the survivor's desire to believe she had control over the situation. Helping the survivor examine these beliefs in the context of working through her memories of abuse can allow for new, more realistic perspectives to emerge. This is particularly so in the group context, where group member (and therapist) feedback can help her reflect on her experience of helplessness during the abuse, challenge her feelings of responsibility, and thereby reduce her tendency to blame herself for what happened to her as a child.

## **DISSOCIATION AND NUMBING**

Sexual abuse is terrifying partly because it is alien to what the child has come to expect in ordinary life. Suddenly the world becomes unpredictable, threatening and overwhelming. The pain, fear and helplessness incest or other abuse engenders leaves the child little recourse but to distort the event or to banish it from consciousness. A common means of coping is dissociation, in order to escape the terror that trauma elicits (Butler, et al., 1996; Classen, Koopman, & Spiegel, 1993; Spiegel, 1991). It is a strategy that children are especially able to utilize. Children lack the cognitive and emotional structures to assimilate sexual abuse, and, not surprisingly, use dissociation as a way to escape from the psychological impact of the event.

Dissociation is defined in the DSM-IV as "a disruption in the usually integrated functions of consciousness, memory, identity, or perception" (American Psychiatric Association, 1994, p. 477), meaning that material dissociated from conscious experience is not readily available to consciousness and may not be integrated into a child's identity. It is therefore not surprising that many survivors of child sexual abuse have difficulty recalling the traumatic events of childhood. Some survivors experience dissociative amnesia for the abuse events they endured until they are well into adulthood. Others may have amnesia for only portions of their traumatic experiences or feel that there are aspects that they do not yet recall

(see section on Unclear Memories in Chapter 8). Some might develop dissociative identity disorder as a way to manage their memories of abuse.

Survivors' difficulty remembering what happened to them will manifest itself in the group process by a tendency to enact, without awareness, aspects of the trauma. As the group interactions elicit experiences related to sexual trauma, group members will demonstrate behaviors, thoughts and feelings that they may not recognize or understand and some of which they do not approve. These may include tendencies to neglect or fail to protect and care for themselves and others, or to victimize or exploit others. It is important for therapists in the *present-focused* groups to help members to recognize these maladaptive patterns and to integrate this self-knowledge and the emotions triggered in the process. Therapists should attend to the effects on current views of the self, pointing to the fact that while this behavior may have at one time been necessary for survival, it is may no longer necessary and may be changed to reflect current circumstances.

In the *trauma-focused* group, where memories are examined directly, the survivor's difficulties in remembering what happened to them will be a common theme. As the group focuses more and more on traumatic memories, some members will find that there are large gaps in their autobiographies, or in the details of specific events, that they hadn't realized before, and some may begin to remember aspects of their abuse that they had not previously known. In addition, even for those with relatively continuous memories for their abuse experiences, the meaning of those experiences will change as they come to engage their memories, learn to manage other dissociative symptoms (such as numbing and avoidance strategies), and examine what they remember (Harvey & Herman, 1994). It is important to help these members integrate this new knowledge into their sense of their own history as well as attending to how this affects their current view of themselves and what feelings the process and new knowledge arouses.

Some individuals will continue to use dissociation as a means of coping and may dissociate during the group meetings. Group leaders should be alert to this and help the member, whenever possible, to identify the cause of her dissociation at a given moment. For instance, a group member was actively engaged in a discussion when she suddenly stopped talking, and assumed a distracted and vacant look. It took a moment to recover her attention. She was asked what had happened that caused her to dissociate. The group discussion had been interrupted by the sound of a child crying in the hallway while an adult chastised it. She reported, "I heard that child crying and it upset me." Another member who was especially prone to dissociation (and was later found to suffer from dissociative identity disorder) would frequently have memories of abuse triggered during the group meetings. The group leaders learned to monitor her for cues that she was distracted and not attending to group process and would quickly intervene to reconnect with her. In a *present-focused* group she would be encouraged to talk about her feelings and to retain a sense of connection to the group during the process, a step toward healing the profound isolation and alienation with which she had always lived. In a *trauma-focused* group she would be encouraged to talk about any painful childhood memories the experience elicited for her.

Some group members, particularly those doing *trauma-focused* work, may also report an increase in dissociative experiences outside the group. One trauma-focused group member reported that after she had started describing her abuse history in the group she had begun spacing out and losing time for extended periods at work – an experience that greatly distressed her because it felt like she was psychologically unraveling and that the effects of

the abuse were now seeping into new areas of her life. The therapists helped her understand that because dissociation had played a large part in her earlier coping (she still was amnesic for several years of the abuse) and this was the first time she had ever discussed her memories in detail, that it was not surprising that dissociative experiences would escalate as she began to explore her memories. Sensing her feelings of being out of control and knowing that there were not many sessions left to continue the trauma work, the therapists presented two options to her about how to use the available group time---they could work with her to help her put the memory aside and learn strategies for regaining control or they could help her further explore the memory so that she could gain a deeper understanding of the experience and better integrate it. In addition, the therapists committed to helping her find an individual therapist to work with her once the group was over. Presenting her with these options along with the knowledge that the therapists were committed to seeing her through the experience was itself important for giving her both a sense of control and hope about the situation. The member chose to examine the memory in more detail and in so doing discovered the moment during the abuse experience where she dissociated as her only means of protecting herself. The member continued this trauma work with an individual therapist and later reported feeling more at peace and in control of her life.

Besides dissociation, it is not unusual for survivors of sexual abuse to use numbing as a means of protecting themselves from painful feelings. Numbing of feelings often operates in conjunction with dissociation, although it can occur independently. Survivors use numbing as a way to cope with distress in their lives. One member became painfully aware of moving into a numb state whenever there were difficulties in the group and in her life, although for a long time she did not recognize the process. In the *present-focused* group, the key was to help her come to identify the experience of numbing as it occurred in the group, which she was eventually able to do. When she reported its occurrence, the group helped her to examine the events in the group and in her current life that might be eliciting this response. By the end of the group meetings she was able to use the experience as a sign that she was troubled, and then to take action to discover the source of the difficulty and rectify it. In a *trauma-focused* group, the emphasis would be similar--- teaching the woman to identify when she was feeling numb, using the group to help her to examine what was going on in her life that might be eliciting this response, and also querying whether she could identify events in her past where she had also become numb and how that helped her tolerate her experiences.

## **DISTORTED RELATIONSHIPS**

Abuse experienced at the hands of trusted adults while at an impressionable age frequently leads to distorted relationships in adult life. A survivor of child sexual abuse has learned that few people, if any, are trustworthy. The stated intentions of others are not necessarily what they appear to be. There is no guarantee that the seemingly benign or well-intentioned individual will not at the next moment exploit or abandon in time of need. More frightening, the person may have sinister intentions all along and intend to be harmful. These early experiences of important others will shape what the victim expects in her relationships.

Given the negative expectations the survivor attaches to her relationships, she develops problematic strategies for dealing with people in her life. One strategy is to avoid relationships altogether. One woman came to the group with a profound sense of isolation and a desire to become more connected with people. Her long-term goal was to be able to

have an intimate relationship and eventually marry. During the initial stages of the group she was able to talk about herself and her isolation. As the group progressed, however, and the members began to develop a deeper intimacy with one another, she became increasingly more silent until finally she retreated into herself, refusing to speak. As the leaders struggled to engage her in the group, she became angry, "Why do I have to speak? Why can't I just listen?" Over the course of the group it became clear that she was haunted by the belief that allowing herself to get close to others would leave her profoundly vulnerable and unprotected, giving them the power to exploit or abuse her.

A survivor may be volatile in relationships, which also serves to distance her from others. She may expect the worst. In addition, she brings to her relationships the rage she felt toward her perpetrator and toward those who failed to protect her. The volatile survivor is intensely ambivalent about relationships. She may throw herself blindly into relationships and then explode in anger and retreat at the slightest injury. Often this pattern reflects the way in which she experienced her abusers, who at one moment might express their love and affection for her and at the next sexually abuse and terrorize her.

Clearly, a history of sexual abuse results in the development of negative expectations from relationships. Although these expectations are appropriate for the perpetrators she encountered in childhood, they are not appropriate to all other relationships she may develop. These negative expectations become the standard she applies to others in her life. The group is a place where she can begin to examine these implicit expectations and beliefs that she brings to her relationships. In the *present-focused* group, this may be done by having the woman describe any unhealthy patterns that she has noticed in her current relationships and negative expectations that arise in the group process. In the *trauma-focused* group, the survivor can be helped to examine the nature of her early relationships and gain insight into how those experiences spawned the negative expectations that color her adult views and contribute to the patterns of relationships she may have experienced since the abuse.

## **MOURNING THE INJURY**

With feelings of safety and acceptance established, the group can turn to the exploration of group process. The loss of innocence, replaced by fear, isolation, helplessness, and a distorted view of one's sexuality, is a painful recognition that may be triggered during the events over the life of the group. In addition to mourning the loss, the survivor may mourn what might have been---having a mother and father who protected her and a sense of security and safety in the home.

One of the themes that may emerge in a *present-focused* group is mourning the injury that was done and the childhood that was lost. As *present-focused* group members begin to experience a sense of safety and protection, they become more aware of the choices that may have made in life, both in terms of their own behavior and the behavior they may expect and even demand from others, particularly mutual respect and adequate interpersonal boundaries. Many of the group members will be acutely aware of the consequences in daily functioning of the injury they suffered in childhood. They may feel handicapped emotionally and feel set apart from the mainstream. They may feel developmentally behind their peers, unable to establish stable, intimate relationships and families of their own, or to enjoy a gratifying work life. For some, these developmental tasks will need to be set aside temporarily, while they continue to explore and practice new ways of thinking and relating to others.

Similarly, having established feelings of safety and acceptance in the *trauma-focused* group, group members can turn to the exploration of the trauma. An important theme that emerges from sharing the traumatic memories is mourning the injury that was done and the childhood that was lost. Many of the group members will be acutely aware of how injuries suffered in childhood affect their daily functioning, and explicit examination of these connections should be made. Facing the painful reality of her abuse is necessary in the process of moving forward with her life.

## **ACCEPTANCE AND SHAPING THE FUTURE**

Having mourned the injury, the survivor will naturally turn to accepting the consequences of her history. The challenges here are common to group members in both present- and trauma-focused groups, however the emphasis is somewhat different. For a member of a *present-focused* group, accepting the consequences of her history may involve the acceptance of handicaps in personal development. The survivor may have perpetuated the abuse in current abusive relationships. She may have difficulty controlling her rage and inflict it upon others. She may recognize that her difficulty in relationships is due to her problems with boundaries and may not be the behavior of others as she once thought. She may see how she places herself in the victim role, thereby inviting others to take advantage of her or betray her. The ownership of problems brought to relationships or other areas of her life is an important and necessary step in acceptance. An important step in shaping a better future is to reconstruct her views of herself. The survivor who tends to blame herself may need to recognize the full extent to which she was a victim, powerless to prevent the abuse. She may also need to see that her acquiescence was the only way she knew to protect herself from even worse traumas. Along with recognizing the consequences of the abuse in her current functioning, the survivor must reconstruct her views of herself and her potential today. For instance, the victimized child who, in spite of her powerlessness, did all she could to protect herself is someone with courage and an indestructible will to survive. Similarly, in the *trauma-focused* group, an important step in mourning the injury, involves accepting her history and its consequences. This includes accepting a lost childhood, as well as the pain it caused her as a child, in addition to the consequences of the abuse (enumerated above) that she still experiences in her adult life. In the *trauma-focused* group, the survivor who tends to blame herself may need to recognize the full extent to which she was powerless to prevent the abuse. She may also need to see that acquiescence was the only way she knew to protect herself from even worse traumas then, but that this coping mechanism is no longer necessary. Both of these realizations may arise from recounting in the group the circumstances of her abuse. Along with reconstructing past views of herself, she must allow these reconstructions to shape her views of herself today. For instance, the victimized child who, in spite of her powerlessness, did all she could to protect herself is someone with courage and an indestructible will to survive that she may use to better advantage now.

For each group member, discovering what is valuable in herself and embracing it as an integral part of herself will help the survivor find hope for the future. By mourning the injury and accepting the reality of her abuse and its consequences, the survivor is in a position to work towards creating a future.

# Chapter 4

## GENERAL GUIDELINES AND GOALS

In this chapter we present the general principles and goals for leading therapy groups for women who have been sexually abused in childhood. Where appropriate we have indicated where differences in application, depending on whether the group is *present- or trauma- focused*, should be observed. The more specific principles for leading *present-focused* groups are presented in Chapter 5 and those for leading *trauma-focused* groups are described in Chapter 6.

### THERAPIST GENUINENESS AND TRANSPARENCY

Within the constraints of her role as a group leader, the therapist should strive to be genuine. Rogers (1957) describes this as being congruent with one's own internal experience. This requires that the therapist be sufficiently self-aware. Being aware of her own internal experience, the therapist can then decide the extent to which it is appropriate to share the experience with the group. Usually it is not so important or necessarily helpful that the therapist share his or her internal experience with the group, but it is essential that the therapist be aware of it.

There are times when self-disclosure can be beneficial to the group. Yalom (1985) considers "therapist transparency" as a potentially powerful tool in group therapy. However, he cautions that it be used judiciously. The needs of all the group members must be taken into consideration because what may be beneficial for some group members may not be beneficial for all. The ultimate principle in making decisions about self-disclosure is not honesty, but responsibility. When making a decision to self-disclose the therapist must be clear how this will benefit and not hinder the group.

It is not uncommon for survivors to ask their group leaders if they too have been sexually abused. If a therapist has such a history, she is advised to think carefully beforehand about how to deal with such a question. If she decides she does not want to share that information, she must think about how to explain her position. Whether the therapist answers the question or not, and whether or not it is in the affirmative, it is important to explore the underlying issue that prompted the question. Does the therapist's having a similar history or not make the room more safe or unsafe?

Having this question raised by one member can raise concerns for others in the group. Given the complete failure of their perpetrators to respect boundaries, the clear maintenance of boundaries by the group leaders is of central importance to most members. Before answering any question, it is necessary to explore how others in the group feel about the therapist answering or not answering the question. This also includes finding out how much

they want to learn or can tolerate knowing. Is it simply a yes/no answer they desire or are the details important and if so, why?

After learning how the rest of the group feels about the request for the therapist's self-disclosure, the therapist with an abuse history may decide to answer the question directly. Appropriate self-disclosure can function as a model for the group. If the leader has herself been sexually abused it can serve many purposes. One of the most powerful effects it can have is to function as a source of hope. Knowing that the therapist underwent a similar experience, was able to work through it, and go on with her life, can be tremendously encouraging. It also can enhance the women's sense of feeling understood and less alone, and can enhance trust. Finally, it can give her courage to face many of the frightening issues that confront the survivor. Nonetheless, it can also lead to false empathy, in which the leader and/or group members inaccurately presume common experiences, thereby hiding real differences.

The therapist should be aware that sharing one's history can have the effect of opening "Pandora's box"; can you set limits on self-revelation after the initial one? Whether or not to disclose one's own abuse history is a thorny question and one that group leaders are well-advised to think through carefully and discuss with their co-therapists beforehand. In thinking through and discussing these questions beforehand, the therapist should decide: 1) whether or not to self-disclose, 2) if so, how much to disclose, 3) how to maintain these boundaries, and 4) the reasoning behind the position she has taken.

## **CULTURE BUILDING**

An essential component in beginning any group is establishing group norms, or "culture building" (Yalom, 1985). Group norms are the set of implicit or explicit behavioral rules by which a group conducts itself. The group leaders can state these behavioral rules explicitly, although often they are imparted through role modeling. The members may also introduce group norms implicitly and it is the job of the leaders to ensure that such behavioral rules are in the interest of the group.

The role of the therapist is to facilitate the establishment of a set of norms that, at their most basic level, will contribute to an environment of safety and acceptance. This serves as a foundation from which the group can work. In order for the group to engage in the "work" of group therapy, there are a number of additional norms that must be established:

a) Members must show a non-judgmental acceptance of one another. Any differences that exist amongst them are to be tolerated. In this regard the therapist may need to intervene occasionally to protect a group member or to facilitate a dialogue between members who are in conflict. If underlying tensions exist, it is important to work through them sufficiently so that they do not create an unsafe working environment. In the *present-focused* group, underlying tensions often reflect the feelings of vulnerability and suspicion of motives that survivors so often bring to their new relationships – and these can readily be explored in the here-and-now process of the group. In the *trauma-focused* group, these feelings may arise in the same way, however in this type of group, the therapists can suggest that members consider and share whether some of these reactions may be related to early experiences in which they were victimized or exploited.

b) Confidentiality is an enormously important issue to most abuse survivors both for the obvious reasons and because the issue may have powerful emotional ties to earlier

negative experiences with attempts at disclosure. Group members typically need to feel fully comfortable with the confidentiality of what transpires in the group to maintain the feeling of safety in the group. It is important to address this issue explicitly in the first session and thereafter if new members join the group. In our experience, it is very productive and reassuring for group members to be able to explore and negotiate this issue as a group. In addition to developing basic rules regarding what, if anything, about the group can be discussed outside the group (and specifically with whom – spouses, children, friends, etc.), members will also want to figure out guidelines for what can be discussed among group members outside the group (for example, if they carpool together) and what members should do if they run into each other in social situations outside the group (particularly if non-group members are present). Whatever is decided, it is important that the group leader explicitly restate the decisions that are made by the group and check in with all group members to be sure each is comfortable with them.

c) Self-disclosure is another important norm to be established in groups. One could argue that it is the most important norm; without self-disclosure there would be no material to work with in the groups and, ultimately, no benefit. The issue of self-disclosure is complex, however. As Yalom (1985) argues, self-disclosure is a subjective phenomenon and therefore difficult to assess objectively. What is extremely self-revealing for one person may not be for another. Thus, it is the subjective assessment of self-disclosure that is critical. The most important aspect of self-disclosure, according to Yalom, is that it is an interpersonal act.

Within the context of either *present-focused* or *trauma-focused* groups for sexual abuse survivors, however, perhaps what is more important is the immediate experience that comes up for both the discloser and the listeners. For the listener, hearing about another member's experience may activate their own memories and feelings about abuse and exploitation. When there is self-disclosure it is very important to explore the person's thoughts and feelings around the disclosure as well as the reactions of others. Indeed our research suggests that many abuse survivors have had rather traumatic experiences associated with their early attempts to disclose personal information, including their abuse. And so trepidation about disclosure of difficult material from their present or past lives may represent a potential early barrier to full participation in the group (Butler, et al., 2000)

It is worth mentioning that the group discussion and negotiation around rules of confidentiality and also the early attempts at self-disclosure, along with the related topics of trust, intimacy, and secrecy, all offer rich initial opportunities for both groups to begin their work. (With all due consideration of the critical need in these early sessions to develop and maintain safety.) In the *present-focused* group, participants can be encouraged to closely examine their internal experience as they contemplate disclosing aspects of the current lives or hear others self-disclose. In the *trauma-focused* group, members can be encouraged to reflect on their experiences of disclosing or choosing not to disclose the abuse while it was occurring.

d) Also related to the issue of self-disclosure is group participation at a more general level. All members are expected to participate in discussions. Certainly, some members will be more active than others. With silent or near silent members, the therapist should turn to them occasionally to elicit their thoughts and feelings about the group. Not disclosing is just as much of an act as disclosing, and it can evoke reactions in other members, which should also be explored.

e) Rules should also be established around attendance, beginning on time, and informing the group leaders about absences. The central norm here is that members view the group as important and, therefore, deserving of respect and consideration.

## **ACTIVATION AND ILLUMINATION OF THE HERE-AND-NOW**

One of the active ingredients in *any* group therapy is working in the here-and-now. Yalom (1985) stresses that working in the here-and-now has two components: activation of the here-and-now and the illumination of that experience. Activation of the here-and-now occurs naturally. We cannot deny that at any given moment each of us has an immediate experience; for instance, right now you are embedded in a particular experience as you are reading this manual. The role of the therapist is to help the group attend to their various immediate experiences. This, in itself, can be powerful.

The second component involves the illumination of process. The idea is to help the group members reflect on their interactions in the group. While each woman is embedded in a here-and-now experience, they are also affecting one another. Often it is useful to help the group recognize how they are affecting each other and functioning as a group. This type of intervention is particularly useful for group psychotherapy where the primary purpose of the group is to work on interpersonal functioning, such as in the *present-focused* groups. However, it is an essential component of the group process that underlies the *trauma-focused* approach as well.

The major task of the leaders is to help the group move beyond the abstract, intellectual level towards the experiential. Working in the here-and-now provides opportunities for members to work with a problem experientially. Whatever the issue under discussion, there is always an emotional response for each person. By shifting the discussion to the here-and-now the member is helped to access her emotional response to the topic. To explore it experientially is to help the members track their internal emotional experience as it unfolds. Once they have immersed themselves in their internal experience in the group, they are then encouraged to step back from that experience so that they can learn from it. Real discoveries about one's experience will only occur if one is in touch with and explores the experience as it unfolds.

Working with *present-focused* groups, the role of the therapist is to help group members attend to their various immediate experiences, particularly as they may exist in relation to the maladaptive patterns of behavior and negative self-image. The illumination of process, as mentioned previously, also helps the group members to reflect on their interactions in the group. While each woman is embedded in a here-and-now experience, she is also affecting other members of the group. It is useful not only to help group members recognize how they are affecting each other, but how the group is functioning as a whole. The primary focus involves examining current functioning (particularly as it pertains to trauma-related problems); and how interpersonal functioning in the group is linked to the behavior in the outside world and to possible choiceful change.

In the *trauma-focused* groups, on the other hand, the aim is not directed at interpersonal functioning per se, but to examine memories of their abuse and to relate these experiences to current functioning. Certainly one aspect of this will involve examining how their abuse affects their interpersonal functioning inside and outside the group. However, it should be remembered that this is not a primary focus. The primary focus is on exploring the

past and linking it to current functioning. Activation and illumination of the here-and-now can be particularly useful for helping members of a *trauma-focused* group to come to recognize their patterns of internal experience and response, as a step toward understanding that the seeds of some of their current maladaptive behavior can be traced back to their abuse experiences. In addition, sometimes examination of here-and-now experience can be the first step to turning to the memories. When members of one *trauma-focused* group found themselves unwilling to speak about their abuse, the therapist followed up with the question, “What is it that is holding you back in the present from talking about the abuse?” Indeed, it is strongly advised to frequently check in with members regarding their ongoing experience – it also makes members feel more safe and respected.

## **GROUP PREPARATION**

### **Clinical Evaluation**

Ordinarily, the group leaders are responsible for the creation of the group. They set the time and place and, typically, are the ones to make the initial contacts and arrangements with the potential members. Because this is a research study, however, the therapists do not have the responsibility of selecting the group participants, or determining the time and place of the group, or even the nature of the intervention.

The study research assistants will conduct initial screening of potential study participants over the telephone and during the baseline screening and assessment interview. Thus, conducting a thorough clinical evaluation is not the role of the group therapist. Participants for the present study will be selected according to screening criteria (Chapter 1) that define a specific target category of the sexually abused population – those at risk for HIV. Women will be deemed ineligible for the study if they meet any of the following exclusion criteria:

- Diagnosed as meeting any of the following diagnostic categories: schizophrenia or other psychotic disorders; dementia; delirium; amnesic or other cognitive disorders.
- Reports ritual abuse.
- Is currently receiving psychotherapy (including individual or group).
- Is currently suicidal (i.e., within the past month).
- Is judged as unable to utilize the group therapy offered in this study (e.g., those who are behaviorally or verbally threatening, hostile, or intoxicated at the time of screening or baseline assessment).

### **Individual Interviews: Orienting Participants to the Nature and Goals of the Group**

Although the group participants will already have received information regarding the nature of the intervention (whether *trauma-focused* or *present-focused*), when the group will be meeting, the length of the group, and so on, it is important that the group leaders review all of this information with the group members on an individual basis. Thus, the group leaders should meet individually, if possible, with each group member prior to the first group meeting. There are several components to group preparation. These include the important

tasks of clinically evaluating group members, informing them about the group philosophy and goals, and orienting them to the particular focus of the group in which they will participate. To accomplish these tasks, all participants must be seen in individual interviews prior to the group.

During the initial interview it is also appropriate to gather information about what the participant views her problems to be and what she would like to work on in therapy. It is also important to inquire about any obstacles that might keep her from participating in the group. (Group therapists should also be aware that each participant has been assigned a “participant manager” whose primary role is to maintain ongoing contact throughout her involvement in the study with the aim of helping remove any obstacles that might prevent the woman’s full participation. This contact consists of monthly phone calls. Note that the nature of this relationship is highly circumscribed. It does not include therapy.)

### ***Purpose of the study***

In orienting participants to the nature and goals of the group it is helpful to first explain the overall purpose of this study. Despite the high prevalence of childhood sexual abuse and the growing interest in treating survivors of CSA, we actually know very little about how best to help women who have had these experiences. In fact, there has been surprisingly little research on psychotherapy for CSA survivors. One fundamental question that has not been resolved is whether survivors benefit more when psychotherapists focus on working through participants’ memories of childhood trauma or on participants’ current problems. Thus, this is the main purpose of our study. We want to know whether survivors of childhood sexual abuse benefit more from focusing on their current problems or whether it is more helpful to talk about their abuse experiences from childhood.

In our experience, it is enormously helpful when our participants understand the importance of the research question and fortunately, the significance of the research question is intuitively obvious to most people.

### ***Sequelae of CSA***

When discussing the purpose of the research study, this is a good time to provide some initial psychoeducation on the sequelae of childhood sexual abuse. (See the section on “Psychoeducation,” page 36 for more information.) When outlining the list of problems that are common for women with histories of CSA, be sure to mention that there is evidence that these women are at a higher risk for HIV infection and that this is so for a variety of reasons—being more prone to sexual revictimization, having problems with drugs or alcohol, or having difficulty asserting themselves in sexual relationships. Consequently, one aim of the study is to see if we can reduce the risk for HIV infection by reducing these risk factors.

To enter a group of strangers and talk about one’s problems and vulnerabilities is difficult for anyone; for sexual abuse survivors, who typically assume that they are intrinsically flawed, bad and unacceptable, the difficulty of this endeavor is amplified. Offering information about the emotional consequences of trauma and sexual exploitation can help allay some of the anxiety they will inevitably feel. Communicating the therapist’s awareness of some of the difficulties they experience is useful, e.g., that despite seeking help they may be deeply ambivalent about change; that they experience frequent or chronic anger, shame, pain, and alienation; that they have difficulty with control, and are unsatisfied in some way with their intimate relationships, if they are able to sustain any; that they are distrustful of

the motives of the therapists. Through beginning the process that will be repeated in the group -- reminding them that something was done to them, that they have been injured -- the work of separating symptoms of a clinical syndrome from the participant's core sense of self begins as well. This is to say that survivors will begin to understand that depression, shame, mistrust, ambivalence or anger is not due to a flawed personality, but results from the trauma itself and the ways they found to cope with it. They learn that these experiences and behaviors are not necessarily essential aspects of their personality but may be changed if they so desire.

#### ***HIV risk criteria***

Everyone in this study was found to be eligible if, along with having been sexually abused in childhood, they also met one of the following three criteria: 1) were sexually revictimized within the previous year, 2) had problems with substances within the past year, or 3) engaged in risky sexual behavior within the past year.

It is important to note that this information about the purpose of the present study is likely to be new information for most if not all participants. We did not advertise that this was an HIV prevention study because of our concern that potentially eligible participants would conclude that they were not at risk for HIV infection and thus not enroll for the study.

The extent to which each of these risk factors will be focused on in the groups will vary depending on the treatment condition to which they were assigned and on what other pressing issues are brought to group. It is important, however, to enlist the participant's agreement that their particular HIV risk factor be a focus of the group if appropriate. (As a group leader, you will be provided with information on each of your participants regarding how they met the HIV risk criteria.

#### ***Orientation to group focus***

During this initial individual meeting, future group members are also prepared for the group intervention. This involves discussing the purpose and structure of the group, with attention to the *trauma-* or *present-focused* aspects depending on the type of group the participant will be joining.

For those in the *present-focused* group, the group's emphasis will be on the challenges that group members face in their present lives (including the HIV risk factors already described) and the interactions and issues that arise in the group. The *present-focused* group will not be focusing on the recall of abuse histories. In a *present-focused* group it will be important that they be aware they will be asked to actively participate in the group process and illumination of the here-and-now.

In the *trauma-focused* group, the focus of the group will be on members examining their memories of abuse. The aim is to help them get a better understanding of these experiences, including the impact of these events on their sense of self and on their past and current functioning (including but not limited to their HIV risk factors). For those who are going to participate in a *trauma-focused* group, it will be important that they be aware they will be asked to discuss their memories of abuse.

In both cases, it is also important to discuss the value of their willingness to use the group to attempt to enter psychological areas they avoid or distort. For example, most sexual abuse victims feel shame, and to avoid shame they avoid revealing many real thoughts and feelings, particularly if their acknowledgment might invite criticism or show vulnerability. If they can tolerate the shame they feel when they describe their inner experiences, the

entrenched feelings of shame may begin to change within the supportive network offered by the group members, and the participants may begin to realize they are not, after all, defective, evil or unworthy.

Two goals that are not appropriate for group work in this study are: (1) “*Recovering memories from periods for which the group member is amnesic* -- although some trauma memories may become more clear or elaborated for those who discuss them in the *trauma-focused* group, and some members may recover new memories incidentally while participating in either type of group, the recovery of previously inaccessible memories is not and appropriate goal of either type of group; and, (2) *Preparing group members to confront their abuser/s* -- many abuse survivors incorrectly assume that to fully recover from the trauma they need to have a “showdown” with the abuser and, therefore, that this should be a goal of therapy. In our view, group work can be helpful to a member who is trying to decide whether or not she wants to confront her abuser by helping her examine the assumption that she needs to, and also to evaluate what is behind her desire, what her outcome fantasies are, and how she will feel should the confrontation have different results. It should go without saying that therapists should not endorse or push group members toward a particular course of behavior.

In our experience it is essential that group members understand the nature of the group to which they have been assigned and the rationale for the approach. This is especially important because they have been given no choice over which approach they will receive and some participants will come into the study with a definite preference for one approach over the other. Understanding the purpose of the study, the importance of the research question, and being presented with a compelling rationale for the particular approach they have been assigned to is usually sufficient to address any concerns they may have and will reduce the likelihood of competing expectations that could disrupt the group process.

#### ***Group structure and rules***

During the individual meeting, it is important to state clearly the basic structure and time frame of the group, the length of time the group will meet, as well as the focus and purpose of the group. General information about the structure of the group should be provided in these pre-group interviews, so that participants will know what is expected of them. Participants should be told when the group will start and end, and that it is important they be on time and attend all groups if they possibly can. Missing meetings is a cause for concern for therapists and group members alike, and participants should be asked to inform the therapists if they expect to miss a meeting.

The leaders should also review ground rules for the group. This includes discussing rules about maintaining confidentiality, attendance and commitment, the use of psychoactive substances (members are not permitted to come high to group), verbal and physical abuse, and outside contact. Admittedly, this is a lot of material to cover but in our experience it is helpful for establishing feelings of safety in the group.

Even with all of this preparation, some group members may not fully understand what to expect in group therapy and thus the group leaders should be alert to this and prepared to deal with issues as they arise. For example, in one *present-focused* group, a member did not completely understand the here-and-now focus of the group, and, because the leaders failed to address the issue as thoroughly as they might have in the first session or two, others eventually joined in an avoidance of some important interpersonal struggles in the group

process. The therapists addressed the issue after it became clear that the women who were using this as a coping mechanism to avoid the deepening the intimacy of the group, were less engaged in the group process. Ideally, it would have been preferable to have the leaders address the problem as soon as it emerged. In another example, in a *trauma-focused* group, one member began to bring her knitting to the sessions and, because the leaders failed to address the issue, others eventually joined in the knitting game. It became apparent that knitting was used as a strategy to avoid fully engaging in the difficult work of examining memories, and in experiencing and sharing the emotions that the stories were evoking. The therapists eventually addressed the issue, however, again it would have been preferable to have the leaders address the problem as soon as it emerged. Since avoidance is a primary coping mechanism employed by trauma victims, therapists should expect and be alert to such developments in the group.

#### ***Protocol regarding therapist/participant contact outside of group***

Participant contact with therapists outside of group should not be encouraged. There are several reasons for this. One reason is the potential detrimental effect on the group as a whole. For example, outside contact with one or both therapists can increase the likelihood of splitting, it can give the appearance of some members being more valued than other members, some group members may be more comfortable discussing issues privately with the therapist and therefore may not fully use the group, and outside contact can lead to the keeping of secrets. These are only a few of the issues that are especially significant for trauma survivors and that are likely to become more problematic if the boundaries regarding outside contact are not clearly defined. A second reason outside contact should be discouraged is the need to standardize the interventions provided in this research study. Therapists will likely vary in their willingness and availability for contact outside the group. This difference can result in the potential for a good deal of outside contact in some groups but not in others, therefore making it difficult to assess treatment outcome. Holding outside contact to a minimum will guard against this possibility.

Participants should be informed that they may call the group leaders to inform them if they anticipate being absent from or late to group. They should be told not to expect a call back. Participants should be given a list of resources they can contact during the week if they are in crisis and need immediate assistance. They should be informed that in the case of a true clinical emergency they should call 911 or take themselves to a Psychiatric Emergency Department. It may be useful to ask all participants to identify the hospital with psychiatric emergency services that is nearest to her. Any other issues should be brought to the next group meeting and not left on the group leader's voice mail.

#### **INITIAL SESSIONS**

The beginning phase of both treatments has three goals: 1) establishing a basic sense of trust and safety in the group, 2) having each group member share with the group the problems she plans to work on in therapy and the goal she has set for herself (participants will be especially encouraged to work on problems related to sexual revictimization, engaging in risky sexual behavior, and substance use), 3) providing psycho-education regarding the traumatic effects of CSA and how that might be manifested in their lives today as well as in

the process of participating in group therapy and, 4) orienting the group members to the orientation (the *trauma* or *present* focus) of the intervention.

Establishing a rudimentary sense of trust and safety is crucial for reducing distress and bolstering their ability to tolerate and cope with the painful affect that will be stimulated by discussion of their current difficulties or traumatic past. This can take anywhere from 2-9 sessions. Indeed in one group, where all of the group's members were not present at any given group meeting until the 9<sup>th</sup> session, the task of establishing safety was clearly re-animated each time a new configuration of group members was present. The task of the treatment during this early phase is to establish a therapeutic alliance and help members identify their feelings of mistrust along with the specific fears that have been activated by being in the group.

The participants will enter the first group feeling unsafe, anxious, and cautious. The therapists should structure the beginning of this session by introducing themselves; welcoming the participants; and reiterating the central purpose of the group. Participants should be asked to introduce themselves, which should include some information about what they hope to gain from participating in the group, and possibly what they might be seeking from other group members, such as understanding, support, or feedback. In the *trauma-focused* group, participants should also include at least some information about their abuse histories. In all groups, participants must be allowed to set limits as to the extent of self-revelation. Most will need careful and gentle solicitations of their responses; others may need curtailment of a tendency to expose too much too soon, as they may in their anxiety leap into a magnitude of self-revelation that will leave them feeling over-exposed and may overwhelm the group's fragile sense of safety.

The fundamental task of the early groups is to establish a sense of safety so that participants will feel able to explore their experience, and for those in the *trauma-focused* group, so that they can reveal their traumatic histories later on. The need for safety cannot be overemphasized; consistent empathy by therapists is absolutely crucial for this type of group and underlies the possibility of safety for participants. In both groups, therapists must be able to recognize the inevitable failures in empathic containment, which occur in all therapy, and attempt to repair them. This attitude also supports another early task of the therapists, which is to reflect survivors' emotions while beginning to challenge cognitive distortions. Therapists, in this manner, begin to model relationships where the survivor's needs and feelings are of central interest, both in the sense of listening and understanding, and of opening the door to new possibilities. For instance, if a group member asks for time to talk and does so by putting herself down or devaluing herself, the therapist might say, "It seems understandable that you need a moment to share your feelings with the group after such a trying day, but I wonder why you devalue yourself as you ask for something reasonable. I wonder if you feel unsure about our interest or expect to be judged somehow."

For the purpose of establishing safety, therapists should be alert to potentially destructive confrontations early in the group and attempt to defuse or divert them. Anger is a pervasive area of difficulty for sexual abuse victims, with some women experiencing frequent difficult-to-control anger, and others feeling out of touch with the emotion. Anger is more likely to be directed at therapists than at group members, but therapists should be prepared to intervene if group members are targeted. Some participants may become angry when therapists encourage greater self-revelation, challenge their cognitive distortions, or attempt to contain excessive emotionality. Participants who have great self-contempt may turn their

anger on the therapists when this contempt is noted. At these times therapists should acknowledge, accept, and help contain anger. It is a theme that will arise repeatedly throughout the group.

It can be assumed that women who have been sexually exploited as children will experience core conflicts about their right to have emotions, and whether they can trust what they feel. Their experience has been that their emotions have no validity interpersonally. In addition, they will distrust the intentions of anyone who professes interest in their inner experience. Disguise of the core self is an automatic and usually unrecognized part of most subjective communication. This pervasiveness of distrust and emotional secretiveness will typify the early groups. It may take many forms, from mute paralysis, aggressiveness, obsequiousness, rigid rationality, to extreme social charm – anything to divert attention from the self. At this early stage, empathy, patience, and focus on the task of making the group a safe place to reveal oneself are paramount. Therapists should assume the issues of interpersonal trust and self-doubt will recur in different forms and will need to be acknowledged and worked through repeatedly, especially in these early groups.

### **Psychoeducation**

During the second (or if necessary third) session, the focus should be on psychoeducation regarding HIV risk factors. Because one of our aims is to reduce the risk for HIV infection, it is essential that we provide education, especially regarding safe sex. During this session, participants should be presented with the rationale for the study particularly as it pertains to the HIV risk factors. This will include discussing the problems that are common for women with histories of sexual abuse. Special emphasis should be placed on the three risk factors: 1) sexual revictimization, 2) risky sexual behavior, and 3) problems with drugs or alcohol.

#### ***Prevalence of CSA and sequelae***

The prevalence of child sexual abuse (CSA) among females in the general population is high, ranging from a low of 4.5% of girls reporting sexual abuse by a father or stepfather (Russell, 1986), to highs of around 13-27% if sexual abuse is defined more broadly (Finkelhor & Dziuba-Leatherman, 1994; Finkelhor, et al., 1990; Koss & Dinero, 1989; Roth, Wayland, & Woolsey, 1990). It is even higher in certain communities where the majority of matched samples of white and African-American women report having been sexual abused (Wyatt, 1985). A large number of those sexually abused as children appear to experience later distress as well as behavioral and interpersonal problems (Chu & Dill, 1990; Gelinias, 1983; Herman, Russell & Trocki, 1986; Westen, et al., 1990).

Numerous studies have documented the psychological and behavioral sequelae of CSA (Browne & Finkelhor, 1986; Beitchman, et al., 1992; Polusny & Follette, 1995). The long term effects of CSA include PTSD (Rowan & Foy, 1993; Rowan et al., 1994), major depression (Pribor, 1992), anxiety disorders (other than PTSD) (Pribor, 1992), dissociative symptoms (Briere, 1991), borderline personality disorder (Herman & Schatzow, 1987), alcohol or substance abuse (Herman & Schatzow, 1987), and suicidality (Saunders, et al., 1992). Along with psychiatric symptoms, research has shown that childhood sexual abuse is related to poor social adjustment and interpersonal skills (Wyatt, 1985; Browne & Finkelhor, 1986), revictimization (Beitchman et al., 1992), sexual dysfunction (Herman, Russell &

Trocki, 1986; Briere, 1988; Gorcey, Santiago, McCall-Perez, 1986; Hunter, 1991; Jehu, 1989; McCarthy, 1990; Mullen, Martin, Anderson, Romans, & Herbison, 1994; Tlamadge & Wallace, 1991; Wyatt, 1990), and relationship problems (Cahill, Llewelyn & Pearson, 1991). Problems in interpersonal functioning may stem not only from the sexual abuse itself, but also from the context of family dynamics in which the sexual abuse occurred, with powerful and lasting effects on the abused child's personality (Pelletier & Handy, 1986). Of these sequelae, sexual revictimization, sexual risk behavior and drug use place the CSA survivor at greatest risk for HIV infection.

### ***HIV risk behavior***

Sexual and drug use risk behaviors are the major routes for transmission of HIV infection. As noted, both risky sexual behavior and substance abuse (Herman & Schatzow, 1987; Conte & Berliner, 1988; Edwall & Hoffman, 1988; Briere, 1989) have been shown to be sequelae of childhood sexual abuse. The use of drugs or alcohol is thought to numb the pain arising from childhood sexual abuse (Walker, 1994). There have been some reports that substance abuse can start as early as the age of nine (Walker, 1994). There are two routes by which substance abuse can result in HIV infection. One is through disinhibition and the diminished control over one's person that comes from intoxication, potentially resulting in risky sexual behavior or sexual victimization (Cooper, Peirce & Huselid, 1994; Kelly, et al., 1993; Koopman, Rosario & Rotheram-Borus, 1994; Stall, et al., 1986). The other is intravenous drug use, involving sharing of needles or hypodermic syringe, and another major route of transmission (Des Jarlais, et al., 1989). Therefore, use of drugs and alcohol can increase the risk of becoming HIV-infected, especially when the sexual partner has HIV infection (Kelly, St. Lawrence & Brasfield, 1991; Ostrow, et al., 1990; Penkower, et al., 1991).

Sexual risk behavior that puts people at particularly high risk of becoming HIV infected include unprotected vaginal, anal, and oral sex (Hearst & Hulley, 1988; Stall, 1987; Winkelstein, et al., 1987). The majority of persons with AIDS have reported one or more sexual/IV drug use risk behaviors as a likely route of transmission of HIV (CDC, 1997). Sexual and drug use risk behaviors tend to co-occur. For example, a strong relationship has been found between high-risk sexual behavior and polydrug use (Stein, Newcomb & Bentler, 1994). Persons who engage in risky behavior have been shown to be capable of dramatically changing their risk behaviors in response to the threat of AIDS (Becker & Joseph, 1988; Catania, et al., 1991; Des Jarlais & Friedman, 1988; Ekstrand & Coates, 1990).

Specific information regarding what constitutes safe sex will be provided.

### ***Sexual revictimization***

Women who have been sexually abused in childhood are at a greater risk for sexual revictimization as adults. In a community sample of 930 women, Russell (1986) found that approximately 60% of the women who had been abused in childhood also reported being raped or having experienced attempted rape after the age of 14, compared to 35% of women with no history of childhood abuse. Wyatt, Guthrie and Notgrass (1992) surveyed 248 women and found that among 61 women who had been sexually abused in childhood 56% reported having been raped or having experienced attempted rape as adults. This was in contrast to 15 (21%) of 72 women who had no history of sexual abuse in childhood. A prospective study of 857 female college students (Gidycz, et al., 1993) examined the

relationship between childhood sexual abuse and revictimization in adolescence and adulthood and showed that childhood sexual abuse predicts revictimization in adulthood. Other researchers have also found that women with histories of child sexual abuse are more likely to be sexually revictimized as adults than are women with no histories of childhood sexual abuse (Mayall & Gold, 1995; Stevenson & Gajarsky, 1991). A recent meta-analysis of 38 studies confirmed that women with histories of childhood sexual abuse are more likely to be revictimized as adults (Neumann, et al., 1996). Given this increased likelihood of being sexually revictimized, this places CSA survivors at an increased risk for HIV infection.

Both sexual revictimization and risky sexual behavior may occur for a variety of reasons. Our research has shown that revictimization is associated with problems in being assertive, socially avoidant, self sacrificing, and needy (Classen, et al., in press). These characteristics are also likely to be related to engaging in risky sexual behavior. For example, a woman may feel unable to insist that a condom be used or she may be so emotionally in need of the closeness that she will do whatever she needs to get it. Dissociation is another factor that may lead to both revictimization and risky sexual behavior. If a woman is dissociating because she has been triggered by something (and this is highly likely to occur in a sexual situation), she may be unable to control what is happening to her body. Helping participants recognize the link between HIV risk factors and other problems she has will be important for participants understanding and agreeing with the treatment rationale.

## **MIDDLE SESSIONS**

It is in the middle sessions that the content and goals of the two different interventions diverge markedly. What is distinct about each orientation is discussed separately in the next two sections; what they have in common is discussed in the third section.

### **The Present-Focused Group**

Assuming the successful completion of the task of establishing safety, the middle sessions for the *present-focused* group will be the ones in which participants work to understand their ways of being in the world and their interpersonal patterns of relating, particularly as it unfolds in group process. Survivors of childhood sexual abuse are often acutely aware of how they struggle in their daily lives. In fact, it is usually the difficulties in their daily lives that bring them to psychotherapy. The aim is to help survivors identify and modify the maladaptive patterns of behavior that have arisen as a result of their traumatic past, including behaviors that are related to sexual revictimization, risky sexual behavior and substance abuse or dependence.

In the *present-focused* treatment the assumption is that by focusing on the here-and-now we can help survivors alter their current functioning and thereby address the impact of their abuse history. The intent is to allow group members to explore their ongoing interpersonal experience in a supportive environment and as part of a community. In the group they are able to set limits on self-exposure, and their subjective experience is overtly valued and affirmed. The abusive events were typified by isolation and secrecy; the survivor

learned that there was no refuge from "self as object" except by inner furtiveness; formative interpersonal events, fundamental to the development of her personality did not include a recognition of her needs or feelings. Hence, she now lives alone with her real self, a murky place, psychologically absent from interaction. Consequently, the victim's subjective sense of self may not be distinct from her sense of herself as an object, except at the level of victimization, where the pain and feelings of danger, disorientation and helplessness are overwhelming. For example, one participant brought a beautiful poem that she wrote to share with the group. At the same time, she had been deeply troubled by recent publicity about a cult where the cult leader sexually molested children. She was surprised at the understanding and support she received from the group as she grieved the loss of a real childhood for the children. She suddenly recognized that it was the loss of her own childhood that she was grieving, and was surprised to find that her poem expressed her grief and hope in a way she hadn't recognized and that it brought comfort and hope to the rest of the group. She was surprised first, that the group listened and understood her feelings, that she expressed them so coherently in the poem, and that she could move others so deeply by her grief and her sturdy sense of hope for the future. Her deep subjective self seemed unavailable until the group empathy helped her recognize her own grief. She was surprised that she could share and explore in safety, and that she was able to have an impact on others both through expression of her feelings and her poetry.

Another aspect of focusing on the here-and-now experience is to identify and utilize group process for interpersonal learning. The group examines how individuals interact with one another and with the group leaders. This helps members step back from their subjective experiences and view them from another vantage point. This enables them to recognize maladaptive interactive patterns, the unconscious messages they convey, basic assumptions they hold, or the ways in which they distort incoming information.

#### ***Process Goals of Present-Focused Group Therapy***

During the middle phase of *present-focused* treatment the focus is shifted to participants' here-and-now experience, particularly as it relates to experiencing trauma symptoms and interacting with one another in the group. There are several process goals for this middle phase of treatment.

The *first goal* of this phase is to help members become increasingly more aware of their own internal affective and cognitive states. The therapists should actively query group members' reactions to the experiences they report from their lives and those they feel in response to what happens in the group. With practice, group members will gradually hone their introspective skills and be able to identify and report their internal experience.

The *second goal* is to help participants tolerate these difficult internal affective and cognitive states. When difficult states are experienced, the goal is to help the participant go through the experience, as opposed to running away from it as they do when they dissociate or use alcohol to numb the pain. Many of the current problems in survivors' lives stem directly from maladaptive coping strategies that they use to manage their trauma symptoms or their negative views of self.

The *third goal* is to help group members recognize the triggers for their trauma symptoms and how they are affected by others, and learn ways of managing their trauma symptoms and expressing their needs, concerns, or fears as soon as they arise.

The *fourth goal* is to help members learn to identify patterns of behavior or response that may put them at risk for HIV infection. Each group member will have her own unique pattern of vulnerability – and so discussion of risky behaviors will need to include all of the following: identifying patterns of relating that might make group members prone to sexual revictimization; recognizing when they are engaging in risky sexual behavior and the circumstances surrounding that behavior; and, understanding when and why they use substances (if they do). Especially with drug use, examining the role and ritual of drug use in a member's everyday life can illuminate how she maladaptively copes with stress and trauma symptoms and consequently puts herself at risk.

The *fifth goal* is to enhance the group's sense of shared experience as well as their differences, to decrease feelings of alienation from self and others, and to promote self-acceptance among all group members.

### **The Trauma-Focused Group**

Assuming the task of establishing safety has been adequately accomplished, the middle sessions of the *trauma-focused* group will be the period in which participants work on revealing the details of their traumatic histories. The intention of this revelation is to allow participants to examine their memories of the abuse in a supportive environment and as part of a community. In the group they are able to set limits on self-exposure, and their subjective experience is overtly valued and affirmed. The abusive events were typified by isolation and secrecy; the survivor learned that there was no refuge from "self as object" except by inner fortiveness -- formative interpersonal events, fundamental to the development of her sense of self, did not include her needs or feelings. Hence, the survivor lived and still lives with her deep self, a murky place, psychologically absent from interaction. As a result the victim's subjective sense of self is not distinct from her sense of herself as an object, except at the level of victimization, where the pain and feelings of danger, disorientation and helplessness are overwhelming. Most participants will go to great lengths to avoid feeling the terrible sense of disorientation and emotional disorder that is the emotional core of the abuse.

An important role of the therapists during the middle phase of *trauma-focused* treatment is to begin to teach the group members about the meaning of their trauma symptoms and to link their trauma symptoms to their trauma histories. The therapists must listen closely to both the verbal and nonverbal communication. Sometimes group members talk spontaneously about their traumatic past and at other times trauma-related material arises covertly. When the trauma-related material is covertly presented, the therapist helps the survivor examine how this material is related to her abuse experiences. As previously mentioned, in the *trauma-focused* approach the emphasis is on the examination and integration of the survivors' traumatic memories of their abuse and this is usually accomplished through successive examinations of detailed accounts of specific abuse. These experiences allow for an evolution in understanding of the meaning and impact of the event, and its ultimate integration into the survivors' understanding of their lives.

#### ***Process goals of trauma-focused group therapy***

There are several process goals for this middle phase of *trauma-focused* treatment:

The *first goal* is to help the person who is sharing the memory to access the verbal, affective and perceptual traces of the memory as fully as possible. This is of central

importance because it addresses a main maladaptive coping strategy, which is to dissociate aspects of the traumatic experience. Consequently, helping survivors to fully access their cognitive, affective, visual, auditory and other representations of the trauma is essential for reconstructing and integrating the meanings and beliefs derived from the traumatic experiences into their conscious experience of self and others. Often the reconstructions occur because the survivor is able to access information that had previously been unavailable or only partially available, thereby enabling her to reconstruct these events more adaptively.

A *second goal* is to work through the transference expectations that the survivor has in telling her story to the group. The aim is to achieve an experience in the group that disconfirms her fears about the judgment of others in response to the trauma.

A *third goal* is to help the individual understand how the trauma is connected to the problems she has chosen as her focus in therapy, including problems that may make her prone to revictimization or to engage in risky sexual behavior and substance use. Drawing the connections between recent revictimizations, or unwise sexual behaviors, or ongoing substance use and early traumatic experiences can be extraordinarily illuminating for survivors. The traumatic experience can thereby be drawn on during the remainder of the therapy to assist the individual as she works on her self-identified problems and towards her treatment goal.

As in the *present-focused* group, the *fourth goal* in the *trauma-focused* group is to enhance the group's sense of shared experience as well as their differences, to decrease feelings of alienation from self and others, and to promote self-acceptance among all group members.

### **Common to Both Interventions in the Middle Sessions: Content and Process**

It is common in the middle sessions of both types of groups for some participants to begin to reveal that they feel overwhelmed by intrusive events, although they may be very conflicted about revealing the magnitude of their woundedness, finding it shameful. The yearning to be "normal" comes up frequently. Others will have great difficulty getting access to their own deeply-buried and long-forgotten feelings about their victimization; they often feel great sympathy for the pain of others, or are greatly moved by the courage, or generosity, or kindness they see in others, but find themselves utterly unable to experience their own suffering. It is expressed instead by convoluted self-perceptions, usually characterized by self-contempt, occasional grandiosity, and contorted personal relationships. An example of one kind of contortion involves caring for everyone but the self, not recognizing that the care for others may be intrusive, and the self-neglect and over-accommodation painful or uncomfortable for others. Revealing themselves with affective awareness is very difficult and circuitous for these participants; patience, support, and gentle confrontation of distorted thinking (e.g., the participant persists in asserting responsibility for the abuse while excusing her abuser) are required by the therapists.

The anger, pain and distrust experienced by sexual abuse victims are monumental; defenses against awareness of victimization are very powerful, as the disorientation they protect against is profound. Therapists should approach this work aware of the maelstrom that composes the inner world of many sexual abuse survivors, and aware also that the participants' relationships with the therapist will reflect that world. Consequently, transference to the therapist is particularly emotionally loaded. Therapists may find

themselves as targets of intense anger, especially if they are perceived as withholding or inadequately empathic while in pursuit of participant self-revelation. Imperfect empathy by therapists may evoke particularly strong reactions of frustration, anger, and discouragement. Conversely, participants often yearn most for affirmation, understanding and protection from therapists, taking for granted that other women are able to understand. Teamwork by both therapists in maintaining empathy and reality testing both is important.

The *present-focused* group is intended to support participants in reaching feelings and in accessing whatever pathogenic beliefs are influencing current functioning and interpersonal relationships. In order to acknowledge and relieve painful suffering, participants must experience it during the group process. Otherwise the group becomes a sterile intellectual exercise. The *trauma-focused* group, on the other hand, is intended to support participants in reaching the feelings of victimization, as tolerated, so that their stories may be witnessed by their peers and their suffering acknowledged. Reaching the suffering will be extremely difficult for many participants; tolerating any expression of shame and suffering will be the hardest task for others. But if they can share emotions with sympathetic others, they may begin to imagine the potential of relationships that are not inherently destructive, indifferent to them psychologically, or exploitative. The importance of establishing as much safety as possible before such fundamental tasks can be attempted is apparent.

It is inevitable in both types of groups that participants will feel ambivalent about choosing to face such suffering and to risk hope. Abandoning the security of distrusting others takes great courage, and therapists should expect to deal with this repeatedly. They should be quick to affirm participants' efforts, while encouraging them to continue. Participants may feel that they hurt too much, and that their pain is too dangerous for the group; they may fear that even the therapists will be unable to tolerate the magnitude of their distress, or to protect them from total loss of control if they attempt to enter it. These are serious concerns for the participants; therapists should offer repeated reassurance, but a demonstrated respect for the courage involved and environment of safety will be the major determinants.

Therapists should not underestimate the difficulty these groups can present for themselves as well. Successful empathy will open them to the participants' distress, while they must stay adequately detached to monitor safety for the group as a whole, and for individuals immersed in the profound and sometimes chaotic emotion that will be triggered in the group process with this population. The work is demanding and should be undertaken only by therapists with an adequate support system.

Therapists may expect that the inevitable moments of empathic failure will likely elicit strong responses in these groups; abuse survivors attempting self-revelation are exquisitely sensitive to loss of empathic containment. It may be difficult to anticipate the point when a participant will feel pushed too hard, inadequately affirmed, or simply misunderstood. It is crucial that therapists be attentive to such failures in empathy; and no matter how inaccurate the participant's cognitive misperceptions may seem to the therapist, before they are addressed the therapist should first affirm the feelings the participant is experiencing. At issue here is her sense of personal truth, fragile and unreliable; having it honored by others, developing trust for her own affective experience, is as important a step in the possibility of autonomy and relationship as is recognizing distorted thinking and expectations.

Trying to help the participant develop a sense of personal truth that she trusts, and doing so in part by challenging belief systems that maintain her pathology, and sometimes her

difficulty assuming responsibility for herself, requires a delicate touch. Therapists must remember how central distrust (of self and other) is to the participants' expectations of others; that whatever the therapist says may be blindly followed without intrapsychic evaluation. Therefore therapists may find that their well-intentioned interventions are repeatedly misinterpreted as abusive; or that their failures to adequately acknowledge the participants' emotions have an impact far beyond what they might otherwise have anticipated. Leaders who seem in some way fragile, withholding, or inadequately empathic or concerned may incite an aggressive response from group members, an enactment of the contempt they hold for their victimized selves. Leaders who are not reliably present evoke the introject of the unreliable parent and complicate trust.

Hopefully the middle sessions will serve to help participants acknowledge their pain and injury. For those in a *present-focused* group this will be particularly so as it is re-evoked in the group process. Ideally, they will begin to recognize the extent to which their beliefs and assumptions about the world as well as their views of self influence their intrapsychic and interpersonal experience. They will have begun to challenge these views and will begin to recognize that they have the freedom to create a new internal and external interpersonal world. In the *trauma-focused* group the middle session will also serve to help participants acknowledge the pain and injury of their victimization, their legitimate suffering, and orient their feelings of anger toward the abusers. Realizing the loss of their opportunity to have lived life undamaged, able to give and to receive love, is usually a long grieving process that will not be completed during the life of the group. It will, however, usually be initiated during these sessions. For those in the *present-focused* group, there will be a growing awareness of the interpersonal ramifications of the injury; for those in the *trauma-focused* group, acknowledgement of the abuse is also often accompanied by awareness of the interpersonal ramifications of the injury. To address these fully is a function of the later sessions of each type of group.

Occasionally, situations may arise that are beyond the scope and capability of the group. There is always this potential in any group therapy. Given our particular population, this type of situation may arise more often. Therapists should use their clinical judgment in deciding if and when a group member should be given a referral for individual psychotherapy as an adjunct to group therapy. If a crisis situation has arisen where a group member would benefit from crisis counseling, a member of our research team can offer her crisis counseling for up to 5 sessions. *Contact the project coordinator for details.*

#### **LATE SESSIONS (FINAL 4 WEEKS)**

Approximately the last four weeks are spent on termination issues. In this final phase of treatment the focus for both types of groups is on consolidating what has been learned and working through the issues that are evoked by termination. Termination is a time to appreciate what has been gained but also to mourn what has been lost. This includes mourning the loss of the group as well as the losses that occurred as a result of their traumatic past, such as not experiencing a "normal" and secure childhood, the failure of parental protection, the loss of innocence, and having one's psychological growth impeded because of the past. It is also a time to plan for the future. Members are helped to identify the progress they have made and to identify goals towards which they wish to continue working.

During the latter part of therapy participants tend to focus on the interpersonal ramifications of the psychological injury done to them through sexual abuse. Characteristically participants start the groups infused with shame, self-doubt and hopelessness. Their expression of emotion swings from numbness to over-contained to explosive, even while the internal sense that their emotions are inherently inauthentic may persist. The feelings of inauthenticity may derive from an unclear sense of self resulting from the experience of being disregarded as a separate and worthwhile person by the abuser and from the unconscious avoidance of the suffering of victimization. Once acknowledgment of and access to this suffering begins, a goal in the middle sessions of both types of groups, emotion and insight may take on a different quality.

As the acceptance that abuse occurred and did real and enduring harm begins to be incorporated into the sense of self, as suffering is more directly experienced, the iron grip of chronic shame and self-contempt may loosen. A group member may feel a new freedom to reflect on behaviors of hers that distress her, such as that she may overeat regularly in huge binges that she feels helpless to control; she may be estranged from her adult children because of her unreliability; she may avoid intimate relationships or challenging work, despite terrible loneliness; she may be aware and afraid of her tendency to attack loved ones because she fears that in relationships she ceases to exist; she may have chosen to have multiple abortions rather than face the chaos and rage she associates with parenting; or, despite her full intentions to protect her small children from the physical abuse she was subject to, she may be explosively angry with them over issues of control. She may feel shame about some of her relationship choices and her need to dampen her emotions and obliterate her consciousness through excessive drug and alcohol use. These behaviors and choices both reflect and perpetuate self-loathing. These behaviors are events for which she must eventually take responsibility, if she is to be able to maintain both self-esteem and her relationships.

One participant's process through a *present-focused* group illustrates a typical progression. This group member was a mother who against her conscious wishes frequently became enraged at her young children, although she has been successful at avoiding physically abusing them. Earlier in the group she worked on acknowledging and expressing anger and betrayal at incidents in the group that elicited emotions she had felt when she had been sexually abused by her mother's boyfriend, and physically abused by her mother. She began to acknowledge that her chosen coping methods of being tough and self-sufficient did not serve her well in her current relationships. In the later sessions she began to discuss the painful issue of her angry explosiveness with her children. Through this evolution she became better able to recognize her inability to manage her behavior solely by self-control without resorting to self-condemnation. That is, she could begin to separate her behaviors from her core sense of self. She also began to realize that she could seek help in managing herself, that there were alternatives to toughing things out alone. This sense of isolation is a legacy of abuse; the group serves to offer members a chance to feel what it is like to be part of a community that welcomes all parts of the self, including the deep and wounded parts. In a *trauma-focused* group, the same aspects would be covered and, in addition, the survivor would have been encouraged to examine how her chosen tough and self-sufficient coping methods were an adaptation to the circumstances she faced as a child but that no longer serve her relationship needs, nor adequately deal with the injury done to her.

Thus the process of change in the later sessions allows the participant to realize in a new way the impact her behaviors and attitudes have on others. Having identified the ways in

which she distorts her interpersonal relationships (and in the *trauma-focused* group, she will have learned to get in touch with the impact of the original injury); the therapists (and by now, the group) can challenge her presumption that behaviors contrary to her conscious intentions derive from an intrinsic lack of worth. And, by this time in the group, such a distinction may be meaningful to the participant. The recognition of opportunities irretrievably lost -- to have learned of love innocently, to be able to love freely and without internal conflict -- is yet another source of pain, and an example of the repeated blows the participant must face as she seeks to heal herself. It should serve as a reminder to the therapists to proceed carefully and respectfully.

The group is a place where she can work on the transition from chronic distorted shame to appropriate guilt when she engages in behaviors damaging to herself or others. Before she can begin to healthily accept responsibility for such behaviors, she must first have begun to approach the idea that she is fundamentally worthy of love and respect, a process begun during the middle sessions as she acknowledged her suffering and oriented her anger. Separation of suffering and self-anger may take a long time and only be imagined in the middle sessions. Unless her basic identity of an immutably pathological self can be revised, she cannot admit her responsibility for destructive acts without self-condemnation. Working through specific versus global culpability through relationships with others in the group, and by discussing relationships with partners and family members, is central to taking control of her life and imagining the possibility of change in the future. It is a way of living proactively into the future instead of reactively from the past, and suggests the powerful autonomous step of assuming appropriate rather than distorted moral agency.

### **Termination**

The flip side of power and autonomy are need and dependency. These important aspects of interaction, generally distorted for abuse victims, may become activated during the latter part of the group, again assuming that safety has been adequately established. This activation may be very intense, the sense of the freedom to depend on, and participate in, a caring community. The feelings may be directed toward the therapists, or other group members, and/or the group as a whole. In addition, transference to female therapists at this time is common -- group members are likely to (re)experience feelings of their needs being ignored, betrayed or unprotected by their mothers, and the threat of imminent abandonment. Mention of these feelings often spontaneously arises without therapist prompting. Although it may be possible in the *trauma-focused* group to process some of these transference issues by examining the earlier experiences that termination seems to echo -- the final sessions are really a time for closure and looking forward, rather than continued exploration and examination of the past. In general, in both types of groups at this time, the focus should be on acknowledging and discussing the experience in the present and planning for the future.

The therapists should begin discussing termination early in the latter half of the group, so that the prospect of ending is consciously acknowledged in the group for an extended period. The ending of the group may be a significant loss for the members; feelings of affection, of need for others, may be difficult for members to discuss, and a generous amount of time should be allowed for them to process their response to this loss.

Very likely termination will once again arouse the conflicts associated with their damaging early experiences of needing others; as mentioned, the group's ending may be

experienced as yet another abandonment and betrayal. It is also likely to re-evoke self-contempt. Since participants have known from the beginning that (and when) the group was going to end, any disappointment or anger they may feel is likely to be experienced as their own fault and as further fuel for self-attack. Termination thus provides yet another opportunity to call attention to automatic self-condemnation, and to model compassion as an alternative approach to the participant's awareness of the discrepancy between conscious expectations and unconscious historical ones.

### **Referrals**

As the end of the group approaches, it is important to consider how to handle referrals. There are two main issues to consider: 1) the needs of the participants, and 2) the needs of the study. Certainly, *the needs of the participants must always come first*.

In most cases, it is likely that both the therapists and participants will agree that the participants would benefit from additional therapy. What we ask the therapists to do is to make a distinction between those individuals whom you believe would be at risk if they did not immediately get into another therapy from those who, while they would benefit, could also manage without it for the next 6 months.

For those individuals whom you believe could manage without therapy for the short-term, we ask that you remind them of the request we made of each of them at the outset of the study, which is that they refrain from participating in any other therapy until their involvement with the study has ended (i.e. 6 months after the group has ended). However, you should also add the qualifier that if at any time they feel they absolutely need therapy, then we encourage them to return to therapy even if the study has not yet ended. They should be encouraged to work with Helen Marlo regarding an appropriate referral.

For those individuals for whom you think continuing in therapy is critical, an appropriate referral should be made.

# Chapter 5

## SPECIFIC GUIDELINES FOR PRESENT-FOCUSED GROUPS

In this chapter we present the basic principles and techniques used for leading *present-focused* group therapy for women who have been sexually abused in childhood. The overriding principle of a *present-focused* approach to group therapy for survivors of childhood sexual abuse is that problems in a survivor's current functioning are likely to have some link to her abuse. Furthermore, by examining current functioning in the process of the group, even without understanding its link to the abuse, the survivor will be able to change her life as she so desires.

The guidelines presented below are meant to provide you with a general map of how to work with survivors in a *present-focused* group therapy. There is no meaning intended by the order in which this material is presented. These groups are *not* structured groups with a particular topic to be covered each week. (With the exception that one session (the 2<sup>nd</sup> or 3<sup>rd</sup>) should be spend providing psychoeducation on the rationale for the study, HIV risk factors, and information on safe sex. This is described in Chapter 4.) Otherwise, the group leaders are to use their clinical judgment regarding the most appropriate intervention at any given time in the group process.

### FOCUS ON CURRENT FUNCTIONING

#### Setting the Stage

The first goal in working with the *present-focused group* is to elicit their commitment to *present-focused* work. Some women will have entered the study with the hope of receiving a *trauma-focused* intervention. They may have in their minds that the work they want to do is to talk about the trauma. Thus, it will be important to have them talk about their feelings about being randomly assigned to a *present-focused* group where the focus will be on group interactions and group process along with their current problems in living. Was this their treatment of choice? Are they willing to keep the focus to the present? It might also be important to discuss the extent to which their childhood trauma will be worked with in the group. For instance, while you will not invite or encourage members to share their stories with the group, you will occasionally point out ways in which these past events seem to be affecting them today as a way to help them make sense of their current experience.

## **Identifying Current Problems**

The main outcome goal of present-focused therapy is to help participants resolve the problems they struggle with in their day-to-day lives. In order to do this the group leaders and the members need to first identify the problems. Sexual abuse in childhood is profoundly damaging and will certainly reverberate throughout the survivor's life. Thus, survivors will have many complaints about their current lives that they will bring to the group. It is also true, however, that they may also have problems in their current lives that they don't recognize as a problem, for example, alcohol dependence. In early sessions it will be important to work with the group members on identifying the issues they want to work on.

The task of the therapist is to stay focused on each survivor's current life problems, and her goals for participating in the group, such as working through pervasive feelings of distrust, difficulty with intimacy, lack of self expression and self assertion, risky sexual behaviors or drug use.

## **HIV Risk Factors**

When having these discussions, it is important to remember that everyone in the group has been found to be at risk for HIV infection. Along with any other problems the members may have identified, their HIV risk factors should also be identified as problems targeted for improvement.

Some of these issues will require direct focus, such as problems with drugs or alcohol. It should be noted that during the screening process all those individuals identified as having problems with substances were asked if they agreed to have this be a focus on therapy. Thus, any person with this risk factor should have already agreed to this problem being a focus.

Other problems, such as sexual revictimization and risky sexual behavior, may or may not need to be directly focused on in therapy. For instance, difficulties being assertive may be the underlying reason for someone being revictimized (e.g., having sex when they don't want to) or engaging in risky sex. For another woman, revictimization or risky sex may occur as a result of her dissociating and thereby lacking the awareness needed to take care of herself. Thus, it will be important to explore these risk factors in some depth in order to determine how best to define the problem.

## **Linking Current Problems to the Here-and-Now**

The most powerful way to work on the current problems that participants have is when being expressed in the here-and-now. When a participant reports on a problem she is having in her life, such as difficulties with intimacy, it can lack the emotional immediacy needed in order to truly understand it or to have any hope of affecting change. It is well known that intellectual insight alone is insufficient. Thus, whenever you see evidence of a member's issues being acted out in the group this is a prime opportunity to engage in some productive work.

For example, Carol suffered from isolation. While she recognized this was a problem and deeply wanted to change this about herself, she seemed at a loss in knowing what to do about it. One meeting another member, Evelyn, was sharing powerfully about a recent conversation she had had with her mother in which her mother briefly mentioned a sexual

abuse allegation made against a family friend but then quickly followed up with “But more importantly” and shifted to another issue. Evelyn was enraged and expressed her raw emotion to the group. While Evelyn was still full of emotion, Carol interjected with a highly intellectualized comment. The group leader immediately noticed how distancing this comment was and inquired whether Evelyn felt connected to Carol. Evelyn said no, stating that she felt Carol was “on another plane.” This led into an important discussion among the group members about their perception of Carol. Carol, although feeling hurt by this, learned that there was a huge discrepancy between what she feels inside (she stated she was feeling for Evelyn) and how she communicates. This was an important first step towards her understanding the dynamics that occur and serve to keep her isolated.

### **Problem-Solving Current Life Situations**

There are some situations and types of problems that simply cannot be dealt with in the here-and-now. For example, one woman came to group distraught because she discovered a peeping tom watching her through the skylight while she was taking a shower in her apartment. Certainly, an experience like that would be disturbing to any woman. Its impact is compounded when the woman has a history of sexual abuse. In this situation it was important to speak directly and concretely about what she could do to deal with this problem.

Another example is helping a woman deal with her difficulties getting her partner to use condoms. One approach might be to elicit suggestions from group members and then trying to role play a conversation she would like to have with him. Another approach might be to explore what is keeping her in a relationship where her well-being and wishes are routinely ignored.

### **FOCUS ON THE HERE-AND-NOW**

*A major difference between a present-focused group and a trauma-focused group is the emphasis on the here-and-now experience as the vehicle for change, both behavioral and attitudinal. According to Yalom (1985), the here-and-now focus is composed of two “tiers”, both of which are necessary. The first tier is the experience of living the immediate present, which includes strong feelings toward group members, therapists and the group itself, and which comprises the major subject matter of the group. “It facilitates feedback, catharsis, meaningful self-disclosure, and acquisition of socializing techniques”(p. 136). The second component is the “illumination of process”, which is the essential vehicle for change. The group “must examine itself,” study its own transactions and “apply itself to the integration of that experience”. The group is thereby both experiential and self-reflective. An overemphasis in either direction will be less effective. High intensity and emotional expression without adequate reflection will be ephemeral; reflection without emotional expression and intensity will be sterile. Encounter groups of the 60’s and 70’s illustrate the former; formal, aloof therapists elicit the latter. These components of immediate experience and reflection are sufficient for change to take place, the past need not necessarily be elucidated.*

## **The Group as a Microcosm of Their Worlds Outside the Group**

An enormous advantage of group therapy is that the group becomes a microcosm of the members' experience outside of group. Members bring their entire beings to the group and so it is inevitable that the difficulties they have in their outside lives will be enacted in one way or another within the group. A group member might come to experience herself in group in the same way she felt with her family of origin and in ways she continues to feel in other relationships. For example, the leaders may at times seem like her perpetrator. At other times, they might be experienced as the parent who colluded with the abuser by refusing to see what was going on. Obviously, it is precisely these dynamics that need to be attended to. The goal is to increase her awareness of these dynamics, to practice more adaptive ways of handling these experiences, and ultimately to modify her experience of herself and the world.

For example, in one group a member spoke about having felt angry because she did not feel taken care of by the group. The therapist asked, "When you think back to when you thought that, what are you aware of? What are you feeling?" The group member replied, now somewhat angrily, "I felt like it was dumb of me to think that you could give me that." The therapist – trying to prompt the member to identify the real object of her anger -- queried, "Are you sure?" When the group member seemed unable or unwilling to acknowledge anything more, the therapist continued, "I don't feel like I am clear on what you need us to do to help you. Think about it. You can get the most out of the group when you can tell us how we can help you. That may be the place where you can take responsibility – clarifying it for yourself and then bringing it out in group... You can say to us 'Guys, this is what I'm needing you to do.'" The member responded, "If I have to do it all myself, then what's the point?"

At this point two issues were clear: the group member was not feeling taken care of by the group and she had great difficulties in directly asking for what she needed. This interchange prompted other group members to respond in a variety of ways (including feeling protective of the group member and also voicing concerns about whether the group really could help). The therapist used the opportunity to remind the group that the difficulties and challenges that arise within the microcosm of the group are likely to be reflections of patterns of relational issues that happen in their lives outside the group. This was why it was so important that they work on these issues as they arise in the group.

### **Attending to Process**

"Process" is defined as "the nature of the relationship between individuals who are interacting with each other" (p.137). A central task of the leaders in the *present-focused* groups is to be constantly monitoring the group process. The therapists' job is to ask themselves what the explicit words and the style of the group members' communications indicate about their interpersonal relationships. The how and the why of the communication is the therapists' concern, both in terms of a single interaction, or a series of behaviors over time that illustrate a pattern in relationships.

In essence, the therapists look at metacommunication, the communication about the communication. For example, there is a different implication for similar communications: "Why are you asking me questions about myself?" "Wouldn't you like to talk about something else?" "Stop focusing on me!" "I need to go more slowly in getting to know you before I tell you about myself." Control and fear of judgment are frequently important issues

for survivors, but how a survivor communicates these concerns to others influences the response she gets, which may not be the one that will help her develop trust with others.

As related problems occur in the group process the therapist should comment on her interpersonal patterns, which helps the survivor recognize what her behavior is toward others and the impact it has; how her behavior influences the feelings of others toward her and her own feelings toward herself. When she is unhappy with an interpersonal pattern she must decide if she wants to change; if so, she must be helped to understand that she now has the power to choose different interpersonal patterns and to experience her own capacity to change, first in the group process and then in her life outside the group.

In a caring and empathic manner, the survivor should be helped to explore her experience in the group. The survivor is encouraged to identify her emotional reactions to interactions in the group as well as the related thoughts and feelings triggered by them. An important aspect of this exploration is that the survivor becomes aware that her emotional reactions are heard, accepted, and understood. The group leaders help the survivor to understand her impact on others and their impact on her. By recognizing her beliefs about the world, the assumptions she holds, or the emotional reactions she has, the survivor begins to exercise more of her own capacity to choose her attitudes and lifestyle, and to assume her own power in her current life.

Therapists need to look for the absence of behaviors as well as their presence -- what members do or do not say. Also they should attend to what happens when a particular group member is absent, how is the group interaction different? Exploring the thoughts and feelings of members toward other members both when they are present and when they are absent is useful input. However, this should be done with the understanding that what is shared in the person's absence will be shared in her presence; it is particularly important with these groups that members feel as safe as possible. Inevitable tensions in groups, in general, will be seen in survivors' groups, such as struggles for dominance, mutual support vs. sibling rivalry, the desire to lose oneself in the group and the fear of losing one's individuality, the wish to get better and the wish to stay with the group, or the need to be noticed and acknowledged by the group therapists. These tensions, and the therapists' comments on the interpersonal patterns of group members in response, will facilitate the recognition of group process.

### **Using Transparency to Facilitate the Here-and-Now Focus**

The therapist's use of transparency, particularly when the therapist talks about her own here-and-now experience, is a powerful means of shifting the focus to group process and interpersonal dynamics as it is occurring in the here-and-now.

Consider the following example: In this particular group, the group leaders had adopted a technique for group facilitation (a technique we are *not* using in this study) which involved mailing written summaries to the group members. One of the group members, Erin, complained about this method and it was agreed to provide oral summaries at the end of the meeting instead. One meeting Erin asked for some time in the group and when she had the floor she began to speak about her displeasure with this new method. She said, "I know that I asked if we could continue the oral summary, but I've come away feeling judged or that other people were being judged. It was so jarring that I came away with more questions than feeling supported. It hasn't felt constructive like the written one did."

Over the course of therapy, it had become evident that Erin seemed to have real problems with authority as she was consistently challenging or disagreeing with the group leaders. Given this context, the leader said, "Rather than simply looking to see if we could change that procedure, for a moment, can we look and see, what does this tell us? What does it tell you about you? What issues are coming up?" Erin went on to talk about wanting to feel received and heard. They discussed how she felt and also what the leaders were attempting to do with the summaries. Referring to the previous summary Erin said, "I didn't totally dislike it. There's some aspect of it that, while it gets some things, it leaves so much unsaid that it might be better not done."

At this point the therapist decided it was important to be transparent and talk about his own internal process. He said, "Sometimes I feel that there's a degree of perfection that you want from me that I can't possibly meet." Erin was clearly taken off guard and meekly responded, "I'm sorry." Hearing in her tone that she was backing away, he said, "Well, no, no. Again, I don't mean to be critical of you here. Please understand that." This was important at this point because it enabled her to resume the exploration. She said, "That's an interesting thing to point out...very demanding...sort of like a little kid." With this statement it was clear that she was beginning to see how she comes across. The therapist continued, "Often when I say or do something, there's a little think in the back of my mind that says, 'Erin's not going to like this.' And I do think that sometimes in the group. And, I'm saying this to you because I don't know if it's possible that other people in your life feel similarly." Erin went on to express her concern that she would have that kind of power over people and her fear that it would prevent them from being themselves. This was an important beginning in helping Erin look at how she keeps people at a distance.

### **Practicing New Ways-of-Being**

One of the most powerful ingredients of *present-focused* therapy is the opportunity to practice new and more adaptive ways-of-being. Insight into one's problems is usually not sufficient for change. When it comes to certain kinds of problems, the real test is whether one can change one's behavior. This is especially true regarding the HIV risk factors. As discussed previously, for some individuals their HIV risk factor(s) will stem from problems that potentially can be worked on directly in the group. For example, one woman might engage in risky sexual behavior because of her difficulties being assertive. Another woman might have such low self esteem and be so desiring of connection that she will make any sacrifice necessary to get the closeness she craves. Yet another woman may have learned that her role in life is to take care of the needs of others and feels too guilty to ask for what she wants. In all of these cases, opportunities may arise in the group for her to practice being assertive or to ask for what she needs. By practicing new behaviors in the group she can get feedback from others and discover how she feels trying these behaviors. Learning new behaviors in a supportive environment may then give her the confidence to try them out in her life outside the group.

Thus, the group leaders should attempt to identify any problems that have the potential to be worked on directly in the group. Alexis, for example, talked about how needy her father was and that because of this she had developed an empathy that results in her being in the position of always looking after others. In fact, this was precisely how she related to the women in the group, by looking after them. When asked if this empathy was just in relation

to men, Alexis stated that she cannot trust women. The leader asked her if she felt she could trust the women in the group. She replied, "Not really." She went on to say that she cannot allow herself to feel anything in the presence of others because her experience is that no one is ever there for her. About the group, she felt like they were "screwing holes" through her and so were able to see how bad she is. This was a prime opportunity to help Alexis try out a new behavior. Could she ask for feedback? Doing this would be a first step towards learning to ask for something for herself and also towards trusting women. Although she was not able to do this, the therapists resolved to be alert to opportunities in the future where she might practice these new behaviors.

## **WHEN ABUSE HISTORY BECOMES THE TOPIC**

### **Spontaneous Sharing of Abuse History**

It is not uncommon for survivors who enter groups for survivors of sexual abuse to spontaneously share their abuse experiences. The group leader may allow this spontaneous sharing – indeed as groups begin, members sometimes insist on it -- but it is important to continue to bring the participants' focus to their here-and-now experience as it emerges in the interaction of the group. For example, in one *present-focused* group, a group member unexpectedly launched into a rather long description of her abuse history. Once she was done, the group leader paused and then gently asked the member, "Can I bring you back to now? What can we work on now? How can the group help you and how the way you relate to others affects your life?" This redirection to the present successfully prompted the group member to identify that she wanted to work on issues of intimacy and trust in her current relationships and the discussion proceeded from there. This redirection would not have been successful if the group had not been properly educated in the rationale for and therapeutic emphasis of the group.

### **When Members Ask to Focus on the Abuse**

Occasionally *present-focused* group members want to speak about their traumatic memories. In general, however, this is not a threat to the integrity of the *present-focused* approach. We attribute this to the careful manner in which the treatment modality is explained as well as the participants' overall commitment to the research study. If individual members do bring up their traumatic memories the group leaders should respond with empathy but not use techniques to help members explore or further excavate memories. In addition, the therapist should ask the person what she was thinking or feeling (or what was said) that prompted her to think of the abuse experience, or ask why she is bringing this out now, or ask how this memory affects her reactions in the present.

For example, in an early session in one of our *present-focused* groups a member complained that she didn't know people's histories and that she had only been *told* that this was a group for women with a history of abuse but that she didn't know this for sure. She asked if people could say something about their histories. When the group leader asked her how she felt after some of the other members told their abuse stories, she seemed to be feeling worse rather than better. It turned out that the real issue was her concerns about safety. This member thought that she would feel safer if she knew people's histories. Rather than

immediately responding to the request, it would have been better first to look at what was underlying her request. Once it was clear that she wanted this in order to feel safe, it would have then been possible to talk about whether this was the best way of establishing safety.

Abruptly shifting away from a discussion of abuse events has the potential to be experienced as a re-enactment of experiences in the past when they unsuccessfully tried to talk about their abuse. Thus, it is important to acknowledge the desire to share their histories. However, given that this is a *present-focused* group, it is important that you explore the underlying meaning of the desire. Is it an attempt to feel safe? To deal with anxiety? To avoid some group process issue? To challenge the group leaders? Given that the group has previously been provided information at the beginning of the group about the rationale for the *present-focused* orientation, therapists can remind participants of the reason for the shift away from the memories and thereby minimize the likelihood that it will be experienced negatively. If the person or other group members indicate that there is a feeling of re-enactment by therapists insisting upon the shift, this can and should be talked about with a here-and-now focus.

### **When Memories are Triggered**

It is not necessary for participants to share their memories if they are triggered during the group, although this might happen and it can be very helpful. Sharing their experience with a group of individuals who accept and understand them can be reassuring. As victims, survivors are likely to feel that they will not be perceived as credible, or that they must protect others, or are endangered if they report their actual experience. Often survivors have come to question their own experience and themselves. Consequently, an important step in their recovery is sharing her actual experience with others who will support her in the face of her pain and frequent mistrust.

When memories are triggered it is important to identify the trigger. Identify triggers that occur both inside and outside the group. Help the member problem-solve what they can do to prevent being triggered or to interrupt the process if they are triggered. Teaching grounding techniques is useful for individuals who struggle with intrusive memories.

### **PSYCHOEDUCATION**

Psychoeducation about the effects of trauma should be provided when appropriate. Psychoeducation about the effects of trauma can both normalize their experience as well as help them make sense of it. However, providing psychoeducation about trauma does not mean that the trauma itself should be explored. *It should not.* For example, survivors of childhood abuse often have difficulties allowing themselves to feel intense affect. This is because they fear being overwhelmed as they were when they were abused. When a survivor approaches an area that activates intense feelings, she may try to steer clear. It can be helpful for her to learn where her fear of intense feelings come from and to reassure her that she will not be “blown apart” by her feelings as she feared she would when she was being abused. This can be followed by reassurance that she will be supported to go only as far as she wants to go.

Psychoeducation can be reassuring for individuals and help to reduce feelings of shame or guilt. One woman, for example, was being extremely self-critical because of the

difficulties she had with intimacy. It was helpful for her to hear that these problems are a natural consequence of having one's trust violated as a child. While this information doesn't make the problem go away or lessen its effect, it does help her to be less invested in being self-critical and frees her up to work directly on the problem.

Psychoeducation about the process and goals therapy can be helpful in facilitating the therapeutic process. Thus, as appropriate it may be helpful to explain why, for instance, you are focusing so intently on the interactions of the group members and how this can be helpful for them in the lives outside the group.

## **EMPATHY**

Empathy is the cornerstone of any psychotherapeutic approach. It involves having an accurate understanding of the participant's point of view and experiencing it as if it were your own. It is important to emphasize that it is "as if" the participant's experience were your own. Maintaining this "as if" stance ensures that the therapist does not get lost in the participant's experience or confuse his or her own experience with the participant's. An empathic reflection does not require that the therapist repeat back to the participant everything that has been said. Instead, it often involves sidestepping much of what has been said in order to reflect the underlying meaning (Rogers, 1970).

In one case, the therapist had gone around the room asking group members what the group could do for them in the sessions remaining and one member indirectly conveyed dissatisfaction with the group. The member said that she had assumed when she entered the group that she would need the group's help in order to have any sort of psychological breakthrough, but she had learned since that she didn't, because instead she had a minor breakthrough while talking to someone at work the previous week. The therapist responded authentically and directly by saying, "I felt a little ouch when you said that. I'm wondering if you're feeling a little disappointed or angry about what's going on in here – that we didn't help you, and you got your help somewhere else?" The group member acknowledged, albeit reluctantly, that there might be "a little bit of that" in what she felt.

An empathic response conveys to the group member a sense of being understood, accepted, and not alone. While empathy is the foundation upon which any good therapeutic alliance rests, we include it as a specific principle of treatment because we have found that empathy is exceptionally important when working with victims of child sexual abuse, particularly empathy from the group leaders. Survivors of child sexual abuse are exquisitely sensitive to the judgments of others. In group therapy they are especially sensitive to the perceived judgments of the group leaders. It is important to recognize that for many survivors, any empathic failure can be experienced as judgment or recapitulation of the trauma. That is, even if the therapist is experiencing empathy for the survivor and communicates it to the survivor, if the therapist is not accurate in understanding what the survivor has communicated, it may be experienced as an injury. Any seasoned therapist knows that it is virtually impossible to be perfectly empathically attuned to one's participants. Given such a situation, how is the therapist to proceed? It is essential that group leaders express empathy towards their participants. At the same time, however, the leaders must be willing to modify their understanding of the survivor in response to the survivor's corrections and to communicate these modifications.

In some individuals inaccurate understanding will elicit rage. It is important to explore the emotional reactions to the therapist at this time. First, however, it is necessary to understand the source of the rage at a conscious level. It is at this time that the facilitators will learn about an empathic failure. Upon understanding the failure, the therapist should make every effort to correct it. Once the survivor feels that the leader understands, she can be helped to explore her rage and to see how it may be linked to pathogenic beliefs about herself and others, particularly those beliefs that suggest a painfully distorted self-concept.

Empathic communications that are stated as tentative, even if inaccurate, are often more tolerable to the survivor than those that are stated with certainty. A tentative statement indicates that the therapist is interested in the survivor's perspective and in achieving an accurate understanding of her experience. It also communicates to the survivor that she is the arbiter of her own reality and in this way it restores her control. Furthermore, she does not need to worry about being controlled by another authority figure. In addition, it will model empathic communication to the other group members who, themselves, may have difficulty in communicating their understanding.

## **PROVIDING A COGNITIVE FRAMEWORK**

An important role of the therapist in a survivor group, is to help the survivor restructure her view of herself. One way in which this is accomplished is to provide a cognitive framework with which the survivor can make sense of her interpersonal experience and begin to change it if she wishes. We assume that she is unhappy with her functioning in her present life because she has pursued psychotherapy. She is likely to be struggling with dysfunctional and often unconscious strategies of coping that have developed as a result of her abuse. She may also have a negative view of herself, which probably includes feelings of inadequacy or badness, developed as a result of the trauma. She is likely to suffer from low self-esteem, and she may have little or no understanding of her low self-esteem as an expression of having been victimized as a child. An important part of the therapeutic process is to help the survivor recognize and ultimately revise the pathogenic beliefs about herself that may have resulted from the abuse, to recognize and change maladaptive coping mechanisms that may be interfering with the development of intimate and trusting interpersonal relationships, and to recognize and modify the behaviors that put her at risk for infection.

Many women who have been sexually abused live their lives with a deep-seated belief that they are somehow responsible for what happened to them. The therapists can be instrumental in helping the survivor to recognize the ways in which she may enact her feelings of victimization and shame in the group process, perhaps viewing herself as helpless or deserving of abuse, or seeing others as unduly dangerous. The sense of responsibility she feels may be a way in which she attempted to gain some sense of control over a situation in which she was powerless, and she may attempt to gain a feeling of control through becoming a scapegoat or provoking others.

Understanding the difficulty in achieving intimacy and self-expression in relationships and in developing trust is of the utmost importance with these women. Having experienced significant individuals in her past to be profoundly untrustworthy, the survivor learned to read carefully every expression of her abuser in order to determine when she might be in danger (Herman, 1997). This wariness she carries with her into current relationships. It will prevent her from allowing herself to be vulnerable with others, an essential ingredient in the

development of intimacy. She may be conditioned unconsciously to respond to cues that warn her of impending danger whether or not they are appropriate to a particular relationship. It will be necessary for her to recognize how and why she does this in order to improve her interpersonal functioning.

Difficulties with assertion, putting the needs of others before her own, avoiding social situations are all natural outcomes of having been sexually abused as a child. She will have learned these ways of being in childhood as ways of keeping herself safe. She will then carry these patterns into her adult life. Feeling unworthy will further reinforce these tendencies. Helping her to recognize all the ways in which these behaviors place her at risk, especially in intimate relationships, is an important goal of *present-focused* therapy.

Another important objective in the therapy is to help the survivor to understand her defensive process as well as the situations that elicit it and to integrate the understanding into her conscious view of herself. As a sexually abused child, a survivor will have used a variety of defenses to cope with the abuse. Dissociation is a common means of coping with trauma, especially in young children who are naturally adept at the process. Dissociation enables the victim to control the experience of abuse by removing herself psychologically from it. This defense is retained as a way to manage extreme negative feelings associated with memories of the abuse. In addition, many survivors report dissociating in the present when faced with situations reminiscent for their past, such as during sexual contact. One serious consequence is that it puts them at risk for infection because they then lack the ability to ensure that sexual intimacy occurs in the way they want it to occur. They also run the risk of further revictimization and retraumatization.

Similarly, many abuse survivors turn to drugs and alcohol as a means to cope with their current experiences of trauma symptoms and other negative affect. One member in a *present-focused* group noted that cigarettes, alcohol, and marijuana were all the same to her, "I use them as a pacifier; I use them to leave my body." When the therapists asked her to identify the circumstances when she would turn to these substances, she admitted that it was whenever she was in "emotional pain." The therapist then asked the woman, "What would happen if you just let yourself feel the feelings?" and whether she could try this the next time she felt the impulse to turn to one of these drugs. Teaching the survivor to identify maladaptive responses to current experiences, particularly those that might put her at risk for HIV exposure, and helping her develop more adaptive ways of coping is a central task of the *present-focused* group. By so doing she will have more conscious control of her thoughts, feelings, and behavior, and be in a position to correct the negative views of herself and any distorted views of others that developed because of the abuse.

# Chapter 6

## SPECIFIC GUIDELINES FOR TRAUMA-FOCUSED GROUPS

In this chapter we present the basic principles and techniques used for leading *trauma-focused* group therapy for women who have been sexually abused in childhood. The overriding principle of a *trauma-focused* approach to group therapy is that problems in a survivor's current functioning are likely to have some link to her childhood abuse and it is by examining the abuse, integrating it into her conscious awareness of self, and understanding its link to current functioning that the survivor will be able to change her life as she so desires.

The guidelines presented below are meant to provide you with a general map of how to work with survivors in a *trauma-focused* group therapy. There is no meaning intended by the order in which this material is presented. These groups are *not* structured groups with a particular topic to be covered each week. (With the exception that one session (the 2<sup>nd</sup> or 3<sup>rd</sup>) should be spend providing psychoeducation on the rationale for the study, HIV risk factors, and information on safe sex. This is described in Chapter 4.) Otherwise, the group leaders are to use their clinical judgment regarding the most appropriate intervention at any given time in the group process.

### FOCUS ON THE ABUSE

#### Working With Memories

##### *Setting the stage*

Obviously, working with memories is the key treatment strategy in *trauma-focused* group therapy. Although many women entering this study will want to talk about their childhood trauma and all will have claimed they are willing to talk about their abuse, some will be reluctant to do so. Even those who want to talk about their abuse will find it difficult. It is essential that you respect where a woman stands regarding her willingness and ability to talk about her abuse experiences, otherwise we run the risk of retraumatizing her.

It is important to work slowly towards the goal of having members talk about their abuse. Before you invite them to disclose anything, you should first have them talk about their feelings about being randomly assigned to a trauma-focused group where they will be asked to talk about their abuse experiences. Was this the treatment of their choice? Do they have any concerns about disclosing? What would they need in order to feel safe enough to disclose? This discussion should help in creating a safe place for the members and may also provide you with important information on what you will need to do to help members do this work. Depending on the group, you may want to spend an entire session on this topic.

### ***First steps***

As a first step in working with their memories, you might ask members simply to say who their perpetrators were (remembering that some will have more than one perpetrator) and perhaps how old they were when the abuse occurred. This first step is a huge one. They are publicly acknowledging their abuse and this alone can make it seem far too real. For some this may also be the first time they have done this. Following this disclosure, ample time should be spent processing their feelings about having disclosed this information.

### ***Spontaneous sharing of memories***

It is not uncommon in a *trauma-focused* group for survivors to spontaneously share their abuse experiences, knowing that that is the emphasis of their group. The group leader should support and facilitate this sharing. Merely the act of sharing abuse experiences can be healing for the survivor. Telling her story to a group of individuals who will accept and understand her experience is crucial. As a victim, she is likely to have felt or may have experienced that her abuse history was something she could not share, possibly because it would not be believed, or she felt she must protect others, or perhaps she was threatened with physical harm if she were to say what had happened to her. Indeed, in a pilot sample for this current study, we found that only about half of the participants had told anyone about the abuse during the time they were enduring it. By keeping this painful information to herself, the survivor may have come to question her own experience and herself. Consequently, an important step in her recovery is telling her story to others who will support her and serve as symbolic "witnesses" to what happened to her (Butler, et al., 2000).

### ***Premature disclosure***

One word of caution, especially in the early phase of the group, is to be sure that a member does not prematurely and singularly reveal too much information about the trauma she's withstood. Some people are prone to the "dump and run" approach. One reason for this is sometimes be fear. A woman might be so afraid of talking about her abuse that she does it all at once in the hope of getting it over with. After disclosing, especially if no one else has disclosed, she risks feeling over-exposed, exploited and ultimately revictimized and, once she leaves the session, she may find it impossible to return. So, if necessary, interrupt a woman whom you fear is saying too much and be straightforward about your concern for how she will feel if she says too much too fast. She will likely feel relieved at your having set some boundaries for her. At such a juncture it would be appropriate to provide some psychoeducation to the entire group about the overwhelming nature of CSA and the difficult emotions it stirs up. This is one of the reasons why abuse survivors can suffer for so long because of their abuse. Because it was essentially an incomprehensible and often terrifying experience or because it may have stirred up other intolerable emotions, they may have protected themselves by doing such things as going numb or leaving their bodies. Thus, it is important that when they talk about it now, they do it in small, manageable doses so that they don't get overwhelmed by it as they did when they were being abused.

### ***Keeping track of all members***

Working with memories in small, manageable doses is essential; otherwise, we run the risk of retraumatizing everyone in the group. Thus, the small manageable doses are for the sake of everyone in the group. As one person talks about her memories, another may have her

own memories triggered. It is important to be cognizant of what is going on with all the group members, paying close attention to signs that members may be dissociating. Check in occasionally with all group members as memories are being talked about. The extent to which you interrupt the flow to check in with both the speaker and the listeners will depend on your clinical judgment about their ability to tolerate the material. In the early phases of the group, when you are still learning about your members, it will be important to check in frequently.

***When members dissociate or are otherwise extremely distressed***

If at any point you are aware of anyone dissociating or in some way showing intense distress as memory work is going on, stop the work and attend to that member. When there is mild distress, such as crying, use your clinical judgment about whether to interrupt the process to focus on that person or whether to wait and attend to that person later. (In most cases you will want to attend to this person after the memory work has been completed.) However, when someone is exhibiting signs of being highly distressed, as is indicated by dissociation, it is paramount that this person is attended to. The basic strategy to use first is some kind of grounding technique. If someone is dissociating you want to her to time and place. You might be able to do this simply by saying their name and making eye contact with them. If this is not sufficient, give further instructions such as asking them to look around the room and to describe what they see. Someone who is dissociating might have left their bodies and so instructing them to notice what it feels like to sit in the chair, to feel their feet on the ground or to feel their bottom on the seat of the chair. The point is to help them shift their attention to their sensory experience. Once this is accomplished and they have returned to a state of calmness it will be important to process what just happened. It will be important to do this with the distressed member and then with the rest of the group who no doubt will have been alarmed by what has just transpired. The goal at this point is to re-establish a sense of safety.

***Deep exploration***

In a caring and empathic manner, the survivor should be helped to explore her abuse experiences. This involves more than just describing her traumatic experiences. Indeed sometimes survivors will return to, or should be encouraged to return to, descriptions of their memories of specific abuse experiences as a means for deeper and deeper explorations of details and meaning. The survivor is encouraged to identify the full spectrum of her reactions to the abuse both at the time of the abuse as well as while she is examining it. These may include emotional, somatic, perceptual, and cognitive aspects of the memory and of her experience upon describing it.

An important aspect of this exploration is that the survivor come to feel that all her reactions -- especially her emotional reactions -- are heard, accepted, and understood. Paivio & Greenberg (2000) have described this as "reprocessing" of trauma memories, noting that it requires accessing maladaptive aspects of the memory or meaning system that generate experiences of fear/anxiety, guilt, shame, and accessing previously inhibited adaptive emotional responses, such as anger and sadness. The adaptive information associated with each emotion can be used to modify the meaning of the memory. Indeed successive descriptions and discussions of abuse experiences can lead to an unfolding of understanding

of the meanings that the child took away from the experience – and often it is these meanings that were and are still the most traumatizing.

For example, one *trauma-focused* group member recounted how her father had first raped her at age 8 after he carried her to her bedroom when she was extremely sick (she had vomited and fainted on the stairs at home). This first telling of the story powerfully conveyed to the group the extent of her feeling of betrayal by her supposed caretaker, and particularly at a moment of great vulnerability (feeling very sick), and the group discussion for that session then picked up this theme. However, it was upon a retelling of this same event in more detail in a later session, that it became clear that there was an even worse aspect to the experience (for her). When she retold the story, with the encouragement of the therapists, she tried to recall the events as they had happened, moment by moment. One of these was that she had asked her father in the middle of it all if she could go to the bathroom because she thought she was going to be sick again. He allowed her to do this. She recounted remembering being in the bathroom and staring down at the toilet before she flushed it. The horror of that moment was her childhood realization that when she flushed she would then have to return to her bedroom and waiting father. Interestingly, it was following this initial abuse event that amnesia set in for the next 5 years of this survivor's life. However, even for those with continuous memories of their trauma, the understanding of the meaning and implications of the abuse is an evolving process, and the *trauma-focused* group provides an environment in which this evolving understanding can flourish.

#### ***Linking the abuse to current problems***

Along with a careful exploration of her trauma, the group leaders can also help the survivor to link her abuse to the present. How do these experiences influence her and her relationships? By recognizing how the abuse has shaped her beliefs about the world, the assumptions she holds, or the emotional reactions she has, her understanding is further enhanced and she will often find that the abuse has less power over her current life.

#### ***Do we need to know if the memories are true?***

It is not uncommon for members to either question their memories, to have gaps in their memories, or to have vague memories. As a therapist, the stance that you take about the nature of memory is important. There has been a good deal of debate in the literature about memories and recovered memories in particular. There is plenty of evidence to indicate that memories are constructions, including memories of childhood trauma (Brewin, Andrews & Gotlib, 1993), and that not all elements of memories are necessarily accurate (Conway, 1992). Sometimes memories are actually a composite of several events. Often it is the gist of the memory that is true, even though the specific details might not be exactly correct (Conway, 1992).

One might conclude it is a problem that we have no way of knowing what is true and what is not true. This is not so. Our purpose is not to assess the veridicality of memories but to help our participants come to terms with, and to deepen their understanding of, what happened to them. What is key here is that it is “their understanding” of what happened. The details of what happened to them is less important than the meaning they derived from these experiences. So when a member questions her memories, it is not the therapist's role to say what is true or not true. Instead, the therapist's job is to help her make meaning out of her experience. One approach to take is to say: “Since we can't go back in time to see what really

happened, let's put that question aside. Whether these memories are true or not, they have meaning and let's see if we can understand what they mean to you."

### ***Recovered memories***

Don't be surprised if some members recover memories during the course of therapy. It is not unusual for memories to spontaneously emerge as a result of therapy (Feldman-Summers & Pope, 1994). Usually this occurs because the person finally feels safe enough to remember. However, remember that recovering memories is *not* the goal of trauma-focused therapy. It is certainly not a problem if memories are recovered, but it should never be our goal to help participants recover memories. Instead, our goal is to help participants *integrate* what memories they have into their conscious awareness of self and the world.

## **Linking Current Problems to Past Trauma**

### ***Current problems as a focus***

The consequences of childhood trauma (sexual abuse) are such that difficulties with current emotional and interpersonal functioning will often become the focus of the group. Since current life problems are what brought these women into therapy to begin with, this is not surprising. Sexual abuse in childhood is profoundly damaging and will reverberate throughout the survivor's life. Survivors will have many complaints about their current lives that they will bring to the group. However, the basis of the model is that improvement results from working through the traumatic events, and because there is likely to be a tendency to avoid these very same upsetting recollections, it is important for the therapists to be conscious about such avoidance.

### ***Redirecting the focus from current problems to the trauma***

If the focus on current problems is being discussed with an awareness by the group members of their connection to traumatic events, then the present-focus may be fine. However it is often necessary to *redirect* the member's attention to the task at hand, while being sensitive to her fears and capacities. The general approach to redirection is to elicit from the member the feelings that are being aroused by the current event she is discussing. Once she is in touch with these feelings, the therapist can begin the process of following the feelings back to their traumatic origins (either directly related to the trauma or as a defense against the trauma). The task of the therapist is to help the survivor determine if their current difficulty is linked to their abuse history. For example, in one session a member began by talking about her missing paychecks and the frustration she felt with her employer. The group leader reflected her helpless feeling back to the member and inquired as to whether this related to her childhood experience. The member stated that it did and then explored her sense of lack of control as a child.

One common example is a difficulty in establishing intimate relationships. The therapist should listen carefully for connections with abuse that may be pursued. The therapist can simply ask "In what way do you think the problem you are describing is related to your abuse?" or "Does this remind you of anything about your abuse?" or "Are there ways in which these situations make you feel like you did when you were being sexually abused?"

***Sometimes an extended focus on current problems is necessary***

Although this is a *trauma-focused* group, it is inevitable and appropriate that some more extended focus on current functioning will occur. This is especially the case when group members experience increased difficulties in life as a result of the work done in group, or simply because life events impinge. When this happens, the well being of the group member and her feelings of safety in the group require that her present situation be appreciated with empathy and some problem solving or focus on coping skills may be appropriate.

When a group member brings up an issue that requires attention (rather than redirection), it should be handled in a three stage process. First, the group leaders should ascertain how serious a threat it is to the member's ability to cope (e.g., is she dangerous to herself or others, is she in danger of decompensation, or is she under increased stress but within her ability to cope). Next, the member should be asked if she would like help coping with this problem, and if so, what skills or methods she has used in the past, and what she can think of to bring to bear. The group can be encouraged to offer ideas or support and the therapists may also contribute, if appropriate. The member should be asked how she is feeling, and supported if she prefers to take things slower in the group for a time. The rest of the group should also be asked how they feel about what has happened, and if possible, the event may be used to support their feelings of safety and support in the group. Finally, if it seems suitable given the troubled member's current state, it may be possible to return the discussion to a trauma focus, by exploring the traumatic roots of either the current problem or the interpersonal process displayed during this interaction (e.g., helplessness, accusations of not enough help, etc.).

**Working with Group Process and Linking Process to Past Trauma**

There will be occasions during *trauma-focused* groups when the interpersonal dynamics within the group needs to be addressed. Whenever possible, this should also be used as an opportunity to link the current dynamics in the group to their traumatic childhood experiences.

In one of our *trauma-focused* groups there were some particularly intense dynamics within the group. One of the group members, Anne, complained bitterly about how she was being treated in the group. She stated that she often felt ignored in the group and that she had to fight to get any time. This is something that often happens to her, she said, and she finds it disgusting. She also stated that she routinely tests people, as she had us, and that most of the time people fail her test, as we most certainly did. Clearly this was a pressing issue that needed to be addressed. There were several approaches that needed to be taken. One was to invite the Anne to describe her experience as fully as she could and for the group leaders to respond empathically to her complaints. The second was to invite the group members to share their reactions to what was said. The third was to somehow resolve the issue and then help Anne and the rest of the group understand this situation in the context of their abuse histories. From the intensity of Anne's anger, the fact that this was a recurring issue for her, and that her complaints were not warranted, it was evident that her experience in group was activating unresolved issues from her past. Prior to working to resolve the issue, it was important for Anne to feel heard and understood. The leaders invited Anne to describe the times and ways in which she felt cut-off or ignored and responded with empathy to her experience. Then, in an attempt to resolve the issue, the group leaders explained how their

approach to leading a group *and* Anne's way of being in the group might have led to this unintended injury. They also asked for Anne's help by asking her to let them know what she needs so that they can learn how to be most helpful to her. Finally, the group leaders talked to Anne about how her experience of being terribly neglected and invalidated when she was a child makes her especially susceptible to these kinds of injuries. Clearly this was a situation where considerable time and effort needed to be spent discussing the group process issues before it was possible to make the link to childhood trauma.

Given that this was such a dramatic event in the group, it was not surprising that continued processing was required the following session. In the next meeting, one of the group members stated that she had had a difficult week as a result of the previous session. She talked about feeling concerned about expressing her anger towards Anne and commented that we saw a side of her that few people see. "This side of me feels ugly," she said. The group leader remarked that it would be important for her to look at these difficult feelings and that since they seem to be familiar feelings for her it would also be helpful to look at how these feelings are connected to her past. The member attempted to describe the feelings. She talked about how her anger "sits like a rock" in her chest. The leader asked whether these feelings were similar to feelings she had with her perpetrator. The member denied this but instead thought that they were similar to how she felt about her mother. Her exploration led eventually into a group discussion about their childhood experiences of being the only sane voices in an insane environment. This particular discussion raises another important issue about trauma-focused work. The context of the abuse is often as important and sometimes more important than the abuse experiences themselves.

### **Providing Ongoing Psychoeducation**

As group members describe their abuse histories or their current problems, it can be helpful to provide ongoing psychoeducation. This can both normalize their experience as well as help them make sense of it. For example, one member had expressed intense affect during a previous session and the following week described how surprised she was at this and the resulting fear that "I would go crazy." She shared how she talked to herself on her way home, reassuring herself that "you'll be okay" but how she was truly terrified that she would lose her mind. In response to this the group leader reflected on it being common for survivors to be afraid to allow themselves to feel the pain of their abuse. Some fear they will lose their minds, self-destruct or harm others. She reassured her that it is normal to fear feeling the pain but that, in fact, allowing herself to feel it and learning to tolerate it, is an important step in the healing process.

Although psychoeducation is an important component of *trauma-focused* therapy, the timing of the intervention is a key factor. Sometimes psychoeducation can help open the door for exploration. For instance, in the above example, providing this information may give this woman courage to talk about her abuse and feel the full depth of her pain. This would be an important step towards integrating this aspect of her experience into her self awareness. However, psychoeducation given at the wrong time might short circuit exploration. For instance, if a woman is talking about her abuse and is accessing her affective experience, providing psychoeducation would pull her away from her affect towards a more intellectualized way of understanding her experience. Instead, it would be important to allow

her to fully explore her affective experience and once that was completed psychoeducation might play an important role in helping her make sense of what happened to her.

### **Eliciting Group Support**

There is a tendency for *trauma-focused* groups to function like support groups. (Although our previous example shows that this is not always the case.) This is because the main focus is on their childhood traumatic experiences rather than on the group process as it is in the *present-focused* group. One way to think about this is that in the *trauma-focused* group, the identified source of their problems (i.e., the perpetrator) is *outside* the room. In the *present-focused* group, where a primary focus is the group process, the identified source of their problems (i.e., themselves) is *in* the room.

In the *trauma-focused* group, the group mobilizes to support one another as they talk about abuse they experienced during childhood. This is especially evident after a member has shared horrifying details of her abuse or when she questions whether it was her fault that the abuse occurred. The group members are usually quick to express their horror and disgust at what happened or to argue vehemently that it was not her fault. This type of group process is one of the benefits of group therapy for survivors of childhood sexual abuse. It helps survivors feel validated, reduces feelings of shame and guilt as well as feelings of isolation. This type of interaction should be encouraged. In situations where group members do not spontaneously provide support, the group leader should invite the group members to give their reactions to what they have heard. This is often all that is needed to elicit support for the member.

### **EMPATHY**

Empathy is the cornerstone of any psychotherapeutic approach. It involves having an accurate understanding of the patient's point of view and experiencing it as if it were your own. It is important to emphasize that it is "as if" the patient's experience were your own. Maintaining this "as if" stance ensures that the therapist does not get lost in the patient's experience or confuse his or her own experience with the patient's. An empathic reflection does not require that the therapist repeat back to the patient everything that has been said. Instead, it often involves sidestepping much of what has been said in order to reflect the underlying meaning (Rogers, 1970). An empathic response conveys to the group member a sense of being understood, accepted, and not alone.

### **Empathic Failure**

While empathy is the foundation upon which any good therapeutic alliance rests, we include it as a specific principle of treatment because we have found that empathy is exceptionally important when working with victims of child sexual abuse. Survivors of child sexual abuse are exquisitely sensitive to the judgments of others. In group therapy they are especially sensitive to the perceived judgments of the group leaders. It is important to recognize that for many survivors, any empathic failure can be experienced as judgment. That is, even if the therapist is experiencing empathy for the survivor and communicates it to the survivor, if the therapist is not accurate in understanding what the survivor has

communicated, it may be experienced as an injury. For some, it may feel like a repetition of their abuse.

Inaccurate empathy often elicits rage. It is important to explore the emotional reactions to the therapist at this time. First, however, it is necessary to understand what the rage is about at a conscious level. It is at this time that the leaders will learn of their empathic failure. Upon learning about the failure, the therapist should make every effort to correct it. Once the survivor feels that the leader understands, the leader can then help the survivor explore her rage and to see how it is linked to her abuse.

### **Empathy Does Not Require Perfect Attunement**

Any seasoned therapist knows that it is virtually impossible to be perfectly empathically attuned to their patients. Given such a situation, how is the therapist to proceed? It is essential that group leaders express empathy towards their patients. At the same time, however, the leaders must always be willing to modify their understanding of the survivor in response to the survivor's corrections and to communicate these modifications. For example, in the account described above of the survivor facing the decision of flushing the toilet and returning to her father in the bedroom, one therapist tentatively inquired whether the reason that moment felt so significant was because she was wishing she could escape -- almost wishing she could flush herself down the toilet too? The group member considered the therapist's suggestion for a moment, but rejected it indicating that she thought, instead, that the reason it felt so significant was because it seemed like flushing the toilet was the act that meant that she had to return to her father, and because she had to act, it felt like she was choosing to return. Upon hearing this, the therapist acknowledged the correction and made it clear that she empathized with what this experience must have felt like for the survivor as a child facing that impossible predicament.

As described above, tentative statements of empathy, even if inaccurate, are often more tolerable to the survivor. A tentative statement indicates that the therapist is interested in the survivor's perspective and in achieving an accurate understanding of her experience. It also communicates to the survivor that she is the arbiter of her own reality and in this way it restores her control. Furthermore, she does not need to worry about being controlled by another authority figure.

## **PROVIDING A COGNITIVE FRAMEWORK**

### **Restructuring Her View of Self**

An important role of the therapist is to help the survivor restructure her view of herself. One way in which this is accomplished is to provide a cognitive framework from which the survivor can make sense of her experiences of abuse. We can assume that because she has pursued psychotherapy, she is unhappy with her functioning in her present life. She is likely to be struggling as a result of dysfunctional and possibly unconscious strategies of coping that developed because of her abuse. She will also have a negative view of self, feelings of inadequacy or badness, which developed because of her abuse experience. She is likely to suffer from low self esteem, and she may have little or no understanding of how this is an expression of having been victimized as a child. An important part of the therapeutic

process is to develop a new understanding of what has happened to her and the ways it has affected and continues to affect her life.

### **Feeling Responsible Gives the Illusion of Control**

Many women who have been sexually abused live their lives with a deep-seated belief that they are somehow responsible for what happened to them. Indeed, as a woman in the *trauma-focused* group recounts her story the group often hears her characteristic way of assuming blame for the circumstances in which the abuse happened or for not being able to avoid or control the situation. The sense of responsibility she feels may be a way in which she attempted to gain some sense of control over a situation in which she was powerless. The group leaders can be instrumental in helping the survivor to recognize the ways in which she was a victim, a child helpless in the hands of an abusive adult. Group members also often join in support of reframing the responsibility for the abuse, laying it at the feet of the abuser.

### **When Relationships Feel Dangerous, Intimacy is Compromised**

Understanding the link between the abuse and the difficulties the survivor has in achieving intimacy with another or other problems in relationships is important. Because of the abuse people proved themselves to be profoundly untrustworthy. The survivor learned to read carefully every expression of her abuser so as to determine when she might be in danger (Herman, 1992). She will carry this wariness with her into other relationships. It will prevent her from allowing herself to be vulnerable with others, an essential ingredient in the development of intimate relationships. She may be conditioned to respond unconsciously to cues that warn her of impending danger whether or not they are appropriate to a particular relationship. It will be necessary for her to recognize how and why she does this in order to improve her relationships.

### **Coping Strategies that No Longer Work**

As a sexually abused child, survivors will have used a variety of defenses to cope with the abuse. Dissociation is one common means of coping with trauma, especially in young children who are especially adept at this. Dissociation enables the victim to control the experience of abuse by removing herself psychologically from it. This defense is retained as a way to manage the extreme negative feelings associated with memories of the abuse. Many survivors also report dissociating in the present when faced with situations reminiscent of their past, such as during sexual contact. Dissociation during sexual contact is dangerous because the limited awareness of what is happening places her at risk both physically and emotionally. Similarly, many abuse survivors have learned to turn to drugs and alcohol as a means to cope with their experiences of trauma symptoms and other negative affect. An important task in therapy is to help the survivor to access this material and to integrate it into her conscious view of herself.

Although the *trauma-focused* approach is not aimed at “recovering” dissociated memories (although this will happen to some degree for some group members), this approach *does* involve restoring some of the dissociated aspects of the memories, such as feeling states, and thereby breaking down the disconnections in experience. By so doing the member will

have a more conscious access to and control of her memories and be in a position to correct the negative views of herself that developed because of the abuse. In addition, teaching the survivor to identify the situations that typically trigger dissociative episodes and/or the impulse to use substances (both of which could put her at risk for HIV exposure), and helping her develop more adaptive ways of coping with these situations, is a central task of the *trauma-focused* group.

# Chapter 7

## GROUP PROBLEMS

Women who have been sexually abused as children are a very interpersonally vulnerable population. They are usually exquisitely sensitive to what they perceive as dangerous exposure of the self, and have developed extensive unconscious defenses for avoiding that exposure. As a result such a woman's social relationships, and usually her self-perceptions and understanding, are frequently disordered to some degree. These problems will typically manifest in the group as difficulties in therapeutic improvement.

A patient's interpersonal problems typically have several focal points, usually interactive: one is confusion about and distrust of her own subjective experience, to the extent that the sense of self may seem excessively plastic in response to the environment; another is the tendency to assume guilt and shame or often self-contempt with great tenacity, in lieu of the unbearable helplessness of victimization; another is the influence of the abuser's introject, with the victim incorporating the experience of being exploited or abused into her felt sense of love and intimacy, perverting it deeply. Anger, at the self and at others, may be associated with any or all of the above issues; problems with anger, such as difficulty with control, or perhaps an inability to experience anger at all, are common for sexual abuse victims. Anger has great impact interpersonally, and therefore is significant in the group; it will be addressed throughout the discussion of the other problems. Patients having unclear memories can present difficulties in the *trauma-focused* group. Different levels of willingness and ability to encounter the reality of the abuse may also divide the groups. One way in which this may manifested is continued or increased substance use. Lastly, the patient is usually deeply distrustful of the motives of anyone who expresses an interest in her subjective life or a desire to know her better or help her. This presumption of ill intent is immediately relevant in the early group meetings, where the first task is to develop trust, and colors the patient's responses to the interventions of the therapists. It is where we will begin our discussion of these difficult areas.

### SILENT MEMBERS

The group's distrust may take a variety of forms. Members may be largely silent, with the therapist having to work hard to draw out even minimal comments. With patients who are distrustful of the therapists' intentions, this is delicate work, requiring persistence, patience and great attention to empathic containment. Patients will need to feel understood as they understand themselves initially; therapist interpretations or suggestions that challenge the patients distorted self-concepts must come later, after the groundwork of trust has been laid. This is not to assume that patients do not come to these groups desiring help; that may be their

conscious intention, but once the group process begins they may feel so endangered that they retreat to whatever safety they know, isolating and painful though it has been.

One extreme in patients' tendencies to be silent is seen in those who retreat to muteness, or appear to frankly dissociate. One patient, for example, would assume a hunched posture with a stricken facial expression when she felt overwhelmed, looking as if she were a million miles away, oblivious to the interactions going on in the group. Therapists should check in with such patients frequently, saying their names, acknowledging their presence and inviting their responses to whatever is going on in the group at the moment. However, it is important to remember that respect must be given to the sources of safety patients have found for themselves, dysfunctional though their choices may be. Though it will be an eventual goal for patients to emerge from and change their distorted attempts at safety in the world, it is not appropriate for therapists to attempt to take those places of safety away from the patients. Rather, patients should, again and again, be invited to try another means of self-defense besides total retreat from emotional presence in interaction. Their silence should be acknowledged, but their emergence should be invited, not demanded. Such persistence at invitation may elicit anger, as the patient's usually reliable refuge seems compromised by the therapist's tenacity; but anger is engagement, and in this case an improvement from total social retreat. Demanding interaction may elicit anger, too; however, it may also be perceived as so threatening that the patient may flee the group entirely.

### **CONFRONTATIONAL MEMBERS**

Another therapeutically difficult way patients may express their distrust is by efforts to control other people in the group, particularly the therapists. Rather than hiding their emotions, they may project them, "taking up a lot of room" in the group, in a histrionic or hypomanic style. Such a style can be intimidating for other patients, even while it may be respected as something they are unable to do themselves. It also may be seen as a reassuring display of power by "one of us." However, such patients are likely to attempt to challenge the therapists, since they are the people in the group with overt power and authority. In an effort to counter the powerlessness they experienced as victims, or for that matter any emotion unacceptable to them, such patients will attempt to project it onto others, and not acknowledge it as an experience of theirs. This style of self-defense, which is very "in your face" and confrontational with therapists, may be particularly difficult to manage. It too requires patience and delicacy, but strict limit-setting. This style also expresses disorder in feelings of trust, attempting to achieve safety by controlling others. When such patients are unable to acknowledge the projection of unacceptable emotion onto others, or when they are unable to render the therapists safe by disarming them of their power as group leaders (which of course the therapists cannot allow), they are unlikely to be able to tolerate the group. They may choose to leave, or they may be asked to leave by the therapists. Such decisions should be made early in the group, to avoid traumatizing the group by disrupting it once members have developed feelings of kinship.

Confrontations will occur among group members in any group. It is likely that the conflict is related to the internal and interpersonal struggles of group members as expressed in the life of the group. The leader should ask herself, as well as the members concerned, "In what way is this conflict tied to the group process?" What does it say about the state of the relationship of the group members to each other, to the leaders, and to the group as a whole?

It may be that one member is frustrated because another member is thwarting the group process, perhaps through fear of revealing herself. The goal of the leader is to help the members arrive at an understanding of the deeper meaning to the conflict.

## **SCAPEGOATING**

Scapegoating is a way of deflecting attention away from an uncomfortable issue and displacing the negative affect that issue evokes onto someone else. If scapegoating occurs, the person who is scapegoated may represent the topic in some way. On the other hand, the scapegoated woman may simply be the easiest target. Whatever the situation, scapegoating is destructive and the leaders must protect the person who is scapegoated and help the group to recognize the real issue they are avoiding. If the scapegoating is not dealt with and eliminated, it will undermine the integrity of the group and all members, not just the woman being scapegoated, will suffer.

## **THE MONOPOLIZER**

A common problem in groups is the monopolizing patient. This is someone who finds it very difficult to be quiet in the group, jumps to speak at every opportunity, and has a hard time giving up the floor. Not only do these patients tend to monopolize the conversation and make it difficult for others to speak, but they typically do not speak about things of real substance or importance. The main reason for the constant verbiage is anxiety (Yalom, 1985). The monopolizer is anxious if silent and so talks in order to quell it. The effect that the monopolizing patient has on the group is to instill frustration and create distance between the monopolizer and others.

It is important that therapists intervene early on in the evolution of the group so as to circumvent the development of a problem. The problem is twofold: one is to help the monopolizer; the other is to protect the group. As Yalom (1985) describes it, the aim is not to get the monopolizer to speak less, but to have her speak more. Eventually, the therapist will have to interrupt the woman and help her to speak from a more meaningful place. In order to do this, the leaders will need to attend closely to what she says and also in what context. You may notice that she tends to claim the floor immediately after someone has said something distressing. In a case like that, an appropriate intervention would be to interrupt her and to ask her how she felt about what she had just heard. If it is difficult for her to access her immediate experience, it may be necessary to follow the question with an interpretive statement such as "I'm wondering if you felt a need to change the topic to something that is not so upsetting". Certainly, these kinds of interventions have to be done sensitively and respectfully. Another strategy in dealing with a monopolizing patient is to elicit reactions from the rest of the group. Again, this must be done sensitively. The strategy is to ask for reactions in a way that will facilitate the expression of genuine, but non-judgmental statements. The woman who is monopolizing needs to feel that the rest of the group wants to hear about her concerns, feelings, and anxieties. Whenever this woman reveals thoughts and feelings of any importance this presents a perfect opportunity to elicit reactions from the group. This approach will help the woman feel heard and valued as a person and will encourage her to communicate at a meaningful level.

## **THE 'SPECIAL' MEMBER**

The 'special' patient is the woman who feels set apart, different from the rest of the group. She uses the difference that she sees between herself and the group to detach herself. In this way she is able to disengage emotionally from topics she finds difficult.

There are many ways in which a patient can decide to see herself as special and set apart from the group. She might compare her distress to that of the other women and conclude that hers is not as serious. Therefore, many of the issues that the group is concerned with are not relevant to her situation. She might use religion; God is her healer and source of support, so she need not worry about the kinds of problems her group members struggle with because she is in His hands. She might use her age, socioeconomic background, or specific aspects of her trauma history, if these distinguish her, deciding that the kinds of problems she has are so vastly different from the rest of the group, they could not possibly understand.

What the therapist must bear in mind is that the way in which she sees herself as a special case is motivated by anxiety. By agreeing to join the group in the first place, she has made it clear that she has issues similar to the other members. However, once in the group her anxiety mounts, overrides her gut sense that she needs help and support in coping with her life, thereby causing her to distance.

Because anxiety is at the root of her attempts to distance herself, the first goal is to support her in an effort to quell the anxiety. By listening carefully to this member, the therapist can reinforce the similarities between herself and other members. The main strategy is to help this woman tolerate her anxiety and connect with the rest of the group. By joining the group in this shared journey of self-exploration and mutual support, she will feel less isolated and able to face her particular fears and concerns in the context of a supportive and caring environment.

## **THE HELP-REJECTER**

The help-rejecter is someone who insists she is looking for help, if only she could find someone competent enough to give it to her. No one in the group, neither the members nor the leaders, can ever provide her with quite what she needs. Embedded in every reply she gives to others' responses to her appeals for help is a "yes, but..."

This woman may believe her problems are so complicated and difficult that there is really nothing that can be done for her. Underlying this belief that her problems are too complex is often some reason why she really does not want things to change in her life. One possibility is that she receives gratification from being someone perpetually in need of help. After all, if she took the advice given to her, perhaps her problems would be solved and there would be no one left to give her the sympathy and support she craves. Alternatively, the intricacy of her problems may be her way of establishing a sense of superiority. Underlying this need to feel better than the rest are feelings of inadequacy and inferiority. By rejecting the help of others, she can keep people mystified and stymied about how to help her. The inscrutability of her needs is a way of keeping people from getting close enough to know her and, as she fears, see her inadequacies.

Rejecting help can also be a way of expressing anger. She may be feeling enraged at the unwarranted blow life has dealt her. Her anger is preventing her from seeing any way to improve her life now or in the future. What may really be fueling the anger, however, is her

fear that all is hopeless for her. What is the point in thinking anything can help her when she "knows/fears" that all is lost.

The task for the therapist is to bypass her help-rejections in order to access the underlying feeling. This woman is working hard to maintain her distance from others and her own feelings. It takes a sensitive and empathic orientation to help her to soften so that she can attend to what is really going on inside of her. For example, following one of her classic rejections the therapist might say "Sue, while you were saying that I was struck with how sad you looked. Is that how it feels to you?" The therapist must strive to "hear" what she is really asking, and to support her. Ignoring what she says and responding to how she communicates, may enable her to speak more authentically.

Paradoxically, the help-rejecter is someone in need of a lot of help. Not only does she need help in coping with her pain, but she also needs help in maintaining relationships with others. She is trying to push people away and is often quite successful at it. The leaders must be careful that she not become alienated from the group. When the help-rejecter rebuffs another member's suggestion, it is often useful to ask the member how it feels to have her advice rejected. Initially this can be threatening to both members but it will enable the help-rejecter to respond to the other member as a person rather than another piece of advice she must fend off. By helping this woman "join" the group, she will benefit from the support she receives and the group will benefit from having supported her.

## **THE PSYCHIATRICALY DISTRESSED**

Problems of survivors can include depression, anxiety disorders, personality disorders, drug abuse, and thought disorders. Clearly there is a wide array of psychiatric problems that someone can bring to the group.

Ideally, the group leaders will have assessed each potential group member for psychiatric problems during the initial interview and anyone who was clearly inappropriate for group therapy has been referred elsewhere. Even with the initial screening, occasionally there will be someone who has joined the group with special needs. The leaders should try to attend to these needs as much as possible without it being disruptive to the group. The task of the therapist is twofold: to be responsive to the special needs of this woman but, at the same time, keeping in mind the overall needs of the rest of the group. The troubled patient should not be allowed to derail the group.

It is important to create as supportive an environment as possible, partly by helping other members provide support for the patient. The therapist should bear in mind, however, that for some disorders there exists a bottomless pit that no amount of group support could ever fill. The leaders should be alert to this possibility and not allow the group to become depleted by or resentful of the person's neediness.

If attempts to support the woman do not improve the situation, it may be appropriate to recommend that the patient receive individual assessment and treatment in addition to the group. If it becomes clear that the special difficulties of this patient cannot be managed in the group and are disruptive, she may need to be removed from the group and referred for individual therapy.

## **SUBSTANCE-USING GROUP MEMBERS**

A special category of distressed group member is the woman who continues, resumes or escalates her use of alcohol and/or drugs during the time she is participating in the group. Therapists will need to be alert to this possibility because, as substances users know well, intoxication is a very effective way to avoid full participation in the group; it can numb the anxiety and dysphoria aroused by group participation and self examination, thereby impeding the process of learning and integrating new information. Typically this maladaptive style of coping is over-learned and difficult to undo in a group format not specifically designed as a substance treatment program. Nonetheless, all group members will be helped to understand the role and impact of substance use in their lives, the connections between various addictive behaviors, and for those in the *trauma-focused* group, how the circumstances of her abuse history contributed to the development of the behavior (such as growing up in an alcoholic home or first using drugs as a way to tolerate abuse experiences). These topics are to be covered as part of the psycho-educational component of the early sessions that focus on identifying and reducing HIV risk behaviors. More generally, however, the sample recruited for this study will have higher rates of substance abuse and dependence than CSA survivors generally, and so it is essential that therapists be alert to evidence of drug use and state explicitly at the outset that all group members must refrain from using drugs prior to or during group sessions. If a group member does show up for a group intoxicated, this crisis will derail the group and, once resolved, will need to be processed by the group members. If a group member admits to continuing use of drugs – for example she describes drinking as soon as she gets home from every session as a way to manage her affect – the therapists should ask her if there is anything the group can do to help her feel less vulnerable when she leaves each time. Women attempting to maintain sobriety as they participate in the group should be encouraged to attend an AA (or other supportive) meeting on the way home from the group (if possible) for additional support. For those whose use seems to be escalating, therapists may want to recommend that the group member seek additional treatment outside the group. This will relieve the group of the responsibility of having to deal with this difficult problem and/or being derailed by it.

## **INTERPERSONAL DISTRUST**

Sexual abuse survivors have been injured both in the development of a sense of self and of intimacy. They were exploited by people normally expected to protect their innocence; they are left with the expectation that interest in them personally will not, cannot, incorporate their own feelings and wishes, will objectify them, and will be dangerous. That is, all interaction can be assumed to be for the other person, not for them, unless and until extensive experience to the contrary suggests otherwise. As long as they feel distrust, they will not let themselves be known, and experience corrective of their injury will not be possible. So from the beginning, the therapists must work very gently with the patients' distrust, keeping in mind how powerfully influential it is for this population. Great patience is required. Therapists may find themselves uncomfortable with being perceived as bad guys; female therapists may be experienced as the mother who stood by and did nothing to stop the abuse. Therapists who seem remote may be attacked by the group for their indifference. If they seem too vulnerable or fragile they may be the target of the group's collective projection of the victim introject,

and be treated harshly (more on this in the section on the abusive introject). Such experiences may be difficult for therapists, who are accustomed to having their good intentions recognized, even lauded.

### **INTRAPSYCHIC DISTRUST**

Universal among our patients is the experience of either distrusting the veracity of their memories of abuse or distrusting the reliability of their own subjective perspective as a source of information, about themselves or about the world. The distrust of memories varies greatly, with some patients who were abused as older children having always retained clear memories of their abuse, never doubting that it occurred; others suspecting they were routinely abused as young children, but lacking more than a few specific memories, with their suspected abusers denying abuse. Others who have recovered memories experience greater doubt if the person they remember as abusing them denies it, but still may experience doubt even if he admits the abuse. Other women may "relive" abuse at times when they are dissociated (or dreaming) but refuse to believe it actually happened because they are not able to recall the abuse when they are not in a trance or dream state. The repercussions of accepting that a person with whom they are still in relationship, and indeed may love, actually did violate both their bodies and their trust in the most intimate of ways rattle the foundations of their relational world views.

Such threats to psychological stability, unhappy though patients may be with their current equilibrium, are very, very difficult to bear. Therapists attempting to help patients recognize the enormity of the injury that was done to them, and particularly the error of self-blame or self-contempt, must remember what a profound shift they are asking patients to make. Self-blame serves at least to give the patient some illusion of having been in control of the abuse, a far more tolerable perspective than the devastating experience of helplessness that actually occurred, and that we are asking the patients to re-experience. We believe that patients who are entrenched in self-hate and self-contempt benefit in the long run from feeling the injury of the victimization, and discovering they can bear it and move on from it. They must be willing to take this chance before they will be able to relinquish the safety (and prison) of self-contempt. In the short-term their pain may increase; and continuing onward, trusting that their lives can improve, that self-contempt is not the only answer, takes a great deal of faith. For very isolated patients particularly, these are extremely difficult tasks. We found that patients would approach consciousness of the inchoate depths of their psychological injury, and turn back again and again to their old cognitive defenses -- self-contempt, emotional numbing, confusion, "it's hopeless, I'll never change; what's the point?," "actually I like overeating/ sleeping/staying in my room." Patients are understandably very conflicted about facing such pain and disorientation. Here again, therapists must be very patient and persistent in gentle confrontation... and humble in realizing we cannot take away the pain, only help patients live more fully with it and in spite of it.

### **THE ABUSIVE INTROJECT**

Another painful area of self-encounter for patients, and therefore of difficulty for therapists, is the patient's manifestation of her abuse by her behavior with others, particularly in her intimate life. The self-contempt mentioned previously could be a manifestation of the

abuser's indifference to the desires or feelings of the victim -- "If I am treated badly, I must be bad." In addition, despite conscious intentions to the contrary, despite a strong desire to protect her children at all costs from what she herself suffered, a mother who has been abused may find herself becoming enraged with young children over issues of power and control, and losing control of her temper. She may be able to avoid actually physically abusing them, yet continually lose her temper over mundane matters. One of our patients felt so strongly that she would be a chaotic and destructive parent that she has had multiple abortions. Another group member is estranged from her adult daughter, at her daughter's instigation, for reasons the patient doesn't understand, though she suspects it derives from her extreme tendency to self-negation, and lack of emotional constancy. These are often extraordinarily painful issues. These issues of behavioral dyscontrol are ones that typically require individual therapy in addition to the group. Again, facing the ramifications for others of the injury that was done to the patient brings yet another area of pain, challenging the patient's efforts to master old feelings of immutable culpability as she faces appropriate responsibility for her behavior with others. The scope of the admitted injury faced by the patient is thus broadened. This opening up of new painful material as progress is made is one of the early obstacles for patients; as they find new pain, not less pain, they want to retreat to earlier refuges, the ones that resulted in curtailed and distorted lives. Therapists cannot prevent the pain, or give them their personal answers; we can witness, support, contain, and be steadfast in staying with them as they progress through whatever steps they feel able to and willing to make in these groups.

### **UNCLEAR MEMORIES**

The issue of patients having very disordered intrapsychic and social lives, and suspecting abuse, but having only circumstantial evidence from their life histories to support it, is a very difficult one, for patients and therapists alike. In such a situation, when a patient has no way of verifying whether abuse actually occurred, she is left in a fog of uncertainty that the therapist cannot ethically clarify. In the present study we are requiring that each participant have at least one distinct memory of sexual abuse before the age of 17 and that they feel they are able to talk about the abuse. This will make the group members less heterogeneous with respect to the accessibility and clarity of their traumatic memories. Although the majority of group members will report relatively continuous memories of their abuse (though their understanding of its meaning may have changed over time), nonetheless, some may still have large unretrievable tracts of memory. In one *trauma-focused* pilot group, one member had never been able to retrieve any memories at all for her life from age 8 to 13, yet she was able to work effectively on examining the abuse memories that she did retain from the period before the onset of the amnesia. In addition, some survivors report clearly remembering abuse by one particular abuser but only suspicions about one or more others. Variations in the characteristics of abuse memories may leave some group members feeling different from other members of the group, and compound their self-distrust.

It is inappropriate for therapists to assert to a patient that her amnesia or suspicions signal that she was indeed abused during that period or by that person. The therapist cannot know, although she can certainly help the patient explore all avenues of her history as she struggles to make sense of possibilities. The repercussions of a therapist's attempts to impose certainty upon this situation can be huge, with the patient following an outside authority rather than integrating her actual uncertain personal history into her own narrative memory, and the

accused abuser and his family can be devastated if the suspicions are false. Given the current prominence in the media of sexual abuse as a source of trauma and the concomitant emergence of well-documented incidents of what appear to be false accusations -- false memories -- it is irresponsible for therapists to assume that they know something about which the patient is unsure or unaware; we consider this to be a major clinical error.

The difficulty for therapists, of course, lies in the urge to support and affirm these patients who have been so profoundly psychologically injured, who so doubt themselves and the reality of their suffering. One wants to affirm that the suffering they experience is real and terrible, and survivable. Since patients so doubt their memories, distrusting themselves, needing affirmation of their experience, therapists must serve as empathic witnesses, yet at the same time avoid planting suggestions. This is yet another fine line and difficult clinical area.

## **WHEN MEMBERS LEAVE**

Occasionally a member will decide to leave the group. This can occur for any number of reasons. Three of the more common reasons are that she is pushing others away and is not understanding how her mistrust and rage may become transformed, she is not getting her needs met, or that she finds the group too frightening. In any case, it is important that her reasons for leaving be determined and, if possible, addressed in the group before she leaves. Her decision to leave may reflect entirely her own issues; however, more often than not it is also a reflection of the group. This does not necessarily mean that there is something "wrong" with the group; on the other hand, it may very well indicate that there is something in the group that needs to be addressed. Whatever the case, bringing her reasons for leaving into the open will provide the opportunity for all members to examine whether or not they are getting what they need from the group.

The decision to leave may be because there is someone else in the group who is demanding too much attention, stifling group process through excessive defensiveness, or derailing the focus of the group. This kind of situation may occur with more psychologically heterogeneous groups; that is, where some members are psychologically more adaptive while others are more vulnerable and in need of more attention. If this is the situation, it is important that the problem be addressed because it is bound to be affecting other members as well.

Some individuals will leave because they find it too threatening to risk becoming more intimate, and to see how the abuse has affected their interpersonal functioning. Before a member leaves, it is important to talk about how the group process is affecting her. Raising this issue with the group provides an occasion to address the fear and anxiety that is generated for all members when talking about the impact of sexual abuse on their current lives. These fears and anxieties should be acknowledged as valid and real, but at the same time the leader can use this as an opportunity to reiterate the general philosophy of these groups; for instance, that we believe that the best way to cope with the shame and fear resulting from child sexual abuse is to talk about the wounds that are left and what the possibilities may be for healing.

The main principle in dealing with a member's decision to leave is to face it head on. If there are problems in the group they ought to be addressed. If a member's leaving is not a reflection of the group, it still provides an opportunity to acknowledge the shame, anger, and anxiety each person struggles with.

Finally, whenever anyone decides to leave, every effort should be made to have the woman return for one last session in order for her and the others to say good-bye. This is important for all concerned. It is a message of caring. It is also a message that no one will slip away unnoticed.

## **CONCLUDING THOUGHTS**

In this manual we have presented two different interventions for leading groups for sexual abuse survivors at risk for HIV infection: *present-focused* and *trauma-focused* group therapy. Sexual abuse may radically alter a sense of oneself and one's future. Unfortunately, there are few places where a survivor can honestly and openly address all aspects of her experience. Providing a safe and secure environment, where she can both find support and face issues that sexual abuse has raised for her, is a significant contribution to a sexual abuse survivor at a critical time in her life. It is our hope that this manual gives you the tools necessary to create such an environment.

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