GROUP AND FAMILY TREATMENT OF POST-TRAUMATIC STRESS DISORDER

Steven N. Allen, PhD, and Sandra L. Bloom, MD

The deeply hurtful changes that many people experience when confronted by traumatic events have been explained in a variety of ways. Among others, there are biologic, behavioral-conditioning, cognitive-behavioral, and psychodynamic etiologic models of post-traumatic stress disorder (PTSD). To varying degrees, each of these models addresses some portion of the typical phenomenology of psychological trauma (i.e., physiologic hyperarousal, intrusive thoughts or images, dissociation, fear, anxiety, depression, anger, guilt, shame, substance abuse, and suicidality). No matter which etiologic model is considered, a fundamental aspect of traumatic phenomenology involves disruptions of an individual’s relationship with the world. This psychological falling away of an individual from family or society after traumatic exposure is one of the most profound facets of PTSD. In this article, we address these interpersonal disruptions and their treatment with group and family techniques.

This article serves to guide the clinician’s efforts in the social reintegration of a traumatized individual. Group psychotherapy and family psychotherapy approaches to PTSD treatment are first discussed. The limited research assessing the outcome of these techniques is then reviewed.

GROUP PSYCHOTHERAPY

Treatment Rationale

Although there are many theoretical explanations for PTSD, the constructivist approach of McCann and Pearlman provides a therapeutically rich system.

From the Veterans Administration Medical Center and the University of Utah, Salt Lake City, Utah (SNA); and The Sanctuary at Northwestern, Northwestern Institute, Fort Washington, Pennsylvania (SLB)
for conceptualizing the psychological effects of trauma. Constructivism attempts to account for both the typical and the unique adaptations to the effects of psychological trauma. Psychological constructivism posits that each person creates an individual, internal representation of the world based on a relatively stable framework of assumptions or schemas. Schemas are cognitions (frequently unconscious) that are developed to meet emotional needs. Core schemas address an individual’s frame of reference, such as attributional explanations of causality (i.e., why did this happen to me?) and expectations for the future (i.e., hope). Other important schemas include safety, trust/dependency, independence, power, self-esteem, and intimacy.

These schemas form the bedrock assumptions on which people guide their lives. Until an individual encounters a traumatic experience, these schemas are taken for granted and rarely questioned. After experiencing a traumatic event, these schemas may change among the psychological victims of the trauma. Post-traumatic therapy seeks to reconstitute schemas by incorporating new or adaptive cognitions.

By virtue of their social and interpersonal nature, group and family therapies provide excellent environments to repair schemas for safety, trust/dependency, independence, power, self-esteem, and intimacy. As Yalom describes, a group represents a social microcosm in which the interpersonal dynamics of group members are evident. Each member’s problems and strengths are manifested in the way they “train” other group members in how to act toward them. In contrast to most social experiences, the process-oriented therapy group provides an opportunity to explore these interactions. The primary mechanism for this corrective interpersonal learning experience is feedback. Feedback on an emotionally meaningful interpersonal level promotes development of more accurate self-perception and behavior change. Feedback, in turn, increases awareness of their interpersonal strengths as well as unconscious, maladaptive interpersonal distortions. Because of the social basis of many difficulties that people encounter, the society of the group affords opportunities for learning more adaptive interpersonal behaviors. An adaptive spiral of behavioral change begins and grows with the support and continued feedback from the group. The group also functions as a “holding” environment in which the members feel safe and belonging. The therapy group in many ways may represent a healthy “family” environment in which personal growth and behavior change are supported.

Group psychotherapy experiences for PTSD patients can provide some particularly powerful and needed interventions. Group experience decreases isolation and alienation as members find that others can understand their experience. Social reintegration begins when group members feel the support of the group and come to believe they are no longer facing trauma recovery by themselves.

Within the supportive atmosphere of a group, members receive the benefits of disclosing what has happened to them and begin integration of their experiences on cognitive and emotional levels. The sharing of the group also promotes the rebuilding of intimacy in relationships. Group psychotherapy allows members to shift from the deeply internal focus caused by trauma exposure to permit a view of other people as also needing help. Within the group setting, this shift is especially empowering because members are given the relatively rare opportunity to help others on an emotional level. Group members help each other move from helpless victim to coping survivor. Empowerment, in turn, also begins to repair damage to the trauma survivor’s sense of control and self-esteem.

Group Therapy Considerations

Group and family psychotherapy provide superb opportunities to address corrective injuries to basic schemas, such as trust and safety. But group and family work must be carefully considered and sensitively timed to avoid possible reinforcement of maladaptive patterns. There are situations in which family therapy work is contraindicated because of intramilial abuse. For individuals who are distrustful, are frightened, or have been especially hurt, beginning therapy with group work may overwhelm the person’s already embattled defenses. Establishing a working level of safety and trust is crucial for therapy. Depending on the integrity of the traumatized individual’s psychological resources, the issues of safety and trust may be best met initially in individual psychotherapy. A gradual exposure to group psychotherapy should be considered. Too rapid movement into group psychotherapy may overwhelm impaired resources, producing secondary traumatization.

As with most therapeutic approaches, empathic relating is fundamental. For post-trauma therapy in particular, empathy can be built by considering how a person has been hurt rather than focusing on the deficiencies of the person. Verbal acknowledgment of the distress of the patient is helpful: i.e., “I’m sorry this happened to you.”

The therapeutic rules of thumb guiding other PTSD treatment methods are applicable to group psychotherapy as well. Ochberg describes three general principles of post-traumatic therapy: (1) There is a general pattern of post-trauma adjustment and the thoughts and feelings that comprise this pattern are normal, although they may be painful and perplexing . . . (2) The therapeutic relationship must be collaborative, leading to empowerment of one who has been diminished in dignity and security . . . (3) Every individual has a unique pathway to recovery after traumatic stress.” In their review of the common elements found across PTSD psychotherapies, Schwarz and Proctor describe five basic treatment factors: (1) supporting adaptive coping skills, (2) normalizing the abnormal, (3) decreasing avoidance, (4) altering attribution of meaning, and (5) facilitating the integration of the self.” In addition, therapy should generally be more structured than in group therapy. Also, therapy should be trauma focused and relatively brief (under 15 sessions). Longer treatment may be necessary if the traumatic experience was intense and prolonged, treatment is distant from the traumatic event, and social support is compromised.

Yalom provides excellent general guidelines regarding the technical aspects of group formation, size, member preparation, therapeutic norms, and leadership. For PTSD group treatment specifically, Koller et al address group preparation, leadership, and composition. Group composition should be relatively homogeneous for the type of trauma experience. Heterogeneity on the dimension of recovery from trauma can be helpful. Group members who are more advanced in recovery can provide hope and guidance to other members. Groups may be either open or closed in format. The closed, time-limited group builds a strong sense of intimacy that can be helpful. Most trauma focus groups follow this format. An open, ongoing group format allows members to develop their intimacy skills when confronted with the task of incorporating new members. This group format may be useful in outpatient programs because the open format more closely models real world social experiences.

An important clinical issue in any PTSD treatment is how to address the individual’s traumatic experience. As Dye and Roth outline, approach (e.g., uncovering traumatic memories) and avoidance (e.g., emphasizing supportive interventions) are two primary therapeutic techniques. In their discussion of
avoidance and approach techniques. McCann and Pearlman provide some useful clinical guidelines. Supportive approaches are indicated when traumatic memories are intrusive and an individual's self-capacities to master or cope with distressing affect are limited. Uncovering approaches may be useful when a person's resources are able to cope with affect, and self-capacities are strong enough to allow increased awareness or recall of traumatic experiences. In a survey of 18 psychologists nationally prominent for their use of flooding or implosive (approach) techniques, it was found that these exposure treatments were used in only 58% of the PTSD cases treated by them. Exposure techniques were contraindicated by marked psychological dysfunction, personality disorder, suicidality, impulsiveness, substance abuse, or treatment resistance.

As yet, there are few outcome data to guide clinicians on the appropriateness of using avoidance or approach techniques. In one of the several recent comparison studies of different therapy methods, the results of stress inoculation training, prolonged imaginal exposure to trauma stimuli, supportive counseling, or waiting list control for the individual treatment of rape victims were examined. All of these methods showed improvement at the conclusion of treatment, but the prolonged exposure treatment was the most effective at 3-month follow-up. In an outcome study of a multimodal (but predominantly group focused) VA inpatient program for the treatment of chronic, severe combat-related PTSD, self-esteem and interpersonal relationships improved, and numbness and arousal decreased by the conclusion of the program. Intrusive symptoms (nightmares, in particular), however, were the least affected. Scarfield et al. observed that a significant subgroup of veterans may not be appropriate for this approach-based treatment because they are too "open and raw" when they are discharged from treatment.

The application of approach or avoidance techniques requires careful clinical judgment. It is wise to recall the deeply idiosyncratic nature of PTSD and design individualized treatments. For example, perhaps supportive, avoidance approaches should be used in treating chronic PTSD, whereas exposure-based approaches may be more effective in acute PTSD. In general, at our current level of knowledge, sensitive dosing of exposure appears helpful, but the clinician must be alert to fluctuations in the patient's coping ability. As our knowledge of the effectiveness of psychotherapeutic approaches to PTSD improves, clinicians may be able to match patients more systematically with optimal treatment approaches. For example, a psychoeducational approach may be indicated for treatment of uncomplicated reactivated traumatic symptoms, whereas a psychodynamic approach may be used for more complicated reactivated trauma symptoms.

Various Group Approaches

A variety of group approaches have been used in treatment of PTSD. These include Yalom-style process groups, cognitive-behavioral, psychoeducational, psychoanalytic, self-help, Jungian dream work, art, movement, and psychodrama groups. We briefly describe some psychoeducational, process-oriented, psychoanalytic, and trauma-focus groups.

Psychoeducational groups can provide an excellent introduction to the beneficial aspects of group treatment. The discussion of the course and symptoms of PTSD, typical emotional dynamics, and interpersonal problems has proved helpful in treating PTSD. Patients and their families are frequently perplexed by the behavior changes that may follow a traumatic event. Learning about the dynamics of PTSD is commonly reassuring. For families, teaching about the effects of trauma on the family can be a potentially powerful tool in decreasing familial denial and anxiety and improving family support. Education about the biology of PTSD and the characteristic phenomenology of PTSD provides patients and their families with a cohesive explanatory system to make PTSD symptoms more understandable.

PTSD patients themselves are often eager to learn more adaptive ways to cope with troubling emotions, such as anger, grief, and depression. Anger management is an excellent starting point in psychoeducational treatment of PTSD. Although clinical observations suggest there are gender differences in coping with anger, both men and women can increase their sense of control through improved anger management. Improved self-control in turn promotes healing of the core schema of control that is commonly injured by traumatic events. In particular, female patients may benefit from learning to express their anger more effectively, whereas exploration of anger in male patients, even those distant from most other emotions, may lead to better understanding of other emotions. Exploration of anger in a psychoeducational group frequently enables patients to discuss other feelings (e.g., hurt, rejection, fear, grief) that emanate from injuries to other core schema. Cognitive-behavioral approaches and anger bibliotherapy are useful approaches to anger management.

Success with anger management provides an improved level of trust on which to base further discussion. Discussion of intimacy has been a surprisingly well-received topic in a largely male veteran population with chronic PTSD. Once intimacy is defined as a concept broader than only sexual intimacy, patients are often eager to explore how to improve their relationships with others. Other topics addressing common themes of PTSD patients, such as forgiveness, tolerance, shame, and traditional gender roles, are also well-received. A structured group cognitive-behavioral approach to improved self-esteem may also prove helpful.

As outlined previously, the process-oriented group approach is a rich therapeutic approach for PTSD treatment. In keeping with the here-and-now focus of process-oriented group, this technique involves aspects of both the avoidance and approach models of PTSD treatment. Although the group may focus on current relationship difficulties, exploration of how trauma-related problems developed may be indicated as well. Process-oriented group psychotherapy promotes an appropriate level of emotional sharing, social support, and reintegration into social functioning. Ideally the interpersonal feedback of a process-oriented group provides a corrective emotional experience.

A well-managed process-oriented psychotherapy group permits an appropriate dosing of exposure with supportive functioning within a social environment. Careful monitoring and titration of the group anxiety level is necessary. Excess anxiety debilitates the group, and too little tension inhibits meaningful emotional work. The reduction of intrapersonal anxiety in a process-oriented format is an important mechanism of change. The reduction of tension in an interpersonal group setting is strongly reinforcing. For example, group members are almost universally surprised to find that when they express their emotions rather than defend against them, the intimacy level of the group reliably improves. Reduced fear of emotional issues is extremely reinforcing.

To address the narcissistic vulnerabilities, defenses, and problem behaviors of combat-related PTSD in veterans, Farson has developed a psychoanalytic group psychotherapy model, the curvilinear progressive-regressive group (CuRePro). This approach attempts to address the complexities of unconscious developmental motivations in a group format. This model involves flexible ther-
FAMILIES AND POST-TRAUMATIC STRESS DISORDER

Families and Trauma

The feminist philosopher Rudick has defined the primary parenting functions as preservation, nurturing, and training. From the point of view of affect theory, Nathan concluded that the family endures the traumatic aftermath, and the primary parenting functions of protecting, healing, and teaching become distorted. Trauma stops the clock, producing developmental changes in the traumatized family as in the individual. Trauma disrupts attachment bonds and involves important internal and external connections. The family becomes unable to provide adequately the safety, affect regulation, and train that its members require. Psychological trauma produces not only biologic and psychological, but also social, and social and social wounds require social healing.

The effects of psychological trauma spread across and down through the generations, similar to an infectious disease that is often difficult to diagnose because the presenting symptoms vary so widely. Although we cannot say which individual will manifest with precisely which symptoms, we can probably say that no member of a traumatized family escapes the nearness of death, horror, despair, or betrayal unscathed. Primate data as well as studies of survival groups provide us with well-documented evidence for the transgenerational traumatic patterns so well recognized by clinicians.

Families and others have written extensively about traumatized families. He has pointed out that families are affected in four ways: (1) simultaneous effects as when natural disaster hits an entire community; (2) vicarious effects as when a family member is the victim of the trauma, and the response of the other family members results in the experience of trauma, as in hostage situations; (3) chiasmal effects as when the traumatic stress actually “infects” other members of the family; and (4) intrafamilial trauma as when the family itself is the source of the trauma.

Clinicians working with traumatized and traumatizing families have noted certain key problems, which include constricted intimacy and expressiveness, overt hostility with unpredictable verbal and physical aggression, and global maladjustments with recurrent crises. Many authors have focused on the primary family members, the traumatized adults in these families have in bonding with and remaining attached to their children. This results in extremely dysfunctional family systems in which affect cannot be properly modulated, the capacity for empathy is greatly reduced, and traumatic re-enactment becomes a routine occurrence. Nowhere are these dysfunctional family patterns so clearly demonstrated as in the incestuous family, which is often characterized by deceit, isolation, role confusion, boundary diffusion, triangulation, violence, and abusive power.

The result of the establishment of such reverberating and resonating patterns of family maladjustment is what Bentovim has termed a trauma-organized system, a system focused on acting rather than talking or thinking. In such families, the original traumatic experiences cannot be touched, and the silence must remain unbroken, the traumatic memories unexplored, and the trauma affect unmodified. As the individual victim of trauma, unresolved trauma leads to traumatic re-enactment in the entire family system, and if these sufficient numbers of traumatized families in a larger system, it is reasonable to speculate that the result can be an entire cultural system within which unresolved traumatic experience sets the normative standards for family life.

Family Therapy Considerations

Given the devastating effects of trauma on the individual family members and the family as a whole, effects that extend unpredictably into the future, therapy with the entire affected family is a vital intervention. The goals of treatment vary depending on the particular situation of each family, but in most cases the first priority is to establish a safe environment for the family. In cases of intrafamilial violence, particularly when children remain within the family system, protection of vulnerable family members must take precedence and the perpetrator must be held accountable for their actions and prevented from inflicting further harm. As Herman has made clear, the establishment of safety is the first priority for any form of treatment, and unless conditions of safety are achieved, treatment is doomed to failure.

Denial of violence within families—both individual and social—always has been and continues to be a major barrier to recovery and must be addressed. This is particularly true because it is the more severe intrafamilial trauma that is most likely to be dissociated or denied, resulting in a systemic error. It has been repeatedly noted in multigenerational studies of child abuse that the parents most likely to abuse their own children are those who have been abused themselves as children but who deny the abuse and idealize their own parents. The debate over the false memory syndrome raises some important issues about the need for good clinical skills, one of which is recognizing the importance of the attachment bonds that family members have for each other even when there is serious family conflict. There may be cases in which the actual perpetrators are strongly motivated to deny consciously or unconsciously their actions.
When the barrier of denial has been surmounted, the family must be helped to recapitulate the traumatic events, allowing for the expression of dissociated affect, mutual validation and self-disclosure, and integration of the traumatic experience into a whole family story that looks backward into the past with a degree of compassion and forward into the future with hope.  

Shenberger\(^1\) makes the point that framing the trauma, particularly when it has been intrafamilial, as the family's "shameful story" indicates implicitly that there are many other real and possible stories for the family to tell. Throughout this part of treatment, the role of the therapist is largely one of educator and trainer, introducing a new cognitive frame for the family to use in their own healing based on a thorough understanding of trauma and its effects. 

Benjamin and Benjamin\(^1\) see stopping the cycle of abuse as a fundamental goal for family intervention, our "responsibility to posterity." Ideally the outcome of family therapy is that the family is able to move past the traumatic experience, having integrated the trauma into a meaningful narrative as part of an overall family story. When this occurs, a family is able to move from a traumatically organized system to a system that is more flexible and responsive to the needs of each individual member of the system in the present, rather than simply repeating a traumatic past.

Acute trauma is most damaging to a family system that is already dysfunctional. As is the case with the individual, even a relatively minor stress can precipitate a crisis in a family burdened by long-standing intrafamilial or intergenerational trauma. In these situations, particularly with adult patients, there are often two family systems to be considered: the family-of-choice and the family-of-origin. Often the approach to each system must be handled quite differently.

For the adult who is the identified patient, the first focus of family intervention should usually be with the family-of-choice. It can be assumed that by the time the family member has entered intensive treatment for post-traumatic issues, the entire family system is experiencing both the vicarious and the chiasmal effects of trauma. Family members need extensive psychoeducation to provide them with a trauma-based cognitive framework within which they can reframe the family problem as a family challenge and survival mission. It is not unusual for violence to have entered the family system as well, and eliminating the violence must be a primary priority. The family members can be instructed toward understanding the role they are playing in a traumatic re-enactment scenario and guided toward a redirection of the family script in a more satisfying direction. It is well-known from work with various traumatized groups that social support is one of the few factors that attenuates trauma.\(^1\) Family therapy sessions can turn the energy of the family from traumatogenic to supportive once the healthier members of the family join together to provide what the identified patient actually needs rather than playing auxiliary roles in the patient's traumatic re-enactment.

Working with the family-of-origin, particularly in those cases of long-standing intrafamilial abuse, poses particularly difficult problems that focus on issues of confrontation. Adults who have been victims of childhood abuse often attempt to precipitate a family confrontation shortly after entering treatment and recognizing their past history of abuse. Unless there is some risk of continued abuse, such early confrontations should be discouraged because it usually leads not to the outcome of reconciliation, validation, and support wished for by the patient, but instead to a dangerous traumatic re-enactment that the patient often cannot tolerate.\(^1\) Family confrontations with perpetrators or those who failed to protect can be extremely helpful to the patient in enabling him or her to speak the truth that has been hidden, renegotiate relationships, and validate his or her own experience. Such disclosure sessions, however, are only of value if they have been planned in advance and the patient is prepared for the negative consequences that may ensue.

It is particularly important that the therapist avoid being caught between the patient and his or her family as the surrogate rescuer, protector, defender. Learning to self-protect is a necessary outcome of treatment, and the therapist must help the patient learn how to do it, not attempt to do it for him or her. Although the patient, with the support of the therapist, may be able to express predominant feelings of anger at the past abuse, one should never underestimate the strength of long-standing attachment bonds to the family-of-origin and the attendant and potentially dangerous grief should those bonds be unnecessarily or prematurely severed. Failure to take such attachment needs into account can result in a situation that is dangerous to patient, family, and the therapist alike. Family confrontational work should occur, whenever possible, in the later stages of therapy when the patient no longer needs confirmation of the abuse and can tolerate the potential loss of attachment to the family.\(^1\)

**OUTCOME RESEARCH**

As with other psychotherapeutic approaches to PTSD, research on outcomes of group and family therapy has lagged behind clinical application. Given that these techniques are commonly used, surprisingly few studies have systematically evaluated treatment effectiveness. For example, in a 1992 review of the efficacy of PTSD treatments, psychopharmacologic interventions received far more attention than psychotherapy techniques.\(^1\) No studies specifically investigating group or family treatment outcomes were reviewed. The few studies to date with group or family components that have examined treatment outcomes are described next.

Several long-term, inpatient, multimodal (but primarily group-oriented) treatment programs for chronic PTSD in combat veterans have provided outcome data. Scurfield et al.\(^1\) found that veterans completing the 12-week treatment program improved their self-esteem and interpersonal relationships and decreased numbing and arousal. Intrusive symptoms were the most resistant to intervention. In another treatment program, significant decreases in PTSD-related symptoms of anxiety and dysphoria were also found. Social reintegration of the veterans was also facilitated, judging from decreases on the schizoid, avoidant, and passive-aggressive scales of the Millon Clinical Multiaxial Inventory (MCMI).

Another multimodal chronic PTSD treatment program combined behavioral, cognitive, and group approaches (i.e., self-help, milieu, and networks) with extensive program evaluation.\(^1\) Although objective measures of the Israeli combat veterans and their families treated in the Koch program did not reflect much change in functioning or symptoms, subjective reports were of improved interpersonal relationships, coping, and reintegration into society.

Marmar et al.\(^1\) compared the effectiveness of 12 sessions of individual psychodynamic psychotherapy with 12 peer-led, self-help groups.\(^1\) All patients in the study were being treated for unresolved grief reactions stemming from the death of a husband. Somewhat surprisingly, both treatments resulted in significant and comparable reductions in grief symptoms. Pertinent to the usefulness of preparing subjects for groups, more patients prematurely terminated from the group (77%) than from individual treatment (32%). Marmar et al speculated the
differential dropout rate reflected difficulties in group cohesiveness related to the variety of reactions of individuals to loss.

In the study of group treatment for sexual-assault victims, an initial exacerbation of symptoms was found. By the end of 30 sessions, however, intrusive symptoms, fear, and depression had improved. These gains were maintained at the end of the year treatment.

Group and family therapies for PTSD have shown some effectiveness in improving interpersonal relationships and social reintegration. They probably decrease arousal symptoms and anxiety but may increase intrusive symptoms, especially for individuals with diminished abilities in coping with distressing affect. Individuals should be carefully prepared for group experience. Given the high frequency with which group and family therapies are used in PTSD treatment, the most striking characteristic of the outcome research on group and family therapies is how little data are available.

SUMMARY

A central feature of PTSD is its effect on social relationships. Trauma affects groups of people, not just individuals. Family systems, neighborhoods, and even whole generations may feel the results of psychological trauma. Because of the social nature of the effects of trauma, post-trauma treatment must address an individual's relationship to others. Group and family psychotherapy are ideally suited to this and are important components of a multimodal approach to PTSD treatment. Group and family psychotherapies provide superb opportunities for social support, social reintegration, and interpersonal learning. As with any powerful technique, these methods must be carefully applied. Although not all patients are appropriate for exposure-based treatments, improved interpersonal coping skills will likely be beneficial to many PTSD patients. Patients should be carefully evaluated for treatment types and assessed for treatment response.

Although group and family therapies currently provide relief and growth for PTSD patients, many considerations remain for the future. For example, how can patients be matched with various treatments for optimal results? How should acute and chronic PTSD treatments be similar and different? What is the effectiveness of group and family therapies for PTSD? What are the social and legal implications of a prolonged course of treatment for a victim whose children meanwhile are being traumatized by the parent's relatively poor parenting skills secondary to their inadequacies and disabilities? Finally, at a global level, how do we improve systems therapy technology to enable us more radically, effectively, and quickly to bring about total system change? Because families and groups are the 'cells' that compose the 'vital organs' we call nations, and these nations in turn make the total body of mankind, the answers to these questions may have a significant determining effect on the future survival of us all.

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