

# Hazardous Terrain: Countertransference Reactions in Trauma Groups

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*From Maggie's field journal:* It's the first night of group. Eight terrified women sit rigidly on the edges of their chairs staring at the carpet, wondering how they will find the strength to talk about what they have been through, desperate for connection yet certain that they will be abandoned and betrayed again. I don't like these beginnings. I'm, tense, already creating a wall to protect myself from stories of the terrible things people do to each other, from allowing in the depth of the woundedness, from having to look in the face (again) the world I live in and to struggle to make meaning (again) of what I see. I'm protecting myself from a grief so deep I wonder if it can be tolerated. Did this tightness show tonight, or did I look as relaxed and confident Maureen?

*From Maureen's field journal:* The first hours of group, when I'm seen as dangerous, are hard for me. Particularly those moments when I'm handed the perpetrator role. It's like a cup of cold water. It happened tonight, when I was describing how we'll be using containment skills throughout the group, and Judy made a face of disgust. At moment I was the offender in her eyes, trying to conceal and deny the awful pain. I flushed and wanted to argue with her, to tell her I was a safe, competent therapist. I wanted to shuck off the slime I felt I'd been covered in.

As these descriptions of the opening moments of a trauma group for adult survivors of childhood abuse illustrate, the dance between vicarious traumatization and countertransference begins immediately, as does the dance between the cotherapists. In the first entry—an example of the impact of trauma work on a therapist—Maggie feared she would be overwhelmed by the impending confrontation with violence and pain. In the second entry—an example of countertransference—Maureen found herself vulnerable to transferences that cast her in the perpetrator role. Both of us were in danger of losing the compassionate objectivity essential to trauma work. In the first example, Maggie might have found herself subtly encouraging silence to protect her fragility, and in the second example, Maureen was at risk of overfunctioning to prove her "goodness."

Trauma survivor groups are full of such pitfalls. This complex terrain requires a therapist to identify, understand, and manage complex relational dynamics. She must monitor her responses to the traumatic stories and presentations of the group members, as well as her responses to the group as a whole, group dynamics, and her cotherapist.<sup>1</sup> Although theoretical and clinical grounding in trauma psychology, and strong group facilitation skills, are critical to successful group outcomes, it is essential for each therapist to have a map that supports her in the intricate work of making visible her inner and often conflicted responses to this work. A map (theory) normalizes and contains the difficult task of challenging defense structures and professional egos. Route-finding skills (method) enable her to explore her reactivity and then to respond appropriately.

The map is provided by the concepts of countertransference and vicarious trauma. This chapter adopts a totalistic definition of "countertransference" (Kernberg, 1965; Racker, 1957) that includes all of the trauma therapist's responses to the client, the client's story, and the client's behavior, as well as the conscious and unconscious defenses mobilized by the therapist to protect her from these reactions (Pearlman & Saakvitne, 1995; Wilson & Lindy, 1994).

In the totalistic tradition, countertransference is an important diagnostic tool (Kernberg, 1965). This perspective suggests that a therapist's internal responses are not inherently negative or positive, nor do they constitute a statement about her competency. They are a source of essential knowledge for the therapist about herself, the group, and its members. Rather than being a burden, countertransference can be appreciated as a primary Source of insight and compassion into the victim's past experience and present reality. Thus countertransference responses are route-finding markers that can be used to guide therapeutic interventions in a grounded and timely way.

McCann and Pearlman (1990) have noted that countertransference concepts do not encompass the specific impact of traumatic material on the therapist, and have developed the concept of "vicarious trauma" to address the inner alterations of meaning resulting from this exposure. Pearlman and Saakvitne (1995) describe vicarious traumatization as "the transformation of the inner experience of the therapist that comes about as a result of empathic engagement with

the client's trauma material" (p. 31). Other authors have conceptualized the therapist's response to trauma as "contact victimization" (Courtois, 1988), "empathic strain" (Wilson & Lindy, 1994), "secondary posttraumatic stress disorder," and "compassion fatigue" (Figley, 1995).

Although therapists have been conducting groups for adult trauma survivors for many years, the literature exploring therapist responses to such groups is surprisingly sparse. The few publications with a primary focus on countertransference issues in trauma group work include descriptions of these issues with persons facing terminal illnesses (Bernstein & Klein, 1995; Gabriel, 1991; Benioff & Vinogradov, 1993), adult children of alcoholics (Vannicelli, 1991), Vietnam veterans (Frick & Bogart, 1982; Walker & Nash, 1981; Parson, 1984), adult children of Holocaust survivors (Fogelman & Savran, 1980), and survivors of childhood sexual abuse (Abney, Anderson-Yang, & Paulson, 1992; Courtois, 1988; Ganzarain & Buchele, 1986; Pearlman & Saakvitne, 1995).

Consequently, group therapists mainly travel this relatively unexplored terrain with maps pertaining to either individual trauma or general psychodynamic group therapy. Neither map exactly fits. It is critical to understand how trauma histories alter the usual group processes, in order to remain grounded in the inevitable flurry of transference, countertransference, and vicarious traumatization reactions. Although understanding the countertransferential traps does not keep them from occurring (Chu, 1988), identifying sources of therapist reactivity is an important first step. Before the therapist can utilize her countertransference responses in trauma group therapy, she must be able to tolerate, manage, and resolve her own cognitions and affects. This processing connects what is happening in her own heart and mind, and enables her to facilitate connection effectively in the group. She is more likely to intervene in ways that promote immediacy (Ormont, 1993) and to demonstrate "willingness and capability to accompany the patient into his past without losing sight of the present" (Kernberg, 1965, p. 53). She is also able to identify unacknowledged individual and group themes and to address them safely. She is able to contain and hold the trauma survivor's disowned parts of self and to make timely interventions that assist the survivor in reclaiming these parts. These examples of countertransference-based interventions enhance the connections of the group members to themselves, each other, and the cotherapists. The hard work that therapists and group members engage in to face themselves, albeit in different ways, leads to a shared joy in the deep connections that occur in successful trauma group work—the connections that are at the heart of trauma recovery.

This chapter examines the link between countertransference and group processes. It focuses on the necessity for therapists to strengthen their capacities for awareness, containment, integration, and presence; these tasks, of course, are also central for trauma survivors. In addition, the cotherapy relationship is viewed as playing a significant role in addressing and resolving therapist reactivity.

Central to our own route-finding efforts are our "field journals." A field journal, as described by Agger and Jensen (1994), is a journal that is used to monitor and process reactions during psychotherapeutic work "in the field." Agger and Jensen used such journals while working under conditions of state terrorism in Chile, and Ziegler (1996) kept one while working near a war zone in Croatia. The field journal allows an exploration of both self and the encountered reality, honoring the front-line trenches therapists find themselves in. "In this way, we became our own informants" (Agger & Jensen, 1994, p. 267). Throughout this chapter we share entries from our own field journals (the majority of these entries are descriptions of a recent group); we hope that our self-disclosure encourages other therapists' inner exploration and, most importantly, gives permission to make mistakes. We have learned that our willingness to question our own fears and defenses, risk exposure, and gently confront each other enables us to maintain clarity with ourselves, each other, and the group.

We realized we needed to continue our field journals through the writing of this chapter. Every time we became blocked, discouraged, or uncertain of where we were heading, we came back to the journal. We would sit together with papers all over the room and say, "Okay, just write for 10 minutes about how we are feeling right in this moment about the topic, about ourselves, about each other." Then we would read it aloud and without feedback to each other. After this, we would say, "Okay, 10 more minutes." We kept doing this until we understood that the blocks had to do with fear. We were afraid of the merging of voices that this chapter required. Our voices had to come closer than in the groups, where our voices dance back and forth, and we were anxious about the impact on our relationship. In the end, we created a balance, using the field journals to portray our individual voices and dialogue for the dance between us.

The group referred to in many of our journal entries and other descriptions was a time-limited 16-week group for severely traumatized Women. The women in the group shared complex and chronic childhood trauma experiences, and many had been revictimized in adulthood. Group participants were aware of this project and gave signed consent for personal and group material to be disguised and adapted for this chapter.

## THE UNIQUE TERRAIN OF TRAUMA GROUPS

Countertransference issues emerge in unique ways in trauma groups. In individual psychotherapy with trauma survivors, the privacy of the office creates a contained environment for rebuilding safety and trust. The therapist concentrates her energy on one person, tailoring interventions to fit the client's uniqueness, and taking the time required to work safely through the client's transference reactions. The trauma group therapist has to build safety and trust in an exposed environment in which she often has little information about each person's history, traumatic exposure, or response to trauma. She observes at first hand the difficulties in building connection, yet cannot respond to each individual. Often trapped in the past and terrified of the future, group members are frequently numb, dissociated, and absent, desperately avoiding contact with what they crave the most: connection to their own selves and to others. Alternatively, they are flooded with affect, hyperaroused, and hostile. They may use dissociation or self-injurious behaviors as a means of coping with restimulated memories. The therapist faces not only all the transference and countertransference issues of individual trauma therapy, but transferences specific to groups, such as family-of-origin simulations (Courtois, 1988) and victim, offender, and rescuer dynamics (van der Kolk, 1993). Managing all of these complex symptoms and dynamics can raise the therapist's anxiety and mobilize her defenses, compromising her usual thoughtful stance. In the following entry, Maureen described how we defended against our own helplessness with one group member by participating in the re-creation of a family-of-origin dynamic.

*Maureen:* Carol came faithfully every session but barely participated. When I watched Maggie attempting to draw her out, I saw Carol cringe. I worried that Carol saw Maggie as a dangerous intruder, and I argued that we should allow her to maintain safety by not drawing attention to her. Maggie, feeling frustrated and helpless by her ineffective attempts to make contact, agreed. Then Carol showed me the rash she developed every week just before group, and I finally got it. Between the perpetrator role (Maggie) and the noninvolved bystander role (me), we had participated in the re-creation of a frightened and lonely childhood. She had to develop a rash to get our attention. Consequently, we accessed new patience and compassion to gently but persistently challenge her isolation.

Another unique aspect of trauma groups is their connection to support, self-help, and advocacy organizations. Vietnam veterans' rap groups and women's groups of the 1970s used groups as a means to make public, through shared disclosure, what had been private. This continuing emphasis on breaking trauma-induced isolation puts the therapist in a different position from her position in either individual trauma psychotherapy or a non-trauma-oriented group. Although this community building is often exhilarating and refreshing, it also brings challenges. Many sets of eyes watch to see whether the therapist is willing to stand with them against violence and injustice. Therapists must take a position of ethical non-neutrality (Benedek, 1984; Agger & Jensen, 1994). Yet acknowledging social injustice may bring feelings of powerlessness, despair, responsibility, and fear. Therapists may unconsciously deny social issues in order to protect their world view. Conversely, an overfocus on political discussions can result in intellectualizations and displacements that may serve to protect therapists, as Fischman and Ross (1990) have noted in their group work with torture survivors. As group members develop community and the therapists' role diminishes, therapists may find themselves feeling excluded, irrelevant, and unimportant.

The fragility of trauma survivors results in slower development of group relationships than in non-trauma-oriented groups. Parson (1984) suggests that combat veterans, weakened by symptoms of posttraumatic stress disorder, lack the ability to explore transference and projective identifications through direct confrontation. In incest survivor groups, support and dependency come first, and confrontation much later (Herman & Schatzow, 1984). Fogelman and Savran (1980) have described a process of experimenting with the amount of confrontation they can use in brief group therapy with adult children of Holocaust survivors. Therapists may chafe at the need to use an oblique and extremely

gentle approach to transference issues. They may become vulnerable to accepting client transferences of despair and hopelessness and may begin to doubt that change is possible.

All trauma therapists engage to some extent with the complicated social systems in which survivors often become enmeshed. Sponsoring agencies or workplaces, individual therapists, criminal justice systems, and other professionals and institutions involved in the client's care may become Sources of indirect (Racker, 1957) or systemic countertransferences. The following entry, in which Maggie wondered how a woman not yet ready for group work got admitted, illustrates these influences on the group therapist.

*Maggie:* It looks like countertransference responses are at play long before the group began. Were we unconsciously responding to the anxiety of the referring therapist, who appeared desperate to have Frances in the group? Did we feel obligated to the referring agency, who was also sponsoring the group? Did we accept her into the group because of our painful awareness of the lack of other supportive community resources? Were we taken in by Frances's own desperation to join, which led her to present herself as much more able to tolerate a group environment than she turned out to be? Were our hearts overruling our judgment because of the violent nature of the trauma and the bleakness of her current life? Why am I saying "we" when I did the screening interview? Somehow I want to share responsibility, but it was my judgment call.

### THE CHALLENGE OF HOLDING

The central task of the trauma group therapist is creating a safe "holding environment" (Winnicott, 1966) in which group members can recover from traumatic injury and regain a connection to life. Group therapists must tolerate and contain negative projections (Hannah, 1984), painful affects, and disturbed schemata. They must hold the collective anxiety, and provide a stable environment in which group members can gently release their tortured pasts.

Trauma survivors and therapists alike must struggle to stay in the present, despite the tendencies of psychotherapy groups to live elsewhere. Ormont (1995) describes how groups prefer to focus on the past, the future, or life outside the group, and suggests that positive group outcomes are dependent on the successful climate of an in-the-moment immediacy. In trauma groups, restimulated memories intensify the need to live elsewhere.

To maintain immediacy or presence, a therapist needs a neutral observing ego that can simply witness without "judging, evaluating or acting" (Ormont, 1995, p. 490). Attention that is impartial, nonjudgmental, and curious opens the mind, "not by attempting to change anything but by observing the mind, emotions and body the way they are. With bare attention we move from automatic identification with our fear or frustration to a vantage point from which the fear or frustration is attended to with the same dispassionate interest as anything else" (Epstein, 1995, p. 111). When the therapist can embrace her countertransference reactions with a gentle, observing mind, she can separate the strands of her reactivity and increase her capacity for holding and presence.

Creating presence in short-term groups and in the early stages of long-term psychodynamic groups is done through gentle, repetitive requests that group members examine their experience in the present moment. It is a slow process, and therapists may easily feel impatient, angry, bored, helpless, and powerless in the face of group members' tentative movements and hasty retreats. When therapists refrain from resolving their feelings through fixing, overprotecting, fusion, avoidance, or denial, they allow survivors the gift of accepting themselves as they are in any given moment. Trauma survivors develop observing egos when therapists are able to hold this nonreactive, bare attention themselves. This is not easy when therapists are "bombarded with so many stories at once" (Fogelman & Savran, 1980, p. 102) and asked to witness the painful sequelae of trauma.

*Maggie:* Sometimes I'm afraid of the dark side, afraid that I'll collapse and be useless. I don't want to acknowledge the depth of my own despair. I keep to myself the times I can only see destruction and devastation, the times I prefer depression to the grief and despair underneath. Then life's joy is trapped below a plain of misery, and it's impossible to I be a purveyor of hope to the despairing, impossible to bring meaning k to the meaningless. There is nowhere to go but back to bare attention, to being with the darkness, just letting it be. When I do this, spaciousness grows around the dark. Then I can bear the pain and don't have to convince unhappy group members to be happy.

*Maureen:* After group I putter. It's the only night of the week that I'm likely to go to bed after my partner. Instead of sleeping, I roam around doing a little of this, a little of that. On smart nights I sit and draw or write in the field journal. When I don't, I sleep fitfully, my dreams attempting to consolidate the unbelievable and the unimaginable. So why do I resist splashing paint or words on paper when I know it will help? My resistance is just like our clients'- the fear of feeling my own pain.

In the following example, Maggie described how a fixation on a group member's story led her to an awareness of unresolved vicarious trauma. If she had not identified this state, she might have been at risk of becoming overly fascinated with the group member or distancing from her.

*Maggie:* I couldn't get Bernadette's story out of my head. A lifetime of battering: her father, her brothers, her uncle, her husband who kept her isolated on a remote island. This is a terrible story, but I heard a lot of terrible stories tonight and couldn't understand why I was stuck on this one. Only when I raised this with Maureen on the drive home did I realize that it brought back a flood of memories of my years working in a women's shelter-unprocessed memories, because I didn't know at that time what to do with the intensity of my reactions. And here they have emerged, raw and staring me in the face 20 years later.

Trauma therapists must stay present in the face of the massive losses of refugees, the death anxieties of AIDS patients, the wounded attachments of abused children, or the shattered beliefs of sexual assault survivors. Particularly difficult is managing the losses, spoken or not, that can multiply until the therapists' hearts and minds ache with the effort of holding and understanding. In an attempt to manage their own anxiety and unresolved losses, therapists may minimize the losses, limit identification and expression, and prematurely encourage action. When death and mortality are present, group therapists may feel helpless and act to protect themselves. Bernstein and Klein (1995) suggest that therapists may cope in group work with AIDS patients by resorting to omnipotence, engaging in untimely interventions, becoming depressed, or merging with group members. Therapists may also silence the topic of death, and the group members may adapt to contain the therapists' anxiety. Conversely, Gabriel (1991) describes how the chronic mourning that accompanies group work with AIDS patients can lead therapists to focus on death and dying rather than on living. In group work with refugees from Bosnia, Maggie struggled not only to contain the losses, but to understand her responsibility for what she heard.

*Maggie:* The losses were so extreme: family members dead or disappeared, homes burnt, and communities broken. Loss of future, of personal dignity, of identity. Loss of meaning-an inability to comprehend what had happened, to understand how the neighbors, lifelong friends, could suddenly turn on them. My presence supported naming these losses, the telling of stories, and a tentative rebuilding of community, but this was not enough. It was excruciating to contain all the despair, anger, and sorrow I felt. At the last group, I asked them what they needed from me. Out of a long silence, Amira spoke: "Tell our stories." I promised that I would, and the public advocacy and education I became involved in provided meaning and community that balanced my grief.

The therapist must also hold what group members abdicate through dissociation. When group space is experienced as unsafe, participants can dissociate, either individually or collectively. Saakvitne (1995) describes how trauma survivors can dissociate from painful affect, memory, self, and each other, and suggests that this retreat can evoke feelings of loss, abandonment, insecurity, powerlessness, and incompetence in a therapist. The therapist may be at risk of violating boundaries in an attempt to seek connection, or of fleeing the present moment herself. The intensity of what has been left behind can be overwhelming. In the following example, Maureen described working with Canadian aboriginal people who had experienced several generations of forced removal from their culture and families at an early age into residential schools, which enforced a harsh assimilation into the dominant culture.

*Maureen:* My worst fears are coming true as I sit in this aboriginal talking circle. I look around the room-the woman holding the talking stick is speaking in a flat monotone, brown eyes never rising from the floor as she lists one horrible experience of physical and sexual violence after another. I know that eye contact is not as

important in this culture as it is in mine (European-based), yet I also know I'm seeing dissociation among the dozen men and women in the circle. Energetically, it's as if the center of the circle is a dissociative vortex, sucking people's life energy and vitality. I'm the only one present in the room, and I can feel my anxiety rising. I feel crushed under the weight of their lost childhoods and shattered futures. I notice an urge to run into the nearby woods and automatically take a deep breath to calm myself. I startle the woman next to me, and I mime that she should breathe too. Gradually the breath moves around the circle.

When therapists experience intense reactions in trauma groups that pull them out of the present moment, they must investigate whether they are responding to traumatic content, personal unresolved issues, or individual or collective transference. In the following, a group member's complaint triggered Maureen's childhood fears.

*Maureen:* These moments when the energy of the group abruptly shifts always come as such a surprise. Tonight it happened near the end of group. I'm relatively at ease and engaged; then Elaine complains about our straying from tonight's agenda. It's like a plate crashing to the floor. Red alert time. Now, I'm blanking out, so all I know to do is to keep my pen moving and hope. . . . I'm realizing these moments are connected to my childhood experiences of tempers flaring and events suddenly spiraling out of control-when plates did crash to the floor. When I could feel safe one moment and then utterly at risk the next; and how, even now, my limbic system responds to any quick change with the same intensity.

After Maureen made this connection to her own childhood experience, she wondered whether Elaine carried a similar terror of unexpected change, and whether she was absorbing Elaine's fear. At the next session she invited Elaine to explore her distress at the group's shift in focus, and Elaine was able to share her anxiety. For the first time, Elaine felt that someone understood her fear. After this intervention, Elaine began to take more risks in the group.

## OVERIDENTIFICATION AND AVOIDANCE

Wilson and Lindy (1994) suggest that most countertransference reactions in trauma therapists fall into the two broad categories of overidentification and avoidance. The overidentified therapist is at risk for empathic enmeshment, leading to loss of boundaries, overinvolvement, and reciprocal dependency (Wilson & Lindy, 1994). Saddock (1993) sees overidentification as the biggest danger in groups with rape survivors and battered women, and Frick and Bogart (1982) caution against overidentification with group themes in group work with Vietnam veterans. In groups, overidentification can result in inappropriate self-disclosure, inability to set clear directions, problems with time limits, and unnecessary availability between group sessions for individual group members (Abney et al., 1992; McEvoy, 1990; Vannicelli, 1991). Overidentification can lead to a reluctance to delve more deeply into a survivor's experience for fear of stimulating additional hurt (Courtois, 1988; Danieli, 1988). The urge to rescue and reparent (Ganzarain & Buchele, 1986; Courtois, 1988; Danieli, 1988) is illustrated in the following entry.

*Maureen:* A big challenge for me is to manage my awareness of the group members as injured little girls. When they tell stories about the awful things they experienced, I don't hear them as adults, but as the little girls they once were. So tonight when Sally pulled out that skipping rope from her bag and described what her father did with it . . . I just can't stop seeing a little girl tied up and tortured. I'm at risk for treating her like a little girl, not a woman who has survived. She needs to be empowered, not infantilized.

Both individual and group therapists may defend themselves by conspiring with trauma clients to avoid discussing difficult subjects (Benedek, 1984; Courtois, 1988; Danieli, 1988; Fischman & Ross, 1990; Haley, 1974). Therapists may use denial, minimization, depression, dissociation, and distancing to maintain a silent collusion with group members, avoiding themes such as death, loss, anger, or responsibility. For example, Fogelman and Savran (1980) suggest that group leaders, shocked by stories of the Holocaust, may allow group members to change the topic. Therapists may resort to a rigid professional stance or use a theoretical approach not appropriate for trauma survivors, such as focusing on Oedipal conflicts with Holocaust survivors. Finally, therapists may strive for false harmony or

stress that life victimizes everyone. In the following example, Maggie explored her desire to distance herself from a group member's neediness.

*Maggie:* Gail irritates me, and immediately I feel guilty for saying that. I want to cover it up by naming her many strengths and gifts to the group. Gail talks too much, and when I intervene she retracts into an old hurt place like a turtle in a shell and keeps talking how she takes up too much space. Part of me agrees with the harshness of her self-judgment. A large part of me, at the moment, if I'm honest. Does my judgment show? Did I cause the retreat? The depth of her need to be seen and heard irritates me, because it stirs up my own unmet needs. I want her to just get a grip and toughen up as I've done. But I'm not as tough as I pretend, and my shell covers a depleted emptiness. When I acknowledge my unmet needs and the sense of invisibility that sometimes lodges deep inside me, I bring home the projection. When I stop running from myself, I stop running from Gail. I see Gail's desperate longing for connection.

Because Maggie was no longer motivated by avoidance, she was now free to consider potential interventions. She might directly approach Gail and the group members, or she might make a statement about her own immediate experience to encourage present reality. Or she might choose simply to hold Gail's longing until she felt Gail was ready to claim it for herself.

Therapists who are also survivors have particular struggles in the areas of overidentification and avoidance. Overidentification is a particular risk for most incest survivor therapists (Briere, 1992); Vietnam veteran therapists (Catherall & Lane, 1992); and therapists wounded by the same system of political repression that has traumatized their clients (Comas-Diaz & Padilla, 1990). Hartman and Jackson (1994), in a discussion of individual therapy with rape survivors, describe how a survivor therapist was both burdened and stimulated by the enmeshment with her client, and fantasized how they could write an article together. Survivor therapists may also have strong defenses that they employ in groups. For example, incest survivor therapists may have entrenched global defenses, such as dissociation, denial, projection, projective identification, and repression (Pearlman & Saakvitne, 1995). Cotherapy is strongly recommended for survivor therapists as a means of managing vulnerabilities (Catherall & Lane, 1992; Pearlman & Saakvitne, 1995; Vannicelli, 1991).

It is important to acknowledge that therapists who are also survivors bring many strengths to group work. They can offer victims a profound empathy and unflinching clarity. For example, Danieli's (1988) research into therapist reactions to Holocaust survivors revealed that nonsurvivor therapists were more likely to use muted language than survivor therapists who were more likely to use words like "murder."

## MANAGING ANGER

Trauma groups inevitably stir up anger in both participants and therapists. Therapists who have difficulty tolerating either their own aggressive urges or anger in others may engage in stifling behaviors. They may join together with group members to keep aggression and rage safely focused on perpetrators- a common dynamic for women leading women's groups. When therapists are unable to cope with group members' projected anger, they may feel victimized (Abney et al., 1992) and may respond with a critical or condemning attitude, feeling hostile toward group members they experience as not appreciating their desire to help. Courtois (1997) suggests that outright displays of anger toward group members are unusual, but that therapists may engage in distancing behaviors such as not preparing for a group session, rushing in at the last minute, avoiding group members during breaks, neglecting follow-up phone calls, or being remote during sessions. Conversely, therapists outraged by accounts of violence may assume that their anger is shared by group members and may prematurely encourage its expression. If therapists are uncomfortable acknowledging their own capacities for violence, they may not be able to tolerate the "perpetrator cloak" that group members so often drape over their shoulders. Haley (1974) highlights the necessity for therapists to examine their own sadistic impulses, especially when working with survivors who are also perpetrators.

In the following example, Maggie attempted to manage her anger by triangulating in the group members' individual therapists. She was displacing her helpless rage at the perpetrators onto other caregivers; this dynamic is similar to how survivors displace rage into revenge fantasies against inept rescuers (Herman, 1992).

*Maggie:* I'm angry at the women's individual therapists, full of judgments about their competence. Don't they understand the basics of traumatic containment, of symptom management? I realize I'd rather think about how other therapists have failed to "fix" their clients than bend my mind around acts of perpetration and neglect. I'd rather blame my colleagues than really see the source of the shame and pain I witnessed tonight. But in this scenario I allow the individual therapist to stand in for the perpetrator, the group member to be the helpless victim, and myself to alternate between the roles of helpless bystander and rescuer. I need to find a way to open my heart to what really happened to the women, letting go of finding a convenient scapegoat.

In the next example, Maureen facilitated a group for women who had been sexually exploited by mental health professionals, and struggled to maintain her observing ego and contain rage.

*Maureen:* The women had been sharing drawings of their self-images, and I was completely unprepared for what I saw. Their pictures represented extremes of isolation, disconnection, and distorted perception. They were unable to talk about the drawings, but their eyes and bodies mutually beseeched me to understand. I remember the feeling of blood rising up to my skin, my heartbeat increasing and my hands clenching. I wanted to rant about the people who had done this to them. But I knew I would be the only beneficiary of such a display, as I was feeling the rage that they were not yet able to feel. I'd be allowed to be a good guy, allowed to keep a safe distance from the knowledge of what my colleagues had done. Instead, I had to find a way to hold my own rage, clearly speak to the inappropriateness of these "helpers," and yet leave them room to struggle with their self-blame and traumatic bonding. I had to learn to sit with their distrust of me.

Frick and Bogart's (1982) description of managing their anger in their group work with Vietnam veterans is useful: "Our interventions consisted of . . . admitting our anger when appropriate but containing, holding and hiding our more acute feelings of anger and checking our own impulses to withdraw from or abandon the group" (p. 439).

## **RESPONDING TO SAMENESS AND DIFFERENCE**

Trauma groups have a homogenizing tendency, focusing on commonality rather than difference. Collectively, the group members form a strong enough ego; they need each other in defined ways to keep the group identity intact (Hannah, 1984; Parson, 1984; van der Kolk, 1993). Therapists must identify how their countertransference responses influence group development around sameness and difference. The therapist may rely excessively on "group-as-a-whole" interpretations as a means of avoiding further explorations, which might uncover differences and potential conflicts among members (Alford, 1995; van der Kolk, 1993; Vannicelli, 1991), or of avoiding their own disturbing reactions to an individual group member. Cotherapists may find themselves reinforcing sameness beyond the developmental needs of the group, reducing their own anxiety by creating "order and wholeness out of chaos and fragmentation" (Alford, 1995, p. 131).

We found ourselves one night describing the group to themselves as parts of a whole, stating that each of their symptoms together formed the complete constellation of posttraumatic stress reactions. Obviously we were striving to normalize symptoms, but when we discussed this intervention, it became clear that our timing was off. The need to emphasize the togetherness of the group was ours, an unspoken alliance between us. Our intervention made it easier for us to sit with the array of feelings in the room, and we didn't have to confront or ask the group members to confront their differences and individual responses.

The therapists may also collude with the group as a whole's desire to avoid certain themes, issues, feelings, and conflicts. The therapists do not address what is present but unspoken—for example, the building resentment toward a frequently tardy group participant, or the fear the group members feel about their experiences. In the following example, the group as a whole was more prepared than we were to tackle a difficult theme.

In our recent group, the theme was terror. The fear was ever-present, palpable in the room. Although we constantly addressed the fear, we found ourselves sidestepping a request to devote the evening to specifically discussing fear and anxiety. Unfortunately, in this instance, we modeled that when confronted with an overpowering emotion, avoid it. Why? Later we realized that we were defending ourselves for different reasons. Maggie connected with fear of being overwhelmed by their stories, which produced such terror. Maureen was afraid she'd feel helpless to mitigate it in any meaningful way.

The therapists may become overly protective of the group as a whole, seeing the group members as fragile victims. This is a particularly common pitfall for beginning group therapists.

*Maggie:* In my first trauma group 20 years ago, with women abused in relationships, the women wanted to talk about sexuality. They said they didn't know anything about healthy sexuality, and some of them had experienced marital rape. My cofacilitator suggested we introduce some discussion of lesbianism into this evening. I thought this would be "too much," that it would raise the women's anxiety even higher, that there was already plenty to cover. I, a heterosexual woman, certainly did not consider myself homophobic, but my cofacilitator, a lesbian, pushed me to address the source of MY anxiety. Consequently we included lesbianism, and it was the most astonishing of all the group sessions. Two of the eight women said they had stayed so long with violent husbands because of their shame about their sexual desire for other women. Another woman revealed a never-told secret about a brief sexual encounter with a girlfriend. A fourth woman confessed to a curiosity about lesbianism that went back to her childhood. That evening, the one I had argued so vigorously against, was a turning point in the group's ability for connection and honesty.

This example also stresses the importance of sensitively addressing difference, even in short-term groups. Even therapists committed to exploration of difference can be surprised at their reluctance to raise these issues if they become caught in the group's desire for sameness. Group participants (members and cotherapists) may be of varied gender, class, sexual orientation, and cultural backgrounds. Gonsalves, Torres, Fischman, Ross, and Vargas (1993) note that when cultural, lingual, and social differences are not addressed, disclosures may be avoided.

Group members will frequently attempt to draw therapists they identify as similar to themselves into their alliance. Therapists with differences may be shunted aside. Therapists who fear abandonment may allow themselves to be drawn into the alliance, while therapists who fear engulfment may protect themselves through self-disclosures that establish their differences.

## **COTHERAPY IN TRAUMA GROUPS**

Much of the non-trauma-oriented cotherapy literature debates the benefits of cofacilitation, but literature describing group work with various trauma populations assumes coleadership (Bernstein & Klein, 1995; Courtois, 1988; Frick & Bogart, 1982; Gabriel, 1991; Ganzarain & Buchele, 1986; Herman, 1992; Herman & Schatzow, 1984; Pearlman & Saakvitne, 1995; Vannicelli, 1991; Walker & Nash, 1981). The dynamics in trauma groups are simply too complex for one therapist to manage alone, but cotherapists must make a significant commitment to their relationship if they expect it to support meaningful therapeutic gains. They must also be willing to address the insecurities that arise from exposing their work to both a colleague and group members.

Successful cotherapy depends on open communication to resolve disagreements and on the ability to accommodate each other's differences (Dick, Lessler, & Whiteside, 1980; McGee & Schuman, 1970; Paulson, Burroughs & Gelb, 1976; Pearlman & Saakvitne, 1995; Roller & Nelson, 1993; Yalom, 1985). Also important are a complementary balance of skills, the capacity to share decision-making power equally, relative noncompetitiveness, and compatibility in orientation (Roller & Nelson, 1993).

Pearlman and Saakvitne (1995) warn therapists to be wary of creating a shared defense or of rescuing each other, particularly from an angry or needy client. In the following example, the two of us were caught in a shared parental countertransference to a member of the group who presented as much younger than her chronological age.

Wendy had a tenuous hold on adulthood. She had trouble containing her internal child states, and her childlike vulnerability put her at risk in the world. We worried about her ability to keep herself safe, and in our worrying we became protective. Wendy found visualization and meditation frightening, and to help her feel safe, we eliminated the meditations with which we usually end the evening. After several sessions, we realized that the unity of this parental countertransference had been so strong that we were willing to sacrifice activities the rest of the group found soothing and containing. Once we recognized we had accepted her transference invitation to be the all-caring parents she never had, we could step back. We reinstated the activities we had dropped, and worked with Wendy to create a strategy that would enable her to manage her own distress during these times.

Yalom (1985) says that most cotherapists unintentionally split roles. One therapist may be more supportive and the other more confrontative of group members; one may focus on the group as a whole while the other may focus more on individual members. Although he celebrates the differences in cotherapists, he cautions that group members frequently drive a wedge into the cotherapy relationship and exploit any existing tensions. Describing cotherapy in incest survivor groups, Courtois (1988) suggests that cotherapists should "function as a team to guard against being split into good and bad parents but their individuality should come through as they engage with the group and its members" (p. 266). The following dialogue illustrates a strong countertransference response by Maggie, a desire to protect by Maureen, and an exploration of our different styles.

MAGGIE: When Tina said you were the head and I was the heart, I felt instant shame. My face flushed and my heart raced. All I could think about was how I was never smart enough for my father. I was aware enough to notice the group members staring at me, and I remember blurting out how this comment had touched some childhood pain. This was the best I could manage, to let Tina see that she was not the cause of my discomfort.

MAUREEN: I didn't react to Tina calling me the head of the group. I knew she had a strong transference to me because of my authority that started in the screening interview. I was a stand-in for her intellectualizing father, who discounted her ideas, and she wanted me to validate her thinking.

MAGGIE: I appreciated that you weren't caught like me, and I admired how you saw a teachable moment and leapt in, tying my response to an earlier focus on shame reactions.

MAUREEN: I felt stung, though, because after the group you said maybe you believed that I don't have a heart. I didn't respond because it felt so different from our usual interactions. You didn't say, "Of course you have a heart and of course I have a head, but how did we get to this pattern?"

MAGGIE: I don't know why I said that. Perhaps I don't want you to have a heart. Perhaps I want you to be the head so I can have the heart role, an ego attachment to being spiritual and open-hearted. So maybe I'm saying, "Sorry, that role is taken." But on the other hand, I felt de-skilled and invisible, because I also have an identification with being smart and articulate.

MAUREEN: Maybe I make it too easy for you. I think I just assume the head role at times because spontaneous teaching moments come naturally to me. You've also been talking about how overextended you are, and I'm trying to help you out.

MAGGIE: If you are going to seize the teaching moment, I'm going to grab the process moment to balance things out. This is a rescue, too, because I take away from you by doing that, and I'm not honoring your process skills.

MAUREEN: I'm also aware that I buffered you from Tina's comment. I saw that you were having a strong reaction, and I looked for a way to call their attention away from you, and so I focused on shame reactions in general. I wanted to give you a bit of time to catch your breath. This touches that place where cotherapists can be a tight unit, taking care of each other rather than maintaining a focus on the group.

MAGGIE: It never occurred to me before that you might have been protecting me. I see now that we both missed an opportunity to go deeper and draw out Tina's transference to us. I had been blaming myself.

MAUREEN: How come it's your fault that we don't go deeper? How come you get assigned responsibility for this?

MAGGIE: If I'm the heart, then it's my job.

MAUREEN: I'm also responsible. Perhaps I'm responding to the group's little scolding that we got sidetracked into process the week before. Maybe that's why I responded to Tina the way I did.

We realized that each of us had played a part in how the group member's comment was handled. Acknowledging our motivations and different styles resulted in a decision both to honor our differences and to encourage each other to stretch.

## CONCLUSION

A rigorous exploration of countertransference and vicarious trauma is essential to the trauma group therapist. This sometimes painful confrontation with self needs the support of a cotherapist, colleagues, and supervisors who share the therapist's theoretical map. External support creates containment for the therapist and encourages the development of a caring and objective internal observer. This enables the therapist to be curious about her motivation and compassionate about her mistakes; it illuminates both her resourcefulness and her Achilles heel.

The complex dynamics of trauma groups require master juggling. Juggling demands a concentration that is never automatic; it requires balance, strength, and consistency. Facilitating trauma groups is akin to juggling random objects of differing size and shape that the participants have tossed. Here improvisation is overlaid on training, technique, and understanding. But a therapist will inevitably drop balls, and trouble only sets in when the therapist is unable or unwilling to admit it. Empathic failures serve as route-finding clues unless therapists are unwilling to risk exposure and refuse to examine their conscious and unconscious defenses.

It is essential for therapists to increase their capacities for awareness, containment, presence, and integration. Awareness can be encouraged in therapists' personal lives through meditation, visualization, yoga, journal keeping, art, other creative activities, and personal psychotherapy. Containment abilities can be built through self-care efforts and a balanced life that includes time spent in activities unrelated to work. It is also helpful to engage in advocacy or political action around the causes of violence and catastrophe. Therapists should beware, however, that pursuing any of these activities may simply replicate coping strategies of compartmentalization and separation.

Therapists' compassionate and aware attention to their internal world deepens and integrates the entirety of their experience. No one lives in continuous moment-to-moment awareness, and therapists need patience as we struggle to return to the present. The necessity for therapists to deepen their own integration cannot be overstressed. Herman (1992) reminds us that when therapists foster integration in themselves and in the survivors they work with, they deepen their own integrity. Therapists who can be present while unflinchingly exploring the reality of trauma can help group members reclaim their futures.

Comments from group members on the final night told us we'd had some success. During our sessions Debra had trouble with the idea that it can be helpful to be curious about painful feelings. "Every week I would go home," she said, "and think that Maggie and Maureen didn't know what they were talking about. I thought it was a really stupid idea that I should be interested in flashbacks when I just wanted help in getting away from them. But somehow I've gotten more interested in these feelings and, at the same time, it's helped me take a big leap into the present."

Wendy described the transformation that came from listening to women exploring their feelings: "I watched everyone sharing painful feelings, without someone trying to fix it and they seemed stronger for it. It gave me the courage to go on and I began to think I could bear my own feelings." Later, after the group was over, she sent a note: "I'm doing things I never imagined being able to do."

## NOTE

1. For the sake of simplicity, we use feminine pronouns throughout this chapter to refer to a therapist.

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