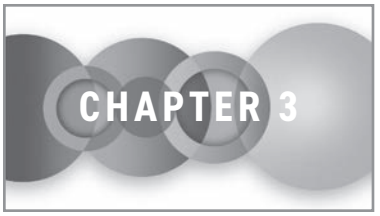

Comparing Group Therapies for Trauma Survivors

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Group therapies for posttraumatic stress disorder (PTSD) and other trauma-related problems are difficult to compare, because they vary in many ways. However, comparison is important for several reasons. For the clinician working with trauma survivors, knowing more about the different ways of delivering group therapy can provide a broader view of possible choices to address a range of related problems. Groups differ in terms of their structure, goals, procedures, hypothesized mechanisms of action, and the knowledge and skills they demand of leaders. They also differ in terms of their evidence base, and hence the confidence we may have in their effectiveness. A more differentiated sense of what happens in groups can also inform personal efforts to become more skilled, and to adapt groups for problems and populations. For the program manager, increased knowledge of groups and their differences can assist with design of programs, selection of clinical offerings, and implementation of program evaluation. For the researcher, a more fine-grained analysis of different group protocols can enable selection of research questions, development of measurement strategies, and selection of assessment instruments.

Despite the complexity of groups, it is possible to identify some important dimensions that can help to categorize and compare them. In Chapter 1, we discussed two broad kinds of group therapies, interpersonal process groups and clinical science-based educational model groups. In this chapter, we expand on these ideas and explore several additional dimensions along which groups may vary and so be compared. We also discuss the importance of comparison of group therapies for trauma survivors and draw attention to various research questions that are of importance to their improvement.

Types of Treatment Groups

One very broad way of describing groups has to do with their presumed ways of influencing the members, and hence their fundamental change goals. Thus, we can speak of one class of groups that attempts to teach coping skills for managing trauma memories, trauma-related emotions and symptoms, or problem situations. Another class of groups focuses on the processing of traumatic experiences, the so-called "trauma-focused" treatments. A third major class of group therapies is the interpersonal process groups that emphasize the coming together of trauma survivors for the purpose of facilitating interactions of group members in ways that may be therapeutic for them. These groups focus on things that happen during the interactions of group members among themselves and with the group leader, and the influence of molar characteristics of the whole group on the behavior of individual members. Note that these broad categories of group type can also be used to describe different approaches to individual psychotherapy.

Coping Skills Groups

Most groups for trauma survivors include an explicit or implicit focus on helping group members improve their skills for coping with a variety of problems. Some, however, make the learning and practice of carefully formulated and operationalized coping skills their primary objective. Skills may be taught that improve coping with symptoms of PTSD and associated problems (e.g., dysphoric mood, sleep problems, physical tension, dissociation), or social situations (e.g., interpersonal conflict, inability to express positive feelings to loved ones).

These groups operate according to the idea that part of what is problematic for trauma survivors is their inability to manage internal states or external situations effectively. They expect that group members will be increasingly able, with encouragement, training, and practice, to take deliberate actions to cope more effectively with their difficulties and problems. The goal is to replace ineffective or dysfunctional coping responses (e.g., emotional avoidance, social withdrawal or anger, inability to self-soothe or reduce physical tension) with more effective ones (e.g., facing feared situations and stimuli, engaging with others, behaving assertively, practicing physical relaxation, or mindful awareness of the present moment). The assumption is that repeated instruction, group discussion, personal self-monitoring of situations that require the skill set, and deliberate practice of alternative responses in challenging situations gradually result in improvement in coping ability. Group members become better able to notice that they are in a situation that requires a coping response, consciously deploy the new skill and experience improved outcomes, use the skill often with gradually improving effectiveness as they begin to master the skill, and over time the older, ineffective responses are replaced by the newer, more adaptive ones. Members become increasingly confident in their ability to cope, and this also serves to reduce the stressfulness of related situations: A person who feels confident about handing a problem feels less stress when confronted with it. In this model, recovery is produced by coping effectively in formerly distressing situations. Confidence in coping renders the situations less threatening, and symptoms are likely to diminish in frequency and intensity.

Note that for those experiencing a range of PTSD symptoms characterized by intense emotional reactions or habitual dysfunctional patterns of responding to trauma-related challenges, learning skills is difficult. Enduring patterns of response that include intense anger,

social withdrawal, overwhelming physiological arousal or panic, or emotional despair may by automatically elicited by trauma-related stimuli. Group members are asked to practice their skills in the context of strong, aversive emotional reactions. To facilitate this, group leaders provide instruction, demonstrate skills in session, arrange role-play practice opportunities within the group, ask members to self-monitor their ongoing attempts to apply their new skills, assign and review between-session practice in skills, and often arrange tasks to supportively challenge the individual with gradual increases in difficulty.

Trauma Processing Groups

Some groups are characterized by an explicit focus on talking about aspects of the traumatic experiences themselves, or trauma-related thoughts and feelings. These groups represent the so-called "trauma-focused treatments" delivered in group contexts. For example, Group-Facilitated Prolonged Exposure treatment (Group-Facilitated PE; Sripada et al., Chapter 7, this volume) involves having individuals revisit, in their imagination, their own traumatic experiences and engage in deliberate self-exposure to situations, people, and activities that remind them of their traumas. Group Cognitive Processing Therapy (Group CPT; Ehlinger & Chard, Chapter 6, this volume) involves having group members write about the personal meaning of the traumas they have experienced and talk extensively about their interpretations of the traumatic experiences. These therapies explain the process of change somewhat differently, but they are similar in expecting that when individuals consciously revisit aspects of their traumatic memories, expose themselves to the stimuli of daily life that elicit their trauma-related emotions and feelings, and/or rethink the personal meanings associated with their past traumatic experiences, this is likely to result in a diminished emotional intensity of trauma-related feelings and thoughts and a strengthened ability to face the memories and cope with the feelings.

An explicit focus on the traumatic experiences themselves is something that many group therapies discourage or actively prohibit from group discussion; members are instructed *not* to talk about details of their traumas. Sometimes, the thinking is that doing so will activate the emotions of others in the group, and that this will be detrimental to individual well-being. In the "phase-based treatment" model (Herman, 1992), the initial groups in which trauma survivors participate are designed to prepare group members to engage in trauma processing that will take place at a later time. By contrast, in trauma processing groups, it is expected that most individuals will not require extended preparation, and that most will be able to tolerate any distress that is activated in the groups. According to this view, activation of distress, if done correctly, can be therapeutic rather than destructive. Trauma-focused groups generally want group members to experience their strong emotions and distress as part of the group experience rather than avoiding them, so that they can experiment with responding to them differently. Note that trauma-focused groups effectively present individuals with the very situations they have been actively avoiding. They elicit strong trauma-related feelings and thoughts as part of the process of group therapy, and in so doing present group members with the stimuli they must learn to manage. Note also that these approaches often supplement the exploration of trauma-related feelings and thoughts in the group itself with assignments to go out into the world and face those situations that they have been actively avoiding, because external situations elicit trauma-related thoughts and feelings and must be confronted and managed if group members are to regain their ability to live effectively in the world.

Interpersonal Process Groups

Trauma has interpersonal effects that are profound and that may in many cases represent a more fundamental disruption of life satisfaction than symptoms of psychological distress (for a theoretical review, see Yalch & Burkman, 2019). This is especially likely to be the case when traumas themselves have been interpersonal in nature, as with child sexual and physical abuse, domestic violence, physical assault, sexual assault, human-made disasters, torture, war traumas, or the traumatic death of significant others. Relationships are of great importance to human well-being. They are a part of life, of living itself, as well as providing individuals with resources and capacities to facilitate resilience and recovery in the face of adversity. Traumatic experiences can cause problems in many aspects of interpersonal functioning and disrupt important personal relationships with partners, family members, friends, and coworkers.

Therefore, some therapeutic groups focus on interpersonal processes, both as mechanisms of change and as targets of intervention (to improve social functioning and repair damaged relationships). Because groups themselves are settings that comprise interpersonal behavior, some of the processes that can take place within groups are held to be potentially helpful to the process of therapeutic change. According to this reasoning, groups can potentially facilitate some very important means of enabling individuals to change. For example, group participation may be more effective than individual therapy in normalizing the experience of distress and symptoms that characterize PTSD. Individuals who see themselves as weak or permanently damaged might benefit greatly from hearing about the experiences of others, and find that their reactions are common, that many strong people develop PTSD, and so on. In groups, members may find that their comments seem to help other members of the group, which can motivate them and help them seem themselves in a positive light.

The receipt of interpersonal feedback on your own behavior from others in the group can be a powerful process (for a review, see Yalom & Leszcs, 2020). Facilitated by leaders, groups may encourage more honest reactions from others and allow individuals to better understand their effects on others. Unlike feedback from a mental health professional, who stands in a special relationship to the client, feedback from peers may have a feeling of genuineness and more powerfully motivate a client to make a change in behavior. For example, a client who experiences strong feelings of shame or guilt related to aspects of their traumatic experience might talk about those feelings in the group context. If the reactions of other group members help them see that such feelings are shared among many of them, and that others do not reject or criticize them but instead help affirm them, then this may help to significantly reduce guilt and shame.

The interpersonal nature of groups means that they can serve as a kind of laboratory for social experimentation. When members have relationships with other group members, they can experiment with acting differently than they might outside of group. Members can try expressing anger more constructively, or practice listening to feedback from a less defensive posture. They can practice friendship skills, communicate liking, and disclose personal feelings and experiences in a context that has many of the attributes of ordinary living, while being managed effectively by group leaders. Such group environments can provide unique conditions that might significantly help trauma survivors develop greater trust in other persons.

According to this thinking, groups can elicit emotions and social reactions that are commonly found in trauma survivors. Individuals who have been greatly harmed by others

may learn a complex of responses, including a reluctance to trust others, misperceiving intentions of harm or aggression, using anger and aggressive behaviors to keep others at a distance, and so on. These reactions in group may reflect how members react outside of the group with loved ones or friends and acquaintances. Interpersonal process groups attempt to use the real-time occurrence of these reactions as a learning experience. Such learning opportunities are likely to have significantly greater impact than a more conventional instructional format that talks about or teaches these same behaviors in the abstract or reviews occurrences that have happened in the past. These spontaneously occurring interpersonal encounters provide significant opportunities for group members to learn about their own trauma-related interpersonal reactions and try out alternative, more adaptive ways of reacting in the here and now. The goal is to see these changes generalize to important relationships in the natural environment, outside the group. Most interpersonal process groups are relatively unstructured, and it is possible that this lack of structure increases the chances that clinically significant interpersonal reactions will occur. It is also possible that group structures and group exercises could be deliberately designed to attempt to elicit these reactions more directly (as Vandenberghe discusses in Chapter 16, this volume).

"Hybrid" Groups

Note that the types of groups described above represent ideal types. However, in actual practice, most groups combine elements of all three approaches, albeit in different ways and to different degrees. For example, it is certainly possible for a skills group to also involve trauma processing. In such a case, as individuals remember and discuss their traumatic experiences, they could be taught to manage that distress using concrete skills. These skills could be taught and practiced in the group and then applied in later sessions of the group as traumatic experiences are discussed. In fact, in both explicit and implicit ways, group versions of CPT and PE do incorporate skills. In Group CPT, members are trained to examine their own trauma-related thoughts as they occur, to challenge their use of questions, to write them down as part of self-monitoring, and so on. Group members learn a skills repertoire for addressing their own negative cognitions that they are expected to use both while the group is meeting, and in the future, to maintain their gains as they face challenging new situations. In Group-Facilitated PE, members develop a generic skill of facing their own fears, both in terms of remembering their traumas in imagination and of ceasing to avoid, and deliberately encountering previously avoided stimuli. Improvements that occur may be interpreted in terms of many mechanisms, including the habituation of emotional responding to stimuli, and development of new skills and confidence for facing traumatic memories and reminder situations.

All groups, including "cognitive-behavioral groups" that focus on the practice of new coping skills or confrontation of trauma memories and meanings, include interpersonal process components. For example, Sripada and colleagues (see Sripada et al., Chapter 7, this volume) suggest that Group-Facilitated PE capitalizes on social support from peers, providing validation and normalization. They draw attention to the importance of receiving feedback from other members, and to the mutual encouragement to complete between-session task assignments. They argue that the group format, relative to individual PE, can increase motivation, provide encouragement, and facilitate buy-in to exposure procedures, and that individual members are often motivated by seeing their peers make improvements.

Similarly, all "interpersonal process groups" involve forms of skills learning. Group leaders often comment on aspects of group process. They may point out the relation of trauma experiences and interpersonal behaviors as they occur in the group. They may engage in many explicit and implicit forms of "teaching" as they help group members to label their emotions, notice their interpersonal response patterns, try out new ways of communicating (e.g., use of "I" statements), or elicit the personal meanings related to interpersonal encounters within the group.

Finally, those groups that focus on skills training or interpersonal process, including those that explicitly ban discussion of the details of traumatic events, do ultimately involve trauma processing. First, whatever emotions or interpersonal processes occur in the groups are likely to be a product of, and be influenced by, traumatic experiences. More importantly, the group members, as they practice skills outside the group or try new ways of interacting with others in daily life between group sessions, will experience trauma memories and emotions in the situations they encounter. In fact, it is the expectation that the coping skills and interpersonal patterns group members develop in the group will help them respond differently to trauma-related feelings and better manage the various trauma-related stimuli they encounter outside the group.

Indeed, a major reason for identifying these three kinds of groups is to enable a more explicit analysis of how they occur, deliberately or without intention, in various specific group approaches, and, more importantly, how they might be better combined to improve group effectiveness.

Some Dimensions of Group Comparison

The forms of group described previously are broadly conceived. To move toward a more fine-grained analysis, the design and delivery of groups can be considered in terms of three additional key dimensions of differences between groups.

Intervention Goals and Target Behaviors

All groups attempt to change specific things, to achieve specific goals and outcomes. Groups differ in their targeted outcomes, whether these are explicitly stated or implicit in the nature of the group and its activities.

Most groups for trauma survivors focus on reduction of *PTSD symptoms* (PTSD symptoms overall, or a specific subset of PTSD symptoms; e.g., irritability/anger or physiological arousal); that is, they are evaluated in terms of their effects on PTSD symptom frequency and intensity, and on the clinical significance of those effects. These groups also concern themselves with reduction of associated forms of emotional distress and related symptoms (e.g., anxiety, depression) and co-occurring problems (e.g., alcohol and drug abuse, sleep problems). In research on group effectiveness, PTSD symptoms have usually been selected as primary outcomes, although other kinds of outcome (e.g., social functioning, life satisfaction, coping self-efficacy) are often also measured. As noted earlier, such groups might explicitly seek to modify various factors thought to cause, exacerbate, or maintain PTSD symptoms, such as posttraumatic cognitions, emotion regulation skills of various kinds, or the ability to face and manage trauma memories and the emotional distress they provoke.

Other groups have been specifically designed to affect trauma survivors' *social functioning*, and so target specific social/interpersonal behaviors. Such groups emphasize development and practice of various social skills. For example, Group Skills Training in Affective and Interpersonal Regulation (STAIR; see Moreland & Weiss, Chapter 9, this volume) teaches group members skills for setting boundaries and communicating assertively to help them improve their important relationships. Interpersonally oriented therapy groups (see Yalch & Burkman, Chapter 15, this volume) help group members identify features of their interpersonal style and its connection to their traumatic experiences, and learn different, more adaptive ways of relating to other people. Similarly, Case Conceptualization-Based Functional Analytic Group Therapy (see Vandenberghe, Chapter 16, this volume) focuses on trauma-related problems that show up as interpersonal difficulties such as having one's needs misconstrued or being invalidated by others, withdrawing from nurturing relationships, dysfunctional efforts to obtain emotional support, friendships being lost, oversubmissiveness to others, or difficulties with encouraging adequate support from others.

To achieve targeted, meaningful outcomes related to symptom reduction, lessened emotional distress, and other trauma-related problems such as alcohol use or interpersonal anger, groups also include as goals the *learning of new repertoires of behavior* (i.e., "skills"); that is, groups attempt to change the ways people cope or respond to trauma-related stimuli or to other problematic situations in their lives. Thus, groups might target changes in coping skills (e.g., mindfulness, relaxation via slow breathing, distress tolerance), trauma-related cognitions (thinking repertoires), social behaviors (e.g., boundary setting, assertion, expression of positive feelings toward others), or problem-specific skills (e.g., refusing drinks, time-outs). A good example of such a group is Dialectical Behavior Therapy (DBT; see Sears & Thompson, Chapter 12, this volume), in which the skills component includes modules on emotional regulation, interpersonal effectiveness, and distress tolerance, among other things.

Most groups for trauma survivors are also concerned with *educating group members* about PTSD and recovery following traumatization; that is, they have goals related to increasing participants' knowledge and understanding of their own experience: what they are feeling, how their bodies are responding, the processes of traumatization, and the processes of therapeutic change. After group participation, it is expected that members will know more about the symptoms of PTSD, have changed attitudes toward their symptoms ("normalization") and themselves as individuals experiencing PTSD (e.g., "PTSD does not mean that I am a weak person"), and increased knowledge about what they will need to do to enhance their own recovery (e.g., it is important to face trauma-related thoughts and feelings as opposed to engaging in emotional avoidance). Hypothetically, such knowledge might improve the predictability and controllability of stress reactions, and help clients do the things that will accelerate their recovery.

Some groups deliberately attempt to influence how individuals spend their time, the *activities of daily life.* For example, Group-Based Acceptance and Commitment Therapy (Group-ACT; see Hazam & Walser, Chapter 13, this volume) assists group members in aligning their actions with their consciously considered values in living. Groups that include behavioral activation as a tactic for improving mood focus on encouraging group members to engage in positive activities between sessions. And some groups might produce outcomes that are not traditionally part of mental health treatments. For example, participation in groups with others similarly affected by trauma might prompt *expression of altruistic behaviors* and involvement in social campaigns to assist other trauma survivors.

Most groups have some primary goals and desired outcomes, but most also include multiple additional target behaviors. Symptom-focused groups also seek to improve various indices of functioning. Interpersonal process groups hope to accomplish a reduction in symptoms and distress, as well as affect group members' relationship quality. Because of the mutual influence among problems and symptoms, it is usually assumed that a reduction in PTSD symptoms will result in improvement of relationships and other outcomes. Similarly, changes in interpersonal responses and skills are thought to put into motion processes that reduce PTSD symptoms.

As well as having different goals, most groups very likely have some goals in common. For example, several of the group therapies described in this book overlap in teaching skills related to the tolerance of emotional distress and mindfulness. Implicitly or explicitly, most groups for trauma survivors attempt to normalize reactions to trauma, reduce shame, and improve hope for change and recovery. Most groups seek to improve trust in other people.

Goals and target behaviors of groups are often explicit in the sense that group leaders are aware of them and deliberately trying to affect them. The group may well discuss their goals and what outcomes they are expecting to be improved. Written materials that are given to group members talk about group goals, and outcomes may even be formally measured for program evaluation purposes or to allow leaders and members to track their progress within the group. Sometimes, goals and outcomes may be more implicit, with little formal articulation of them in the minds of the leaders or within group discussions with the members.

Hypothesized Mechanisms of Change

Closely related to the dimension of group goals and desired outcomes is the concept of mechanism of change. Group are designed to intervene in key change processes that have been identified in psychological theories or schools of psychotherapy, and group leaders trained in various therapies sometimes have differing beliefs about what they are trying to do. Any changes that result from group participation are likely to be attributed to specific change mechanisms that are derived from the theoretical underpinnings of the group approach itself. For example, some groups are specifically intended to change trauma-related cognitions. Group CPT helps group members understand, notice, challenge, and replace negative cognitions ("stuck points") that are thought to create distress and maintain posttrauma problems (as Ehlinger & Chard discuss in Chapter 6, this volume). CPT is a highly structured, manualized approach to changing cognitions. But many groups seek such cognitive changes by fostering therapeutic insights, improving understanding of PTSD symptoms and personal reactions, increasing the predictability and controllability of symptoms, and so on.

In contrast to a focus on challenging negative cognitions through rational self-argument and other means, some group therapies seek to accomplish very different changes in the ways that individuals respond to their thoughts and beliefs. Group ACT (see Hazam & Walser, Chapter 13, this volume) does not focus on helping individuals rethink or eliminate negative thoughts; instead, it aims to help group members approach and accept their distressing thoughts and emotions, and cease trying to control them. Inner Resources for Stress (IR; see Waelde, Chapter 11, this volume), other mindfulness training groups, and many forms of group meditation aim to improve skills for maintaining present-moment

awareness of thoughts, feelings, physical sensations, and external stimuli, allowing attention to move away from dwelling on distressing thoughts and sensations.

As noted earlier, improvement in skills is an important focus of many groups. Many groups and their leaders are likely to attribute any therapeutic effects to changes in deliberate use of skills to manage symptoms, situations, and problems. According to this logic, individuals are trained to replace maladaptive responses (e.g., automatic emotional reactions elicited by trauma reminders, anger, interpersonal withdrawal, situational escape and avoidance) with alternative responses ("skills") that are more appropriate and "adaptive" in the same situation. Instead of responding automatically, such as when trauma emotions suddenly appear and behavior is strongly emotional and "out of control," individuals are helped to notice what is happening and deliberately, consciously practice what they have learned in the group. Skills may include but are not limited to social skills, emotion regulation skills, acceptance, self-talk, mindfulness, gratitude, skills for selection of environments (facing difficult situations).

Trauma-focused therapies provided in groups focus on creating changes in the way the trauma memories or trauma-related situations are processed. Exposure therapies ascribe change to a variety of mechanisms, including classical conditioning extinction of fear responses and habituation to emotionally evocative stimuli, and change in the ways that fear memories are stored and organized in memory. These procedures also are hypothesized to affect interpretations and appraisals, as when group members learn they can tolerate their memories and that their emotions and symptoms are not "dangerous." Or group members may learn to better distinguish between "then" and "now" when in the presence of trauma reminders.

Some interpersonal process therapies invoke other mechanisms of change. Case Conceptualization-Based Functional Analytic Group Therapy (discussed by Vandenberghe in Chapter 16, this volume) is hypothesized to achieve effects via the naturally occurring consequences that group members (and group leaders) provide for one another during groups, and systematic attempts to generalize new interpersonal responses to the outside social environment. This behavioral model of change sees interpersonal behaviors as operant responses shaped by their consequences and seeks to help group members try new, hypothetically more adaptive behaviors and experience different, more reinforcing consequences.

Note that most mechanisms of change can be broken down into more molecular change processes. For example, skills-training interventions can be seen as comprising a variety of subskills that form components of the larger skill-as-a-whole. To replace an ineffective or maladaptive response with a more adaptive skill, an individual needs to have knowledge about why and how the skill is expected to help, to notice when a situation that elicits the "old" response and requires the occurrence of the new skill, to remember the learned replacement skill, to apply it competently, to notice its effects, and to continue practicing the skill over time, so that it may become more effective and eventually come to "automatically" replace the previous response.

The list of hypothetical change mechanisms and therapeutic "techniques" is very large, and groups are likely to use, deliberately or implicitly, many of them at the same time. The overall impact of any group likely results from an interaction of a variety of mechanisms to produce change. Note that if a group is effective or ineffective in achieving its therapeutic goals and achieving or failing to achieve its desired outcomes, these results do not necessarily validate or invalidate the presumed mechanisms of change that the group leaders believe in and seek to apply.

Behaviors of Leaders

A third key dimension along which groups can be compared is related to the behaviors of group leaders in conducting the group process. In some ways, the behavior of mental health providers in groups is similar to their behavior in individual psychotherapy. Whether providing individual treatment or group therapies, clinicians educate their group members about traumas, PTSD, and recovery processes; structure and direct the therapeutic session; assess the well-being of members; provide feedback; make therapeutic suggestions and recommendations; and elicit client thoughts and feelings. However, many behaviors are unique to groups and there are ways in which group leaders need to modify their behavior with individuals when leading groups. Leaders of groups determine and guide group behavior and interactions. They design, implement, and manage many aspects of group structure, including session length, frequency of meetings, duration of the group intervention, size of group membership, and length of time spent on various activities during group sessions. Then, in line with the specific nature of their group intervention, they direct the group process and manage interactions between individuals in the group. In the interests of creating flexible treatments that can be adapted to treatment settings and thus increase uptake by clinicians and programs, some group therapies, such as Seeking Safety (see Najavits & Krause, Chapter 10, this volume) and Trauma Affect Regulation: Guide for Education and Therapy (TARGET; see Ford & Reid, Chapter 8, this volume), permit leaders to deliver them in a variety of forms. For example, Ford and Reid indicate that several adaptations of TARGET group therapy are currently available, permitting variation in session duration (from 30 to 120 minutes), intensity (from a single session to open-ended), group structure (including both closed groups and rolling entry), group size (from three to 12 members), and other features. However, it is not known whether and to what extent such differences affect treatment outcomes.

Specific to the group therapy environment is the facilitation of group discussions. Leaders may identify topics for discussion, or help the group direct its own selection of topics. This likely looks different in a group environment than in individual psychotherapy. Leaders promote interactivity between members, asking members to elaborate on their comments, and noting commonalities or differences between members. They manage the topics of discussion and the interactions among members; they seek to build a sense of community and mutual similarity and support, and avoid unnecessary or unproductive conflict. Leaders help members keep to the topic and ensure that all members have a chance to participate. Leaders interweave teaching points in discussions and make observations of group behavior and process. They act as timekeepers, managing the duration of discussions. They often provide feedback to individuals within the group, and sometimes to the group as a whole.

Because individual members interact with one another in groups, there are opportunities for problems to arise. Some individual group members may say and do things that interfere with the goals and structure of the group. These can include conflicts between members that require active management by leaders. Or an especially intense reaction by an individual (e.g., dissociation, strong anger, getting up and leaving the group session) might require departure from the planned activity of the group so the leaders can focus more of their attention on that member. Thus, in groups, leaders are active in monitoring the reactions of group members to prevent or manage individual reactions or conflicts between members. For example, in groups that involve talking about traumatic experiences (and other kinds of groups as well), leaders actively manage the emotional well-being of members as they

remember and talk about their traumatic experiences and/or their effects. If intense distress occurs that is deemed unhelpful or undesirable for members, they do things to lessen that distress. In other cases, if a client is thought to be avoiding emotions that are important to the treatment process, leaders may seek to increase emotional experiences.

In many groups, leaders engage in teaching. They provide information and instruct members in the development of new ideas and skills. Sometimes, teaching is quite formal, with didactic instruction that includes identified teaching points and interactive exercises. Leaders may model desirable behaviors and skills, and conduct behavioral demonstrations. They may arrange group activities that give members the opportunity to learn and practice new coping or interpersonal responses, and to participate in role-play exercises. The instruction process may include assignment of between-session tasks and review of efforts to complete tasks.

Leaders also continuously assess group members through observation of behavior in the group and listening to what group members are saying. In some groups, they administer questionnaires before the group begins, or during ongoing group meetings, to inform the conduct of the groups and allow members to better see how they are acting and feeling.

Specific kinds of therapy groups, then, reflect a combination of treatment goals and target behaviors, mechanisms of change that provide the rationale and guiding principles of the group intervention, and a mix of leader behaviors. Different groups combine these things in different ways.

Implications

Thinking of groups in terms of these dimensions and discriminating among not only broad types of groups but also the many elements of their process and structure (specific treatment goals and behavior targets, hypothetical change processes, leader behaviors) should prove useful in important ways. Specifically, having a clear understanding of what groups do and how they work helps to improve the effectiveness of group therapies, sharpen conceptualization, guide dissemination, and inform development of group therapy research.

Improving the Effectiveness of Group Therapies for Trauma Survivors

A careful articulation of what is happening in specific group therapies, especially of individual treatment goals and desired behavior changes, should enable both group leaders and group members to work more effectively toward their fulfilment. To the degree that goals have been made specific, and to the degree that leaders and members all understand and agree upon the goals, they may be more likely to attain them. Knowing what they are trying to accomplish, and keeping these things in mind, should allow groups to focus and self-correct as the group progresses. Then, if these things are measured and used to evaluate the effectiveness of group therapies (measurement-based care; see Ruzek, Chapter 21, this volume), it should be possible for leaders to make changes throughout the group that benefit the members, and for researchers to make progress toward experimenting with variations on group design to improve the likelihood of achieving the various different kinds of group goals.

A recognition of the various ways in which groups differ from one another is important if individuals are to be matched more effectively with group therapies and thus achieve

better outcomes. In principle, depending on the assessment of the individual, identification and prioritization of individual needs, the formulation by therapist and client as to the factors affecting the problems, and the conceptualization of the processes by which the PTSD and related problems have been caused and/or are being maintained, different kinds of group therapies might be selected. An individual who is experiencing large disruptions to important personal relationships or anger problems in the work environment that threaten their employment might benefit especially from an interpersonal process group of one kind or another. A person who cannot tolerate thinking about the trauma or has overwhelmingly intense anxiety when remembering their experience might benefit from a trauma-focused group. A person who seems to be coping very poorly with a range of situations, or who is currently functioning very poorly due to co-occurring alcohol use, or reports significant thoughts of suicide, might benefit from some kind of coping skills training. If group therapies emphasize different outcomes and operate according to different change mechanisms, then matching the individual with a specific kind of group therapy should result in better outcomes.

Note that it is not necessary for a single group therapy be delivered in isolation from another. It is possible that individuals could attend two groups, simultaneously or in sequence, each with different, potentially interactive effects. Indeed, several group therapies already raise the possibility of an adjunctive role in treatment. For example, developers of several treatments included in this volume, including Group ACT, DBT, and STAIR, suggest that their groups might facilitate or enhance the delivery of trauma-focused interventions. Many problem-focused groups, such as those dealing with trauma-related anger management problems (Morland et al., 2010) have often been used as adjuncts to other, more PTSD-centric interventions. In more intensive treatment settings, such as Department of Veterans Affairs (VA) residential PTSD treatment programs, it is common to offer a range of group therapies simultaneously. What is intriguing about involving clients in more than one group is the possibility that two or more different kinds of outcome mediated by two or more different processes of change might operate synergistically to strengthen overall effectiveness for group members. Groups that focus on symptom reduction via working through the trauma experience, or mastery of coping skills, might be combined with groups that address interpersonal functioning. This could ensure that both critical areas of treatment outcome—symptom and distress reduction, and improvement of family and friend relationships—would each receive careful attention. And it is possible that if improvements can be obtained in both domains, they might potentiate each other and facilitate clinically significant recovery.

Improving Conceptualization of Group Therapies

Such a framework of analysis should help clinicians develop a more refined set of ideas about the groups they run. Obviously, groups are not monolithic things; they combine all kinds of elements, many of which can in principle be modified individually within the context of a particular group approach. An interpersonal process group can incorporate elements of skills training, or a skills training group can be designed to use naturally occurring interactions between group members as opportunities to enhance training. Thinking this way can also help leaders entertain the possibility that many discrete influences may be operating in the group, and that attributing change is a complicated issue that requires thought and should be regarded more as hypothesis than as fact.

Guiding Efforts to Disseminate Group Therapies

In the real world of service delivery, it will be difficult for individual clinicians to master many different types of group therapies and for treatment centers to offer many different forms of group therapy for trauma survivors. This means that matching individuals to specific group therapies might be very difficult to achieve in the real world, because clinicians might not be competent in multiple group formats, and what is available in any clinic may be limited to one or two options. Just as, in recognition of a similar problem for individual psychological treatment, trans-diagnostic or trans-problem interventions have been developed, so groups that effectively target many of the sequelae of traumatization might be envisioned and tested. As part of such development, it may be useful to combine elements of skills training, trauma processing, and interpersonal process in groups. Possibly, this could be done in novel ways that combine the strengths of the different approaches to achieve more powerful, more multifaceted outcomes.

Barriers to the implementation of any evidence-based group therapy include the amount of education, training, and supervision required to successfully implement them. Clearly, some group therapies are more complex than others and may require a longer period of instruction for leaders, or prove easier in achieving adherence and competence in delivery. It is important that differences in intensity of training procedures be studied in terms of effects on outcomes, as well as ability to prepare clinicians to deliver the treatments.

Different group therapies also differ somewhat in terms of the "tightness" of their protocols. Most treatments that aspire to become evidence-based treatments, including group therapies, are operationalized in detailed treatment manuals that lay out exactly how procedures take place. This is necessary if groups are to be formally evaluated, for researchers must be able to specify what practices are being evaluated and have confidence that group leaders in research trials are adhering to the manualized procedures. However, clinicians usually prefer manuals that allow them flexibility in adapting the group protocols to their setting and group members. When clinicians feel able to adapt treatments, they are more likely to adopt them.

In recognition of this, some group therapies allow considerable flexibility in delivery to different individuals and groups. Some group therapies (e.g., Seeking Safety and TARGET, discussed in chapters to come) give considerable latitude to group leaders regarding many aspects of group delivery (e.g., number of sessions), although the effects of such adaptations have not been subjected to much investigation and more research on evaluation of such adaptable group therapies would be helpful. The developers of some group therapies suggest that leaders can decide to provide shorter versions if circumstances limit their ability to stick to the standard, longer protocol. This is useful in helping to increase the uptake of specific group therapies by clinicians or organizations, because the groups can be fitted to the features of the delivery setting. However, it is important to note that only those group formats (with the specified number of sessions) that have been formally evaluated using robust research methodologies can be considered evidence-based. Without empirical demonstration, group variants cannot be assumed to be similarly effective to those that have been studied. Some work suggests that some forms of adaptation may not interfere with treatment effectiveness (Levitt et al., 2007) and research on adaptation of psychological interventions is growing. In a review of the evidence on adaptation of evidence-based mental health treatments, Stirman et al. (2017) concluded that research suggests that adapted protocols, when compared to the original format, yield small, if any effects, but that "when

additions are discrete, well-defined, and based on sound theory and an understanding of the population for which the intervention is being adapted, they may result in better outcomes than standard protocols" (p. 409). This issue of the potential for adaptation of group therapies, and the design of flexible intervention methods, requires more research and development, both to improve effectiveness of the interventions and to increase the probabilities of effective dissemination.

Informing Development of Group Therapy Research

Such a framework might inform more systematic research on the conduct and comparison of group therapies. Although it has not been our goal in this chapter to attempt a formal typology of group leader behaviors, group goals/outcomes, and group mechanisms of change, such typologies could in principle be developed to guide assessment of groups and measurement of the group environment and group process themselves. Many key research questions about the effectiveness of group therapies for trauma survivors have received little attention, and we highlight below some important areas for research to help better understand the processes and outcomes of treatment in groups.

Much more research on group therapies is needed to better establish evidence for the effectiveness of the various kinds of treatments. To date, most group therapies are not well supported by randomized controlled trials (RCTs) or other rigorous study designs. In their review of the efficacy of group psychotherapy for PTSD, Schwartze et al. (2019) concluded that group therapies are associated with improvements in symptoms of PTSD and that the efficacy of exposure-based cognitive-behavioral group therapy is empirically well demonstrated. However, they also concluded that "little is known about the effects of group treatment approaches other than CBT [Cognitive-Behavioral Therapy] and the comparative efficacy to alternative treatments such as individual therapy or pharmacotherapy" (p. 415). Comparison conditions should go beyond use of passive waitlist or other passive controls to enable comparison with other, more active treatment comparators. In these studies, researchers and clinicians should specify which measures will be used to judge the effectiveness of the interventions, and which are primary and secondary measures. Studies usually include a variety of dependent variables, and it can sometimes be difficult to evaluate the effectiveness of group therapies that affect one measure while having little effect on others. It is critical that interventions be shown to change outcomes important to group members, whether those be PTSD symptoms, social functioning, or other clinically significant variables.

It is also important to begin to better establish the mechanisms of change in groups deemed effective. Many therapies, group or individual, are grounded in models of psychological change that have been adopted by their founders (and providers who deliver them) and are thought to underly their effectiveness. However, in the absence of efforts to systematically measure change processes and link them to group outcomes, the models remain hypothetical accounts, and it remains possible that other factors are responsible for whatever changes are observed. If different groups are thought to operate according to different mechanisms of change, even when they produce similar changes in symptoms or other outcomes, there should be significant group differences in effects on change processes. To date, there are very few comparisons of group therapies for trauma-related problems using RCTs, and none that measure change processes and compare the interventions in terms of the degree to which these processes have been engaged.

It would be useful to see more research studies comparing group therapies head-to-head. Such studies would enable determination of which groups are most useful for which outcomes. It is very likely that some groups will be more effective than others in reducing PTSD symptoms, improving interpersonal relationships, improving work functioning, or increasing positive emotions. Groups will also likely be differentially effective in teaching effective coping. Presumably, the group that produces the greatest reductions in PTSD symptoms will also have significant effects on other clinically important outcomes, because PTSD severity is a driver of many other trauma-related problems. However, the most effective PTSD treatment may not necessarily be the *most* effective option in addressing other kinds of outcomes. A group for trauma survivors that is designed specifically to change interpersonal functioning will priobably have more impact in that domain than a group designed to remediate symptoms of distress, although this needs to be established in research.

Note also that many symptoms comprise the phenomena of "PTSD" and "complex PTSD." Despite the fact that most symptoms occur in combination and effective treatments reduce many of the symptoms, it is also very likely that different group therapies will be differentially effective in reducing specific symptoms. For example, symptoms that are related to physical arousal, such as hyperarousal, anger problems, and irritability, might respond differently to Group PE, group CPT, or a group mindfulness approach such as IR. All are likely to reduce these symptoms, but they are likely to achieve those reductions via different mechanisms of change and might vary in terms of their symptom-specific impact.

An expanded conception of the various outcomes that are addressed in groups might enable development of instruments that measure a wider, more comprehensive set of clinically significant outcomes. Then, it would be possible to compare groups across multiple domains of outcome, rather than simply reduction of PTSD symptoms or specific behavior changes (e.g., reduction of substance abuse). Such instruments might accelerate investigation of ongoing controversies in the field, such as the importance of matching persons to group interventions based on current level of emotional regulation capacity and readiness for trauma-focused interventions (i.e., the rationale for phase-based interventions). As well as having different goals, most groups will very likely have some goals in common. As noted earlier, most groups seek to normalize stress reactions, reduce shame, improve hope for change and recovery, and improve trust in other people. Measuring these outcomes across different approaches to group therapy for trauma survivors would allow a comparison of the effectiveness of different kinds of groups in achieving these changes.

As noted earlier, many groups explicitly set out to help their members develop and use coping skills of different kinds. Explicitly or implicitly, this is a key target of group therapies, reflecting a key assumption as to the mechanisms underlying therapeutic change. However, many fundamental questions related to skills training in groups have received little attention to date. For example, little is known about the relative usefulness of specific skills. Are some better than others for achieving specific kinds of outcome? Do groups effect change in ability to perform skills, and after being trained, do group members actually deploy those skills in the situations for which they are intended to be used? Is what matters that members have an actual ability to apply a skill, or only that they feel confident about their ability to cope? Are perceptions of self-efficacy related to actual coping competency? Is it better to focus more intensively on one or two skills and achieve mastery of use, or is it appropriate to teach many skills on the assumption that individuals will use some of them? It is axiomatic that group members will sometimes need to use their skills when

they are experiencing intense distress or negative mood in the natural environment. Does this mean that instruction should take place under conditions in which the group member is exposed to heightened stress? How might skills trained under conditions of relative calm versus deliberately induced stress compare? Groups vary greatly in number of sessions and duration of treatment. It seems likely that a more extended time for learning and practicing skills will be associated with greater mastery and increased uptake and sustained use of skills, but that should be tested in research.

Relatively little is known about the extent to which those instructed in various coping skills continue to use those skills after treatment is completed, how long such use continues, and the relationship of ongoing skills use to future well-being and longer-term outcomes. Presumably, the purpose of most forms of coping skills training is to change how individuals cope posttreatment. The idea is that use of more effective coping responses will enable individuals to live more effective lives, cope with future adversities, and prevent relapse. A few forms of group therapy do explicitly address the longer-term maintenance of the skills. For example, in IR (Waelde, Chapter 11, this volume), substantial session time is devoted to helping clients develop an ongoing daily formal meditation practice. This may be more common in group therapies that focus on mindfulness skills, because various forms of meditation generally involve a daily "practice."

These are very important research questions, because it is likely that the development and use of coping skills is a central influence on the effectiveness of group therapies. Neacsiu et al. (2010) reported that participants in DBT increased their skills usage three times more than participants in a control treatment, and that use of these skills fully mediated reductions in suicidality, depression, and anger, and partially mediated reductions in nonsuicidal self-injury. Much more research with various skills and various group therapies is needed to examine whether other group therapies accomplish mastery and use of skills, and whether skills usage is associated with therapeutic benefits. More research that examines the skills training process would be useful. A review of the models described in this volume shows that a wide array of different coping skills is included in various group therapies. Most structured group therapy protocols include several coping skills, but little is known about which of the skills, if any, are more effective than the others. Generally, the kinds of dismantling studies, or laboratory investigations, that would enable us to conclude that one skill is especially effective (or ineffective) have not been done. If we had reason to believe that specific skills were differentially effective for clients, we could explore ways of increasing (or decreasing) attention and group time for those skills. More broadly, looking across the groups, there is a great deal of variation in the kinds of tools for coping—cognitive, behavioral, interpersonal—in which group members receive instruction. While many of these skills might be helpful to trauma survivors, it seems likely that specific skills will perform better, along several important dimensions, when compared with others. For example, skills might vary in their effectiveness for group members. How do skills such as paced breathing, distraction, and self-soothing with the five senses compare as tools for distress tolerance? How do various mindfulness training procedures, and the slightly different mindfulness skills that are being learned, compare? As another example, how do the various emotion regulation skills covered in the group versions of STAIR, TARGET, and DBT vary in their effects?

Skills might also vary in terms of their "teachability," such that some may be easier than others for group members to learn and for group leaders to teach. Skills might also vary according to how easily they can be integrated into longer-term coping repertoires of

group members. Perhaps simpler skills will prove easier to incorporate into daily life, easier to remember, or more likely to be accessed under conditions of emotional stress and arousal. Presumably, the utility of skills acquired in therapy groups will be strongly related to not only their immediate impact on the situation in which they are being tried, but also to the likelihood of their repeated and continuing use in managing emotions, relationships, and problem situations. The idea of skills training is not that skills be used once to comply with a "homework" task assignment, or even on several occasions in the course of treatment. They are seen as providing clients with a new, more effective repertoire of coping behavior. Like any other skills (e.g., sports, martial arts, mathematics), they are expected to improve with continued practice, and possibly, to yield better results as an individual becomes more proficient. More research is needed to test these underlying assumptions of skills training and to examine whether trained skills are continuing to be used in the months and years following termination of therapy.

It would also be useful to know to what extent individuals participating in groups whose theoretical underpinnings are not specifically focused on the teaching of coping skills do in fact develop and use new skills. For example, interpersonal process groups probably impart new skills for coping with trauma-related interpersonal situations, and it is likely that trauma-focused group therapies that emphasize emotional processing or cognitive restructuring also enable their members to develop and deploy new skills for managing trauma reminders and/or trauma-related situations. And it would be useful to determine whether previous development of emotion regulation skills changes the way individuals respond to trauma processing groups.

As with specific coping skills, it is also the case that relatively little is known about what specific behaviors of leaders, if any, are associated with outcomes. Are some behaviors, such as the frequency of facilitating group discussions, assignment of between-session tasks, or the degree to which groups are structured according to agendas, significant predictors of different kinds of outcome? In this vein, Callaghan (2006) developed a Functional Assessment of Skills for Interpersonal Therapists methodology that can be used to classify categories of therapist behavior and functionally define leaders' skills so that their relation to the client outcomes can be evaluated.

As a final example, it would also be very useful to examine the concepts that underlie some of the assumptions of interpersonal process therapies in relation to more traditional CBT approaches. It is not just that the different approaches emphasize different domains of outcome (e.g., interpersonal behaviors vs. symptoms). Some interpersonal group therapies employ methods and an underlying set of concepts and hypothesized mechanisms of change that are quite different from traditional cognitive-behavioral group therapies. Case Conceptualization-Based Functional Analytic Group Therapy (and by extension other group-delivered interpersonal process therapies) seeks to elicit and use spontaneously evolving in-group interactions between members as a behavioral change opportunity and mechanism (Vandenberghe, 2009). The idea is to work with behaviors at the time they actually occur in the group, treating the interpersonal behaviors that take place in the group itself as exemplars of important extragroup behaviors, and trying to shape those behaviors, using them as *in vivo* teaching opportunities. This is different than most CBT approaches that teach skills through instruction and more "artificial" role-play activities, and that rely on between-session task assignments for application in the real world. It would be useful to see whether this kind of group-based *in vivo* teaching approach differs in its impact compared with more traditional CBT instructional methods.

Groups that seek to change interpersonal behaviors, whether they be interpersonal process groups or skills training approaches that focus on social skills, are predicated on the assumptions that interpersonal behaviors learned in group therapies will generalize to the natural environment and show impact there. But to what extent does generalization take place? Do individuals who try out new interpersonal responses in group therapy take those new ways of interacting into their families and social networks? Are they displayed in the work environment and do they translate into greater success at work or reduced rates of job loss? What can be done to increase generalization? How important are between-session task ("homework") assignments to the generalization process, and if they are important, how many practice assignments are sufficient to achieve generalization? These are empirical questions, best addressed via empirical study rather than by appeal only to theory.

The group therapies included in this volume do not exhaust the range of groups that have been used or tested with trauma survivors. For example, present-centered therapy (PCT), a treatment for PTSD that has been evaluated in both individual and group formats, has shown significant effectiveness (Belsher et al., 2019). Because it was originally developed to be a treatment comparator in trials of CBT treatments for PTSD, its components exclude trauma exposure, cognitive restructuring, or behavioral activation. However, PCT has performed well in treatment comparison trials and may be associated with lower treatment dropout rates. Therapeutic components of PCT include the establishment of positive therapeutic relationship(s), normalization of symptoms, validation of experiences, provision of emotional support, and an increasing sense of mastery and self-confidence in dealing with problems. PCT is a structured, manualized supportive therapy. Eye Movement Desensitization and Reprocessing (EMDR) is an evidence-based individual treatment for PTSD (International Society for Traumatic Stress Studies, 2018), and research on group EMDR suggests that it, too, promises to be effective in achieving significant reductions in PTSD symptoms and other mental health difficulties (Kaptan et al., 2022). Anger management groups that apply cognitive-behavioral intervention methods also are widely used with veterans and other groups, since problems associated anger and irritability that affect critical personal relationships and ability to function effectively at work are common among those with PTSD and these groups have been found to be effective in reducing anger in some studies (Morland et al., 2010; Van Voorhees et al., 2021). But the group therapies included here do give a relatively comprehensive sense of the kinds of groups that have received research attention and the content and components of intervention that are included in most kinds of group therapies for trauma survivors.

Conclusion

Fundamentally, any comparison of group therapies should also include a comparison of their relative evidence bases. Unlike those described in this volume, many of the group therapies that are most commonly offered to trauma survivors in routine care settings have not been manualized and trialed. Some of the most common of these include group education for trauma survivors ("psychoeducation groups") and generic "support groups," both of which are general labels that ignore very large differences among these groups in terms of content and process. By contrast, some specific group therapies for PTSD and trauma-related problems have been very carefully designed, are grounded in well-developed theory and methods, and have accumulated varying levels of research support. This suggests that

use of these better developed groups should take priority over delivery of general support or educational groups in most treatment settings, and that when clinicians use group therapies of their own design, it is important that they gather evaluation data to help them ensure the effectiveness of their services and compare their own outcomes with those generated by group therapies like those included in this volume.

Although it is generally true that research on the effectiveness of group therapies for PTSD is quite limited to date, the groups included in this volume vary widely in the degree to which they have been subjected to research evaluation using strong evaluation methodologies. Several have been evaluated in RCTs and can be regarded as having a reasonably strong evidence base. Others are in the very early stages of research and development but have been included here because they address important issues in the field, incorporate novel ideas about the nature of interventions, and/or extend group approaches to relatively overlooked subpopulations of trauma survivors. For example, issues and interventions that address various effects of racial trauma (see Endsley & Erazo, Chapter 14, this volume) are greatly needed in order to increase attention to critically important societal needs, improve outcomes, assist neglected groups, and increase the body of research that bears on their well-being. And group therapies for other important neglected populations that have been exposed to high levels of traumatization, such as those afflicted with serious mental illness (see Martin & Lysaker, Chapter 17, this volume), must also be developed and researched. Ultimately, all group therapies for PTSD and other trauma-related problems should be exposed to empirical tests of their effectiveness, both in absolute terms and relative to one another. There may be times when the laudable goals of a specific therapeutic approach may not be effectively achieved by an existing group intervention, and knowing this might encourage the investigation of alternative means of addressing those goals. Or a hypothetical mechanism of change might be engaged to different degrees by differently structured therapeutic groups. Several group therapies may claim to assist members with similar goals, and they should be systematically examined to determine and compare the degree to which they are successful, and how outcomes are different between groups. Without the development and peer review of empirical evidence, it will remain difficult for clinicians, prospective group members, organizations, and researchers to decide which ideas about group process have credibility, which group therapies are effective, and which should be recommended to individuals with problems.

Development and improvement of research on group therapies is much needed. To be of maximum service to those using our trauma services, we must have good reason to be confident in our group therapies and, given the conclusion of several reviews that group therapies are not as effective as individual treatments (e.g., Haagen et al., 2015; Schwartze et al., 2019; Sloan et al., 2013), it is imperative that research-based arguments be developed to support the delivery of group therapies for trauma-related problems.

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