GROUP, *Vol. 31, No. 4, December 2007*

Group Treatment for Traumatized Adolescents: Special Considerations

Gloria Batkin Kahn[1] and Seth Aronson[2]

Effects of trauma on the developing adolescent make therapeutic intervention particularly crucial for further growth to continue. This article will discuss the impact of trauma on adolescent development as well as principles of group therapy with traumatized adolescents. The unique role of the group therapist will be highlighted.

KEYWORDS: Adolescents; trauma; group therapy.

Working with traumatized adolescents necessitates an understanding of the effects of trauma on the cognitive, emotional, and social aspects of development. Because adolescents are in the process of growing, when a trauma occurs at a young age, the growing process receives an assault, and development may be arrested, until some therapeutic intervention occurs (Keyser, Seelaus, & Kahn, 2000).

Group therapy is considered by many to be the treatment of choice for adolescents (Aronson & Scheidlinger, 2002). Most adolescents spend the majority of their time in groups and are often more comfortable with peers than adults. After a traumatic event, family members are often unable to deal with the trauma constructively and may be unavailable to the adolescent. The group offers a model for the restoration of an optimal, caring family consisting of empathic adults and understanding peers (Keyser et al., 2000). Such a group creates for the adolescents a supportive circle of others who will accompany them through their suffering, allowing them to share

1 Private practice, Hartsdale, NY. Correspondence should be addressed to Gloria Batkin Kahn, EdD, ABPP, CGP, FAGPA, 82 Pinecrest Drive, Hastings-on-Hudson, NY 10706. E-mail: globatkahn@aol.com.

2 Private practice, William Alanson White Institute, New York City.

ISSN 0362-4021

the painful narratives of their experiences.

This article will discuss the impact of trauma on adolescent development as well as the principles of group therapy with traumatized adolescents. We will describe practical considerations of working with this population, with a focus on the special issues of the adolescent group therapist's leadership role.

The Normal Developmental Tasks of Adolescence

Adolescence is a complex developmental period, involving the negotiation of various tasks. These issues color the background of any adolescent group, and the group therapist working with traumatized adolescents must be prepared for these issues to arise.

Peter Blos (1967) described adolescence as the second separation–individuation period, following Mahler, Pine, and Bergman (1975). The adolescent must negotiate not only the physical separation that accompanies adolescence (e.g., leaving home for college), but the psychological separation involved in relinquishing the connections of childhood. This developmental push toward independence occurs while still acknowledging a very real dependency on the family, causing a dichotomy that often leads to conflict. Erik Erikson (1959) described the major task of adolescence as identity formation. Youth must consider identity in many forms: gender, career-oriented, racial, ethnic, and religious, to name but a few.

Harry Stack Sullivan (1953), among others, highlighted the importance of this period for learning to negotiate intimacy. This intimacy is first confronted during preadolescence, in Sullivan's thinking, in intense friendships, in which self-esteem may depend on the esteem given by the best friend. This sense of being valued by a chum has enormous ramifications for future mutually enhancing, intimate relationships.

With the onset of puberty, the adolescent experiences great physical changes. Concerns over body integrity, sexuality, and attractiveness accompany these physiological changes. Stabilizing one's physical sense of self and integrating it into a new identity is a further developmental challenge of this period.

Finally, studies have shown how the developing adolescent's brain undergoes many changes, differentiating into various structures (Kandel, Schwartz, & Jessell, 2000). The adolescent's brain grows to accommodate new structures that, in turn, help to mediate judgment, object relationships, affect regulation, and other functions.

WHAT CONSTITUTES TRAUMA FOR THE ADOLESCENT?

Van der Kolk (1997) defined trauma as "the result of exposure to an inescapably stressful event that overwhelms the person's coping mechanisms" (para. 1). For the adolescent, "any experience or event that threatens the [youth's] sense of safety and security to such an extent that it is perceived as unmanageable" (Keyser et al.,

2000, p. 210) may constitute a trauma. Trauma may be acute, such as a one-time experience (being involved in a car accident), or chronic (repeated sexual abuse). Although not all loss is traumatic, trauma always involves a loss of some kind (Aronson & Kahn, 2004).

Symptoms of Trauma

The Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 1994) divides the symptoms of trauma into three clusters: reexperiencing, avoidance, and hyperarousal.

The *reexperiencing* symptoms may include nightmares, intrusive recollections of the event, flashbacks, and distress when exposed to cues relating to the event. *Avoidance* includes any attempt made by the adolescent to avoid a thought or feeling related to the traumatic event, amnesia or dissociation for the event, feelings of detachment from others, diminished interest in activities, and feelings of a foreshortened future. The *hyperarousal* cluster includes sleep difficulties, concentration and attention difficulties, hypervigilance, and a heightened startle response.

Other authors (Janoff-Bulman, 1992) described changes in the adolescent's so-called assumptive world as a result of exposure to trauma. The individual's basic assumptions about the world, himself or herself, and others change due to the trauma. Relational patterns may become rigid and inflexible, often with the traumatized individual rotating between the roles of victim and abuser. The assumptions are such that this is the way of the world, and one can expect nothing more.

The experience of self and other is also affected by trauma. A self-representation that is characterized by a sense of damage and deficiency may develop. The painful affect that may accompany such representations may be dissociated, with a possible ensuing loss of self-cohesion. Splitting and projective identification may be prominent. Thus the group leader may find himself or herself pushed into a role that seems unfamiliar (e.g., abusive victimizer in response to the victimized adolescents).

IMPACT OF TRAUMA ON ADOLESCENT DEVELOPMENT

Identity Formation

The peer group has a crucial role in creation of identity. If, as is common after trauma, the adolescent withdraws from his or her peers, then the peer group is lost as an important resource (Aronson & Kahn, 2004). Also lost is the building of the connections in which the sense of one's value as a person is seen in the eyes of the other, the friend. Sullivan (1953), as previously mentioned, saw this chumship as the prototype of future intimate relationships. Adolescents try on various roles, playing with identities to see which fits and feels good. Trauma can cause a rigidity of role

and leave the adolescent stuck where he or she was when the trauma occurred. Fo example, a woman who had been sexually abused as a young adolescent in 196; continued to wear her hair in the same bouffant hairdo, à la Jackie Kennedy, for th next 40 years, until the sexual abuse was addressed in therapy.

A major part of identity formation includes career choice. Trauma can produce a foreshortened sense of the future, creating lack of interest regarding educational goals or career. It was quite common after 9/11 to hear adolescents refusing to bother with homework or discuss college possibilities, explaining, "We'll probably all be dead anyway." The foreshortened sense of the future frequently is underlying the traumatized adolescent's lowered tolerance of frustration or of any suggestion that working on something now would have future payoff.

Intimacy

Adolescents who have suffered trauma frequently withdraw from peers and have difficulty even leaving the house. Their absence from school and peer activities limits the opportunities for peer interaction. Even if the adolescent is physically able to be with peers, typical symptoms of trauma, including detachment, limited affect, dissociative episodes, or negativity, tend to create distance, rather than the wished for closeness. If the trauma has created an actual loss, the adolescent may feel too vulnerable to risk hurt again from the possible loss of an attachment. Wallerstein and Blakeslee (1989), in their studies of children of divorce, found that the girls from divorced families frequently showed no symptoms until late adolescence, when, instead of moving toward intimacy, they veered away from intimate attachments. Indeed, many of the girls from the divorced families did not enter into a serious committed relationship until their late 30s.

Separation–Individuation

The process of separation may be severely affected for the adolescent. Nightmares and sleep disturbances may make waking up at a normal hour for school difficult, resulting in school absence or lateness. In the days following 9/11, the New York City schools reported a 38% absenteeism rate ("A Bad Day for Attendance," 2001). Anxiety for their own or their family's safety frequently created a fearfulness about leaving the home. Agoraphobia and separation anxiety are frequently seen. A boy whose family had been in a terrible car accident, resulting in his grandmother's death and severe injury to other family members, afterward felt that he needed to call each of his parents hourly to check on them. He refused to leave the house unless he had his cell phone and his parents promised to keep theirs on. Another boy, who had been through a similar situation, would get dressed to go to school, but then suffer a severe panic attack, which continued until he was back in his bed. For these and other adolescents, who normally would utilize their involvement outside the house

to create an identity separate from the family, the posttraumatic anxiety cut them off from peers, thus hindering individuation.

Stabilization of Body Image

When trauma has affected the body, for example, in the case of an accident or an illness, the traumatized adolescent may react with fears of physical injury to his or her body and lack of self-cohesion. In addition, an adolescent who has suffered sexual abuse, and concomitant lack of integration of identity (particularly of body image), is likely to dress either in extremely baggy clothes to hide himself or herself or in provocative clothes to call attention to his or her problems. There can be shifts in and out of either self-presentation because of the instability of body image and lack of self-cohesion.

The Development of Cognitive Processes

Adolescents, although full-grown in their bodies, have brains that are continuing to develop. The nature of one's experiences has a profound effect on the development of cognitive structures. The prefrontal cortex (which provides executive functioning) is still immature during the teen years, without fully developed capacity for assessment of cause and effect (Siegel, 1999). Parents and teachers need to function as life jackets in helping the adolescents swim toward goals. If the adolescent suffers trauma, the development of the prefrontal lobes, which manage executive functioning, may be arrested, and the adolescent continues into adulthood with the following features of immature executive functioning: difficulty seeing cause and effect, for example, "If I don't take the SATs, I'll still get into a good college"; preoccupations in the here and now, for example, "Do we have to talk about 9/11 again? I want to talk about my silly curfew for this weekend"; difficulty focusing on the future; and a sense of omnipotence, for example, "I can drive twice the speed limit and not have an accident."

Trauma can cause a regression in an adult's executive functioning, but with treatment, he can function again as before. A traumatized adolescent, who has yet to grow to a more developed, mature level, can remain stuck at his adolescent level of development and needs help for his cognitive functions to proceed with further growth.

WHY GROUP THERAPY FOR TRAUMATIZED ADOLESCENTS?

Group therapy is considered by many to be the treatment of choice for adolescents (Aronson & Scheidlinger, 2002). Most adolescents spend the majority of their time in groups and are often more comfortable with peers than adults. After a traumatic event, family members are often unable to deal with the trauma constructively and

may be unavailable to the adolescent. The group offers a model for the restoration of a caring family, consisting of empathic adults and understanding peers (Keyser et al., 2000). Such a group creates for the adolescents a supportive circle of others who will accompany them through their suffering, allowing them to share the painful narratives of their experiences.

A therapy group for a traumatized adolescent can also provide the sorely missed connection with peers. After a trauma, one of the symptoms of posttraumatic stress disorder (Johnson & Lubin, 2000) is a withdrawal from others. This disconnection from others can arrest further development. The adolescent needs his peer group to serve as a security blanket, allowing the developmental task of separation–individuation to proceed. The traumatized adolescent, who has isolated himself, loses the opportunity to build peer relationships. In the therapy group, the traumatized teen can find a haven, where he can begin again to make the connections vital to his emotional growth.

PRACTICAL CONSIDERATIONS OF A THERAPY GROUP FOR TRAUMATIZED ADOLESCENTS

Group Membership

In a therapy group, it is essential that members be prescreened to assess their suitability for the group (Scheidlinger, 1985). Traumatized adolescents need a group comprising adolescents who have been through somewhat similar experiences to feel safe and understood. An adolescent who has been sexually abused does not belong in a group with an adolescent who has suffered other types of trauma, for example, loss of a parent from 9/11. In assembling a group, above all other factors, we look for a thread of commonality in the trauma. Thus an adolescent whose father died of cancer would fit in a group with adolescents who had suffered parental loss from 9/11.

However, in terms of comorbid symptoms, we have found that it is most important to select group members with a range of presenting behaviors. For example, a group of all depressed people would lack energy, while a group of all acting-out adolescents would be difficult to manage and would tend to encourage inappropriate behavior. A group with mixed symptomatology will ensure that a subgroup endorsing the pathological symptoms does not hijack the group. For example, after 9/11, the prevalence of malicious mischief in New York City and surrounding suburbs increased dramatically (West Chester County, New York, police officers, personal communication, October 19, 2001). Two adolescents, who each had become engaged in nightly vandalizing of cars, were both in the group. At first, when either recounted an episode of vandalism, the other joined in a gleeful manner, which fueled the exuberance of both. Most of the group then connected to this enthusiasm and joined in the excitement, totally derailing, for a time, any discussion of the

underlying sadness creating the need to act out.

As in all groups, the membership should reflect balance in terms of personalities. A mix of extraverted, vibrant energetic adolescents with more thoughtful, quiet, introverted types provides a good working balance for growth in the individuals. A group comprising adolescents with varied levels of social sophistication can actually be helpful to all members. The very differences can create healthy discussions and growth.

In one post-9/11 group, Andy and Jim, two boys who had both stopped doing any school work altogether, were bragging about their exploits in avoiding responsibility. Rachel, one of the girls in the group, was clearly shocked by what she was hearing. Rachel had lost her father in 9/11 and subsequently withdrew into books, becoming quite isolated. She was overly identified with her dad and, because of her parentified manner, usually on the periphery of the group. After listening to the boys for a while, she broke in, asking them if they ever wanted to get married because she thought no girl would want to marry someone who was so irresponsible. Emily and Jenny, much more socially engaged than Rachel, previously had distanced themselves from her, but now joined Rachel in her feedback to the boys. All three girls collaborated in rebuking the boys. For the first time since she joined the group, Rachel's eyes twinkled as she sensed a connection to the other girls. As they left that day, the three girls walked out together, chatting.

Closed Versus Open Groups

Groups that are time-limited in nature are focused, often highly structured, and closed to new members once they begin. They often follow a curriculum. Introducing new members midway can be very disruptive. Open-ended groups are more geared toward longer-term exploration of issues. They can more easily assimilate new members at different points in the group's development. These groups also tend to include higher functioning adolescents, for example, adolescents who are not actively expressing suicidal ideations, engaging in substance abuse, or severely depressed as a result of the trauma.

Group Size

We recommend 8 members as optimal, which allows for the absence of a couple of members, without diminishing the size of the group significantly.

Group Rules

It is important that all group rules are discussed with each member before they enter the group. Some therapists advocate having the adolescent sign a written agreement, acknowledging an acceptance of the group rules. These rules should

include attention to the following issues: confidentiality, attendance, outside contact, and nature of the relationship with the group members (Kahn, 1992). A discussion of each follows.

Confidentiality

It is agreed that everything said in the group as well as the identity of all group members is confidential forever and is not to be shared with anyone outside of group, including family and friends. The therapist should be allowed to share themes or pertinent information with the group member's individual therapist or psychopharmacologist. It is important to be explicit that the therapist will *not* share information with the adolescent's family, except if the member is engaging in self-injurious behaviors, engaging in activities dangerous to themselves or others, or being abused. In these situations, it is understood that the therapist is legally bound to report the danger or potential danger/abuse.

Attendance

It is expected that each member will attend every session. In longer term groups, three absences in each calendar year are allowed without charge.

Outside Contact

It is agreed that contact outside of group will be for therapeutic purposes only (Stone & Rutan, 1993). *Therapeutic purpose* means a healthy, constructive purpose. For traumatized, isolated adolescents, socializing with other members to combat loneliness can be therapeutic. These peer connections can be beneficial to the traumatized adolescent's recovery.

It must be made clear that the relationships will be platonic only. It has been our experience that romantic/sexual relationships that develop between group members destroy the sense of safety within the group and often lead to group forces and interactions that are destructive and undermine the fabric of the group.

LEADERSHIP ISSUES WITH A THERAPY GROUP FOR TRAUMATIZED ADOLESCENTS

Successful leadership of a group for adolescents requires an active therapeutic stance. The leader needs to speak plainly and authentically in a down-to-earth manner. Although it is necessary to find a common ground for dialogue, too much slang by the leader may reflect an overidentification with the adolescents and a blurring of boundaries, leaving a void in the group leadership, rather than being the adult leader who provides safety and stability for the traumatized adolescents.

The leader's active stance might entail setting firm limits and having a fair degree

of tolerance for anger and frustration. Adolescents can be quite adept at testing the limits and being provocative toward the group leader. Personal questions may be asked of the leader. It is important to remember that some of these questions may represent the adolescents' efforts to get to know and trust the leader. In a group for traumatized adolescents, the group asking the leader if he or she ever experienced loss may not be an effort to provoke the leader as much as an attempt to see if the leader can truly understand and empathize with the adolescents' experiences.

Hallowitz (1990) suggested that personal questions directed to the group leader by the adolescents might stem from a real curiosity to understand how a respected adult functioned—what choices he or she made, and why. The adolescents might be searching for a role model and really need to hear the personal answers that an adult had found for himself or herself.

The role of the leader may also entail holding the difficult affects expressed in the group until members are ready and able to introject these affects and more readily integrate them. Traumatized adolescents may be filled with unbearable feelings and memories, many of which they cannot put into words. Such feelings remain unprocessed and unmetabolized. The leader must demonstrate a willingness to be open and listen to the experience. Holding and accepting these difficult experiences may entail the therapist's teaching the group members relaxation techniques or deep breathing exercises to better deal with acceptance of such affects. Ziegler and McEvoy (2000) defined the central task of the trauma group therapist to be the creation of a safe "holding environment" (Winnicott, 1965), in which group members recover from traumatic injury and regain a connection to life.

MANAGING COUNTERTRANSFERENCE REACTIONS SPECIFIC TO TRAUMA

Overidentification and Avoidance

Generally, adolescent group therapists may be susceptible to concordant identifications with adolescents. The urge to compete with the adolescent's family, rescue, and reparent the adolescent may also be present. These identifications may be particularly strong in a case of trauma, especially when the therapist has experienced the same trauma (as happened in New York following 9/11 and in New Orleans following Hurricane Katrina). This may lead to the therapist both colluding with the group and avoiding discussion of the trauma in a group. Alternatively, the therapist may adopt a rigid, professional stance so as to avoid empathic engagement with the group, which could lead to overpowering affect. Supervision and consultation (e.g., caring for the caregivers) can be useful in this regard. Debriefing in the safety of the consultation sessions offers an opportunity for the leader to deal with the traumatic resonance that he or she may experience.

Induced Feelings of Being the Victimizer

Trauma survivors may develop representations of themselves as victims and representations of others as victimizers. These relational configurations may be enacted via projective identification in group. For example, anger about the traumatic event and its aftermath may be enacted in group, with the adolescents attempting to provoke the leader. The leader may join the group in directing anger at the perpetrators, in some cases, or at those outside of the group, for example, the parents. Once the anger enters the group, it may be expressed at the leader through provocation. The group leader may enact the role of a harsh, punitive, critical figure, in essence recreating victimization of the adolescents and reinforcing the adolescents' self experiences as powerless and victimized. Such enactments are, of course, inevitable, but exploration of them in group may help the members develop insight into their roles and their ability to recreate the trauma in different relationships.

Vicarious Traumatization

Pearlman and Saakvitne (1995) described *vicarious traumatization* as "the transformation of the inner experience of the therapist that comes about as a result of empathic engagement with the clients' trauma material" (p. 31). The concept has also been called *contact victimization* (Courtois, 1988) and *secondary posttraumatic stress disorder* and *compassion fatigue* (Figley, 1995). Most writers do not address the specific impact of traumatic material on the therapist. In trauma work with an adolescent group, it is essential that the group therapist monitor his or her responses to the adolescents and be aware of enactments that may alert the therapist to feelings of being traumatized himself or herself. Of course, such reactions are more complicated when the therapist has himself or herself been a victim of the same trauma (e.g., a community trauma such as a devastating fire in the town in which both therapist and adolescents live). Cotherapy, supervision, and/or consultation are critical for the group therapist working with traumatized adolescents.

Managing Anger and Difficulties With Authority

Adolescents traumatized by 9/11 frequently developed contempt for adult authority. Sentiments such as "Those in charge had been sleeping on the job. See, adults don't know what they are talking about. Don't even bother to listen to them. They shouldn't be in charge" were frequently heard in group therapy, with accompanying devaluing of the group leader.

In these situations, where the therapist is faced with the challenges of an adolescent in the throes of an intense negative transference or with severe difficulties with authority, the therapist needs to maintain his or her own center and contain any impulses to join in a destructive battle. Instead, it is of prime importance that

the therapist's response be one of calm validating of the group member's position, letting him or her know that the leader understands how he or she feels. If the group member has felt injured by the therapist, this must be validated, and effort must be spent to lessen the effects of the bruising. The wise therapist will also move away from a one-on-one encounter, encouraging the other group members to join the discussion with their feedback.

CONCLUSION

Recent events have underscored the need for therapeutic intervention after a traumatic event. Adolescents who have suffered trauma are particularly in need of therapy because the trauma interrupts their normal cognitive and emotional growth. In the days after 9/11, many families were impaired by their losses; thus therapy groups played an extremely important role in providing support and a healing space. For adolescents who are still in developmental flux, group treatment can be a powerful tool in the treatment of trauma. With proper selection of group members and a well thought out group contract that provides structure, group therapy can provide a safe space in which the adolescent can find commonality with others; understand the sequelae of trauma; and continue cognitive, social, and emotional growth. An active, attuned group leader, knowledgeable in both developmental norms and trauma theory, able to handle powerful negative or positive transferences, and aware of and able to manage his or her own countertransference issues, can help create safety in the setting where adolescents feel most comfortable—the group.

REFERENCES

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Association.

Aronson, S., & Kahn, G. B. (2004). Group interventions for treatment of trauma in adolescents. In B. J. Buchele & H. I. Spitz (Eds.), *Group interventions for treatment of psychological trauma* (pp. 89–113). New York: American Group Psychotherapy Association.

Aronson, S., & Scheidlinger, S. (2002). *Group treatment of adolescents in context: Outpatient, inpatient and school.* Madison, CT: International Universities Press.

"A bad day for attendance in city schools." (2001, November 1). *The New York Times*, p. D1.

Blos, P. (1967). The second separation–individuation process of adolescence. *Psychoanalytic Study of the Child, 22*, 167–191.

Courtois, C. (1988). *Healing the incest wound: Adult survivors in therapy.* New York: W. W. Norton.

Erikson, E. (1959). *Young man Luther.* New York: W. W. Norton.

Figley, C. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in*

those who treat the traumatized. New York: Brunner/Mazel.

Hallowitz, E. (1990). *Group treatment of adolescents.* Paper presented on a panel at the American Orthopsychiatric Association, Miami Beach, FL.

Janoff-Bulman, R. (1992). *Shattered assumptions: Toward a new psychology of trauma.* New York: Free Press.

Johnson, R. J., & Lubin, H. (2000). Group psychotherapy for the symptoms of posttraumatic stress disorder. In R. H. Klein & V. Schermer (Eds.), *Group psychotherapy for psychological trauma* (pp. 141–169). New York: Guilford.

Kahn, G. B. (1992). *Adolescent groups: Mastering your fear: Guiding process.* Paper presented at the annual meeting of the American Group Psychotherapy Association, New York.

Kandel, E., Schwartz, J., & Jessell, T. (2000). *Principles of neural science.* New York: Appleton and Lange.

Keyser, J., Seelaus, K., & Kahn, G. (2000). Children of trauma and loss. In R. H. Klein & V. Schermer (Eds.), *Group psychotherapy for psychological trauma* (pp. 209–238). New York: Guilford Press.

Mahler, M., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant.* New York: Basic Books.

Pearlman, L., & Saakvitne, K. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors.* New York: W. W. Norton.

Scheidlinger, S. (1985). Group treatment of adolescents: An overview. *American Journal of Orthopsychiatry, 55,* 102–111.

Siegel, D. J. (1999). *The developing mind: How relationships and brain interact to shape who we are.* New York: Guilford Press.

Stone, W. N., & Rutan, J. S. (1993). *Psychodynamic group psychotherapy* (2nd ed.). New York: Guilford Press.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York: W. W. Norton.

van der Kolk, B. (1997, March). Posttraumatic stress disorder and memory. *Psychiatric Times,* 14(3). Retrieved November 14, 2007, from http://www.psychiatrictimes.com/p970354.html

Wallerstein, J. S., & Blakeslee, S. (1989). *Second chances: Men, women and children a decade after divorce* (2nd ed.). New York: Ticknor and Fields.

Winnicott, D. (1965). The theory of the infant–parent relationship. In *The maturational processes and the facilitating environment* (pp. 37–55). New York: International Universities Press.

Ziegler, M., & McEvoy, M. (2000). Hazardous terrain: Countertransference reactions in trauma groups. In R. Klein & V. Schermer (Eds.), *Group psychotherapy for psychological trauma* (pp. 116–140). New York: Guilford Press.