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Group Therapy as an Ecological Bridge to New Community for Trauma Survivors

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Abstract

Group therapy counteracts the isolating effects of interpersonal trauma and enables survivors to connect with sources of resilience within themselves and others. By providing an alternative relational experience in which the survivor and her safety are valued, groups empower members to establish self-affirming and supportive relationships in their outside lives. The current paper reviews the psychological impact of chronic interpersonal violence and the relevant literature regarding group therapy for trauma survivors. We describe an approach to group treatment for complexly traumatized patients developed at the Victims of Violence Program, and through a clinical vignette, illustrate some of the ways in which group therapy can expand the relational world of survivors.

Key words: group therapy, interpersonal trauma, abuse, posttraumatic stress

Groups as an Ecological Bridge to New Community for Trauma Survivors

Interpersonal trauma violates one's sense of safety in the social world. Profound isolation results from ruptured trust, shame, fear of future violence, and the wide range of protective or defensive measures that victims develop in the wake of trauma, particularly under conditions of chronic exposure. In isolation, victims are prevented from functioning to their fullest capacities. Their personal power and competence are diminished by post-traumatic symptoms, a shattered sense of meaning, and disrupted self-cohesion. Additionally, in the context of abusive relationships characterized by domination and subordination, survivors are taught to devalue themselves and their physical and emotional safety, frequently placing them at risk for further trauma.

We conceive of individual and group psychotherapy for trauma survivors as transitional spaces within which they can restore foundations of safety within themselves and with others. Individual therapy offers survivors an opportunity to develop trust and experience the possibility of a safe hierarchical relationship. Groups provide survivors with experiences of community that counteract their isolation and enable them to connect with sources of resilience within themselves and others. Importantly, groups also offer a model of reciprocal relationships marked by caring and compassion. They serve as a microcosm in which survivors can rework problems associated with their traumatic past within a safe and structured relational network. The norms of the group stand in sharp contrast to those of the original abusive relationships, and provide a framework within which survivors can learn to value themselves and their safety. They are empowered to seek out affirming and compassionate relationships in their lives outside of group; it is in this way that groups serve as an ecological bridge to new community.

In this article, we briefly review the effects of interpersonal trauma and the empirical

evidence regarding group treatment efficacy. We describe a model of group treatment designed to meet various clinical needs and recognize the resilience of survivors of complex trauma at different phases of recovery. Using a clinical example, we demonstrate some of the ways in which group treatment can serve as an “ecological bridge” (Harvey, this issue); in other words, the ways in which it can facilitate transition from positions of helpless isolation, distrust, and withdrawal to positions of engagement within intimate, social, and community relationships.

Effects of Chronic Interpersonal Trauma

The psychiatric sequelae of chronic interpersonal trauma such as childhood abuse and domestic violence are considerably more diverse, numerous, and pervasive than would be suggested by the diagnosis of uncomplicated posttraumatic stress disorder (PTSD; American Psychiatric Association, 1994) that is frequently associated with single-incident or circumscribed trauma. In addition to PTSD, survivors of chronic interpersonal trauma often report symptoms of other anxiety disorders, major depression, dissociative disorders, conversion disorders and somatization, personality disorders, eating disorders, and substance abuse (Dube et al., 2001; Edwards, Holden, Felitti, & Anda, 2003; Felitti et al., 1998; Herman, Perry, & van der Kolk, 1989; Loewenstein, 1990). Adult survivors of childhood abuse are at increased risk for self-destructive behavior and suicide attempts (Boudewyn & Liem, 1995; van der Kolk, Perry, & Herman, 1991). Childhood sexual abuse is a strong predictor for revictimization in adulthood (Coid et al., 2001). Survivors of chronic interpersonal trauma are also more vulnerable to a variety of physical health problems (Drossman, Leserman, Nachman, Zhiming, Gluck, et al, 1990; Wurtele, Kaplan, & Keairnes, 1990).

Herman (1992a) formulated the concept of complex PTSD to describe characteristics of survivors of prolonged and repeated trauma commonly reported in the literature and observed in

clinical practice but not adequately captured by the narrow diagnostic criteria of simple PTSD. Complex PTSD involves three broad areas of disturbance: (a) a complicated and tenacious symptoms picture with multiple complaints, including somatization, dissociation, and affective dysregulation; (b) characteristic personality changes, including relational difficulties and disturbances of identity; and (c) vulnerability to repeated harm, either self-inflicted or perpetrated by others. The DSM-IV field trials (van der Kolk et al., 1996) confirmed that PTSD, dissociation, somatization, and affect dysregulation were highly interrelated, and that these problems co-occurred most frequently among survivors of early onset interpersonal trauma. Furthermore, a considerable proportion of participants who no longer met criteria for PTSD continued to suffer from high levels of these other symptoms.

Group Therapy for Survivors of Interpersonal Trauma

Group therapy has a number of unique advantages for survivors of complex trauma. Social disruption is frequently a primary effect of traumatic events (Sewell & Williams, 2001). It is thus not surprising that the power of group interventions lies in their potential to restore and rebuild social connections. Herman (1992b) identifies the experience of commonality as a central curative component of group therapy for trauma survivors. Joining with others who have experienced similar traumas creates a sense of belonging, reduces feelings of isolation and alienation, and provides support and understanding not available elsewhere. Groups are especially helpful in combating the sense of secrecy, shame, and stigma that characterize the experience of survivors of child abuse (Herman & Schatzow, 1984), rape (Koss & Harvey, 1991), or combat (Lifton, 1973). Groups provide an opportunity for previously unrecognized resilience among group members to be noticed and utilized. They promote empowerment by offering group members the opportunity to share coping skills and help one another. They foster

self-esteem as the survivor learns to value herself through establishing connections with valued others and experiencing their acceptance (Harney & Harvey, 1999). Allen and Bloom (1994) note that by virtue of its social and interpersonal nature, group therapy provides an excellent environment for repairing the cognitive schemas for safety, trust/dependency, independence, power, self-esteem, and intimacy that are often disrupted by psychological trauma.

Based on a comprehensive review of empirical studies of group psychotherapy for adult trauma survivors, Foy et al. (2000) found that regardless of approach, group psychotherapy was associated with favorable outcomes in a range of symptom domains. Abatement of PTSD and depression were the most commonly included outcomes, but efficacy was also demonstrated for other symptoms, including dissociation, self-esteem, anxiety, fear, and global distress. Beneficial effects have also been found in studies focusing specifically on victims of complex trauma (primarily adult survivors of childhood sexual abuse) and including a wide variety of group treatment approaches such as problem-solving (Richter, Snider, & Gorey, 1997), affect management (Zlotnick et al., 1997), psychoeducation (Lubin, Loris, Burt, & Johnson, 1998), body-oriented interventions (Westbury & Tutty, 1999), trauma-focused therapy (Classen, Koopman, Nevill-Manning, & Spiegel, 2001; Saxe & Johnson, 1999), and process groups (Carver, Stalker, Stewart, & Abraham, 1989; Hazzard, Rogers, & Angert, 1993). Commonly reported improvements involve reductions in PTSD symptoms (e.g., Lubin et al., 1998), depression (e.g., Richter et al., 1997), and dissociation (e.g., Zlotnick et al., 1997), as well as increases in self-esteem and locus of control (e.g., Hazzard et al., 1993).

Group Treatment at the Victims of Violence Program

The Victims of Violence Program (VOV) is an outpatient clinic of the Department of Psychiatry at the Cambridge Hospital, a public-sector hospital affiliated with Harvard Medical

School, which serves an economically disadvantaged, multi-racial, and multi-cultural population.

VOV provides victims of crime and violence with a range of clinical and community services, among which the group therapy program is a central component. Most VOV patients are survivors of prolonged and repeated interpersonal violence. Many are victims of chronic childhood abuse who have also experienced multiple traumas during their adult lives. Patients seeking services at VOV typically have a very complicated clinical presentation consistent with complex PTSD, as well as a variety of other stressors, such as unemployment, housing difficulties, and health concerns. Their comorbidity, multiple risk factors, and adverse life circumstances would frequently serve as exclusion criteria for many other types of group treatment.

The VOV approach to group therapy has several distinguishing features. It is informed by an explicit theoretical framework for trauma recovery, and uses this theory as a basis for focusing treatment, identifying existing sources of strength, and matching patients to appropriate groups. Group guidelines and support are used to provide a framework for the development of individualized treatment goals. The connections among group members are mobilized to rebuild relational capacities damaged by trauma. Co-leadership by therapists is intentionally designed to provide an alternative relational model. All VOV groups “model” the norms and values of safe and supportive community ecosystems.

Stages-by-Dimensions Approach

The VOV utilizes a model for trauma recovery that integrates (a) an ecological view of trauma (Harvey, 1996); (b) recognition that recovery from trauma unfolds in a progressive, identifiable series of stages (Herman, 1992b); and (c) a multifaceted definition of what constitutes recovery and resilience (Harvey, 1996). The ecological framework (Harvey, 1996,

this issue) draws upon the theoretical premise of community psychology to emphasize the complex interactions of individuals and their environments (Kelly, 1968, 1986; Moos, 2002), the reality of varied - even resilient and agentic - adaptations to conditions of extreme adversity (Riger, 2001; Sandler, 2001), and the viability of both clinical and community interventions (Cowen, 1994; Koss & Harvey, 1991). Within this framework, individual variations in traumatic response are attributed to a complex interplay of person, event, and environmental factors. These factors interact dynamically to produce individual difference in posttraumatic response and recovery. Thus, to be effective, interventions must be attuned to and achieve “ecological fit” with the survivor’s unique personal, interpersonal, environmental, and socio-cultural circumstances. The ecological perspective provides an overall framework for assessing the symptoms and strengths and formulating the care of patients seeking treatment at the VOV (Lebowitz, Harvey, & Herman, 1993).

The stage model of trauma recovery developed by Herman (1992b) is based on the assumption that helplessness, meaninglessness, and disconnection from oneself and others are central components of the experience of interpersonal trauma. Empowerment and the creation of new meanings and connections are thus key aspects of the recovery process, which unfolds over three stages. The initial treatment goal and first stage of recovery involves the establishment of safety. This focus may begin with the body (e.g., regulation of basic functions such as sleep and eating; management of intrusive PTSD symptoms; control over self-destructive behaviors) and proceed outwards to the environment (e.g., establishment of a safe and stable living situation; attention to issues such as work and money). Only once safety is established can recovery move to the next stage where the focus is remembrance, integration, and mourning. The therapeutic work of the second stage involves carefully paced in-depth exploration of the traumatic experience(s), with

the goal of integrating memory, affect, and cognition, rather than simply facilitating catharsis. This stage inevitably involves a period of intense grief and mourning, during which the victim is sustained by his or her connections to the therapist and peers, the hope of building new, more adaptive relationships, and the creation of new meaning in the traumatic experiences. The third stage of recovery involves reconnecting with others through the process of establishing mutual, non-exploitative relationships. The survivor may have to renegotiate the boundaries and limits of longstanding relationships, particularly those that have been abusive (Herman, 1992b; Lebowitz et al., 1993). The value of a phase-oriented approach to working with trauma survivors has been recognized across theoretical orientations and is now a core feature of many treatment models (Ford, Courtois, Steele, van der Hart, & Nijenhuis, 2005).

The VOV uses criteria developed by Harvey (1996) for assessing resilience and conceptualizing recovery in eight interrelated domains. These include (a) authority over memory: the process by which survivors experience a sense of choice and control over the remembering process; (b) integration of memory and affect: the extent to which survivors experience their memories as interwoven with feeling, including new feelings born of remembering and reflecting on the past; (c) affect tolerance: the degree to which survivors can bear painful feelings and experience their emotions in a differentiated way; (d) symptom mastery and positive coping: the extent to which survivors can anticipate, manage, contain, or prevent the cognitive and emotional disruption that arises from posttraumatic arousal; (e) self-esteem (self-care and self-regard): the degree to which survivors experience themselves as worthy of care and behave in ways that promote their best interest; (f) self-cohesion: the extent to which survivors can experience themselves as integrated or fragmented in regard to cognition, affect, or behavior; (g) safe attachment: the survivor's ability to negotiate and maintain personal safety within

relational contexts and to develop feelings of trust, safety, and enduring connections with others; and (h) meaning-making: the process by which the survivor assigns new meaning to the trauma, to the self as survivor, and to the world in which the trauma occurred (Harney & Harvey, 1999; Harvey, 1996).

The stage model and the recovery criteria reviewed above can be integrated by using the eight criteria as dimensions of psychological functioning to be examined across each of the three stages of recovery. We call this a “stages-by-dimensions” analysis. This approach produces a matrix that can be used to identify the central tasks and sources of resilience within each dimension at each stage, thus providing a well-defined focus for treatment as well as explicit recognition of the specific strengths that the survivor brings to the recovery process. It is important to note that this model does not imply an invariant progression from one stage to the next in all domains. Rather, recovery is conceptualized as a dynamic process in which the individual may be more recovered and resilient on some domains than in others. He or she may move back and forth between stages based on the nature of the traumatic material encountered at the time, current life stressors, and the total resources of the individual. Survivors will also not typically be at one stage on all dimensions at one time. As treatment progresses, however, a consolidation of gains is expected, reflected in increased coping skills, increased integration of traumatic memory, and a more balanced perception of self and the world (Harvey, Liang, Harney, Koenen, Tummala-Narra, et al., 2003; Lebowitz et al., 1993).

Stage-based Matching of Patients to Treatment

A major contribution of the VOV group treatment approach is its well-developed rationale for how to match patients to appropriate group treatments based on their stage of trauma recovery and the domains in which they experience greatest difficulty. Stage 1 groups are

offered to patients whose primary needs involve the establishment of safety, stability, and self-care. These groups have a didactic format with an emphasis on helping participants develop behavioral, cognitive, and psychosocial skills for managing their symptoms and caring for themselves appropriately. They are present-focused and actively discourage significant disclosure of trauma histories to protect group members from becoming overwhelmed (Harney & Harvey, 1999). The VOV program currently offers three Stage 1 (safety and stabilization) groups: (a) Trauma Information Group, a manualized psycho-educational group where participants learn about the effects of trauma (Glass, Hamm, & Koenen, 1998); (b) Stress Management Group, a group aimed at helping participants achieve mastery over posttraumatic symptoms (Flannery, Perry, & Harvey, 1993); and (c) Safety and Self-Care Group (SSC), a group for participants who actively harm themselves or care for themselves in otherwise inadequate or self-destructive ways (Harney & Harvey, 1999). Survivors are ready for a Stage 2 group when safety and self-care are reasonably established, symptoms are under a comfortable degree of control, social supports are reliable, and life circumstances permit engagement in the demanding endeavor of trauma-focused work (Herman, 1992b). The VOV program offers separate Stage 2 groups for women and men, as well a Co-ed group. These groups have as their focus the integration of the traumatic past with patients' present lives. A new group called Passageways was recently created to bridge the first and second stages of recovery, using expressive techniques. Stage 3 groups are not usually offered within VOV, partly due to the nature of the patient population served by the program and partly because heterogeneous psychotherapy groups that focus more generally on interpersonal issues are often more appropriate for individuals in this advanced stage of recovery than groups that revolve around their identity as trauma survivor.

Focus on Individual Goals

During the screening process and early group sessions, members are helped to formulate specific individual goals attainable within the lifespan of the group that organize and focus their group work. The type of goals set for Stage 1 versus Stage 2 groups will clearly vary; patients in Stage 1 groups will work on goals related to safety, stabilization, and self-care, whereas the goals of patients in Stage 2 groups will focus on the integration of past trauma within their current lives. The stages-by-dimensions approach provides a helpful framework for identifying appropriate treatment goals.

Relational Focus

A fundamental characteristic of the VOV treatment groups is the utilization of the connections that develop among group members as a central vehicle for change, with the underlying idea that the damage created by interpersonal trauma can only be corrected in a safe relationship. Although the interpersonal process among group members is not the focus of these groups, they rely heavily on the interpersonal context to facilitate the progress of individual group members. For example, a key aspect of these groups involves giving and receiving empathic feedback, and time is specifically allotted for this purpose after each member shares his or her goal-related work. Group leaders model the empathic feedback process and help members do the same. This feedback process is distinct from the process of “trading stories,” and provides members with a reparative experience of mutuality and equality that counteracts the experiences of humiliation and subordination so familiar to the patients we treat. The group is also used as a powerful context in which survivors can rework maladaptive attributions about themselves and their experiences in the here-and-now. Negative and self-blaming self-statements that impede recovery are actively confronted by others who have had similar experiences. The direct use of

the relational context of the group to facilitate healing distinguishes VOV group treatments from approaches that seek to effect change primarily by psychoeducation (e.g., Lubin et al., 1998), exposure and cognitive restructuring (e.g., Schnicke & Resick, 1993), skills training (e.g., Linehan, 1993), or other means.

Co-leadership

Co-leadership is a central feature of the VOV group program (Koss & Harvey, 1991). For the group members, co-leadership sets an example of a relationship of mutuality and collaboration in contrast to the relationships of domination and subordination that characterize the histories of so many patients. It provides an alternative experience of adult care taking, and models a cooperative and collective approach to solving problems and handling differences. It minimizes attributions of power and control to a single group leader. It also communicates the notion that one person cannot “do it all” without support. Co-leadership also has a number of important benefits for the group leaders. Most importantly, it provides therapists with the peer support and feedback that is essential in preventing vicarious traumatization and burnout (Yassen, 1995). In this way, co-leadership keeps the leaders safe so that they can extend safety to the group.

Having reviewed the literature on group therapy for interpersonal trauma and described the VOV approach to group treatment, we now present a vignette reflecting some of the ways in which groups can mobilize the resilience of individual members and function as a bridge to new community at different stages of recovery. Identifying details have been changed to protect patient confidentiality.

Clinical Vignette: Lisa

Lisa was a participant in the Women’s Time-Limited (WTL) group, a prototypical Stage 2 group for patients who have achieved sufficient safety and stability to look more directly at

their traumatic experiences and their impact. This group involves active exploration of survivors' trauma histories with the overall aim of integrating memories and feelings about their past into their present lives. Participants included in such groups are typically doing reasonably well in their life, have several supportive relationships and a steady, strong individual therapy that addresses the impact of their trauma history, are involved in some consistent work or study, and have been free of any self-harming behaviors for at least one year. The specific domains of trauma recovery targeted by the WTL group include authority over memory, integration of memory with affect, self-esteem, safe attachment, and meaning making.

The clinical example of Lisa illustrates the ways in which the secrecy that fostered divisions within this patient's family, and then within herself, was replaced over the course of the group with a sense of choice about her ability to remain private or disclose her thoughts, feelings, and experiences. Increased abilities to integrate memory with emotion led Lisa to a stronger sense of self, which in turn, enabled her to widen her social support network significantly.

After six years of individual therapy, Lisa felt ready to join a psychotherapy group for female trauma survivors. Her therapist had suggested group treatment through the years, but Lisa's anxiety and fears about possible condemnation from a group made this a dim possibility until this point. Lisa had assembled a life of which she was quite proud, given the tumult of her earlier years. She had a solid relationship with her partner, and was the parent of a daughter, now four years old. She was a conscientious professional, respected for her careful work yet unknown to any social degree by her colleagues. She had a few good friends, but was always aware of an inner pressure to be pleasant and keep herself tucked away. Her partner was her steady confidante. To Lisa's own amazement, she widened her support by establishing an intimate

rapport with her therapist.

Shame and self-blame were central themes early in her individual therapy. She had been abused by her father, a man beloved in the community for his humor and helpfulness. He had begun sexually abusing her when she was about four years old and continued until she reached puberty. Its end was marked by a bitter confrontation. Lisa's rage stood in stark contrast to the dissociative demeanor that she usually assumed when her father was near. Lisa suspected that her mother always knew about the abuse. She never addressed this issue with her directly, out of a desire to avoid feelings associated with this profound betrayal. She had one sister; the abuse by her father had created a deep sense of division between the two. Initially, she felt that she protected her sister by enduring the abuse. Later, she yearned to confide in her sister, but feared that she would not be believed or that she would taint her sister's seemingly close relationship with their father. Now in her adulthood, Lisa rarely saw other members of her family, all of whom resided in another state.

Disclosing the abuse to her sister was Lisa's primary goal as she interviewed for the WTL group at the VOV. She was apprehensive, though reachable, during the interview. She called to cancel her interest in the group not long after this first meeting. She stated that she did not know how she would mesh with the other members, and feared that her account would not be taken seriously. These fears were normalized for Lisa. Joining a new community, particularly one of abuse survivors, was understandably fraught with fear and anxiety for her. She had learned in the proverbial first group – namely, her family of origin -- that betrayal was insured and isolation was her only protection. This lesson had now outlived its usefulness, however, and she acknowledged her restlessness to shed what had become a stifling armor. Rather than abandon her fears, she agreed simply to see if her worries would be confirmed. She closed this

conversation with a renewed zest to begin group.

In the first few weeks of the WTL group, as expected, Lisa felt extremely shy and anxious. She fought the urge to dissociate, and would speak in a quiet, wavering voice, barely able to make eye contact with the other members. Her goal to disclose to her sister was broken down and it was recommended that she initially aim to speak about some aspect of her experience within group, with affective presence. Breaking the silence with a group of peers would be the first step toward breaking the silence with her sister.

Concurrently, Lisa witnessed the work of others in the group. The members felt her presence when they spoke. She gave thoughtful, heartfelt comments in response, and earned their respect and compassion. She was remarkably able to discuss the aftermath of revealing more of herself in group. She would refer to feeling anxious or dissociated, or signal that her fears of being disbelieved or disliked were activated. These statements served as an invitation for the other group members to help her alter the internal script that she would be betrayed if seen. They affirmed what she had shared and let her know how they experienced it, contradicting the toxic response that she expected. They would help her ground herself if needed, and praise her for the risks she was taking. As the group progressed and this graduated exposure to her past continued, Lisa appeared more embodied. She laughed more often, indulged in sarcasm, and shared poignant memories.

By the time the group moved toward its final five weeks, Lisa decided to forego her initial goal and not disclose to her sister. She felt it would be too rushed. She realized that the important preparation she needed – rehearsing the disclosure, exploring her hopes, assessing likely outcomes – would require much more time. At this point, the group and the group leaders could see the growing impact of her work as Lisa became more confident in

evaluating her needs and in considering what was important to her in this process. She expressed contentment in her therapeutic work, and gradually wanted to disclose more until the close of the group. Her use of the relational connections in the group impacted her authority over memory. Memories that at one point had seemed terrifying to share she was now able to approach incrementally. Lisa's memories were varied and contextual. There was a sense of release when she would speak to her childhood experience, as if the lens was finally sharpening. Armed with the validation of attentive group members, her experience began to take a narrative shape, told in a somber, adult voice.

Lisa also utilized her experiences in the group to rework her sense of relationship with other people in her life. Faced with an upcoming family event, she used the group to strengthen her ability to let her sister know that she would bypass that gathering but wanted to make alternative plans for their own individual families to get together. This was something she had not dared do in the past. Similarly, she considered approaching her mother for some private time, something her mother historically was loath to do for fear of alienating her husband. She rehearsed what she might say, surprising herself with the sudden grief she felt at how much had been lost between the two of them.

Lisa was as reluctant to end group as she had been to begin. She laughed heartily about this at the end of the group. She planned to participate in another such group at some point in the future, after having fully digested this experience. Her accomplishments were evident to herself as well as to the other group members. Not only did Lisa have a more authentic relationship with her family, but she had shed her reflexive secret stance and became more open with others about her present life. A few months after the group's end, for example, she hosted a party at her home for her colleagues for the first time. The group provided a crucial template of acceptance that she

could now transfer to another social setting.

Conclusion

The groups described in this paper were developed to address different therapeutic goals depending on a survivor's stage of recovery and dimensions of psychological functioning most affected by trauma. They have in common an underlying ecological perspective that focuses attention on the group member's relationship with her environment at each stage of recovery. Thus, early in recovery when the goal of treatment is the establishment of safety and self-care, the group focuses not only on assisting the individual stabilize her symptomatic response, but also on helping her secure physical and emotional safety in the larger world. Later in recovery when reviewing the past becomes the focus of treatment, the group work draws attention to the ways in which the member's larger world may have kept her from seeking safety or caused her devalue herself. Consideration is then given to qualities of the larger environment that signal safety, support, and validation (replicated in group rules, values, and boundaries).

In the clinical vignette, we see an example of how group treatment, through its provision of an alternative relational experience, offers survivors the opportunity to rebuild the sense of belonging, connection, and community that trauma destroys. A commonality among the groups described here is the belief that a safe, structured network of relationships among peers and authority figures creates a crucible within which the isolation and alienation felt by trauma survivors can be reduced, their self-worth can be strengthened, and their values and expectations regarding interpersonal relationships can be reworked. In the clinical example, we see both the terrible legacy and enduring resilience that Lisa brought to the experience of group treatment. We see, too, evidence of how the group mobilizes the resilience of the individual member and how the anchoring of self to safe others in the treatment setting creates a bridge to new outside

relationships. Lisa's ability to talk about her abuse in the group and thereby receive the support, empathy, and respect accorded to her was a veritable antidote to the years of invisibility and silence that she endured. As a result, she reclaimed parts of herself that had been shut down, and then reclaimed aspects of the relationships with her sister and mother that had not seemed possible previously. She was also more able to engage socially with her colleagues and integrate different aspects of her life. Lisa used group therapy in a way that fundamentally shifted her experience of herself and her relationships in her life beyond the group. In this way, groups function as bridges out of worlds in which violence and abuse, shame, and secrecy are familiar realities to new worlds in which survivors are able to seek and find membership in communities that reject violence, offer safe haven, and affirm the value of intimate, caring, and compassionate relationships.

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