

GROUP THERAPY WITH ADOLESCENT GIRLS IN FOSTER CARE:  
A TREATMENT MANUAL FOR CLINICIANS  
AT THE RUTGERS FOSTER CARE COUNSELING PROJECT

A DISSERTATION

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## ABSTRACT

The estimated 513,000 children presently living in foster care in the United States are at particularly increased risk for mental health problems as a result of neglect and physical, emotional and sexual abuse endured in their dysfunctional family settings. They experienced traumatic separation from their homes, families and friends and ongoing disruptions to their daily lives. However, only twenty percent of foster children in need of mental health services actually receive them. In response to this deficit in services, this treatment manual was created to provide clinicians, specifically within the Foster Care Counseling Project (FCCP) at Rutgers University, with a tool that helps them provide group therapy for adolescent females in foster care. This manual is intended to give clinicians basic theoretical knowledge about group psychotherapy, adolescence, and the foster care population, as well as provide a sense of structure and practical guidance on the process of facilitating a group of this nature. It is a resource that outlines logistics that need to be anticipated prior to the first group session; supplies handouts and important forms; describes the different stages of group development and potential challenges that may arise; and recommends activities created to meet the therapeutic needs of the foster care population as well as the developmental needs of adolescents in general. Although this manual was based on a therapy group for adolescent females within the FCCP, most principles and activities can be applied beyond this particular population and agency.

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Nothing makes us so lonely as our secrets.  
Paul Tournier

Für Marie.

In unbekannter Verbundenheit.



## CHAPTER I

### BACKGROUND INFORMATION

#### I. DESCRIPTION OF THE POPULATION

##### 1.1. Statistics/Prevalence

According to the most recent statistical publications, an estimated 513,000 children currently live in foster care in the United States (AFCARS, 2005). Between 1980 and 2003, the number of children and adolescents in foster care almost doubled. The Child Protection Data Report published by the Association for Children in New Jersey, however, suggests that the prevalence rate (of foster children in New Jersey at least) has plateaued in the last few years (ACNJ, 2007). The report indicates that the number of children entering foster care in New Jersey has remained more or less steady over the last years (although the total child population in New Jersey has grown), while the number of children exiting care has increased. According to Simms, Dubowitz & Szilagyi (2000), further positive trends in foster care include “reliance on extended family members to care for children in kinship care placements, increased efforts to reduce the length of placement, acceleration of termination of parental rights proceedings, and emphasis on adoption” (p. 909).

In 2007, twenty percent of the 51,255 children that were under Division of Youth and Family Services (DYFS) supervision in New Jersey lived in out-of-home placements (ACNJ, 2007). Out of these 10,342 children that were removed from their biological

families, forty-seven percent lived in non-kin resource families, thirty-six percent lived in kinship care, fifteen percent in residential settings and group homes, and two percent in independent living facilities. Forty percent of the children stay in foster care for less than one year, almost thirty percent stay between one and three years, and almost a third of these children remain in foster care for more than three years. Race and ethnicity data on the state as well as the national level revealed a shocking overrepresentation of Blacks in foster care. ACNJ statistics showed that more than twice as many Blacks as Whites were in out-of-home care in 2007, which is especially disturbing considering that Black children make up only about sixteen percent of New Jersey's child population, in comparison to fifty-seven percent for Whites.

In regard to age distribution, infants and children between age 0 and 5 make up the largest group of children in out-of-home care. This may be due to the fact that there are higher safety standards for very young children. According to ACNJ, young children are more likely than older children to be removed from their homes if there is suspected mistreatment. The second largest group in out-of-home care is adolescents. Non-permanent exits (i.e. going to a juvenile detention center or medical facility; running away; death; deciding after age 18 to leave care; or passing age 21, at which point youth are no longer eligible for services) are not included in the already very high prevalence rate of adolescents in care (ACNJ, 2007).

Before giving a rationale for why group therapy is particularly valuable for individuals in care, one first needs to look beyond the published data. Who are these 513,000 children? What does it mean to be in foster care?

## 1.2. The Foster Care Experience

Most of the 513,000 children and adolescents in foster care share a similar fate: the majority of these young individuals know what it is like to be separated from their parents and siblings, they know what it is like to have the State child protective services as parents; they know what it is like to live in a chaotic environment; they know what it is like having to adapt to new places and people and what it is like to have to switch homes, schools and lose friends on a regular basis. They know what it is like to want nothing more than to get away from a dysfunctional home, and they know what it is like to want nothing more than to go back to that dysfunctional home to be reunited with their beloved-hated parents<sup>1</sup>. They know what it is like to feel “different”, to not “fit in”, and to have to answer difficult questions about being in foster care to peers who live completely different lives. They know what it is like to be neglected, rejected, physically, emotionally or sexually abused; they know about the impact of AIDS, drugs, parental mental illness and incarceration; they have experienced homelessness and hunger, witnessed domestic violence, death, diseases and suicides. They do not know what it is like to have a safe and carefree childhood. They are immature adults, brave survivors who have no sense of self-efficacy. They know all about hope, uncertainty and disappointment; they are the prototypes of both learned helplessness and resilience. They have learned that there is no such thing as stability. To them the world is an unsafe, unpredictable place and relationships are transient and untrustworthy. They have learned to expect and prepare for the worst and some of them have decided to just give up, as

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<sup>1</sup> Fairbairn (1952) offers a helpful explanation for this phenomenon: According to object-relations theory, the libido is not about seeking pleasure, but about seeking objects. It does not matter if the connection is pleasurable or not – a connection with others is an end in itself. This explains why foster children love and seek out their abusive parents, even if this connection is painful.

they are convinced that their future holds little promise for them - and so they enter adolescence with no reason to believe that anything worthwhile will be lost by dropping out of school, doing drugs, committing crimes or getting pregnant at a young age. Many of these children have attachment, identity, and trust issues. Closeness to them means threat, not comfort; it means becoming vulnerable. "If you do not get close to people, you won't get hurt" – this seems to be the motto of many of these children and adolescents. Intimate relationships are both desperately desired and deeply feared.

Despite the fact that these children all share a similar fate, many feel lonely and isolated because they do not know any other children who have similar backgrounds. This is in part due to the fact that children keep the fact that they are in foster care to themselves, as they are too ashamed, embarrassed and afraid to share this well-kept secret. So many of them "live a lie" in order to not get judged. Not sharing this "secret" prevents them from finding out that there are 512,999 other children out there who know exactly what they are going through.

Francine Cournos, a psychiatrist and former foster child, published an article in 1999, in which she talks about her traumatic experience of being in foster care; the "cycle of attachment and desertion"; her desperate attempts of finding her way "back to the child who knew the pleasure of being close to other people" (p. 479); her experience of starting psychotherapy at the age of 21 to work through her past and her worry regarding the lack of therapeutic services for today's foster children.

There are many silent foster children who have no adequate way of speaking about their experiences. [...] These hours of low-cost treatment continued for many years and were essential to re-establishing myself and becoming a successful wife, mother, friend, and professional. They were



also the key to finding the words that gave my experiences coherence and to discovering that I could make myself heard. I fear that many of today's foster children will never be given the resources or the opportunity to do the same.

(Cournos, 1999, p. 480)

## II. STATEMENT OF THE PROBLEM

### 2.1. Psychopathology among Children in Foster Care

The World Health Organization reports that almost twenty percent of children and adolescents worldwide experience some type of emotional or behavioral problem.

According to the U.S. Surgeon General, about every tenth child in America suffers from severe impairment due to a mental illness (Austin, 2004). APA's Public Policy Office published similar numbers and warned that "child and adolescent mental health problems are at a point of crisis for our nation" (APA, 2008).

While these numbers are upsetting, the prevalence of mental health problems of children and youth in foster care is even more shattering. Several studies have revealed that foster children have more mental health problems than the general population or the population of poor children. These studies indicate that as many as 80 percent of adolescents involved with child welfare agencies have behavioral or emotional disorders, developmental delays, or other issues requiring mental health interventions (Farmer, Burns, Chapman, Phillips, Angold, & Costello, 2001; Landsverk, Garland & Leslie, 2002; Taussig, 2002). According to these authors, their high risk for physical and mental health problems stems from the maltreatment they have experienced, the separation from their homes and families, and the ongoing disturbances to their everyday lives. Similarly, studies by dosReis, Zito, Safer, & Soeken (2001) and Halfon, Berkowitz, & Klee (1992) revealed that compared to other children, children in foster care show a

disproportionately high prevalence of mental disorders: between 50 and 80 percent of children in care suffer from moderate to severe mental health problems. According to Halfon, Zepeda, & Inkelas (2002) these high numbers are in part the result of experiences associated with dysfunctional family settings and the acute reactions to the traumatic experience of being placed in foster care and separated from parents and often siblings.

Recent studies that investigated the mental health of children in out-of-home care showed that these children display multifaceted psychopathology, characterized by attachment difficulties, relationship insecurity, unsafe sexual behavior, trauma-related anxiety, conduct problems, defiance, inattention/hyperactivity, self-injury and food maintenance behaviors (Tarren-Sweeney, 2008). Pilowsky & Wu (2006), who examined the prevalence of psychiatric symptoms and substance use disorders among 12-17 year olds with a lifetime history of foster care placement, found that foster care youth had more past-year psychiatric symptoms, more conduct symptoms, and more past-year substance use disorders than those never placed in foster care. Shockingly, they were about four times more likely to have attempted suicide in the preceding 12 months and five times more likely to receive a drug dependence diagnosis within the same time frame.

A report published by the Task Force on Early Mental Health Intervention investigated the impact of early risk factors on later mental health disability (APA, 2003). It suggested that the etiology of mental health problems can be divided into five categories: biological risk, genetic risk, family relationship risks, experiential risks, and social environmental risks. While exposure to one of these risk factors can be enough to

cause severe mental health problems, the majority of children in foster care experience several of these risk factors.

- Many foster children are prenatally exposed to alcohol, tobacco and other drugs, which have been found to have an impact on neuro-cognitive processes and behavior (Cornelius, Ryan, Day, Goldschmidt, & Willford, 2001).
- They often have caregivers who suffer from severe mental illnesses. Genetic studies have shown a disproportionate prevalence of neurobehavioral abnormalities in young children of schizophrenic and depressed mothers compared to infants of mentally healthy parents (Dawson, Frey, Panagiotides, Yamada, Hessel, & Osterling, 1999; Hans, Marcus, Nuechterlein, Asarnow, Styr, & Auerbach, 1999).
- Insecure attachment and maladaptive parenting styles, such as harsh punishment, inconsistent rule enforcement, poor anger control, verbal abuse, lack of emotional warmth and communication are experienced by many foster children and have been found to contribute to psychopathology in children even if their parents were not mentally ill (Johnson, Cohen, Kasen, Smailes, & Brook, 2001).
- Traumatic experiences, such as exposure to domestic violence, physical and sexual abuse, which are common among children in foster care, can lead to an increased risk for Post Traumatic Stress Disorder, depression, aggression, irritable bowel syndrome and externalizing behaviors (Buka, Stichick, Birdthistle, & Earls, 2001; Kendall-Tackett, 2000).
- Many foster care children were raised in disadvantaged communities, where they experienced poverty, homelessness, and discrimination, which is associated with poorer mental health outcomes (Booth & Crouter, 2001).

Garbarino & Bedard (2001) referred to these risk factors as “social toxicities” that “contain widespread threats to the development of identity, competence, moral reasoning, trust, hope...” (p. 41). As foster children are exposed to multiple social toxicities, it is not surprising that the prevalence rate for psychopathology is exceptionally high among this particular population. Hence, mental health services are of utmost importance for children and adolescents in foster care. Simms and his colleagues (2000), therefore, propose that health care practitioners improve the health of children in foster care by performing timely and thorough admission evaluations, providing continuity of care, and playing an active advocacy role.

## 2.2. Lack of Mental Health Services

A large number of studies have focused on the lack of mental health services that foster children receive despite great financial expenses. Geen et al (2005) published a paper in which they investigated Medicaid spending on foster children. They found that states distribute about ten billion dollars per year in state and federal funds to meet the physical and mental health needs of individuals in the child welfare system. They further found that there is a large state variation in Medicaid expenditures (New Jersey is among the top states in regard to both Medicaid spending and spending per enrollee), ranging from \$1,309 per child in Arizona to \$19,408 in Maine. They also discovered that states generally spend more money on infants and older children (relatively) as opposed to middle school age children; boys as opposed to girls; and Caucasian as opposed to African American and Hispanic children. Garland (1997) found similarly disturbing results in regard to racial and ethnic differences in court-referred pathways to mental

health services for children in foster care. She found that, in a sample of 142 foster care children between the ages of 2 and 16, Caucasian youth were more likely to receive orders for psychotherapy and to have documented use of psychotherapy than were African American and Hispanic youth, even when the potential confounds of age and type of maltreatment were controlled for. DosReis et al (2001) found that children in foster care consume fifteen to twenty times the amount of mental health services than other low income children covered by Medicaid.

In consideration of these enormous expenses, one would assume that the mental health needs of children in foster care are serviced. Unfortunately, this is not the case. Halfon et al (1992) revealed that only twenty percent of foster children in need of mental health services actually receive them. Phillips (1997), who investigated the psychiatric needs of children in foster care, found similar results: out of a sample of foster children, 80 percent were identified by social workers as requiring treatment from a mental health professional, though only 27 percent had received services. Placement instability, inadequate child mental health resources; and insufficient local authority funding were among the reasons given for not referring children for treatment. Another study investigated the contextual predictors of mental health service use among 2,823 child welfare cases. Results indicated that although 42.4% of the children had clinical-level Child Behavior Checklist (CBCL) scores, only 28.3% received mental health services during the investigated year. In regard to contextual factors, out-of-home placement, age, and race/ethnicity were found to be strong predictors of service use rates, even after controlling for CBCL scores. Greater coordination between local child welfare and mental health agencies was associated with stronger relationships between CBCL scores

and service use and decreased differences in rates of service use between White and African American children (Hulburt et al., 2004; Staudt, 2003).

Research seems to be congruent: children in foster care do not receive the mental health services they need in order to reduce psychopathology or counterbalance the many risk factors and traumatic experiences that they encountered throughout their lives. What are the long term consequences of the unavailability of services for these children?

### 2.3. Long-Term Consequences

Several studies investigated long term effects in the Adverse Childhood Experiences (ACE) Study. In a sample of 9,508 participants, Felitti and his colleagues found a strong dose-response relationship between the number of categories of childhood exposure (psychological, physical, or sexual abuse; violence against mother; or living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned) and the presence of multiple risk factors for ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease, all of which are considered to be the most frequent causes of death during adulthood (Felitti, 2001). More specifically, compared to those participants who have never been exposed to any of the ACE categories, participants who had gone through at least four categories of childhood exposure had 4- to 12-fold increased health risks for alcoholism, drug abuse, depression, and suicide attempt; a 2- to 4-fold increase in smoking; poor self-rated health;  $\geq 50$  sexual intercourse partners and sexually transmitted disease; and a 1.4- to 1.6-fold increase in physical inactivity and severe obesity. Participants who (similar to most children in foster

care) experienced multiple ACEs were likely to have multiple health risk factors later in life.

Several studies found shocking results in regard to dreadful experiences and suicide risk. Pilowsky found an increased risk for suicide attempts and drug disorders in individuals who have had a lifetime history of foster care placement (Pilowsky, 2006); Dube, Anda, Felitti, Chapman, Williamson, & Giles (2001), who also used the ACE study, found similarly disturbing outcomes. Dube and his colleagues found a highly significant, graded relationship between ACE score and suicide attempts during adolescence and adulthood. Compared with individuals with no adverse childhood experiences, the adjusted odds ratio of ever attempting suicide among individuals with at least seven experiences was 31-fold – though alcoholism, depressed affect, and illicit drug use, which are strongly associated with such experiences, seem to have partially mediated this strong association. The authors stressed that prevention of these experiences and the treatment of individuals affected by these risk factors may lead to progress in suicide prevention.

Unfortunately, research has shown that former foster care children do not only suffer from poor mental health later on in life. Barth, who examined the experiences of youth after foster care, found that his sample of 55 young adults were often suffering from poor health, inadequate education, severe housing problems, substance abuse and criminal behavior. He further hypothesized that the investigated sample actually may have been higher functioning than many former foster adolescents who could not be reached in the study (Barth, 1990). McDonald (1996), who reviewed 29 studies to assess the long-term effects of foster care, found similar results. He found that in comparison to

those not receiving childhood out-of-home care, adults, who had been placed in childhood out-of-home care had poorer school performance; higher rates of school dropout, public assistance, homelessness, arrest, and chemical dependency; lower marriage rates; and poorer mental and physical health. He also found results that are indicative of the children's resilience. He states that these children "typically maintain contact with at least one biological family member, have reasonable social support systems, and do not differ from the general population in unemployment rate". McDonald also identified crucial factors in determining outcome: type of placement, reason for admission, age at placement and discharge, number of placements, time in care, disposition, caseworker activity, and contact and closeness with biological and foster families. Pecora, Kessler, O'Brien, Roller White, Williams, Hiripi, English, White, & Herrick (2006) found comparable results in terms of low rates of postsecondary education and fragile economic situations. They reported that about "one-third of the investigated foster care alumni had household incomes at or below the poverty level, one-third had no health insurance, and more than one in five experienced homelessness after leaving foster care". In light of the previous findings, this information is not surprising. The authors did however add an important piece. They found that two foster care experience areas were estimated to "significantly reduce the number of undesirable outcomes in the Education outcome domain". These two areas were positive placement history, meaning high placement stability and few failed reunifications, and having broad independent living preparation, meaning having concrete resources upon leaving care. The latter was estimated to significantly reduce the number of undesirable outcomes in the employment



and finance domain. This speaks to the importance of providing youth with adequate independent living tools before they exit care.

In summary, research shows that not providing children with sufficient services can have severe long-term consequences, not only for the individuals involved, but also for the economy. The Task Force on Early Mental Health Intervention points out that “failure to provide early childhood intervention leads to enormous societal and economic costs” (APA, 2003).

#### 2.4. Statement of the Problem Specifically For Adolescents/Females

Adolescents are excessively egoistic, regarding themselves as the center of the universe and the sole object of interest, and yet at no time in later life are they capable of so much self-sacrifice and devotion...On the one hand, they throw themselves enthusiastically into the life of the community, and on the other hand, they have an overpowering longing for solitude. They oscillate between blind submission to some self-chosen leader and defiant rebellion against any and every authority. They are selfish and materially minded and at the same time full of lofty idealism...At times their behavior to other people is rough and inconsiderate, yet they themselves are extremely touchy. Their moods veer between light-hearted optimism and the blackest pessimism. Sometimes they will work with indefatigable enthusiasm and at other times they are sluggish and apathetic. (Anna Freud, p.138)

Anna Freud’s portrayal of teenagers illustrates very well that adolescence is a time of contradictions, confusion and paradoxes in a child’s development. According to Erikson’s psychosocial stage theory, adolescence is the time of identity development versus identity diffusion. It is the time when teenagers should learn to answer the question “Who am I?” – a time where the young individual acquires self-certainty as opposed to self-doubt. As indicated by Erikson, the adolescent seeks leadership from someone who inspires him and gradually develops a set of ideals. This is a rather difficult

task for any teenager. Now imagine how difficult this task is for someone who grows up in a chaotic, unsafe, unpredictable environment without any adequate role models? How would one not acquire an attitude of self-doubt, if he or she was abandoned by his or her own mother and then rejected by foster family after foster family?

The literature shows that most children in foster care are in desperate need of mental health services. There is an even greater sense of urgency for individuals who are about to “age out” of the child welfare system. A significant number of young adults in New Jersey (about 6 percent of the children in out-of home placement were between the ages of 18 and 21 in 2007 as opposed to 3 percent in 2006) remain in the child welfare system until services end. The children who age out of care “often lack the support they need to move successfully into adulthood” (ACNJ, 2007). Since children in foster care are only eligible for Medicaid until they turn 21, and since previous research suggests that few of them will be likely to afford health insurance after that point, this may very well be the last opportunity for them to receive mental health services at all.

As mentioned above, adolescents are the second largest group in the foster care system. Nevertheless, when one examines the Child Protection Data Report by the Association for Children of New Jersey, it becomes apparent that data on youth and aging out of placement is “completely lacking” (ACNJ, 2007). This fact is indicative of the very problem: adolescents are often the overlooked, neglected and somewhat feared age group. For instance, attachment literature focuses primarily on the impact that separation from an early caregiver has on infants and young children. Hardly any of the literature concentrates on the impact that early childhood separation has on interpersonal relationships (or lack thereof) of older abandoned foster children and adolescents.

In New Jersey, while DYFS has been able to improve its pace and was able to increase the number of finalized adoptions by 13 percent from 2003 to 2006, older children are still the least likely to be adopted and the most likely to have spent years in foster care. They are also the ones who are the most likely to have encountered the most changes in placements - especially considering that the number of children who were moved two or more times in foster care has risen by 17 percent within the last few years (ACNJ, 2007). This is extremely problematic, as research shows that volatile placement histories contribute negatively to both internalizing and externalizing behavior of foster children, and that children who experience numerous changes in placement may be at particularly high risk for these deleterious effects (Newton, Litrownik, & Landsverk, 2000). Since externalizing behaviors also proved to be the strongest predictor of placement changes, the authors concluded that behavior problems can be viewed as both a cause and as a consequence of placement disruption.

Tarren-Sweeney (2008) also found a relationship between type of placement and severity of psychopathology. He found that children in residential care have more mental health problems than those in family-type foster care, while those in kinship care have fewer problems. These findings are of concern for older children, as they are more likely to live in residential care than younger companions. Also, while placing children with kin when possible has been a key element of DYFS' reform plan, data indicated that in New Jersey the number of foster children initially placed with relatives actually dropped by 20 percent from 2003 to 2006 (ACNJ, 2007). ACNJ further hypothesized that older children may be more likely to be reunified with their parents, as it is more difficult to find families who are willing to house an older child. While reunification is a desirable goal, it

should only occur when it is in the child's best interest. Current research, however, gives reason to believe that this may not always be the case and that children are possibly being prematurely returned to their families; data showed that children under DYFS supervision were 35 percent more likely to be abused or neglected after family reunification in 2005 compared to 2002.

Independent living facilities and group homes are further options for adolescents in foster care. Vaughn, Ollie, McMillen, Scott, & Munson (2006), who explored prevalence and predictors of current and lifetime substance use, substance abuse disorder, and poly-substance use among 406 seventeen-year-old youth in foster care, found that having a diagnosis of Conduct Disorder and/or living in an independent living situation significantly increased the likelihood of current and lifetime substance use and disorder.

While the trend that the number of children entering foster care in New Jersey has plateaued while the number of children exiting care has increased is a positive development, it would be useful to explore the reasons why these children are exiting. Are they prepared for adulthood or are they simply signing out of DYFS to escape the calamity of being in foster care?

Cassandra Simmel conducted a study based on a statewide longitudinal sample of adopted foster youth. She found results that stress the importance of establishing a group specifically for females in foster care. She found that the strongest risk factors for the display of behavior problems were sexual abuse, neglect, and having been placed in multiple foster homes (Simmel, 2007). While there are males who are victims of sexual abuse, it is no secret that sexual abuse is much more prevalent among females. It is

crucial to give these young women the opportunity to talk about their traumatizing experiences in a safe, male-free setting.

Premature reunification, exposure to substances at independent living facilities, numerous disruptive placements, a decrease of first time kinship placements, lack of role models and therapeutic services in addition to early childhood trauma, poor long-term outcomes and the ongoing experience of being rejected by adults who would rather adopt younger children seem to be an amalgamation of horrendous circumstances for a child that is in the midst of his/her identity development. It is not surprising that the data revealed a rather high prevalence rate of suicide attempts among this population.

### III. GROUP THERAPY AS A SOLUTION?

For many years group therapists have had to fight the general view of group psychotherapy being the “second class treatment”. Over the last several years, however, numerous meta-analytic reviews have been able to support the effectiveness of group psychotherapy as a treatment modality. For instance, in their meta-analytic study, McRoberts, Burlingame, & Hoag (1998) compared 23 outcome studies with one another and did not find any differences in outcome between the group and individual treatment modality. A much larger meta-analytic follow up study by Burlingame and his colleagues (2003) found that “the average recipient of group treatment is better off than 72 percent of untreated controls.”

A thorough review of the literature reveals no studies that have investigated the effectiveness of group therapy versus individual therapy in regard to the foster care population. While further research would be helpful in determining the “treatment of

choice” for this particular population, I hypothesize that the group approach may in many ways be the better treatment modality for children and youth (and particularly females) in foster care.

Listed below are the reasons why group psychotherapy (as opposed to individual treatment) might be the treatment of choice for this particular population.

### 3.1. Maximizing Therapist Resources

In light of the distressing findings that there are limited services for children and adolescents in foster care, providing group therapy for these children brings about several advantages. As mentioned above, DYFS and other child welfare agencies all over the country struggle trying to find psychological services for children in the system, as the need for services exceeds the capacity of mental health providers (Austin, 2004). Often times, children are on waiting lists for individual therapy for more than a year. By the time a therapist is available, the child is often no longer an "open DYFS case" (due to reunification or adoption) or the child has been moved to another foster placement that is out of the range of the mental health care provider that finally had an opening for the child.

Groups allow children to be treated faster and put less of a burden on the economy compared to individual treatment. Psychopathology in the United States not only burdens the economy in terms of inpatient, outpatient and medical treatment, but also in terms of lost income due to potential later unemployment (NIMH, 1995), maintenance of prisons etc. Several group treatments (evidence based group treatments for specific disorders such as PTSD, adjustment disorder, several anxiety disorders,

bulimia nervosa, MDD, dysthymia, ODD, substance abuse published by Bieling et al, 2006; Layne et al, 2004; Malekoff, 2004; evidence-based interventions with foster care population such as "Multidimensional Treatment Foster Care", Fisher et al, 1999; "Wraparound", Burns et al, 1999; and "Therapeutic Foster Care", "Multisystemic Therapy") have been shown to decrease oppositional and defiant behavior and increase prosocial behavior and societal functioning, which means that groups may increase the likelihood of helping these children become contributing members of society.

While reducing the load of the economy is a positive side effect of group, the merit that group therapy has for these children is much more important. Apart from economic benefit and advantages in regard to getting children off the waiting lists, there are several clinical reasons why group therapy as opposed to individual therapy is particularly beneficial for this population.

### 3.2. Yalom's Therapeutic Factors and Foster Care

Irvin Yalom (1995) is currently one of the firmest advocates for group psychotherapy. Yalom believes in the primacy of interpersonal learning in the here-and-now crucible of group interaction. According to Yalom, group members recreate their interpersonal world in the context of the group and have the opportunity to learn about their maladaptive behaviors and distorted perceptions of other people. They then have the opportunity to learn new ways of being with other people. Ideally, this interpersonal learning can then be translated outside of group to the actual interpersonal world of the patient. In his attempt at uncovering and exploring those aspects unique to group psychotherapy that make it an effective means of helping people with psychological problems, Yalom

created a list of “Therapeutic Factors” that he believes are primarily responsible for therapeutic change in the context of group psychotherapy: (1) Installation of hope, (2) Universality, (3) Imparting information, (4) Altruism, (5) The corrective recapitulation of the primary family group, (6) Development of socializing techniques, (7) Imitative behavior, (8) Interpersonal learning, (9) Group cohesiveness, (10) Catharsis, and (11) Existential factors. Three of these factors are particularly therapeutic for children in foster care: installation of hope, universality, and the corrective recapitulation of the primary family group.

While many children in foster care may differ in their outwardly displayed behaviors, presenting problems and psychological disorders, most of their underlying core issues are similar: attachment difficulties, feelings of rejection and abandonment, mistrust in the world and intimate relationships, feeling ashamed, isolated, unloved, unwanted and abnormal, fear of getting close to people. According to object relations theory, the type of object that the infant connects with early on in life (which in the case of a foster child usually is the unavailable/ unloving/ rejecting/ dismissive/ controlling/ neglectful/abusive/ sick/ uncaring mother) becomes the prototype for all later connections. Fairbairn (as cited in Mitchell and Black, 1995) believes that we project our internal object relationships onto new interpersonal situations, creating a self-fulfilling prophecy, meaning that we provoke old expected behaviors. This may be the reason why foster children often times end up getting rejected by foster parents, friends.

A process-oriented here-and-now group is the perfect setting to tackle this phenomenon, as the therapist has the opportunity to see first hand how the child connects and relates to others in the room. Yalom (1995) views groups as a "social microcosm", in



which clients, over time, interact with the group members in the same way as they interact with others in their social spheres. The rationale behind a process group is that clients project their interpersonal relationships onto the group. While people rarely talk about the way they relate to each other in real life, a here-and-now-oriented group has that very purpose. Through exploring your own reactions towards group members and hearing how others react to you, one begins not only to tolerate greater levels of interpersonal anxiety but to also change the way you view the world and the way you interact with the world. The goal is that one makes positive changes within the group and brings that change outside of the group into the real world. Through the creation of a safe place and engaged and honest feedback of the group members, group can serve as what Yalom calls a "corrective recapitulation of the primary family group" for these foster children.

Most foster children did not have what Winnicott (1965) called a "good-enough mother", who met the child's needs and provided a warm, nurturing and responsive ("holding") environment. Most foster children never experienced subjective omnipotence, but were immediately forced to face the scary, uncontrollable outside world. According to Erikson's psychosocial stage theory, developing trust (through a positive maternal relationship) is the first task of the ego. If children do not learn to trust themselves, others and the world around them, they may lose the virtue of hope (Erikson, 1968), a phenomenon which is often seen in foster children. For children who have experienced the concept of learned helplessness (Seligman, 1975) first hand, one of Yalom's most important therapeutic factors is the installation of hope, which is a powerful and often times contagious phenomenon of group therapy.

Group therapy not only draws from the general ameliorative effects of positive expectations but also benefits from a source of hope that is unique to the group format. Therapy groups invariably contain individuals who are at different points along a coping-collapse continuum. Each member thus has considerable contact with others – often individuals with similar problems – who have improved as a result of therapy. I have often heard patients remark at the end of group therapy how important it was for them to have observed the improvement of others (Yalom, p. 4).

A group facilitator can motivate an individual to keep going and to not give up, but the message is immensely more valuable and credible if it comes from someone who has been where that individual has been before and came out in a better place.

One of the most mundane and yet most valuable aspects of group therapy is that it brings people together. For a population that feels alienated, scapegoated and isolated, this very fact is therapeutic within itself. What is even more significant is that a group that is specifically for children in care gives those children the opportunity, perhaps for the first time in their lives, to connect with people that can relate to their particular experiences. As mentioned previously, despite the large number of children in care, most teens do not know a single child that is also part of the child welfare system. This goes along with the third important therapeutic factor that is specifically valuable to foster children: group, as opposed to individual therapy, gives the opportunity for universality. This is especially important for foster children, who possibly have been feeling abnormal all of their lives as they believe that their experiences, feelings, thoughts and problems are unique to them. For children who have been feeling “different” from their classmates for a long time, the disconfirmation of their feelings of uniqueness, a realization that someone else is “just like me”, is a powerful, normalizing experience. Suddenly, a problem that has been very isolating suddenly becomes less isolating. It allows these children to correct their misperception that the negative emotions they are experiencing

are unique to them. Group challenges this misperception directly. Group is a normalizing experience, which is exactly what these children need.

Because foster children hardly ever talk about their feelings and experiences in everyday life, they neither learn about others' comparable feelings and experiences nor "avail themselves to the opportunity to confide in and ultimately to be validated and accepted by others" (Yalom, p. 6). The experience of being accepted by others can heal the wounds of a child who at the core feels unlovable due to maternal rejection. Additionally, a consistent, respectful, caring and safe ("holding") environment can slowly correct the perception that the world is an unsafe place; that relationships are unreliable; and that intimacy, trust and hope should be avoided.

### 3.3. Cognitive Behavioral Therapy (CBT) Interventions and Foster Care

From a CBT perspective, groups are valuable in that they can serve as a platform for exposure, psychoeducation, modeling (of communication, problem solving skills etc.), and challenging dysfunctional beliefs. Being able to bring up topics in a group that one wouldn't dare to talk about in normal life can be extremely cleansing. Traumatized children keep their memories (of sexual abuse, being "given away" etc.) and emotions (such as guilt, shame) buried inside to not feel exposed and embarrassed. Their avoidance of these taboo topics only perpetuates their post-traumatic stress. Having the opportunity to share traumatic experiences with others in a safe group-setting (exposure) and being able to witness that the reaction of the group members is much different from what the client had anticipated (challenging dysfunctional beliefs) may in the long run change their core beliefs of being deficient and unlovable.

Psychoeducation about topics that the specific population relates to (in this case abuse, depressive symptoms, etc.) is another valuable CBT piece that should be incorporated into the group, to give the clients an explanation for how they may be feeling or behaving. The group setting is also very well suited for role plays, group activities, and therapeutic games. It can even be beneficial to be in a room together while working on individual projects, such as genograms, lifebooks, timelines and decorating binders. Anything that strengthens group cohesion, allows members to get closer to one another and slowly brings down the wall of defenses that have been built up in order not to get hurt again, is a reparative experience.

One final group phenomenon is the preparative and preventative aspect of group. Through communicating with one another, participants learn and grow through each other's experiences. Often times groups serve as "wake-up calls". For instance, one girl's pregnancy and subsequent abortion makes the rest of the girls aware of the reality of what it means to not use contraceptives. Similarly, a group member's stressed-out comment about college application deadlines helps the rest of the girls realize that it is in the realm of possibility for them to go to college as well.

#### 3.4. Reducing Stigma, Anxiety and Resistance Through Universality

Many foster care youth who attend therapy are not there of their own free will. They may be mandated by court or feel pressured by DYFS to attend. They can make it very clear that they do not want to be there and show their resentment verbally, physically or through silence. These children very often feel the stigma of being in therapy.

To them being in therapy is just another thing to be embarrassed, feel “crazy” and feel “different” about. Group therapy can provoke less resistance in foster children, who experience it as less threatening and less stigmatizing. As a matter of fact, some children even get very excited when they are being screened to be a part of a group – to be a part of a “family”. Sometimes children and especially teenagers attend individual therapy for months without saying much to their therapist. Their defenses, or what Boyd-Franklin (2006) calls “healthy cultural suspicion” against the therapist or the institution, are so high that they are simply “unreachable”. These children quickly open up once they are switched to a group setting. Groups can often times reach the unreachable children.

### 3.5. Providing Role Models and Mentors

Many children in the child welfare system grow up without having had any positive role models to give them hope or make them want to “work towards” something. The concept of a good future and a normal life is so foreign to them that dreams of going to college or having a fulfilling job are not even in their repertoire of possibilities. Coming to group and being around mentor-like adults, who are so vastly different from the adults that some of these children grew up around, is an eye-opening, “hope-yielding” experience, especially if the mentor is a fellow foster child who was able to “come out on top”. The groups that are being run through the Foster Care Counseling Project at Rutgers (see below) are usually facilitated by two relatively young group leaders (graduate students). In addition, one or two undergraduate students provide these children with transportation. Sometimes, the undergraduate students even take the children out for a meal or show them around campus, teach them independent living skills or function as a tutor. The

above mentioned research by Felitti (2001), Pecora (2006) and Pilowsky (2006) convincingly supports the notion that older youth in foster care do not do well during the transition to adulthood – which makes sense considering that the adults that they most likely compare themselves to, did not live healthy, fulfilling lives themselves.

Several studies raised the question whether contact to a mentor-like person had an effect on the long-term outcomes of former foster care youth. A study by Munson and McMillen (2008) found positive results: the presence of a mentor and the duration of the relationship at age 18 were associated with better psychological outcomes, such as fewer depression symptoms, less stress and more satisfaction with life at 18-1/2. While longitudinal data collected at ages 18 and 19 did not show a relationship between long term mentoring and current employment or past year alcohol or marijuana use, these young adults reported less stress and were less likely to have been arrested at age 19.

Ahrens, Richardson, Lozano, Fan & DuBois (2007), who also investigated whether foster care youth have better adult psychosocial and health outcomes if they have a mentor during adolescence, found that mentored youth had significantly more positive outcomes when compared to those without a mentor. Specifically, they reported significantly better overall health, were less likely to have been diagnosed with an STD, and were less likely to report suicidal ideation (possible because a mentor symbolizes hope - "I could be like that some day"), and were less likely to report having hurt someone in a fight in the past year. The authors also found a trend towards more participation in higher education among mentored youth.

Munson & McMillen (2008) wrote:

Mentoring relationships, or consistent connections between caring non-parent adults and children, can be life changing. Whether it is through structured programs or through relationships that develop on their own, mentoring has been shown to benefit youth. Emerging theories postulate that these benefits may occur through a variety of mediating processes, such as changes in social and emotional development, cognitive development, identity development and all of the above.

#### IV. THE TREATMENT MANUAL FOR THE FCCP AT RUTGERS

##### 4.1. Introducing the Foster Care Counseling Project (FCCP)

The Foster Care Counseling Project (FCCP), which is located at the Center of Applied Psychology (CAP) on Rutgers' Livingston Campus in Piscataway, offers mental health services to children and adolescents in foster care referred to the project by the New Jersey Division of Youth and Family Services (DYFS). The Project was founded in 1989, when David Brodzinsky responded to a request for proposals from DYFS. Almost twenty years after the creation of the program, more than 120 therapists and over 600 families have benefitted from its existence.

In this setting doctoral graduate students from the Graduate School of Applied and Professional Psychology (GSAPP) at Rutgers University provide individual, family and group therapy at the GSAPP clinic on Busch Campus. All graduate students are being supervised individually by the program director, a doctoral level, licensed psychologist with more than 20 years of experience in this field. The therapists meet once a week with their young clients individually, interacting for about 50 minutes each time. They also work in close collaborative effort with DYFS caseworkers, teachers, and

caregivers to best meet the needs of the child in care. While the clinicians generally see their clients at the GSAPP clinic, they also do in-home therapy (the initial session is usually held at the family's home for assessment reasons, even if the following sessions are held at the clinic) and school visits, if needed. Clinicians tailor their treatments to the developmental, cognitive and emotional needs of the child, ranging from play therapy, to dyad work with the caregiver, to structured CBT activities to more insight oriented psychotherapy and grief-work with adolescents. Most clinicians treat their clients from an integrative treatment approach that is being adjusted to the child's needs. In addition to receiving cognitive behavioral, psychodynamic and systems-trainings at GSAPP, the students receive client-specific weekly trainings at the FCCP and complete an extensive "Trauma-Focused CBT" online course.

All clients are referred to the project by their DYFS caseworker. Many have an extremely negative or at least ambivalent opinion of DYFS, since DYFS is the one who separated them from their biological families. Some of these children perceive the clinician as "one of the DYFS people", which can be a difficult hurdle to overcome: while clinicians want their clients to open up and work on their core issue of mistrusting the world, they cannot guarantee the client full confidentiality, as the program has a contract with DYFS and is, therefore, required to write quarterly progress reports to them. Nevertheless, while many children initially come in feeling suspicious and reluctant, most are slowly able to build a relationship with the clinician.

The clinicians usually stay with the project for about a year, though some continue to see a few of their cases for longer. If the children are being removed from their placement, therapists do their best to provide continuous service in order to give the



child some consistency and help him or her transition into the new environment. This means that clinicians will sometimes drive to shelters, group homes, juvenile detention centers, independent living facilities to be able to see the child in their new setting. If the child continues to need services after the clinician leaves the project, the case is transferred to one of the new, incoming clinicians. The transition is announced early so that the transfer can be processed with the child in a healthy (non-retraumatizing) way.

The project does not only work closely with graduate students from GSAPP, it also recruits between 10 and 15 undergraduate students each year, who get field work credits for providing transportation for one of the referred foster children. Often times, the role of the undergraduate student is far more than just a transportation aide. Some become mentors, role models, homework aides, mall-companions etc. The graduate and undergraduate student form a collaborative treatment team to best serve the needs of the young individual. They attend weekly team meetings and trainings together.

#### 4.2. Obstacles Regarding Group: Treatment Manual as a Solution

The FCCP has run several successful time-limited groups over the course of the last nine years. Unfortunately not many of these groups continued beyond the departure of the particular student clinicians who facilitated the group. While an extensive analysis of the obstacles that group facilitators were faced with would go beyond the scope of this paper, it is important to be informed about what has already been tried before one runs into the same problems each year. Interestingly, most previous facilitators encountered the same (mostly logistical) challenges regarding getting groups up and running: getting referrals specifically for group (lack of coordination between local child welfare and mental health

care agencies was one of the “barriers” mentioned in the research above; i.e. Staudt, 2003); providing reliable, continuous transportation for the group members; scheduling difficulties (coordinating schedules of facilitators, children’s after school activities, foster parents, DYFS caseworkers, transportation aides, etc.), and the start-up time commitment (such as taking care of the logistics, setting up screenings). By the time everything is arranged and ready to go, a lot of valuable time has gone by. This is a challenging process that student clinicians face before the beginning of each group – each year, incoming therapists feel like they have to start from scratch.

A treatment manual would give an incoming clinician the chance to start from where the previous therapist left off. The wheel “group therapy” would not have to be reinvented each year. It would assist in turning group therapy into a sustainable component of the Foster Care Counseling Project. Many graduate students who enter the FCCP are beginning therapists. Many of them have little experience in working with a population that is as vulnerable and as much at-risk as the foster care population and only very few of them have had prior training in working with groups, let alone foster care groups. By now, several books have been published that are helpful in guiding clinicians who are lacking group experience through the process of running a group. For instance, Rutan, Stone and Shay (2001) and Yalom (1995) published excellent books about the psychodynamic group psychotherapy model. Bieling, McGabe and Antony (2006) focused on the cognitive behavioral processes of running a group and give directions on how to facilitate groups for specific disorders, such as Panic Disorder, Obsessive-Compulsive Disorder, Social Anxiety Disorder, Depression, Eating Disorders, Substance Abuse, Personality Disorders and Schizophrenia. MacLennan and Dies (1992), Malekoff

(2004), and Schechtman (2006) published valuable books about group therapy with adolescents; and Carrell (2000) published a manual for therapists, which includes numerous group exercises for adolescents. While books and manuals on how to run groups with teenagers are useful (as foster care youth certainly deal with regular adolescent issues), youth in the child welfare system deal with issues that are more idiosyncratic to the experience of being in care (parental substance abuse/incarceration, separation from family members, dealing with rejection/attachment issues, dealing with the child welfare system etc.) that are not being addressed in manuals for "regular" teens. To my knowledge there is no such manual or book, which would be invaluable for clinicians at the FCCP. The book that comes the closest to the target population is the "Handbook of Social Work with Groups", by Garvin, Gutierrez and Galinsky (2006). The authors of this book wrote about the values of adapting an "ecological-systems perspective" and even included a brief chapter on group work in child welfare. Therefore, a treatment manual is needed to give clinicians the theory and tools that they may lack in order to serve several clients at once.

Vakoch & Strupp (2000) state that training manuals are often used to provide guidelines and teach new approaches and techniques to therapists. Their use is particularly recommended for beginning therapists and therapists-in-training (Moras, 1993). Another advantage is that manuals present a common frame of reference for the supervisor and trainees. Treatment manuals not only increase the rate of skill development, but they allow for "quality control" of therapist performance (Morgenstern, Morgan, McCrady, Keller, & Carroll, 2001). Manuals further seem to improve the clinical work of clinicians "by providing sufficient structure and specificity to facilitate a

sustained, productive therapeutic focus” (p. 87). In their study counselors who were using manuals not only were very satisfied with their experience but were also highly confident in their ability to use the techniques effectively.

As the field of clinical psychology is progressively placing more importance on evidence based treatment, creating a treatment manual for clinicians at the FCCP would be a first step in creating a program that is standardized across groups at the project and amenable to program effectiveness evaluations. In order to improve treatment outcomes for at-risk adolescents, clinicians need to know which interventions are effective and which are not.

#### 4.3. Resistance around Running Groups

Group work, unique among the therapeutic modalities, places together clients with wide-ranging differences for the purpose of personal change. Bringing together such diverse clients can be extremely challenging for practitioners, who must enable group members to embrace diversity as a means to develop the cohesion necessary for effective therapeutic work. Foundation texts in group psychotherapy rarely address this issue or provide appropriate intervention methods for achieving such cohesions. (Yalom, 1995)

While the above mentioned obstacles (transportation, getting referrals etc.) are very valid, we would be missing an important aspect if we did not mention the “elephant in the room”. It is clear that foster youth are in desperate need of psychological services. Unfortunately, in addition to the apparent lack of health care providers, many clinicians are reluctant to working with youth, especially when they come in the form of two or more. Malekoff (2004) describes a typical reaction of a colleague when he tells him about the kind of work that he does:

You work with them in groups? I don't know how you do it! (smiling, head shaking) I tried it just once or twice. That was enough. What a disaster. I couldn't get them to do anything. They wouldn't talk. They were, like, totally out of control, did whatever they wanted, and didn't listen to a thing I said, a real waste of time – mine and theirs. You work with them in groups? Really? (Translation: What a jerk.). (Malekoff, p.4)

This reaction reflects the anxiety that health care providers often experience when it comes to running groups in general, and particularly when running groups with (troubled) adolescents. At times, clinicians may feel overwhelmed, resentful, clueless, lonely, structureless, powerless, disrespected, and rejected, sometimes they may not really want to be there or feel like the experience is not worthwhile. Should these feelings arise, clinicians should take them seriously and consider whether there might be a parallel process going on between what they are experiencing and the way the members feel in regard to their foster care and group experience. The beauty about group therapy is that this is all "grist for the mill".

#### 4.4. This Manual: Intentions and Instructions

The purpose of this treatment manual is to give those clinicians that are passionate about their work with underprivileged youth a valuable tool that will help them feel safe and prepared for the journey. This manual is intended to:

- address the training needs of clinicians intending to facilitate group therapy for adolescent girls in foster care;
- provide new/incoming clinicians at an agency with a tool that allows them to quickly start new or continue with existing groups (without having to "reinvent the wheel" each year) and facilitates consistency of implementation;

- give clinicians basic theoretical knowledge about group psychotherapy, the foster care population, and the developmental needs of adolescents;
- offer practical guidance on the logistical and structural preparation processes that are involved in setting up this particular therapy group;
- provide clinicians with a resource that includes information regarding topics likely to arise in groups of this type and descriptions of the challenges inherent in group work;
- deliver a detailed description of activities tailored to meet the unique needs of this particular population during all stages of group development;
- function as an efficient tool that decreases the amount of time and effort that clinicians have to put into preparing for the group therapy sessions and creating handouts, fliers, and important forms;
- decrease clinician's resistance, anxiety and sense of being overwhelmed around running groups;
- motivate ambivalent clinicians to give this challenging but rewarding work a try.

While the manual is based on and will make references to two groups (the MIA and the TALK group) that were run specifically for adolescent females in foster care, the reader will notice that most principles are applicable to the entire foster care population. Also, despite the fact that this manual was originally written to turn the group therapy format into a sustainable service of the Foster Care Counseling Project, the treatment manual can certainly be applied more broadly to other settings where adolescents in foster care receive treatment.

The literature informing the development of this manual is drawn from many fields, mainly the areas of attachment theory, the child welfare system, adolescent

development, group theory, prevention, risk and resilience, and cultural competency. While this manual provides some very basic knowledge regarding group therapy, its focus lies more on creating a link between adolescent needs, the foster care world and group work. Hence, this manual cannot function as a replacement tool for the superb, fundamental literature on the theory and practice of group psychotherapy or adolescent development. A more in-depth analysis of these areas would go beyond the scope of this manual.

While this first chapter was developed to give the reader some theory and background information about the foster care experience and the need for treatment and group therapy as a treatment solution, the following portion of the manual will be more functional. The second chapter, “Before the Beginning,” reminds the reader of very practical matters that need to be considered, organized and put in place before the group can even begin, such as transportation and referral questions and recruitment, group format and composition issues. The third and fourth chapters, “The Beginning” and “After the Beginning,” state the goals, challenges and therapist expectations during the first, middle and final stages of group development, as well as names of valuable activities that will foster the achievement of these goals. The final chapter (“Challenges, Recommendations and Implications”) lists challenges that need to be anticipated during group, provides some final words of advice; and discusses limitations and future suggestions of the manual. The appendices includes both useful materials mentioned throughout the manual, such as consent forms, fliers and handouts as well as the detailed descriptions and a reference list of the activities that were named throughout the previous chapters.

Finally, I would like to mention something about the tone of the manual. The reader will notice that it is not written in a very scientific tone but rather in a more personal language. The reason for this is that this work IS very personal. Therefore, it will be addressing you, the group facilitator, directly from this point on. I chose to write the manual in a way that reflects and parallels the tone of the group as much as possible. When I think about the textbooks that I have learned the most from, they were books where the author wrote about his or her own experience including mistakes; summarized important points in bullet points; and revealed his or her personality.



## CHAPTER II

### BEFORE THE BEGINNING

#### I. RECRUITMENT

##### 1.1. Undergraduates: Transportation Aides and Mentors

###### 1.1.1. Expectations and Responsibilities of the Undergraduates

As mentioned earlier, the FCCP takes on about 10 to 12 undergraduate students each year. These students receive field work credits for which they are required to provide transportation to and from therapy for one foster child, write a paper about their experience, and attend a team meeting, supervision, and a weekly class where they learn about foster care related issues. These undergraduate students are carefully screened before they can join the FCCP team; however, not all of them will be suited for your group and, therefore, have to undergo another screening process by you and your co-facilitator.

Ideally, the one or two undergraduate students that you pick for your group would be females, who are reliable, responsible, mature, open-minded, emotionally available, confident, humorous yet professional, thoughtful, empathic, emotionally stable, show initiative, are team compatible and open to advice, are not afraid of being rejected; and are excited about this opportunity even if they have to do more work than their classmates. Unlike the rest of the undergraduate students in the field work course, they have to pick up several adolescents and bring them home, which takes up an entire

afternoon and evening. They are also asked to meet with the two group facilitators once a week to process and plan the group sessions.

Choosing exceptional undergraduate students is crucial, as they will be interacting with your group members more than you will. Their role is not an easy one: they are not much older than the members themselves, yet they have to be aware of the fact that they function as role models. During transportation, they have to set clear boundaries regarding personal information and withstand when the members are testing their limits (e.g., they may be asked whether or not they do drugs, how old they were when they had sex for the first time), but have to do this in a non-rejecting, empathic manner. They have to act in a way that makes the members feel comfortable and understood; nevertheless, they have to clearly communicate that they are not therapists and that therapy does NOT start in the car. They need to communicate whenever necessary that they will keep the information being provided by the members on the long car rides confidential from the outside world, but it will be passed on to the group facilitators. Whenever they feel that something they hear may be relevant for group, they should encourage the member to “bring it into group”. They need to connect with the members but not be “one of them”. They can join the members in many activities (goofing around, singing in the car etc.) but can’t gossip or joke about absent members. They carry a lot of responsibility and their roles need to be very clear to them: yes, they are transportations aides, but really they are so much more than that. They are mall-companions, tutors, role models, mentors, older/admired “siblings” – to most members, they represent the “possibility” that they never dared to dream of but that becomes more possible through the presence of one or two accomplished people who are not much older than them.

### 1.1.2. Screening Process

Both you and your co-facilitator should be present at the two-step screening process, in order to get a good picture of who you are going to be working with. My co-facilitator and I introduced the concept of the group and gave a “job-description” of who we were looking for (see prior section) to all undergraduate students during one of the team meetings. Afterward we asked interested students to write down their availability (afternoons and evenings) and why they were interested in being part of this experience. Of course, they had the opportunity to ask questions and their names on paper did not obligate them to ultimately be part of the team.

After the meeting, we, as co-facilitators, shared our “gut feelings,” compared the students’ available times with ours and read over their statements. Usually the “right” person stands out from the beginning.

The following week, we met with all students who were still interested. During this meeting, we strongly emphasized the intense time investment and the significance of their commitment and reliability when working with foster children who could be re-traumatized if they were connected with yet another unreliable person. Please be sure to communicate the following points during this second screening:

- Participation in group takes up a lot more time and work than what is required of them for their field work course, nevertheless, this is a unique opportunity for any undergraduate student; it looks great on their CV, as this is the type of extracurricular activity that could help them get into graduate school. However, do NOT draw them in with this argument. Their participation should mainly be intrinsically not externally motivated: just like you, they should do it because they care.

- If they sign up for it, quitting is NOT an option! If they have any doubt whether they will be able to sustain the emotional or time constraints for a year, it is absolutely understandable and their honesty and self-evaluation is much appreciated. For the sake of the wellbeing of the group members, however, these undergraduates will not be able to take on this role.
- Ask the students to think about it and contact you if they are still interested after having given it some thought.

The ones that will call you will most likely be the ones that are genuinely interested. The right ones will not be discouraged by your warning. They will be aware of the additional work but will feel privileged and enthusiastic about this opportunity. If there are several equally suitable candidates, you are going to want to make the team as diverse as possible. Having an ethnically homogenous treatment team is not recommended. It is nice for the members to have leaders that “look like me”.

### 1.1.3. Complicating Factor

What makes this process a little more difficult is that while you are probably going to need at least two undergraduates to provide transportation, there is no room for more than one student to attend the group session. Having almost as many co-facilitators as members is intimidating and feels “weird” to everyone. Taking turns is not an option and neither is switching after six months; as both alternatives jeopardize the process and safety within the group. You are going to have to explain this dilemma to both the undergraduates and the members and find a solution.

We discussed the option of having one undergraduate only transport three to four members and be given the opportunity to take part in the group, while having several undergraduates transport the remaining members individually. We opted against this, as the members loved the shared-car experience. Our solution consisted of both undergraduates being able to take part in my TALK-group, as I did not have a graduate-level co-facilitator. While this worked just fine, I preferred sharing the enormous responsibility of running an intense group like this with another, more trained doctoral student clinician. However in the MIA-group, one undergraduate had the opportunity to participate in group meetings and to balance out this privilege, she was required to transport more members. The second undergraduate student took the girls to mall trips and the movie theater and participated in all of our holiday, birthday and group celebrations.

## 1.2. Supervision/Regular Team Meetings

One of the most important pieces of advice I can give is to process this intense experience of running a group with this multiply traumatized and highly vulnerable population as often as possible! I worked through my emotions at my weekly, very healing, crying-together-laughing-together-chocolate-eating-prep-evenings with my co-facilitator and undergraduate; during our supervision with our program director, without whom I probably would have given into my strong counter-transference reactions (i.e., adopting all of the girls, not taking breaks for vacations, maybe even making the mistake of not reporting an abuse out of a fear of betraying the members and destroying the safety of the group); after a rough session at home on my couch with my amazingly supportive

personal CBT and psychodynamic supervisors (a.k.a. roomies); in my own psychotherapy; and with my peer-supervision-group supervisor/dissertation chair.

Do not try to go through this process alone. Vent, share insecurities, try to understand the reasons why certain members or experiences push your buttons, and analyze parallels to your own “inner child”. Apply the advice that you would give your members to yourself, otherwise, you will run the risk of vicarious traumatization. Every helper needs a helper.

### 1.3. Members/Getting Referrals

There are different ways to recruit members for your group, though the process is often draining and time-consuming.

#### 1.3.1. Drawing Members from Individual Case Loads

The easiest way is to take clients from your own caseload or to use the weekly team meetings at the FCCP to go over your colleagues caseloads and take clients from those.

The problems that you may run into are the following:

- If you use clients from your own caseload, you will obviously see them in both settings – individually and in group, which can cause some difficulties.
- Time, scheduling and transportation issues may come up, if adolescents have to come into the clinic twice a week. You may try to schedule group and individual therapy on the same day, if it’s not too draining for the client.
- Individual therapists often feel very protective of their clients and may not want to refer them.

### 1.3.2. Referrals from DYFS Caseworkers

Caseworkers who are aware of your services may refer clients specifically for group. However, few caseworkers think of the group setting as a treatment option when making referrals. We, therefore, found it helpful to attend local DYFS staff meetings to introduce the benefits of the group setting directly to the caseworkers. Also, if you contact a caseworker in person or on the phone regarding an individual case that you are treating, ask them to look over their caseloads to see if someone would be a suitable candidate. The secretary of the FCCP also sent out fliers and reminder emails to the caseworkers whenever there were available spots. She is also the person that will discuss the financial aspect with the caseworker; the group treatment (unlike the individual treatment) is not covered by the contract that the FCCP has with DYFS and, therefore, needs to be charged separately, resulting in additional costs to DYFS. In addition to this financial aspect, there are other reasons why some caseworkers may prefer making referrals for individual as opposed to group therapy: While therapists are required to write quarterly reports on their individual cases to keep DYFS informed of the members' progress, you merely report the group members' attendance/participation (not their progress) back to DYFS; meaning that DYFS is less informed but it helps the member feel safer (hence, to be more open/disclosing) in therapy. Also, while children are often mandated to participate in individual therapy, members cannot be "forced" to participate in group by the courts or DYFS; meaning DYFS is less in control but the members are much more motivated, as they participate in group at their own free will. These factors make it harder to receive referrals for the group from DYFS, but most caseworkers who had clients that

participated in group saw enough progress to recognize the value of this treatment-approach and as a result, referred more children.

### 1.3.3. Foster Parent Meetings

Other important venues for recruitment are the foster parent meetings that take place one evening a month at one of the DYFS offices. Many parents who feel overwhelmed or helpless as they see their foster child struggle with interpersonal relationships, display attachment difficulties, or withdraw and isolate themselves will be grateful to find some assistance.

### 1.3.4. Posting Flyers

Finally, you can reach out directly to adolescents. You can post flyers at places that are frequently visited by adolescents (at schools, churches, youth facilities, doctor's offices etc). See Appendix A, for an example of a group flyer.

## II. CREATION OF THE GROUP

### 2.1. Philosophy

Yes, this is going to be a group for teenagers who have experienced trauma, but yet it is not a trauma group specifically. Yes, it's a group for teenagers who share the foster care experience, but it's not a group for teenagers who identify exclusively or would like to be labeled as "foster kids". Yes, it's a group in which members may struggle with psychological issues, but the group is neither diagnosis bound nor is the main focus on



psychopathology. Your members are neither trauma survivors or victims, nor crazy or deviant. Our members would neither like to be looked upon as such, nor would it be helpful for you to think in labels. First and foremost, your members are teenagers – teenagers with “tough pasts and promising futures”. Yes, their psychopathology or dysfunctional behaviors may be the focus of some of the sessions, which means that you will be talking about drug abuse, depression, violence, promiscuity, etc., but it needs to be clear that this is not a diagnosis-specific therapy group and will, therefore, not touch upon these topics in depth.

The main focus is on trust issues, attachment difficulties, and feelings of rejection, loss and abandonment. Yes, this group needs to evolve into a place where your members feel safe enough to mourn tragic experiences and understand the impact on their feelings, thoughts, behaviors, interpersonal relationships and self-esteem, but the goal is to help them rise above the hardship and identify strengths and resources and form healthy relationships. Yes, the expression of hidden tears is therapeutic, but the expression of authentic smiles, contagious laughter, familiar disappointment, and painful anger is equally curative. As such, your group should invite the entire, authentic person to participate: moodiness is better than a mask!

Yes, cognitive-behavioral strategies will be utilized and there will be role plays, psychoeducation and exposures, but the main focus should be on interpersonal / transference / here-and-now-related processes. Different members require different approaches in order to be reached. Some may express themselves best through words, but many may find it easier through music, art, play – or ambivalently with a slice of pizza in

their mouths. Multiple members require a setting that employs multiple learning modalities.

Yes, you, as the group facilitator, are going to have to provide the main structure, enforce boundaries, interpret, assess which intervention the members may benefit from the most, be alert, push conversations into certain directions, and be directive, but one of the most important messages that you have to bring across to the members and remind yourself of again and again, is that this is their group! Both you and the members share the responsibility and are accountable for the outcome of the group. Together you come up with topics they may benefit from; together you make up a group contract and choose the rules they need in order to feel safe enough to open up; together you name the group, plan holidays/celebrations and determine the pace. Out of a fear of silence or things getting out of hand, or out of your own desire of wanting to do a perfect job or wishing to make it as easy as possible for children who have already had to endure a lot, you may feel the urge (or be pushed by your members) to take full responsibility, over-structure, fill the silence or make decisions for them. While this impulse is natural and comes from a good place, it takes away the members' opportunity to practice autonomy and for once be in control of something. Hence, there are very few things that you determine without their input; even then, be sure to give them a rationale for it. Transparency is key. Uncertainty, surprises, unpredictability and uncontrollability are to be avoided if possible.

## 2.2. Time Format

Most outpatient groups meet for 60 to 90 minutes, while inpatient groups tend to run shorter due to the reduced attention span of acutely distressed members. Besides attention

capacity and acute stress level, other factors that should be considered are age, general frustration tolerance, clinical issues/diagnoses (ADHD etc.) and structure of session (less structured sessions can meet for longer than very structured sessions). Our group ran once a week for 90 minutes, though after a year we ended up meeting for two hours, as our members wished to meet for longer. I would recommend scheduling a 90-minute period in the beginning. Most adolescents will not require a break, but you and your members can discuss what they need in order to function best.

### 2.3. Time-Limited versus Open-Ended Groups

Generally, there are several advantages and disadvantages to both options, and as stated above, the length of treatment depends on the goals, objectives and needs of the group.

Time-limited groups meet for a previously determined amount of sessions and usually do not allow new members to join after the first session. These types of groups tend to be more focused, have fewer dropouts and are more structured and goal-oriented. On the other hand, because of the predetermined ending of the group, not all group stages may be reached and there is less time for here-and-now/process interventions. Open-ended groups do not have a set ending date but continue. New members are added throughout the year, as old members drop out or finish the group. Since there is more time, there can be more of a focus on group processes and the group will be more likely to transition through all the stages of group development. Since there is no set end of treatment, drop-outs can be more of an issue as well as a loss of focus. There are groups that combine the two options: they meet throughout the year and take a break during the

summer. Buchele (2004) summarized that limited, short-term groups aim at immediate symptom reduction, while unlimited, long-term groups explore more in-depth.

There are many reasons why I believe that having a continuous group is preferable over having a time-limited one when working with youth in foster care. For one, children who have trust issues and are scared of losing yet another close person, are most likely either not going to join a group at all (where the goodbye is predestined) or they are not going to let themselves get close to anyone in the group, which would be counterproductive. Since the needs of the members evolve around forming trusting relationships, they need to transition through all the interpersonal stages of group development and they need time to process the feelings that come up along the way. I would even go as far as saying that most members benefit because the group is ongoing; these children long for something ongoing. There is no “quick fix” when it comes to curing long-learned dysfunctional relationships. It might take some members months until they feel safe enough to tell their story. This type of change takes time. Our group was a continuous group; nevertheless, we took a two-week break over the winter holidays and did not meet every week over the summer. The breaks were planned far in advance and the members chose how often they wanted to meet over the summer break. These “temporary goodbyes” were important, as we were able to, afterwards, process their deeply entrenched feelings of rejection, their anger, their fears (around being left behind, becoming too dependent)...and the ultimate goodbye (of losing fellow group members).

#### 2.4. Open versus Closed Groups

While some members are going to end the group prematurely, from my experience this has little to do with the fact that the group has an open end and more to do with external

reasons such as placement changes. Surprisingly few members just dropped out. After they were given a rationale, most children understood the importance of announcing their termination in advance and the potentially re-traumatizing consequences/ramifications of yet another unexpected separation. They both respected and appreciated this rule.

Nevertheless, the shift of members that comes along with having an open group setting is certainly an issue that needs to be thought through thoroughly. Obviously, as Buchele (2004) states, adding new members to a group that is already in progress may be disruptive to the group's process and cohesion (p. 107). While this is a clear advantage of closed groups, closed enrollment is often times not practical: while each member is unique and could never simply be replaced by a new member, the openings created by terminating members need to be filled and new troubled children need the group. And change, while scary, is not always bad but can lead to growth. While adding new members is a difficult undertaking that requires a lot of sensitivity and processing, many groups successfully do so along the way. Timing plays a big role in it. Buchele confirms that it is much more difficult to add new members at session 5 of a 10-week group than at session 5 of a long-term, open-ended group. Also, it makes a difference how often new members are allowed to enter and how many are admitted at once. The disadvantage of adding one new member at a time is that it prolongs the time of turmoil and uncertainty and hinders the group from moving on; on the other hand, the one new member tends to blend in more easily. The shortcoming of admitting several members at once is that it increases the risk of sub-grouping, as the old group might feel threatened by the new one.

There is no ideal way when it comes to the admission of new members. If your supervisor does not have a clear preference, I would recommend negotiating the options

with the group and going with what they are most comfortable with. As mentioned before, children in foster care are used to having little control over what happens to them; usually things are just decided for them. Giving them control will not only be a new experience for this population, but will also help the members master the tasks of adolescent development (individuation, decision making, taking responsibility, and planning for the future). Most importantly, the more they feel like they had a part in the decision-making process of admitting new members (shared responsibility), the more invested they will be in making the transition work.

While timing and quantity matters, what makes or breaks the success of this transition is how you communicate the upcoming change to the group. When changes happen within families (e.g., older siblings move out, new siblings are born), it is imperative to explore, address and ease the expressed and unconscious worries of the children. Group facilitators should express that old “siblings” who leave will never be forgotten, that they remain unique and cannot be replaced – and that the new members will not be more loved than the already existing children although they may require a little more attention in the beginning. If the existing “family” does not feel threatened by the new arrival and knows that they will “keep their place” and continue to get attention, they cannot only accept and welcome the new person but may actually be excited about the opportunity to be a “big sister” and pass their knowledge on.

## 2.5. Group Composition Issues

According to the group work literature by Malekoff (2004) and Shepperd (2008), variables that should be considered when screening a group in general are: age range, gender, race and ethnicity, cognitive capacity, religious and sexual orientation,

socioeconomic background, health and physique, personality style, diagnoses, intensity of problem behavior, the child's crisis level, severity of emotional distress, vulnerability of the child to disclosures that could be detrimental, willingness to work in a group setting, ability to take turns, capacity of impulse control, ability to relate to others positively, level and type of disability, frustration tolerance, prior psychiatric or psychological treatments, life history, resources/support systems, willingness to commit to attend all group sessions.

In regard to trauma specific groups (Buchele, 2004), additional features that can be assessed are: type and intensity of trauma, time passed since trauma, direct or indirect exposure, ability of patient to describe trauma experience, transient crisis or long-term problem, ability to feel safe and trust, ability to tolerate differences, ability and willingness to bear uncomfortable feelings.

While it is helpful to keep these traits in the back of your mind when screening your members, you most likely are not going to be able to adhere to all of them in the "real world". In practice, you are going to need to use your clinical and personal judgment to determine who is an eligible member.

#### 2.5.1. Inclusion and Exclusion Criteria

As mentioned above, this group is not diagnosis-bound, meaning your members neither have to meet the criteria for post traumatic stress disorder, nor do they, even though most of them will, need to fulfill any other DSM-diagnosis. You may see group members who display internalizing or externalizing behaviors, show symptoms of a mood or anxiety disorder, have issues around eating or substances, or present histrionic, narcissistic, schizoid, antisocial, obsessive, avoidant, dependent, passive-aggressive, borderline or

even slight paranoid tendencies. However heterogeneous the members may be in regard to the emotional or behavioral difficulties that they present, the group runs under the hypothesis that the majority of these problems stem from traumatic interpersonal experiences related to foster care.

While there may not be many exclusion criteria, there is one criterion all potential members must share: the experience of being or having been separated from a close family member. The reasons for the separation (death, drug abuse, incarceration, physical, emotional or emotional neglect, sexual abuse, poverty, sickness), the duration of the separation, the current living situation (foster care, kinship care, shelter, reunited, adopted), or who they were separated from is irrelevant. What is relevant is that the experience caused some sort of damage to the inter- or intrapersonal development of the child. While some may express their pain in internalizing and others in externalizing ways, your “typical” members suffer from attachment difficulties and a shattered sense of self and safety.

The following inclusion criteria should be met by your future members:

- Adolescent females between the ages of 15-19
- Current or past foster/kinship care experience/separation from family members
- Displayed or masked emotional distress as a result of the traumatic experience. For instance:
  - Attachment difficulties
  - Trust issues regarding self, others, the world (inability to trust or trusting too easily)



- Interpersonal difficulties
- Problematic/deviant externalizing or internalizing behaviors (aggression, withdrawal, promiscuity, delinquency etc.)
- Psychological problems (depression, anxiety, substance abuse etc.)
- Impacted personality (pessimistic, obsessive, paranoid etc.)
- Impacted sense of self (low self-worth, feeling unlovable, unwanted)
- Shattered sense of safety, continuity, reliability, permanency
- Interest in, ability and willingness to listen to life stories of others and – when ready – share theirs
- Ability to relate to others
- Outwardly expressed or “hidden/masked” excitement about the opportunity of meeting peers with similar experiences. They should be able to articulate at least one positive anticipation from participation in group (ambivalence and anxiety are welcome).
- Being able to articulate some goals or ways in which they would like to change
- Ability and willingness to bear some uncomfortable feelings
- Motivation to work on interpersonal, trust and attachment issues
- Willingness to commit to attend preliminary sessions; After preliminary sessions: commitment to attend all sessions and not to terminate without enough prior notice.

While the screening approach is rather liberal, it is important that the level of psychopathology of our members does not get in the way of their ability to function in the group. Therefore, the following exclusion criteria are recommended – though your own judgment will be more important than the following list:

- Mental retardation, low level of intelligence, thought disorder
- Homicidal or suicidal ideation
- Acute crisis (individual treatment recommended before adding member to the group)
- Inability to sit through the session or other problematic behaviors that may hinder own or other's participation
- Severe psychopathology: any diagnosis or behavior that is severe enough to interfere with their ability to attend reliably, physically and mentally (such as severe current substance abuse or suffering from a psychotic disorder)
- Severe personality disorders (even if not diagnosed before the age of 18), such as Borderline, or Psychopathic/Antisocial Personality Disorders

The following (“grey are”) criteria are only exclusion criteria if you do not see any potential for progress in these areas. If some of your members do not possess some of the following skills when first entering the group, you are going to have to assess whether those members will be willing to process and work on their difficulties and whether these issues could cause continuous distress in group.

- Inability to follow structure
- Inability to listen to and respond to others / showing no interest in others
- Severe dread of self-disclosure
- Severe non-psychological mindedness, lack of insight / self-reflection (introspection)
- Primarily relying on massive denial, withdrawal, severe avoidance, projection, externalization of conflict and acting out
- Unwillingness to define goals and work on them

- Low level of frustration tolerance and impulse control (adolescents should possess at least a moderate degree of frustration tolerance and impulse control, otherwise individual treatment is indicated before member can take part in the group setting)
- Inability to tolerate differences

### 2.5.2. Homogeneity versus Heterogeneity

Malekoff (p. 71) quoted Northern (1988, pp. 122-123) by saying that a group “should be homogenous in enough ways to ensure their stability and heterogeneous in enough ways to ensure their vitality”. Buchele (2004) stated that the balancing of a group “entails planning for an optimal degree of heterogeneity. Such heterogeneity should not compromise the integrity, cohesion and functioning of the group” (p.104). Yalom (1995) similarly wrote about the homogeneity/heterogeneity controversy. On the one hand, he stated the advantages of a heterogeneous mode of composition as follows:

The social microcosm theory postulates that, since the group is regarded as a miniature social universe in which patients are urged to develop new methods of interpersonal interaction, the group should thus be heterogeneous in order to maximize learning opportunities. It should resemble the real social universe [...]. (Yalom, p. 261)

On the other hand, he stated that

The cohesiveness theory, underlying the homogeneous approach to group composition, posits, quite simply, that attraction to the group is the intervening variable critical to outcome, and that the paramount aim should be to assemble a cohesive, compatible group. [...] Members of cohesive groups have better attendance; are more able to express and tolerate hostility; are more apt to attempt to influence others, and are in turn themselves more readily influenced. (Yalom, p. 262)

Trying to reconcile these two approaches, the group that you create should be homogenous enough to cultivate group cohesion and increase feelings of within-group

safety but heterogeneous enough to allow the members to learn from each other's differences and to allow the generalization of growth from the group world to the outside-of-group world.

In our case, a group that has the experience of universality as a primary treatment goal, it makes sense to assemble a group of people that share commonalities in important areas, so that universality can actually be experienced. It would be counterproductive to set up a situation that confirms a member's feeling of uniqueness/matchlessness. In order to prevent this type of loneliness, it is useful to make sure that no member is alone with anything she presents – in regard to personality, experience (especially when it comes to sexual abuse), ethnicity, sexual orientation etc. Every member should have at least one other member they can relate to them/that is “like them” in areas they might feel insecure about. This might be one of your most important tasks when putting the group together.

The group should be heterogeneous regarding:

- Diagnoses, type and intensity of presenting problem, types of trauma experiences
- Diversity: ethnic, racial and cultural backgrounds; religious beliefs; sexual orientation; socioeconomic backgrounds; physical disabilities
- Personality styles (timid vs. risk-taking, shy vs. outgoing, active vs. passive, positive vs. negative attitudes, internalizing vs. externalizing behaviors, motivated vs. ambivalent etc.)
  - In order to make sure that the group is active enough to cohere, there need to be at least a few members who display an outgoing personality, excitement about the group, are motivated to work, are willing to take a risk and “put

themselves out there” and posses at least a moderate degree of psychological mindedness/sophistication. These traits are contagious, decrease feelings of ambivalence of other members and increase early group cohesion.

The group should to be homogenous regarding:

- Foster care experience (trauma, loss, separation)
- Developmental level/age: 15-18 years
  - Schechtman (2006) and others generally recommend homogeneity regarding age due to developmental concerns. Therefore, a developmentally mature 14-year old or a less mature 19-year old may benefit from participating in the same group – as both may struggle with the same developmental tasks (individuation, development of sexual identity etc.)
- Gender: in this case only females
  - While Carrell (p.20) states that young adolescents tend to work better in same-gender groups whereas older teenagers benefit more from mixed-gender groups, it ultimately is the objectives of the group that should determine the composition. In this case, the decision to run a group exclusively for females was based on the hypothesis that many females in foster care had experienced sexual abuse and would feel safer processing these experiences in a single-gendered setting.
- Quality of object relations, attachment/trust issues (though the way in which these present themselves may be different, e.g., dysfunctional interpersonal relationships, trusting too easily or not at all, having no boundaries)

### 2.5.3. Group Size

Most group work experts recommend a group size of six to eight participants (Shechtman, 2006; Smead, 1995 etc.), though Malekoff and Carrell ran groups with up to 12 or even 20 members. Yalom (1985) considered eight members as an optimal number, as the “sense” of group would not be disrupted even if two members were absent at the same time. When determining the size of a group, factors like age of members, objectives and rationale of the group, need of the members, setting, and sometimes financial aspects play a role. Malekoff (p.71) quoted Hartford (1971, p.162) as follows: “The group must be small enough for each person to be heard and to contribute, and also to feel the impact of the group upon his beliefs and behaviors. However, groups should not be so small as to over-expose members or to provide too little stimulation.”

In our case, most members will have received little attention from adults growing up and can, therefore, benefit from a smaller group. In my experience six members are ideal though two more or less should work just fine. Do not start the group (meaning the first session) with less than four members and do not allow more than eight. If the dropout of two members causes your group to consist of just three people, you may continue with those three for a period of time, but screen new members and add them at the same time.

It is important that your members show up to all sessions, but if there ever happens to be a group to which only two people show up, do not cancel it. Be creative, do something special with them, take them out somewhere, let them choose how to make use of the time and don't make them feel like they need to talk the entire time now that they are alone with you. Most importantly, show them that you are happy that they came and

that having a group with just the two of them is equally worthwhile. Believe me, they may play it off, but they will test, if they are “important enough.”

## 2.6. Issues of Diversity

A topic that cannot be neglected when working with the foster care population is the issue of diversity. As indicated by the statistics above, a disproportionately large number of children in foster care come from an ethnic minority (mainly African American) background, they come from different socioeconomic environments and many are in homosexual relationships – which may partially be due to the fact that many females in foster care experienced sexual abuse by men and may therefore feel safer in romantic relationships with females. The issue of diversity is of high importance because your teenagers may not only be confronted with discrimination in school on a regular basis, but also because it may play itself out in subtle (seating arrangement, activity level) or not so subtle ways (curse words/jokes regarding race, sexual orientation etc.) in group. If it does, it can be both therapeutic and anxiety-provoking. As Hurdle says: “Counseling groups with racially and ethnically diverse members can be both challenging and enriching for the group members and its leaders” (p.361).

The group that this manual was based on was very diverse in regard to sexual orientation, SES, ethnic, racial, cultural and religious backgrounds. Nevertheless, these girls did not seem to experience each other as “different” within the group. Since my co-facilitator and I had anticipated the issue of diversity to be much bigger of an issue in group than it turned out to be, we explored potential reasons to make sure that the lack of conversation about it was not due to an “elephant in the room” that was too

uncomfortable to be addressed...or that they were so concerned with wanting to “fit in” that they did not want to jeopardize their “groupness” by pointing out their differences...or that this type of silence was an expression of resistance or ambivalence on our part and that my co-facilitator and I unconsciously sabotaged this topic because in fact we were the ones feeling uncomfortable bringing it up. Having taken all these possible explanations into consideration, looking back I would say that the girls simply had “bigger problems” than to explore the ways in which they looked, loved, prayed, or pronounced differently. The shared experience of *being in foster care* seemed to overweigh other, what they called “superficial”, differences.

This does not mean that the members did not know what it was like to feel different and to feel misunderstood – which is why the group called itself the “MIA’s” (Misunderstood Individuals Associating / Missing In Action). These girls more than anyone knew what it was like to not fit in, to be stared at, judged, ostracized, scapegoated, humiliated, laughed at, cursed out, avoided, rejected, neglected, overlooked – due to their sexual orientation, ethnic backgrounds and (according to them first and foremost) for being in foster care. Having to talk about issues like sexual abuse, having to make up a lie about why their (foster) parents had a different skin color than them, or explain why their mother is in prison or decided to give them away was more pressing. The foster care issues overpowered the teenage issues – at least in the beginning.

Even though our members experienced themselves as “the same” within the group setting, it would be a fatal error for any therapist to assume that issues of diversity can be ignored just because these girls share the similar experience of being in foster care. Being culturally competent, and sensitive to issues of diversity is crucial. McRae and Short



(2004) suggest that facilitators gain in depth knowledge of the cultural and personal backgrounds (including their history, level of acculturation, family traditions, interpersonal communication styles, history of oppression) of the clients that they are working with and to explore how their own cultural values contribute to the dynamics and processes of the group.

Working across differences such as race and culture requires awareness of self and others, understanding of racial and cultural differences, and willingness to develop skills that enhance interpersonal communication. (McRae & Short, page 138)

Green (1999) among many other authors states that providing services in ways that are culturally acceptable to client groups will enhance their participation, power, and engagement in services. My hypothesis is that the MIA-girls were able to bond as much as they did (despite their cultural differences or maybe even because of them) because the facilitators were sensitive to issues of diversity from the beginning (even before the screening process). Having done a lot of reading about running groups with culturally diverse members before hand, we knew that finding the “right” composition was important for two reasons:

One, to ensure that group therapy would not be an isolating experience for any of the girls. In her book chapter on “Skills and Methods for Group Work with Racially and Ethnically Diverse Clients”, Donna Hurdle (2004) writes: “If possible, the selection of multiple members from the same racial or ethnic group is preferable to a single person in order to reduce isolation and build support” (p. 356). As mentioned above in the chapter on “Homogeneity versus Heterogeneity”, the purpose of this group was to create a space where girls who were used to feeling isolated and different could find a place in which

they could experience themselves as similar as others and as part of something.

Therefore, creating a group that exists of only one “externalizing” girl in the midst of a bunch of “internalizing” girls, one African American in the midst of Caucasians, one homosexual or bisexual in the midst of heterosexuals, one sexually abused girl in the midst of girls who could not relate to this type of traumatic experience, could have resulted in another “isolating experience” within the group, which is the very thing that we wanted to avoid. We were very conscious of these issues during the screening process.

The second reason why we paid careful attention to the composition of the group during the screening process was because we were aware that the constellation of individuals in our group would have a large influence on the dynamics (i.e., power and communication issues, stereotyping, subgrouping etc.) that would develop within the group. An interesting study by Davis (1997) focused on racial balance and composition in interracial groups, an aspect which had previously received little attention. . In his study with undergraduate students he found that Blacks and Whites differ in their perceptions of what constitutes an ideal racial balance within a group. Mc Rae & Short (2004) on Davis:

Black people seem to prefer groups with equal numbers of Whites and Blacks, whereas White people seem to prefer groups that are proportionate to societal representation. For example, if Whites see themselves as being in the majority of 70% of the population, then they are more comfortable in a group in which they are the majority. (p. 139)

Davis’ study along with McIntosh’s paper “Unpacking the Invisible Knapsack” (1998) made us aware that the imbalance in terms of racial compositions in most groups is one of the many privileges and unconscious norms that Whites enjoy (and take for

granted). Because of the above mentioned overrepresentation of African American children in foster care (and probably also because we knew of unconscious attempts of Caucasian therapists to remain in a position of dominance and power by creating a group in which their own race outnumbers the minority race), our group consisted of more children of Color than White children. The composition of the group that we created seemed a more accurate representation of what Yalom calls a “social microcosm” – at least within the foster care world.

Both Hurdle (2004) and McRae & Short (2004) wrote about how the racial composition of a group is related to issues of power, status, authority, leadership, member roles, subgroups, privilege, prejudice and verbal participation. McRae & Short stated that the members of the majority subgroup are the ones who have more status and the ones who set the norms within the group. Most members conform to the norms of the group, not necessarily because they agree with them but because they want to be part of the in-group. The norms of the majority often are experienced as an invasion of personal boundaries by the minority. For instance, talking about the reason why one ended up in foster care may be more “normal” for White members, who according to McRae place value on “verbal fluency” (p.139) but could be experienced as snitching or gossiping by African American members who may be uncomfortable around sharing family business with strangers.

Hurdle states that differences in power and privilege within a group are likely to parallel those of the outside world. For instance, Caucasian members may speak first and more often and are more likely to take on an “informal leadership role” (p. 356). Empowering each and every single member is important so that the lack of power that

people of Color often experience in their daily lives does not get repeated in group. If it does, it is important that it gets addressed on a group level in the here-and-now.

According to Davis et al. (1995) group facilitators need to “stop the action and confront directly when there is a problem between persons of different races” (p. 163). As much as group leaders may want to avoid such difficult discussions it is important to model healthy interactions and to let the members know that the group is the place where these kinds of conversations are possible and encouraged.

Most of the activities and interventions we utilized in group had the goals to empower our members to take control, speak up, assert themselves and provide them with a sense of ownership – which is important for the foster care population as well as people of color, who often feel invisible, powerless and suppressed. The activities aimed at teaching our members the communication, problem solving, assertiveness skills they needed in order to make themselves heard and advocate for themselves, as well as at increasing our members’ level of empathy so they could hear each other. Plenty of activities (holiday celebrations, pot lucks, reunions) were geared to educate them about new customs, perspectives and traditions so they could appreciate diversity and be aware of and sensitive to other cultures and ways of living. When planning activities for your group, please be sure to not only think about which activities you want to pick, but also pay attention to:

- how they are administered:
  - Round robin technique versus finding volunteers: going around the circle and asking everyone to contribute is preferable to finding volunteers to speak as it

often ends up being the same person (often from majority group) getting her voice heard.

- Democracy: when making decisions, be sure to ask everyone for their opinion and take a vote afterwards.
- Anonymous feedback form: gives members who do not feel comfortable yet raising their voices in front of everyone the chance to still be heard.
- Role-plays/switching chairs: helps them take other perspectives.
- what you focus on:
  - Resiliency: focus on their strengths, talents, gifts, resources, survival skills.
  - Empowerment and self-advocacy: metaphorically feed them first but then teach them how to fish so they can learn to feed themselves and then provide for each other.
  - Self-reflection: when do they themselves talk in ways they don't want to be talked about (judging, gossiping, stereotyping, being disrespectful etc.)?
  - Seek out and do not avoid: look for themes that invite conversations about diversity, talk about how these issues play out outside and inside of group.
- and how you do it:
  - Openness: Make as few assumptions about their worlds as possible. Try not to probe but instead let the members teach you about their stories (through timelines), their families (through genograms), their cultures (through music, potlucks, and pictures) and their perception of the world (through poetry, art, metaphors, and conversations).

- Boundaries: While the girls can be in charge of most of the content, do set strong boundaries around the “tone” of the group to ensure that every girl feels safe to take personal risks. The expression of all types of emotions is encouraged (including anger), but the ground rules are that they treat each other with respect, and that no one laughs at or hurts each others feelings on purpose. Even if they are joking or are not trying to be hurtful, words like the N-word are not allowed.
- Be aware of own biases (see below).

In the light of the above mentioned diversity literature, it certainly was not ideal that both leaders of our group were members of the same (majority) race – and even if I identified more as an “international student” with a very noticeable foreign accent, I still look like someone of the “majority group”. According to Hurdle, there is evidence that a person of Color for the most part prefers a leader from the same ethnic background, when given the choice. Since we were not able to provide that for our group, we were conscious to not also have the undergraduate student that we picked be a member of the majority race. As I and my co-facilitator may not always have been aware of all the ways that our Eurocentric backgrounds unconsciously shaped the dynamics of the group, we always tried to detect and reflect upon our own cultural attitudes, biases and stereotypes that revealed themselves in various ways. For instance, instead of asking our members what it was like to be raised by their *parents* before having been removed by DYFS (which is a question that is influenced by White standards, as it only focuses on the nuclear family), we ask our girls to define *family* and to talk about whoever played an

important role in raising them. That way they can include the extended family system as well as significant family friends and the like into their stories.

While the difference of race, ethnicity and/or cultural background between some of the members and the facilitators was an issue that may have increased our members' suspicion and mistrust towards us in the beginning of treatment, it was no longer an issue after the members realized how much we cared about them. As mentioned above, within-group diversity was never an issue of concern to the members but it was actually my accent (and my German chocolate treats) that sparked questions about the history of my country and started a conversation about race, culture, discrimination, stereotypes, judgments, national burdens, and shame, guilt and insecurities regarding one's origin, accent, skin color, privileges and the like. Since my nationality is a very loaded and shame/guilt-provoking topic for me, I obviously would have preferred not having been the trigger for this type of discussion. But then again, how could I ask them to talk about issues that they would rather keep inside, if I do the same. Like the girls always said: Don't talk the talk if you can't walk the walk.

## 2.7. Place/Set-Up

As mentioned before, your population needs as much stability and continuity as possible. I would recommend making as few changes as possible after initial arrangements (regarding meeting day/time, meeting place, and rituals on how to begin and end each session etc.) have been made. Even seemingly little external changes can have a big effect on the internal feelings of safety of a member. Therefore, anticipate interferences; plan and communicate changes accordingly (e.g., start the group as late as possible to

begin with, so that the day and the starting time does not have to be changed due to after-school activities).

I suggest assigning a room for the entire year in advance. If you have a choice, pick a comfortable room that is big enough so that one does not feel suffocated and small enough so that one does not feel lost. Must-haves are tables (that are usually pushed aside but can be used for art activities, pot lucks etc. when needed), a room that allows anonymity (no windows in the door, otherwise put a screen in front of it), a big board/white board, a clock that everyone can see, and tissues; good-to-haves are a music system (speakers) and a TV with DVD player.

The room we used was large but had a little comfortable sitting-corner with a couch and nice chairs, the view out of the window was scenic, the floor was carpeted (so that we could sometimes sit on the floor). It was well equipped electronically but did not have a camera in it; it had a chalk board and a white/magnet board, a clock, big tables with wheels, and was close to the bathrooms.

When it comes to setting up the room, always make sure to:

- Push the tables aside so that ‘nothing stands between’ the members;
- Sit in a circle so that everyone can see each other.
- Leaders should
  - not sit right next to each other (too intimidating) but mingle with the group,
  - sit in a way that allows you to make eye-contact with each other,
  - switch seats occasionally to break up potential cliques and to give everyone the chance to sit next to a “parent” once in a while.



- At least one of the facilitators – preferably the more punctual and organized one should be able to see the clock.

Regarding bathroom breaks, snacks and punctuality:

- We did not allot a time slot for bathroom breaks. If someone needed one, they asked and quickly stepped out without interrupting. They were asked to, if possible, go between (not during) activities.
- Snacks and drinks were not provided every session. When the leaders brought snacks, we all ate them together, usually some time towards the end of group. If they needed nourishment earlier, they could bring it up.
- Getting to group and starting it on time was important to us; ending the group on time was difficult for both facilitators and I don't think we set a very good example for that – although we tried to not go over too much (unless special circumstances demanded it).

There are varying opinions when it comes to serving snacks (and the timing of it), sitting too comfortably, bathroom breaks, disruptive windows and the like, as these factors might provide too much distraction and promote unwanted interruptions. Many facilitators minimize all factors that might distract members from being in the moment and being attentive. They accurately voice the concern that some members might use these opportunities to withdraw or change the subject. The co-facilitators of this group were aware of these risks and took them into consideration when planning. To us, creating a comfortable, warm, homey atmosphere was more important, as most members

have never had the chance to experience a safe, comforting home environment. We preferred our members expressing something with their feet on their chairs or as mentioned before, ambivalently with a slice of pizza in their mouths than not at all. When we realized that someone was staring out the window or isolating herself from the group, it usually said something about her or what was going on in the room; and we were able to process it and explore which defense mechanisms/strategies others use when they can't tolerate a subject. In general, if we felt like our approach regarding quick bathroom breaks, kicking back too much etc. were misused, we brought it up, talked about the meaning behind the behaviors and collaboratively found a solution for it.

## 2.8. Rules

As mentioned above, I'm a great advocate of giving adolescents as much control in decision-making and group-creation processes as possible. While there are very few areas in which the opinion of your members is more essential than when it comes to creating the group contract, there are some policies that are nonnegotiable and need to be communicated from the screening session on. The two rules your members have to agree to after the screening session or at least before the first official group session revolve around confidentiality and attendance. These two rules need to be stated clearly on the consent form, which you explain and hand out to your (potential) group member during the screening session. See Appendix I for an example of a consent form.

Other rules very much depend on the needs of your members and your own values and personal style. I tended to be rather permissive around issues regarding language and behavior. I did not mind if the members had their feet on their chairs, joked around, got louder or cursed, as long as I did not feel that they were trying to test reactions or push

boundaries. To me those behaviors were a sign of them getting comfortable, being able to take a break from their chaotic world outside, relax and be themselves. Their expressive tone of voice and uncensored language was seen as their being invested in the group and having enough trust to display authentic emotions, which is something that I believed needed to be supported rather than reprimanded – or in the very least be processed. Malekoff (2004) stated nicely that group facilitators frequently do not recognize that these types of adolescent behaviors often indicate that they have “established a sense of trust and intimacy” within the group (p. 78). He also quoted Wineman (1952), who differentiated between “reasonably controlled wildness” versus “total destruction or panic producing breakdown of behavioral controls” and was of the opinion that “swearing does not necessarily denote hostility, insult, or the like, but can be a cultural pattern for vehement or empathic expression of positive feeling, sheer good spirits, or pleasure” (p.95). While I was not strict on cursing in general, I was, however, very rigid when it came to members making statements that could possibly hurt each other. As mentioned before, there were no jokes, mocking, or name calling around race, physical appearance, religious beliefs, or sexual orientation. The “N-Word” was not allowed; neither were comments like “that’s gay” or jokes about Jews or someone “looking like a terrorist”. Of course, we talked about the reasons for those rules and processed the issues as they came up, but I’m sure that most members were surprised about my firmness on this – as I was doubtlessly viewed as a rather laid-back group facilitator otherwise. Yet, this policy created an awareness of other’s sensitivities and was respected by the members.

Generally, adolescents will push boundaries. It is part of their developmental tasks. Adolescents in foster care may do so to an even greater extent. Nevertheless, for

the most part, they will respect boundaries as long as they are reasonable and make sense to them. Capriciousness does not work. Be fair, predictable and consistent when rules are broken. As Malekoff said, an “arbitrary use of authority” is as equally harmful as an “almost-everything-goes policy” (p.78). It took me a while to internalize this, but “almost everything goes” can be translated into “I don’t really care”. Setting limits does not mean that you are trying to limit your members’ freedom but that you want them to be safe as they explore the world. Setting limits means you care; giving structure provides safety and contracts grant predictability, which is therapeutic for children of parents who often cared too little.

In addition to your members’ needs and your personal values, other variables that can be considered regarding limits according to Malekoff are the policies of your agency, the sensibilities of colleagues who will be within earshot of the group, and values and expectations of parents and other adult stakeholders.

#### 2.8.1. Attendance/Participation

- It is agreed that your members attend all sessions, unless they are sick (missed school because of it) or are in some other crisis that prevents them from participating.
- The members are to show up on time and not leave early.
- Planned absences are to be announced to the group in advance, others need to be announced to the therapist and the transportation aid 24 hours in advance.
- We did not define a number of “excused absences”. The expectation is to attend ALL sessions. If members miss too often, it needs to be addressed.

- ⇒ Regular and timely attendance is important. Irregular attendance and tardiness prevents the group from cohering and progressing. Having to repeat information that was being disclosed the previous week to get everyone back to the same level hinders the process. If your members do not want to attend a session for whatever reason, they are asked to show up anyway and bring their ambivalence up in group.

### 2.8.2. Confidentiality

- To ensure that the group is a safe place, everything that is said in the group is and will stay confidential forever – even after members leave the group.
- This means that there will be no disclosure of any information, stories, names (including name of school) to anyone outside of the group, including best friends, partners, family members, or caseworkers.
- However, members are allowed to talk to people outside of group about their own experiences, as long as no other information is being shared.
- Similarly, group facilitators will not disclose any information unless it is for supervisory reasons. They will not share information with family members, teachers, or caseworkers of the members, or contact the police – no matter how deviant the members may be or how important the revealed information might be. Information sharing with individual therapists or other professionals will be addressed with each participant in advance
- The only instances when group facilitators are obligated to break confidentiality is when an adolescent is engaging in or is planning behaviors that could cause serious harm to herself or others, is being threatened, or is being maltreated. In those

situations the therapist is legally bound to report the (current or possible) danger to the proper authorities. Also, if a member discloses an incident of past abuse that has not yet been reported, a report may need to be made – especially when there is a chance that the offender might currently put other children at risk. These situations are extremely challenging for the survival of a group, as your group members may view your actions as a betrayal (even if you discussed these cases with them beforehand) rather than an attempt at keeping them safe.

- ⇒ Confidentiality is the most important rule of the contract. Your group will fall apart and possibly retraumatize the members if it is not respected. Hence, breaking confidentiality jeopardizes future participation in group. Please explain the relevance of this rule thoroughly and make sure that your members understand its significance.

### 2.8.3. Termination

- In this type of (open-ended) group, your members agree to attend until they have achieved the goals that they came to work on.
- If a member wants to leave before the goals are accomplished, Buchele, et al. (p. 109) require the departing member to complete a three-step process to prevent members who have experienced many losses throughout their lives from being retraumatized by this leaving process.

1. The member needs to attend an individual session with one of the group facilitators to explore the reasons for the departure, find possible solutions or help the member communicate the termination to the group.

2. After the individual session, the member will discuss their exit feelings in the next group.
3. The member will attend three more sessions to give herself and the group enough time to process the termination and get some closure. The exact procedure and whether or not there should be a goodbye ceremony (which we decided on in our group) should be decided by the group.

#### 2.8.4. Respect (Behavior/Language)

- Members need to agree to be respectful to one another. No hurtful comments should be made on purpose and no violent acts – physically or verbally - are permitted. If unintentional hurtful comments are made, we take responsibility, express genuine regret and try to understand the reasons behind them.
- Remind the members that this is supposed to be a different type of place: one where they do not have to worry about being mocked, ignored, neglected, laughed at or hurt. In order to feel safe, they have to be respectful and empathic to the sensitivities of other members. Specify this and give examples for what is appropriate and inappropriate (e.g., name calling, jokes about certain issues).
- Reactions should be expressed through words not behaviors. Do not just get up and slam the door, do not punch a member or not show up to a group – talk about what it is that offends, frustrates, upsets or overwhelms you to make you want to leave, hit, or withdraw. If you feel it, chances are that others will feel similarly and will be glad that it gets expressed by someone and then processed. Obviously, this rule does not mean that members can't cry, yell or express authentic feelings in noisy ways.

- Other issues that can be addressed on the contract: take turns, do not interrupt, let everyone talk, try to contribute, do not change the topic when it gets uncomfortable and do not start laughing when someone shares something personal or difficult.

#### 2.8.5. Outside Contact

- Most group experts warn against out-of-group contact as it runs the risk of undermining group processes (Stone & Rutan, 1993). Therefore, most adult group contracts include a policy against any type of socializing outside of group.
- While various undesired consequences can result from outside contact, we did not fully prohibit it for several reasons. In adolescent groups we have to assume that some outside contact will occur regardless (on the bus, through common friends, digitally etc.). Rather than banning it completely and having the members rebel against it or hide it, we educate them about potential risks (of clique-building, hurt feelings of members who do NOT get contacted outside of group etc.) and ways to keep those connections as constructive as possible. Also, for traumatized, isolated adolescents, outside contact can be a “vehicle for tentative reconnection” (Buchele, p. 108) and is seen as “therapeutic and helpful”.
- Nevertheless, as recommended by Buchele, our members need to follow some rules regarding outside contact.
  1. Relationships of group members can be platonic only (which is also why siblings can’t be admitted into the group). If members date, it brings too much additional turmoil into the group and might, in case of a fight or breakup, result in unsteady attendance or the premature termination of a



member. Dating members will not be able to use the group setting to talk about their feelings.

2. Any interaction that occurs outside of group will not be kept secret from but will be shared with the group. Unknown conversations or meetings create cliques and subsequently the division of the group (sub-grouping).
3. Calling or getting together with another group member to “stop loneliness or sadness or just to talk or laugh is healthy” (p.108) and permissible; partying together or using the group for other unhealthy, counterproductive purposes is prohibited.

## CHAPTER III

### THE BEGINNING

#### I. INTRO/PERSONAL NOTE TO THE GROUP FACILITATORS

Yes, I know: THIS IS SCARY! I remember it quite well. You and your co-facilitator have gone through a long process of getting referrals, screening potential group members, talking to DYFS workers, solving transportation problems and all those crazy logistics, consulting with your supervisors, planning the first session...and now here it is: the big day!

You wonder if everything will run smoothly, if the kids will get along, if they will hate you because they think you are DYFS, if they will participate or chose to be silent, if you made enough copies of the handouts, if things will get out of hand, if your nervousness will show. You think about the worst case scenarios, the nightmare moments; you go over your outline again to make sure that everything is structured.

And now guess what? Most likely, the group will NOT run smoothly, not everyone will like each other, there might be a lot of silence or disagreements, most members won't know what to make of you and some of them might dislike you in the beginning, you might forget some important handouts or materials and you might not be very structured. But if there is one single thing that I have learned, it's that NONE OF THAT MATTERS IN THE END!

I promise, all you need to bring is your heart, your genuineness and patience. THAT is what matters! You can plan a perfect group, have great ideas, be prepared...if you don't use yourself/realize that you yourself are the most powerful tool, everything else will be meaningless. What these kids need in the end is not the right amount of handouts, but someone who cares and shows patience.

And here is the great news: if you signed up to run this group despite the internal and external resistance that you are facing, it means that you already possess what it takes to run a meaningful group. You already care! And these kids will be able to tell. Maybe not after the first few sessions and maybe (no, most likely) they will test you until you want to give up (that's where the patience part comes in), but always remember: their abrasive behaviors towards you most likely have very little to do with you...and everything to do with their history and their much needed defense mechanisms. One of the biggest mistakes you can make is to take it personally, when really they are just testing if you are just like the other adults that have disappointed them throughout their lives. If you are patient and withstand (and later point out) their testing, if you stand by their side no matter how often they try to push you away, you give them a potentially life-changing gift. It will impact the way they view adults, relationships – and, most importantly, the way they view themselves.

As Malekoff said: "Perhaps the greatest challenge in working with adolescent groups is that, no matter how prepared one is, one is unprepared. One of the greatest allies and advisors is your creativity" (p. 110). Now, this does not mean that trying to prepare as well as possible is useless. OF COURSE you are trying to bring some structure into their unstructured, uncontrollable, unsafe and unpredictable lives, but what to strive

for, in order to meet both their foster care and developmental needs, is a balance between flexibility and structure, NOT perfection! It's the imperfect moments – the above mentioned nightmare moments – that ultimately have the most potential for growth. A group in which conflict does not occur sounds great but is not therapeutic! It would be counterproductive for many reasons. It might mean that your members don't feel safe enough to express viewpoints that deviate from the group. It deprives them of the chance to learn to deal with conflict in a productive way and learn that relationships don't need to fall apart after an argument – and that they remain lovable, even after a fight (which means that love and anger can coexist). So conflict needs to occur at some point. And it will. Ultimately. And most likely (and I'm sure you will be extremely relieved to hear this) NOT in the first group meeting. Not according to my experience and not according to Tuckman's stages of group development (1965), which predict that conflict will not occur until the second "storming" stage – as indicated below.

Remember, your first and most important goal of the journey is to create a safe place; and on your road everything, and I mean it, absolutely EVERYTHING that happens in group is grist for the mills. Use the moment! Look for parallel processes. You are nervous? Make use of that feeling! You can be sure that the girls are even more nervous – and that they're trying their hardest to hide that fact. Just like you. Just imagine how relieving it could be if you voice it: "Boy, am I glad to see you all but wow, am I nervous!" It's a simple sentence, but it normalizes their experience; it models that it is acceptable to express uncomfortable feelings that they may usually keep to themselves; it shows that appreciation and anxiety can coexist; and it makes the group leader less anxiety provoking and more human and approachable. Genuineness is so important!

These kids especially will detect phoniness more than anyone else. So, be yourself, show emotions, don't be the stereotypical (emotion-provoking but not emotion-showing) shrink that they expect and fear.

I know there is not much I can say at this point to take away the anxiety that you are probably experiencing right now – and feeling a moderate degree of anxiety is actually a good thing (as it helps you relate to your group members and shows that you are taking it seriously). But I would like to take away some, so please just keep in mind that deep down these kids want this group to work more than you do. They long for a healthy family, and you can give them a sense of family in group.

I wish you a great start to a journey that for me became the most challenging but also the most gratifying and fulfilling experience since the beginning of my psychology training.

## II. THE FIRST TWO STAGES OF GROUP DEVELOPMENT

Several authors have come up with different theoretical models of group development, trying to examine patterns about how small groups change over time. One of the most famous theoretical models was developed by Tuckman (1965), who stated that groups go through four linear developmental stages: forming, storming, norming, and performing. Later on, a fifth stage – the adjourning-stage - was added (Tuckman & Jensen, 1977), describing the termination phase. Other models, such as Tubbs' System Model (1995), found similar sequential patterns: Orientation, Conflict, Consensus, Closure. As mentioned in the introduction above, group experts seem to agree that the "messy" part in which conflict arises usually does not occur in the first stage of group development.

Malekoff, who similarly differentiated between five different stages – the Preaffiliation Stage, the Power and Control Stage, the Intimacy Stage, the Differentiation Stage, and the Separation Stage - composed a poem that nicely describes what happens in group throughout the process of its development.

A group  
begins  
by building  
trust,  
chipping away  
at the  
surface crust.

Once  
the uneasy  
feeling is  
lost,  
a battle rages  
for who's  
the boss;  
Kings and  
Queens  
of what's  
okay  
and who  
shall  
have the  
final say.

Once that's  
clear  
a moment  
of calm,  
is quickly  
followed  
by the  
slapping of  
palms.

A clan-  
like feeling  
fills  
the air,  
the sharing  
of joy,  
hope,  
and despair.

Family

Dramas  
are replayed,  
so new  
directions  
can be  
made.

Then in  
a while  
each  
one  
stands out,  
confident  
of his  
own  
special  
clout.

By then  
the group has  
discovered  
its  
pace,  
a secret gathering  
in a special place.

Nothing  
like it  
has occurred  
before,  
a bond  
that exists  
beyond  
the door.

And  
finally  
it's time  
to say  
good-bye,  
a giggle,  
a  
tear,  
a

hug,  
a  
sigh.

Hard to  
accept,  
easy to  
deny,  
the  
group  
is gone  
yet  
forever  
alive.

So if you've  
asked me  
"what is  
going  
on in  
there?"  
I hope  
that my  
story has  
helped  
make it  
clear.

Maybe  
now  
it is  
easier  
to see,  
that a  
group  
has a  
life,  
just  
like  
you  
and  
like  
me.

– A. MALEKOFF (1994)

Figure 1. Poem "What is going on in there?" (Malekoff, p. 59)

During each of these stages of group development, different challenges emerge and different goals need to be reached for the group and its individuals to be able to grow.

## 2.1. Stage 1: The Initial Stage

### 2.1.1. Challenges/Fears of Your Members during the Initial Stage

As beautifully illustrated by his poem, Malekoff stated that the first (preaffiliation) stage revolves around creating a safe place and establishing initial trust. This is not an easy endeavor, particularly for a population that has strong defense mechanisms to keep them from getting hurt again. Although I have already quoted him many times, I would like to again quote a paragraph by Malekoff, as it not only perfectly describes the processes and goals of the first stage, but also addresses the particular needs and challenges of both the adolescent and the foster care world in regard to this trust-building first phase.

Establishing trust is a predominant feature of this early stage. Members relate to one another, to the worker and to the situation “at arm’s length” (characteristically referred to as approach-avoidant behavior). The worker provides structure, thereby reinforcing a physical and emotional safety, and invites trust gently in this, the early life of the group. The beginning of the group may be particularly difficult for adolescents who have come from unstable family environments characterized by inconsistent handling and unpredictable comings and goings. When a lack of trust pervades one’s life experience, one can expect that experience to be carried into the group. Practitioners must tune into this reality, as well to the natural tendency for some (not all) adolescents to mistrust adults in positions of authority. The members gradually move toward making a preliminary contract with the group. When a group consists of adolescent members for whom a lack of trust is a major theme in their lives, the work in the earliest stage of the group may be particularly intense and subject to reworking with every shifting tide and transition that the group experiences. [...] Young people living in families that are seriously dysfunctional may be hypervigilant, endlessly surveying the scene for land mines. Structure, predictability, flexible handling, clarity, and consistency



in the group over time are all necessary precursors to developing a feeling of trust. Any appearance of trust with any less care is likely to be no more than a pleasant illusion. (p. 53)

The last sentence is important. In group, things often are not as they appear. If deeply traumatized adolescents are too open and trusting at the beginning, it's a problem (see below: early/premature disclosure). If everyone just voices excitement about being present, they most likely want to fit in and do not dare to display the scared side.

Members who act like they could care less and voice that they are never going to trust anyone usually care the most and have the strongest desire for trust. We need to be patient and trust that what's underneath the surface will reveal itself once your members are ready.

The feelings that your members experience when they first enter the group are both hope and anxiety. You can expect that there is a lot of ambivalence, even if it does not get expressed. Make sure that you bring the other sides of the ambivalence into the group, if the members do not dare to bring them up:

Tabel 1  
Potential ambivalence of group members.

Anxiety/Avoidance	Hope/Approach
<ul style="list-style-type: none"> <li>• Fear of the unknown</li> <li>• Fear of not being accepted</li> <li>• Fear of getting hurt</li> <li>• Fear of being vulnerable</li> <li>• Fear of getting involved</li> <li>• Fear that things won't be confidential</li> <li>• Fear of not succeeding</li> </ul>	<ul style="list-style-type: none"> <li>• Want a family-like setting</li> <li>• Want friendship</li> <li>• Want relationship with facilitator</li> <li>• Want to accomplish purpose of the group</li> <li>• Want to achieve personal goals</li> <li>• Want to reveal themselves</li> <li>• Desire closeness</li> <li>• Want acceptance</li> <li>• Want to gain trust and not get disappointed</li> </ul>

The left side of the chart, Anxiety/Avoidance, causes your members to be very cautious, withdraw, avoid strong feelings or certain topics that could evoke “uncontrollable” feelings, keep their distance, be very suspicious, be resistant to committing to the group, and display a tough façade. The right side, Hope/Approach, causes members to give the group a chance and to carefully explore and check out what and who is around them.

### 2.1.2. Tasks of the Facilitators during the Initial Stage

By paying attention to the following points, you can make this extremely anxiety-provoking process easier for your members.

- Be more active in the beginning. Your members are more dependent on you in the first few sessions, as they have not yet developed relationships with each other. They

need you for guidance, direction, structure, and approval. Make sure to provide a good orientation.

- Make everyone feel welcome, valued and important. Give everyone room to contribute without putting pressure on them.
- Promote communication among them (the activities below will help); build bridges, help them discover commonalities. Reinforce it, when they are reaching out to one another; back off if communication works without you.
- Acknowledge and ease their fears (see above); let them know that they are all in the same boat.
- Express excitement about the opportunity of coming together as a group and convey confidence in the potential of the group and the growth of the individual members.
- Help the group develop common goals, purpose and norms. Always communicate that it is their group.
- To reiterate what Malekoff stated above: “Structure, predictability, flexible handling, clarity, and consistency in the group over time are all necessary precursors to developing a feeling of trust.”
- Model the kind of tone and interaction that you would like to see within the group.

### 2.1.3. Goals of the Initial Stage and Corresponding Activities

Below is a list of objectives that are relevant during the first stage according to Corey and Corey (2003), Malekoff (2004) and Shechtman (2006). Under each objective are examples of tasks and activities that promote the achievement of that objective.

- Creation of a physically and emotionally safe and secure place in which trust can develop (most important task).
  - Comfortable, predictable/familiar set-up of room
  - Creation of constructive group norms
  - Predictable meeting time, place and structure of sessions
  - Explaining the presence of cameras. Most rooms at the training clinic at GSAPP have cameras for supervisory reasons, which may make your members feel suspicious and unsafe. Explain the purpose of the cameras, that you do not plan on using them, and that you would never turn them on without asking for their permission first. You could even cover them up to ease their doubts.
- Orientation to group
  - Facilitator to the group (explanation of your role etc.), members to the facilitator, members to other members
  - Members to the situation, time, place, frequency, content, structure of meetings, boundaries etc.
  - Developing norms, values, pattern of communication, purpose of the group, group and individual goals. (Even if discussed with individual members during screening, these issues need to be covered with everyone present so that they can become a reference point.)
- Forming relationships/bonding as a group
  - Introductions (Icebreakers)
  - Searching for commonalities = basis for cohesiveness (Icebreakers)

- Sharing outside interests (Icebreakers)
- Recognizing ambivalence (Worries and Excitement - Activity)
- Bonding as a group (Group Statement, Group Name, Group Rituals etc.)
- Warning about premature disclosure
- Developing a language of feelings
  - Assisting children in learning to identify and talk about their emotions
  - Model how to talk about feelings, pay attention to your own feelings, look for parallel processes
  - Address resistance
  - Talking about worries and fears
  - Promote empathy: teach how to put self into others' situations; model how to recognize emotions of others and react appropriately and empathically.

## 2.2. Stage 2: The Transition Stage

Although it is not very likely that you are going to encounter the characteristics that are unique to this second (“storming”) stage during the first few sessions, I am still going to mention them at this part of the manual, as some members may display difficult behaviors earlier than expected. According to Corey and Corey (2002) (in Sheppard, p.44), the characteristics of this stage are the following:

- Anxiety. In addition to the above mentioned anxieties of the first stage, group members are experiencing additional fears around sounding stupid, losing control, being misunderstood, being rejected and not knowing what is expected of them.

- The testing process and building trust. During this stage, your members begin to test whether they can trust you and the group. They might show up late, be disruptive, obnoxious, rude or hurtful, may curse more to see how you react, take advantage of bathroom breaks, answer the phone during the session and so on. Children in foster care may test how much they can push you until you give up on them/reject them like other adults have. While this is probably not going to make you feel much better, their testing actually means that they already have developed initial trust but are scared to let themselves get much closer. The more they get attached to you and the group, the more they have to lose. And, of course, they expect this good thing to only be temporary. Because in their world, good things never last. Corey and Corey stated that members usually are more tentative (less disruptive) when trust is still low, as they are still trying to test the climate. When trust is established, members begin to take more risks.
- Defensiveness. During this stage members rely on skills that they typically use in stressful situations. They show “real” emotions, the types that get them in trouble outside of group – not the type of socially acceptable emotions that are often displayed during the first stage. As uncomfortable and difficult as these (often dysfunctional) behaviors may be for everyone in the room, it is necessary for them to be displayed in group so that change can occur. As soon as the member has some trust and is ready to be confronted with her own coping/defense mechanisms, you can explore the need, benefit, function, origin and outcome of them within the group.
- Struggle for control. As mentioned before, most of your adolescents have had little control over their lives before but were victims of their environment, which is

- extremely anxiety provoking. While some have accepted their fate and have given up trying (principle of learned helplessness), others turn into over-controllers. In their attempt to gain some control within the group setting, your members may present characteristics such as competition, rivalry, jockeying for position, and jealousy.
- Conflict. Some members can tolerate conflict well; others have the tendency to avoid it, as they are too scared to jeopardize the peace. However scary it may be, conflict needs to be worked through for the group to be productive.
  - Challenges to the group leader. Some of your members will push your buttons until you are going to want to give up. Corey and Corey state that “one of the most powerful ways to intervene when you are experiencing strong feelings over what you perceive to be resistance is to deal with your own feelings and possible defense reactions to the situation” (p.183).
  - Resistance. In his research, Shechtman (2006) lists four primary types of resistance shown by children in this stage of a group in the order from most to the least prevalent: 1) refusal to respond, 2) distracting behavior, 3) outburst of anger, 4) verbal aggression.

While Smead (1995) stated that children often struggle less with trust than adults, thus moving into the working stage more quickly, traumatized adolescents may stay in this stage for a painfully long time. This does not mean that you will not be able to move on until the very last member has established a good amount of trust, but it does mean that you will hit bumps and be thrown back into previous stages whenever trust is endangered through different circumstances.

### III. STRUCTURE OF THE SESSIONS

#### 3.1. Check-In

During the first few minutes of every group session, find out where your members are at. Each member needs to talk between one and three minutes about pleasant or unpleasant experiences of the week, dreams, current feelings, what they are proud of, what they remember from last session or still need to process (unfinished business), what they have learned, how they may have behaved differently from their normal behaviors/patterns, if they have problems, are in a crisis, if they have a new issue for the topic list or need the group's help for something etc. Go in order and let the group decide who goes first. Make sure to take turns (that it's not always the same person going first), that they talk for at least one minute and do not go into too much detail during the check-in. If they have some urgent issues to discuss in the current group session, they may communicate it to the group during the check-in.

At the end of each check-in, the group can assess the urgency (remember that adolescents often experience extreme mood swings and that perceived "crises" often are not as urgent as they may seem in the moment) and discuss collaboratively whether to attend to the particular issue, discuss the issue of a member that has been waiting for a few sessions, or stick with the topic/activity that was on the agenda (timeline etc.) for the day.

The advantages of check-ins are that this procedure gives the facilitator a picture of the "mood of the group" and gives shy/withdrawn members the opportunity to contribute and speak about their lives (mild form of exposure), which they might not do otherwise. Also, members learn to prioritize, problem-solve, make collaborative



decisions as a group and learn empathy. Back off as much as possible and only intervene if you feel like they are missing something important or if you have an urgent issue to discuss yourself (elephants in the room, potential conflict, needed apologies or explanations from last week etc.). Always admit and apologize for mistakes that you made, as it models appropriate behaviors, shows that you are human and make mistakes, and communicates that you have thought about the members outside of group. Usually, group issues and real acute crises have first priority, as the group would not be able to work productively otherwise.

### 3.2. Topic/Activity of the Day

Depending on what the group has decided, throw you agenda overboard or attend to it. At the end of the activity, before the wrap-up, hand out the feedback forms (see appendix) and give each member a minute to fill them out in private. If we had a snack, we usually handed it out at the end of the group.

### 3.3. Check-Out/Wrap-Up

During the last 10-15 minutes, start the ending ritual that your group has agreed upon. Buchele (2004) suggests an ending activity, where each member has to give three words that reflect how they feel at the very moment. This procedure teaches the members to use “feeling language”, recognize and pay attention to their own emotions. It also provides the facilitator with a barometer of their emotional states and indicates whether or not an immediate follow-up (individual session, phone call) is needed. When using this ritual, Buchele recommends providing the members with a cheat-sheet of feeling words, as they

(in the beginning) may lack the appropriate vocabulary to represent their current state (p.109).

Other check-out rituals may involve a group poem, in which they vow to keep everything “in the room”, a group hug, or another circle activity in which they share what they have learned, what they take home with them, if they had an eye-opening moment, what they appreciated, admired or learned about another member. Let your members be creative. They know best what they need in order to leave with a good feeling.

#### IV. IMPORTANT FIRST ACTIVITIES

I’m sure that there are plenty of great and not so great ice breakers and first activities that you have come across throughout your life. In my opinion, the good ones were the ones where I learned something about the others around me, got a feel for the group and the leader, was pushed to share some information about myself without having to disclose too much and where I had fun without having to make a fool of or embarrass myself. If there is a good icebreaker that you remember, make sure that it is suitable for your particular population and the aims that you are trying to achieve during this first stage. The sharing of information is important as it enables your members to see what they have in common and foster trust and early group cohesion, at the same time it should not feel like they are disclosing something unwillingly, are revealing too much or are feeling unsafe.

So before you start your icebreakers, make sure that the group members understand that they MAY but do not HAVE TO share information. Give them examples for how they may deal with questions that they do not want to answer.

List of Activities:

- I AM YOU
- THE CIRCLE
- BOWL OF QUESTIONS
- MY SCAR
- DREADING THE DARK WHILE REACHING FOR THE STARS
- MY GOALS, OUR GOALS
- CREATING OUR GROUP CONTRACT
- OUR GROUP STATEMENT
- FINDING A GROUP NAME
- OUR TOPIC LIST

⇒ See Appendix B for or a detailed description of icebreakers and handouts.

## V. NEW TRADITIONS – THE CREATION OF RITUALS

### Rationale and Objective

- Creating rituals is one of the most therapeutic and valued gifts you can build into your therapy sessions. Many children in foster care do not have a traditional way to celebrate the holidays, a special way to celebrate birthdays, no routines, habits, customs, no occasions where they get together as a family, wear nice clothes, take pictures and share food and memories.

- Obviously, group therapy cannot compensate for the lack of everyday rituals that usually are practiced in most families (morning routines, time for homework, household chores, dinner with the family at night, summer vacations, birthday celebrations) of your members. But the creation of new traditions in a healthy, “family-like” setting can still be healing.
- Every ritual you develop with your members brings a piece of safety, predictability, structure and control into their worlds. It brings everyone in the group including the leaders closer together, helps emotionally deprived adolescents feel special, and gives them the opportunity to give back. Being part of a functional family-like group is healing and provides hope, and it may replace some memories of traumatizing holiday or birthday celebrations with happier ones.
- Yalom’s curative group factors that apply here:
  - a. Instillation of hope
  - b. Altruism
  - c. The corrective recapitulation of the primary family group
  - d. Development of socializing techniques
  - e. Imitative behavior
  - f. Interpersonal learning
  - g. Catharsis

#### Description of (Ritual-Creating) Activities:

Some of the above mentioned activities such as the creation of a group statement, finding a name for the group or creating a check-in/wrap-up protocol are activities that foster the creation of traditions and rituals. Other activities that have the same goal are:

### 5.1. Holiday Celebrations

Please pay attention to the religious, cultural and ethnic backgrounds of your members when determining which holidays to celebrate. Do not just celebrate the ones that are familiar to you. You do not have to be an expert: just have your members educate you and the other members about the holidays that are important to them and how they are celebrated traditionally. Of course, not every holiday needs to be celebrated with a big festivity but your members backgrounds need to be acknowledged – even if it's just with a card for Hanukkah, a special snack policy during Ramadan, talking about the life of Mahatma Gandhi for Gandhi Jayanti, or talking about the principles of Kwanzaa. A mix between giving your members the opportunity to be part of the planning of festive events and giving them a little surprise here and there is usually much appreciated by your members.

#### Example Holiday Celebration:

For the last session before the winter break, the MIA girls wanted to do a pot luck to which everyone brought their favorite dish (which encouraged members to share something about themselves, their family traditions or their cultures with the other members) and play Secret Santa (which compelled members to think about what the person whose name they drew might like). Also, they wanted this celebration to be like a real “family reunion” to which “older siblings” could return. So we invited members who had left the group and included their names in the Secret Santa draw. The group facilitators put up festive decorations, brought music and prepared a gift for everyone (we

made a photo/scrapbook for everyone that included individual and group pictures we had taken throughout the previous sessions, as well as quotes, poems or artwork by the members). The evening was one of the most special sessions I have had. Neither of the facilitators had any idea how much this celebration would mean to the girls and how much of an impact it would have. The most amazing moment was when one of the girls asked if she could say grace before we ate. So we all held hands, bowed our heads and listened to the shaky voice of a brave MIA girl thanking the Lord for the blessing of MIA and the most peaceful Christmas celebration she had ever had. What a deeply-touching night!

## 5.2. Birthday Celebrations

As mentioned before, not every holiday needs to be celebrated but celebrating birthdays is a must. Many children in foster care are used to their parents forgetting or for whatever reason not contacting them on their birthday. Do not make that same mistake. We celebrated our members' birthdays either on the day of or during the week of their birthdays. Our birthday ritual started about 20 minutes before the end of the session. Every member received the same type of gift, just more personalized versions of it: a journal (in their favorite color), balloons, a card signed by each member and their favorite candy. After the unwrapping, each member told the birthday girl what they loved about and wished for her.

### 5.3. Others Celebrations: Group Anniversary, Valentine's Day, Celebration Before Summer Break...

These are optional and do not need to be celebrated in a big fashion. Therefore, I will just list a few ideas. As your anniversary activity you could ask your members to pull out their personal, secret and group goals and discuss their achievements and set new goals. It is nice to process the accomplished progress of a group and share “remember when” moments of the beginning of group. You could also look at old pictures and revise your topic list. For Valentine's Day, you could bring them all a flower and bring blank cards that they can write to one another during the session. For the last group session before the break, make sure to address their anxieties regarding this temporary termination, which is most likely going to trigger memories of traumatizing separations. Talk about previous goodbyes they have experienced and reassure them that this break is only temporary.

#### Materials

- To be discussed within the group/among facilitators. Definitely a camera, and generally cards, balloons, gifts (journal), music equipment, collage material, candles etc.

#### Reminders to Group Leaders

- You will notice that most of your adolescents dread the winter holiday season and may display more psychopathology around this time of the year. Most members have memories of a chaotic, unhappy Christmas with their biological families;

nevertheless, being with strangers or continuously changing foster parents or shelters is equally traumatizing. Make sure that you talk about the dilemma of not wanting to be “with” someone and not wanting to be “without” someone and give them room to express their loss, anger, sadness, disappointment and wishes in regard to this season.

- Gifts: make sure to set a price limit; remind them how important it is that everyone remembers to bring their gift so that no one will feel left out or disappointed and offer them help in case they do not have any gift ideas.
- Always process what this celebration/ritual means to the members.



## CHAPTER IV

### AFTER THE BEGINNING

#### I. STAGE 3: THE WORKING STAGE

##### 1.1. Characteristics, Goals, Challenges and Implications for Clinicians

According to Corey and Corey (2002), during the Working Stage, members begin to bring topics that are important to them to the session and are willing to explore them with the other members. They also state that this stage is characterized by the members' "attention to the dynamics within the group" (p. 218). Smead (1995) similarly found that members become more active during this stage of group development: children begin to follow group norms, deal more with here-and-now related issues, ask for help from other members, benefit more from feedback and ideally begin to apply skills they learned in group to situations outside of group.

Malekoff (2004) also described the development that members usually undergo during the progression of this stage. At the beginning of the stage, members will explore and test, compete for power and leadership, and try to determine their role and status. Ideally, by the end of the stage, they will "have found their place in the group, have found others they like, feel more accepted and understood, better accept and understand members, see themselves and the other members as distinct individuals, recognize similarities and differences and see differences as useful, acknowledge each other's

uniqueness, see their own particular contribution [and] feel some affection for and desire to share with other members” (Malekoff, p. 161).

This suggests that the group leader can be less active during this phase, as members learn to depend more on each other, become more of a support system for one another and start to take more control and responsibility for the content of the sessions and their own progress. They still need you to “be there” for them. Even if you play a less central role, you are still in charge of maintaining the “holding environment” and being the “good enough parent” that provides safety, and mirrors but also “lets go”. Intervene when necessary but let them make mistakes.

During this stage, the group leader is going to have to pass numerous tests. Does my therapist actually care? – Even if I’m bad? Am I just a job to her? Is she just like my mom? Does she accept me? Will she protect me? Is she going to give up on me? Am I going to be a disappointment to her? Members will project their fears (and silently, also, all of their hopes) onto you; as mentioned before, it will be hard to withstand their testing and not react according to their transference. If you remain caring and patient and show that you are dependable, while setting limits, your members will see that others begin to trust you and they may timidly choose to do the same. As they begin to trust you and the other members and witness that the disclosures of others are safe and create closeness rather than the anticipated rejection, they will likewise be willing to risk more exposure of themselves – their experiences, opinions and feelings. As members realize that their goals can be met within the group and begin to thereby understand the meaning of the group for them, they become more focused during the sessions, extend their self-focus, and start to desire to be helpful to others. They may begin to view you as a unique

“person” and will no longer project their internal picture of “bad adults” onto you. Also, the group itself becomes more important to your members; they begin to strongly identify with it and “see the group experience as unique” (Malekoff, p. 161). Of course, the fear of losing the very thing that is becoming so important to them always accompanies them and may particularly reveal itself before breaks or during crises or arguments in group. Nevertheless, you will notice that as their own sense of worth and their faith in lasting relationships slowly grows, they begin to express opinions and characteristics that deviate from the group. At the end of this stage they feel safe enough to know that dissimilarities or even arguments will not lead to the end of an interpersonal relationship.

#### 1.2. Trauma and the Working Stage

In addition to the above mentioned transference (and countertransference) related challenges that may arise during this stage of group development, what makes this working stage both difficult and valuable content-wise, is that most of your members will now be ready to really talk about traumatic life experiences. As Foa et al. (2009) mentioned in their section on treatment management, therapists must establish a therapeutic alliance, pay special attention to safety issues, and ensure that there is enough trust among the members, especially “if the trauma [they experienced] had interpersonal aspects (e.g., assault, rape)” before starting with the actual interventions to reduce PTSD symptoms. While most members may have touched upon some of these traumatic memories during the circle-activity or the presentation of their lifelines or genograms during the first two stages, it is usually during the working stage that they feel safe enough to share in depth what happened to them and which symptoms they are

experiencing as a result. For you as the group facilitator, this means that you need be able to provide an outlet, guide them through this process and contain an immense amount of affect – which can be extremely difficult at times.

While not all your members will meet full criteria of a PTSD diagnosis (see the DSM-IV-TR for a precise description of the three clusters: (1) re-experiencing of the trauma, (2) avoidance and numbing, and (3) hyperarousal) or “differ greatly from one another with respect to symptom severity, chronicity, complexity, comorbidity, associated symptoms, and functional impairment” (Foa, p.10), many of them will display at least a few trauma-related symptoms, such as anger, guilt, shame, dissociation, “alterations in personality, affect dysregulation, and marked impairment in intimacy attachment” (Foa, p. 23). Common trauma symptoms among children are developmental delays, regressive behavior, negative expectations or a sense of foreshortened future, and impaired cognitive functioning, initiative, self-esteem, outlook and impulse control (Foa, p. 62). A successful PTSD treatment should therefore not only reduce the severity of typical PTSD symptoms, but also decrease associated symptoms, potential comorbid disorders such as depression, substance abuse, and other anxiety disorders, and enhance the quality of the patients’ lives. Since PTSD is a complex, multifaceted disorder that can disrupt virtually every aspect of normal functioning, one needs to know which interventions have been found to effectively target the “cognitive, affective, behavioral, and physiological response channels” (Foa, p. 23) that are affected after a severe trauma experience. No matter if you are generally an advocate or an opponent of CBT, when it comes to the treatment of PTSD, the evidence supporting the effectiveness of (individually administered) CBT in adults is “quite compelling” (Foa, p. 557). In their

book “Cognitive-Behavioral Therapy for PTSD – A Case Formulation Approach”, Zayfert and Black Becker (2007) similarly state that CBT has not only “accumulated the most evidence in support of its efficacy [...] for treatment of PTSD but also for common co-occurring problems” (p. 4). Zayfert and Black Becker summarized that out of the three core components of CBT – psychoeducation, exposure and cognitive restructuring - “CBT that includes *exposure* has amassed the greatest amount of empirical support across different trauma populations” (p. 5). Exposure can sometimes be potent enough to successfully treat some forms of PTSD alone; nevertheless, the authors generally recommend utilizing other CBT techniques in addition. The authors propose that while exposure is extremely effective in targeting anxiety/fear-related emotions and dysfunctional cognitions (e.g., beliefs about danger), cognitive restructuring is the technique of choice “when PTSD is predominantly characterized by shame or anger rather than fear [...] or when it comes to modifying guilt and thoughts about responsibility” (p. 5). Since many children in foster care experience emotions around fear and anger, as well as shame and guilt, they could certainly benefit from both interventions – exposure and cognitive restructuring. Research has shown that both techniques are effective. For instance, in a CBT study in which some rape survivors were treated with a strong cognitive restructuring focus while others were treated with more of a focus on exposure therapy, 80% of patients afterwards no longer met criteria for PTSD and most showed a noticeable improvement regarding their depression (Resick et al., 2000 in: Zayfert and Black Becker, 2007). It is important to keep this in mind because, when you are about to ask your members to confront themselves with their most dreaded fears, their deepest secrets, their most shameful, anxiety, guilt and embarrassment-

provoking memories, you better be confident that what you do with them works! So when conducting a PTSD treatment, it is absolutely crucial that you not only internalize the theoretical cognitive-behavioral model behind this anxiety disorder –

- how (according to behavioral theory) fear initially develops through classical conditioning, is maintained through operant conditioning, and fails to be extinguished because traumatized people avoid trauma reminders both behaviorally and cognitively (Zayfert and Black Becker pp. 4-12);
- how (according to cognitive theory) pathological fears develop because, as a result of a traumatic event, people begin to incorrectly evaluate benign stimuli as dangerous since they initially processed the experience inadequately (made false associations/interpretations) and lacked corrective information; and
- how the trauma survivor's coping style, resources, the accessibility of social support and the response of others play an important role in the development of PTSD –

but that you also know how to translate these concepts so that they make sense for your members. While by that point some members may trust you enough that they will go along with whatever intervention you propose, this is actually something to be very cautious about. Please keep in mind that many of your members initially trusted the person that later took advantage of their trust by making them expose themselves/do things that they did not want to do. Encouraging them to expose themselves in group (exposure = talk about a traumatic event) without giving them a logical rationale for it may very much remind them of the traumatic event itself. So spend as much time as it

takes on psychoeducation and on providing rationales for exposure and cognitive restructuring.

In order to prepare yourself for the challenging endeavor of treating patients with a trauma history, I recommend that you read the two previously cited books: 1) Zayfert and Black Becker not only do a wonderful job giving a sound and understandable CBT conceptualization for PTSD, but they also offer practical instructions on how to administer psychoeducation, exposure (in vivo and imaginal), and cognitive restructuring – providing worksheets and vignettes for each area. 2) Foa et al.’s book gives less practical advice but provides different diagnostic and assessment measures for adult and childhood PTSD and gives a detailed description of various PTSD treatments (including CBT, psychopharmacology, Eye Movement Desensitization, group therapy, psychodynamic therapy, psychosocial rehabilitation, hypnosis, couple and family therapy and creative arts therapy) and their efficacy. While several different individual PTSD-targeted CBT models, which tend to share common components summarized by the acronym PRACTICE<sup>2</sup>, have shown good results in the treatment of children and adolescents, TF-CBT (Trauma-focused CBT) is the most thoroughly tested model and “is superior to comparison conditions for improving a variety of child symptoms, including PTSD, depression, internalizing symptoms, general behavioral symptoms, and shame” (Foa, p. 560). All of the studies mentioned by the authors were conducted with sexually abused children; some of them were conducted with children (like the foster care

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<sup>2</sup> PRACTICE: “*Parental* treatment, including parental skills; *Psychoeducation* about common child and parent reactions to trauma; *Relaxation* and stress management skills; *Affective* expression and modulation skills; *Cognitive* coping skills; *Trauma* narrative and cognitive processing of the child’s traumatic experiences; *In vivo desensitization* to trauma reminders; *Conjoint* child-parent session; and *Enhancing safety* and future development.” (Foa et al, p. 559)

population) who experienced multiple trauma histories. Since TF-CBT has been found to be an effective approach, I would strongly recommend that you complete the TF-CBT-online workshop. It is divided into the sub-categories of psychoeducation, stress management, affect expression and modulation, cognitive coping, creating a trauma narrative, cognitive processing, behavior management training, parent child sessions and evaluation. It can be found under the following link (<http://tfcbt.musc.edu/>) and is free of charge. Continuing education credits can be received after every module, but one needs to complete the entire course to receive a certificate. Since this web-based learning course was primarily designed to assist clinicians with the individual work of traumatized children and youth, it cannot be applied into the group therapy world in its entirety. Nevertheless, I found this site to be one of the most valuable tools in my preparation for foster care work. While individual work with trauma populations allows the therapist to focus on the individual member in much more depth than group work does, there are several advantages of group therapy that individual work cannot offer.

There are several potential advantages of group therapy, including the opportunity to deliver effective treatment efficiently, the implicit inclusion of social support and social contact, and the availability of social learning through modeling. For persons with PTSD, in particular, group therapy may be especially useful for providing opportunities to develop trusting relationships and a sense of interpersonal safety, thus, ameliorating isolation and the alienation that often accompany PTSD. (Foa et al, p. 577)

In addition to Foa's arguments for group therapy with traumatized populations (which come from a rather CBT-oriented point of view), Buchele and Spitz (2004) provide a list of additional ( in parts dynamically-oriented) benefits of group therapy for people who experienced psychological trauma:

a) Cost effective; b) Can diffuse transference and attenuate ego regression, which may prolong or complicate treatment; c) Provides social supports



and facilitates the development of interpersonal skills; d) Offers opportunities for acquiring new information, coping skills and self-expectations; e) Provides peer feedback, which is easier at times to hear than from the leader; f) The mutual identifications and mirroring in the group are powerful therapeutic factors (p. 233).

While the research evidence for group therapy with PTSD has shown pre- to post-treatment change of small to large effect sizes, more well designed randomized studies with sufficient sample size are necessary to warrant recommendation of a specific type (psychodynamic, supportive, interpersonal, process-oriented, CBT) of group therapy (Foa, 2009). Because I believe that the foster care population benefits from both CBT interventions, as well as a supportive, interpersonal and here-and-now-focused approach, the group that you create should incorporate all of these aspects. In addition to this, creative arts interventions (dance, drama, music, poetry, and psychodrama) should be utilized to enhance the physical, emotional, cognitive, and social functioning of children and youth that either lack verbal skills or are not ready, willing or able to find the right words to describe traumatic events and therefore require nonverbal interventions to access and process their experiences. According to Foa (2009) “an abundance of CAT (Creative Arts Therapies) case studies describe treatment success” (Foa, p.604) in patients with PTSD, although there is no empirical evidence supporting the efficacy of the CATs at this point in time. If you would like to gain some background knowledge and get some ideas for creative activities, I recommend the book “Creative Interventions with Traumatized Children” (2008) by Cathy A. Malchiodi.

Since most of the above mentioned books prepare a therapist for individual work with traumatized patients, I would like to recommend a valuable book that specifically focuses on group work with traumatized populations. “Group Interventions for Treatment

of Psychological Trauma” (2004), which was published by the American Group Psychotherapy Association (AGPA), consists of 8 modules, which provide group interventions for the treatment of trauma as well as an overview of evidence-based group approaches to trauma with children, adolescents and adults. It not only offers very practical advice (how to set up trauma groups, inclusion criteria, number of therapy sessions, etc.) and gives background knowledge and session outlines for cognitive behavioral as well as present-centered supportive group therapy approaches (both of which I find essential when it comes to working with the foster care population), but it also focuses on often neglected countertransference aspects, the management of extreme affect and the effects that trauma groups can have on therapists.

One final aspect, which is crucial to remember when you make your way into the trauma-cluster of the working stage, is that you involve the individual therapists of your members. A collaboration is necessary, as the individual therapist might have insight that you are lacking, make suggestions or process crises in individual therapy that may have been triggered during a group session. In addition to this, they can assist you with in vivo-exposures or other PTSD interventions that require an in-depth focus on the individual member which group psychotherapy cannot provide. For some individual therapists, particularly ones that do not have a CBT background, completing exposures with distressed or fragile patients seems counterproductive and they may, therefore, be reluctant to approaches that increase their patient’s (or their own) anxiety. Especially if a patient has been in treatment for a while but has not shown any progress in regard to her PTSD symptoms, exposure might be the very thing that will help the patient. As Foa

states, “[...] it is important to note that many patients who appear fragile can tolerate and substantially benefit from processing their traumatic experiences” (p. 17).

### 1.3. Potential Topics of This Stage

The following table shows the (unranked) topic list that the group came up with during our sessions. It is organized into topics that reflect general adolescent issues and those that are more idiosyncratic to the foster care population. While this list can give you some ideas of topics that may arise in adolescent foster care groups, I would strongly recommend developing your own list with your members.

Table 2  
General vs. specific issues

General Adolescent Issues	Topics More Specific to the Foster Care Population
<ul style="list-style-type: none"> <li>• Family</li> <li>• Who am I? Identity-development</li> <li>• Personal choices/regrets/what I’d do differently/what I’ve learned</li> <li>• Being a girl</li> <li>• Sexual orientation</li> <li>• Friendships</li> <li>• Aggression</li> <li>• Gossiping</li> <li>• Peer pressure</li> <li>• Dreams/goals</li> <li>• Cultural differences and stereotypes</li> <li>• Loneliness</li> <li>• Body image</li> <li>• Self-esteem</li> <li>• Substance use</li> <li>• Sex, pregnancy</li> <li>• Relationships, breakups, heartache</li> <li>• Suicide</li> </ul>	<ul style="list-style-type: none"> <li>• Broken homes, broken families</li> <li>• Being separated from parents and siblings</li> <li>• Past experiences: what and who made you who you are?</li> <li>• “The day that everything changed”</li> <li>• Clarification of terms like KLG, adoption, long-term foster care, transitional living, independent living, group homes, therapeutic foster homes</li> <li>• Being a part of a foster/kinship family: what I like, what I hate.</li> <li>• Transracial/transcultural placements</li> <li>• Hiding your foster care background from classmates</li> <li>• Maintaining relationships with bio-parents</li> <li>• Family relationships, loyalty conflicts</li> </ul>

<ul style="list-style-type: none"> <li>• Self-harm</li> <li>• Fears</li> <li>• Gang involvement</li> <li>• Music, poetry, movies</li> <li>• Sharing information about myself</li> <li>• Talking about emotions</li> <li>• Morals and values: what is right, what is wrong</li> <li>• Outside world: politics, religion</li> <li>• College and future plans</li> <li>• Termination, keeping in touch</li> </ul>	<ul style="list-style-type: none"> <li>• Identity development in a chaotic world</li> <li>• Things we care about</li> <li>• Role models/ lack thereof</li> <li>• Debating placement/choices/having to make decisions</li> <li>• Court</li> <li>• Dealing with DYFS: frustration, what are my rights?</li> <li>• Leaving DYFS: Should I sign out of DYFS after I turn 18 or stay until I'm 21? Advantages and disadvantages</li> <li>• Life after DYFS: How to prepare for the future, independent living skills, financial support, independent living facilities, my rights and obligations to DYFS</li> <li>• Confessions/secrets</li> <li>• Domestic violence</li> <li>• Neglect and emotional abuse</li> <li>• Physical and sexual abuse</li> <li>• Shame</li> <li>• Death, loss, separations</li> <li>• Drug abuse (personal and parental)</li> <li>• Confusion about parents: anger/hate/disappointment versus sadness/love/compassion; wanting to be both close and far away.</li> <li>• Guilt/feeling responsible</li> <li>• What it feels like to be "given away"</li> <li>• Psychological disorders: PTSD, depression, bipolar, personality disorders</li> <li>• Hating goodbyes</li> </ul>
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### 1.3.1.Organizing Topics into Clusters

Once you have decided on the topic areas to be addressed in the group, the topics should then be organized into clusters by your members, such as the following:

### My Life-Story

- Past experiences: what and who made you who you are?; being separated from parents and siblings; “the day that everything changed”; sharing information about myself; hating goodbyes

### My Family

- Family; broken homes, broken families; “new” family; transracial/transcultural placements; confusion about parents; maintaining relationships with biological parents; family relationships; loyalty conflicts; role models/ lack thereof

### Me – My Interests, Self-Perception, Identity and Values

- Things we care about; music, poetry, movies; outside world: politics, religion; morals and values: what is right, what is wrong?; who am I? Identity development in a chaotic world; personal choices/regrets/what I’d do differently/what I’ve learned

### My Feelings

- Talking about emotions; aggression, fears, shame; hiding your foster care background from classmates; confusion about parents: anger, hate, disappointment versus sadness, love, compassion; wanting to be both

close and far away; guilt/feeling responsible; what it feels like to be given away; termination, keeping in touch

### My Sexuality

- Sexual orientation, sex, pregnancy

### My Loss, My Trauma

- Parental drug abuse; domestic violence; neglect; emotional abuse; physical abuse; sexual abuse; confessions/secrets; death, loss, separations

### My Foster Care Life

- Clarification of terms like KLG, adoption, long term foster care, transitional living, independent living, group homes, therapeutic foster homes; being a part of a foster/kinship family: what I like, what I hate.; debating placement/choices/having to make decisions; court; dealing with DYFS: frustration, what are my rights?; leaving DYFS: should I sign out of DYFS after I turn 18 or stay until I'm 21? advantages and disadvantages; life after DYFS: how to prepare for the future, independent living skills, financial support, independent living facilities, my rights and obligations to DYFS

My Life as A Teenager – Dating, Drugs, Violence, Prejudice & Diversity, Loneliness, Future

- Relationships, breakups, heartache; loneliness; friendships; being a girl; body image; self-esteem; gossiping; peer pressure; gang involvement; drug abuse (personal); cultural differences and stereotypes; dreams/goals; college and future plans

#### My Psychological Difficulties

- Psychological disorders: PTSD, Depression, Bipolar Disorder, Personality Disorders; self-harm; substance use; body image; suicide

#### 1.3.2.Prioritizing

When the members were asked to rank their topics, it became very clear that they first and foremost wanted to learn about each other and their backgrounds before they could talk about more general things such as college or friendships. It was interesting to observe how, after the first stage had apparently been successful in establishing enough trust for them to be able to move on to the next step, they were almost yearning to get their stories off their chests and learn more about what made them who they are. Of course, their ambivalence and anxiety remained, but they made it clear: “we want to talk about our lives.”

#### 1.4. Important Activities of The Working Stage Organized by Clusters

Below you will find a list of activities that are particularly valuable during this stage of group development as they foster self-awareness and insight, require members to go beyond the type of disclosure that was required in the icebreaker activities of the first

stage, bring members closer together, promote interpersonal learning and trust, confront members with significant, suppressed memories in a safe way, and help them make a connection between those memories and the symptoms and intra- and interpersonal difficulties that continue to arise across different situations. The activities are inspired by the topic list the members created and are organized according to the clusters posted above.

Cluster: My Life-Story

1.4.1.MY LIFE-LINE \*<sup>3</sup>

1.4.2.OLD ME, THEN ME

Cluster: Me – My Interests, Self-Perception, Identity and Values

1.4.3.PAPER BAG-ACTIVITY \*

1.4.4.OBJECTS LIKE ME

1.4.5.FISH FOR A THOUGHT

1.4.6.PERSONAL VALUE SYSTEM AND SELF-ESTEEM

1.4.7.MY THEME SONG \*

Cluster: My Family

1.4.8.MY FAMILY GENOGRAM (FAMILY TREE) \*

1.4.9.THE FAMILY FLOOR PLAN

1.4.10. FAMILY SCULPTING \*

1.4.11. FAMILY CHOREOGRAPHY

1.4.12. SURVIVAL ROLES IN A FAMILY: A PSYCHODRAMA \*

1.4.13. FAMILY MEMORIES

Cluster: My Feelings

1.4.14. CARD GAME \*

1.4.15. THE WIZARD: A GUIDED IMAGERY EXERCISE \*

1.4.16. THE LOSS CYCLE: A MODEL FOR DISCUSSING DEPRESSION  
AND SUICIDE \*

1.4.17. THE SHAME GAME

1.4.18. WORDS THAT WOUND \*

1.4.19. LOVE LETTERS

Cluster: My Sexuality

1.4.20. SEX TALK-ICEBREAKER \*

1.4.21. LET'S TALK ABOUT SEX, BABY \*

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<sup>3</sup> “\*” indicates that the particular activity was an important one.



- 1.4.22. SEX: EVERYTHING YOU WERE AFRAID TO ASK \*
- 1.4.23. ROLE PLAYING DIFFICULT SITUATIONS \*
- 1.4.24. HEARTACHE

Cluster: My Trauma

- 1.4.25. MY LOSS \*
- 1.4.26. CBT IN GROUP
- 1.4.27. OPRAH SHOW \*

⇒ See Appendix C for a detailed description/list of references to these activities

## II. STAGE 4: THE BEGINNING OF THE LIFE AFTER GROUP

### 2.1. Goals and Challenges during the Final Stage

Since this is an open-ended group format, the final stage of group development (termination phase) will not be discussed in great detail. While it is not necessary to prepare your members for the end of group (because of the open-ended set-up), it is on the other hand crucial to prepare them for the termination of fellow group members and to – in turn, prepare the departing member for this process.

In chapter 10 “Leavetaking, Moving On, and Looking Back: The Ending Transition in Group Work” (pp. 186), Malekoff (2004) listed some of the below posted group dynamics that are likely to arise during the separation stage of group development. They are a reflection of the “members’ ambivalence and difficulty accepting the reality that the end is rapidly approaching” (p. 187) and can be expressed in different ways by different members. Should your members display any of these dynamics, make sure to process it with them in the moment.

- Reawakened dependency needs
- Excluding the facilitators

- Regressive behavior
- Devaluation of the experience
- Denial
- Flight (“I’ll leave you before you leave me”)
- “Constructive” flight: moving on to other groups and relationships
- Worsening of psychopathology
- Expression of strong affect
- Flashbacks, memories of past separations/bereavements
- Unconscious or conscious attempts to blackmail the facilitator/terminating member  
(to prevent changes from occurring)
- Scapegoating/devaluing the terminating member

These behaviors may also be demonstrated by your members before temporary separations, such as summer and winter breaks or before the termination of a member. Preparing your members for upcoming separations or terminations in a timely manner is crucial. As part of this process, be sure to educate them about the types of behaviors they may be inclined to display. Explore as a group how members dealt with these types of situations before. What were the reasons for their behaviors and what were the (positive and negative) consequences of their actions? What would they like to do differently this time? As suggested plenty of times throughout this manual, collaborate with your members to find out what they need to make this process easier for them. In order to prevent re-traumatization, explore with your members what it was that made previous separations painful. Write down on the white board what they came up with and work on solutions as a group (see example below).

## OLD VERSUS NEW GOODBYES

Table 3  
Problems and Solutions regarding goodbyes

<b>Problem: What made previous goodbyes painful</b>	<b>Solution: What we can do to make this goodbye less painful</b>
<ul style="list-style-type: none"> <li>• Goodbye came as a surprise/shock, without prior warning or:</li> <li>• Back-and forth/indecisiveness; not knowing when the separation is going to happen/expecting it any day → Anxiety/uncertainty</li> <li>• Had no chance to get used to the idea, no time to work through/process it/share how I feel about this</li> <li>• Having no control over the way the goodbye happened</li> <li>• No opportunity to ask the person why he or she was leaving → therefore taking departure personally (“left because of me”/“didn’t care enough about me to stay”)</li> <li>• No time to ask how person feels about me; no time to tell person how I felt about him/her; no time to talk about the impact we had on each other or what we mean to each other</li> <li>• No time to share memories</li> <li>• Not knowing if separation is temporary or permanent (if person will come back) → hoping/waiting and getting disappointed</li> <li>• No time to ask person about his/her plans</li> <li>• No time to wish person well</li> <li>• No time to plan reunions</li> <li>• Not knowing if I will be remembered or forgotten about</li> <li>• No pictures, memories, things to remember person by</li> <li>• Event had big impact but was not “celebrated” accordingly</li> </ul>	<ul style="list-style-type: none"> <li>• Learning about upcoming goodbyes early on</li> <li>• Setting a date and following through with the plan</li> <li>• Group activities that get us used to the idea and prepare us for the goodbye; express feelings around it</li> <li>• Being part of the planning-process: what type of goodbye do we want?</li> <li>• Terminating members discloses reason for termination; remaining members disclose their fears.</li> <li>• Sharing how we feel about each other, how we benefitted from each other and progress, talking about what we are going to miss</li> <li>• Time for walking down memory lane</li> <li>• Clarification of time-frame</li> <li>• Clarification of plans</li> <li>• Expressing our wishes for one another</li> <li>• Maybe holiday-reunions?</li> <li>• Sharing what it is that will remind us of each other (“What I will remember about you”)</li> <li>• Taking pictures, creating memories, scrapbooking, goodbye letters, appropriate goodbye-ceremony</li> </ul>

Providing your members with a different, less traumatizing goodbye than they have experienced in their past is imperative. Malekoff similarly wrote: “A good ending experience in a valued group is a powerful counterforce against the impact of growing up in a capricious environment, in which unpredictable comings and goings (i.e. separation, divorce, dislocation, death) seem commonplace” (p. 188).

## 2.2. Implications for Clinicians

In addition to dealing with memories of your own losses and resolving personal countertransference reactions (e.g. feelings of guilt for “abandoning” your members before breaks, for leaving them altogether in case you are the departing person, or for introducing them to a member who they became close to and is now leaving), that can be particularly strong during this stage, your tasks as a group facilitator during this stage of group development are to help the members deal with these similar goodbye issues; solutions can be derived out of the right side of the table above.

Bieling et al. (2006), Buchele (2004) and Malekoff (2004) give similar advice around preparing your members for this difficult time as that posted in the table. While their suggestions intend to prepare the members for the actual ending of a group (which ultimately comes about in time-limited group formats), most of their recommendations can be applied to any situation that involves a separation – whether it might be the period before a long break or the departure of a member or facilitator. Malekoff advises to prepare the group for separations early on, to promote the expression of feelings through review and recapitulation, to help members “reexperience their groupness through shared activity” and to provide “availability of support beyond the group” (p. 189). Buchele (p.

111) recommends taking at least three sessions to process the ending stage. This goes hand in hand with our termination group rule, in which the member is asked to attend three more sessions after communicating her termination plans to the group to give herself and the group enough time to process the termination and get some closure. Allowing time for discussion of termination issues, including thoughts and feelings about the ending, reviewing “what members have gained from the group (where they were, where they are now, and where they are going), what obstacles they have overcome, and what goals they will continue to work on” (Bieleing, p. 41), devoting time to finding out how departing members will proceed after group and what their future plans are, and planning a goodbye activity (special event/celebration) are essential interventions according to Bieleing, Buchele and Malekoff. Buchele additionally emphasizes the idea of giving each departing member the opportunity to be “in the spotlight while the other members, one by one, tell the member who is leaving what positive thing she will remember about that member, what she has learned from knowing that person, and what characteristic of that person she will try to make a part of herself” (p. 111). She also highlights the importance of the facilitator providing a review of the departing member’s progress and gains and providing her with wishes and goals for the future. Buchele suggests bringing special foods to the last session to mark the occasion and asking members for permission to tape part of the session, which later will be transcribed and given to each member. Bieleing proposes that sharing the “effective ingredients” of the group for each group member “will be important for relapse prevention and maintenance of CBT skills” (p. 41).

### 2.3. Important Activities during the Final Stage

The following activities were assembled to give your members the experience of a “good ending”. There is no doubt about the fact that you will not be able to take their sadness and anxieties away – which by the way should not be the goal anyway. The activities incorporate all of the ideas my group members came up with in order to minimize the risk of creating another traumatizing goodbye (see table above: “Old Versus New Goodbyes”).

Names of Activities:

- OLD VERSUS NEW GOODBYES \*
- WALKING DOWN MEMORY LANE \*
- OLD ME, THEN ME, NOW ME, FUTURE ME \*
- WHEN THE SEASON COMES TO A END
- A FAREWELL CIRCLE \*
- TRANSITIONAL SPACES AND PLACES
- ROCK AND REFLECTIVE GARDENS AND RITUALS FOR BUS RIDE \*
- CANDLE CEREMONY \*

⇒ See Appendix C for a detailed description/list of references to these activities.

## CHAPTER V

### CHALLENGES, RECOMMENDATIONS & IMPLICATIONS

#### I. CHALLENGES

Below you will find examples of challenging members and situations that you may encounter when running groups and when working with vulnerable populations.

Providing solutions to all anticipated difficulties would go beyond the scope of this manual, but a list of helpful references will be provided.

##### 1.1. Challenging members

As we all know, some members are easier to work with than others, but we also know that some colleagues do not have any difficulties working with the very client that you had the most problems with. In the book “Complex Dilemmas in Group Therapy” by Motherwell & Shay (2005), Shay raises several questions as to what this may have to do with:

When asked to contribute a chapter on treating difficult patients, I was immediately confronted with several questions. What constitutes a difficult patient? Are such patients difficult to treat, difficult to sit with, difficult to help, or difficult to like? Are they difficult for the therapist, for the group, or both? Are they difficult in life or just in the group? Is the degree to which a patient is considered difficult correlated to a diagnosis, defenses, or countertransference? Would there be a consensus among therapists as to who are the difficult patients? Is that description highly variable, contingent on specific patient-therapist-group factors? Perhaps a difficult patient is one who has few life-saving options beyond being needy, whining, threatening, and the like. Or is it one who invites difficult countertransference from the therapist, a patient who forces us to face difficult aspects of ourselves? If the latter is the case, it is not the patient who is difficult, but rather unresolved or not accepted aspects of the self.

Finally, do the patients experience themselves as difficult, or are they utterly confounded by the reactions they evoke in others? (Motherwell and Shay, p.41)

Of course there are some patients whose diagnosis (Axis I or II) makes them challenging to deal with, for instance “Betty the Borderline”, “Neal the Narcissist”, “Albert the Alcoholic” (Motherwell and Shay, p.47), but as Shay indicated, there are several other explanations. When dealing with a member expressing difficult behavior, always assess and process in supervision whether this behavior is something that also causes the member problems outside of the group; whether the difficulty in dealing with this member is related to your own issues; or whether the member’s behavior serves as a function for the group as a whole – and intervene accordingly.

The following literature describes several prototypes of difficult clients. (See reference pages listed for a description of these types of members and examples on how to manage them in a therapeutic setting.)

- “Cognitive Behavioral Therapy in Groups”, Bieling, McCabe and Antony (2006)
  - Quiet and silent type
  - Overbearing type
  - The helper
  - The disbeliever
  - The drifter
  - The not-appropriate-for-group member
  - ⇒ View pp. 106
- “Group Exercises for Adolescents: A Manual for Therapists”, Carrell (2000)
  - The distracters



- The attractor

⇒ View pp. 26
- “Group Work with Adolescents: Principles and Practice”, Malekoff (2004)
  - Involuntary group members: resistance and motivation

⇒ View pp. 94
- “Complex Dilemmas in Group Therapy”, Motherwell and Shay (2005)
  - “Betty the Borderline”,
  - “Neal the Narcissist”,
  - “Albert the Alcoholic”
  - “Angry Angela and Controlling Connie”,
  - “All about Adam”
  - “Getting Our Affairs in Order”

⇒ View pp. 47
- “The Theory and Practice of Group Psychotherapy”, Yalom (1995),  
Chapter: “Problem Patients”
  - The Monopolist
  - The Silent Patient
  - The Boring Patient
  - The Help-Rejecting Complainer
  - The Psychotic Patient
  - The Characterologically Difficult Patient
  - The Borderline Patient

⇒ View pp. 369

## 1.2. Challenging situations

Below you will find a list of difficult situations that you may encounter. References will be provided for some, while others will be discussed more thoroughly.

### 1.2.1. Transference

As mentioned above and throughout this manual, your members may project many characteristics onto you that have very little to do with you. Having your love, perseverance and patience tested again and again may be a very frustrating experience for you; but if processed properly with your members, it may result in a very important growing experience for them. As Sheppard states:

Transference is a desired aspect of psychotherapy, particularly group psychotherapy. Transference can take many forms in group work with children: Opposition to authority, reactions to others in patterned ways based upon past trauma – distrust; need for control; extreme opposition; resistance to structure and rules; patterned ways of eliciting needed attention from others (monopolizing, crying, withdrawing, making demands); reacting differently to male versus female group leaders. Regardless of the way in which transference manifests itself in group, it must be dealt with in the context of interpersonal group process for change to occur. [...] the goal is to guide the child in resolving the situation in new and more adaptive ways (p. 33)

In my experience, of course there were moments when the members' transference reactions were not always easy to deal with, but my group facilitator and I were (for the most part) able to acknowledge their attitudes towards us as nothing personal. As a group, we explored where their reactions came from and what the function was, while giving feedback on how their behaviors made us feel. The members experienced a new kind of reaction than the one they were used to and in turn were able to change or at least

question their actions.

The following literature deals with transference-related issues.

- “Complex Dilemmas in Group Therapy”, Motherwell and Shay (2005), Section III:

#### Complex Defenses

- “Unraveling Projective Identification and Enactment”, “Axis II Had Me Spinning”, “Will the Real Expert Please Stand up?”, “Serial Scapegoating”

⇒ View pp. 73

#### 1.2.2. Group Being Difficult to Handle

- “Group Exercises for Adolescents: A Manual for Therapists”, Carrell (2000)
  - Your group is completely apathetic, nonverbal, and appears bored out of their collective guard;
  - The group is chaotic, disruptive and attentive to any agenda but the scheduled one;
  - The group is not supportive, nurturing, or even attentive to one another;
  - The group seems to have their own agenda, and it isn’t yours;
  - You as the therapist say or do the wrong thing;
  - A group member says or does the wrong thing.

⇒ View pp. 34

#### 1.2.3. Countertransference

Transference reactions were tolerable – what was much more difficult to deal with

were issues related to countertransference, which Azima in Riester & Kraft (1986) defined as "The therapist's subjective, emotional and conflictual response to an individual patient or the pressure of the group as a whole, which [...]integrates both intrapsychic and interpersonal phenomena" (p. 141-142). Countertransference can be issue-specific, stimulus-specific, trait-specific, or child-specific (Brems, 1994) and can play out through therapists walking on eggshells with group members, avoiding certain materials, feeling sleepy or hypervigilant, experiencing shame and guilt, or having rescue fantasies (Buchele and Spitz, 2004). McWilliams (1994) writes: "Countertransference with depressive individuals [which is the case for many victims of trauma] runs the gamut from benign affection to omnipotent rescue fantasies, depending upon the severity of the patient's depressive issues" (p.240). My "omnipotent rescue fantasies" ranged from extreme anger towards anyone who had ever hurt my members to having fantasies of adopting them. Finding a balance between being the good enough mother while maintaining the role of a therapist was a constant struggle for me and raised a lot of practical issues regarding boundaries. For instance, ending therapy when one of my members was once again removed from her foster parents' home and moved to a different district would have resulted in another "abandoning" experience for my member. However, driving to the shelter each week, holding therapy sessions at shelters and parks and driving her to the group sessions pushes the boundaries of what a therapist normally does. In those moments, it is absolutely crucial to have someone "on the outside" that makes you aware of what you are doing, gives you his or her input, and explores your behaviors with you. My issues around boundaries and my rescue fantasies were not only discussed during supervision but also during my individual therapy.

Overall, the fact that our members did not have mother-figures who could provide them with the very basic things they needed, caused me and my co-facilitator to be much more self-disclosing, advice-giving and boundary-pushing than we had been with other (non-foster care) clients. We gave our members hugs, helped them with college essays, held their hands, and sometimes cried with and for them. Working through my (transference) feelings of guilt for “abandoning” my members when it was time for me to return to Germany (validating their experience of relationships being only temporary) was an issue that I struggled with for a while.

I cannot stress enough how important it is to a) have a co-facilitator, b) make use of supervision, c) work through your own issues and d) educate yourself about providing treatment for traumatized populations.

Out of the below posted literature, I particularly recommend the first reference, as it specifically focuses on countertransference issues when working with traumatized populations in the group setting.

- “Group Interventions for Treatment of Psychological Trauma”, Buchele and Spitz (2004)
  - Module 7: “Countertransference: Effects on the Group Therapist Working with Trauma”
    - ⇒ View pp.194
  - Issues around: vicarious traumatization, holding, over identification and avoidance, managing anger, managing affection and sexuality, managing induced feelings of being the victimizer
    - ⇒ View pp. 100

- “Complex Dilemmas in Group Therapy”, Motherwell and Shay (2005), Section V:

#### Powerful Therapist Reactions

- “Containing and Using Powerful Therapist Reactions”, “Legally Incompetent?”, “Fear and Loathing”, “Tolerating the Intolerable”

⇒ View pp. 153

#### 1.2.4. Confidentiality

Out of all the potential challenges mentioned in this chapter, I found the issues related to countertransference and ethical issues around confidentiality to be the most difficult ones to handle. Wanting to create a safe place in which confidentiality is respected while having to write quarterly reports to DYFS – and communicating this dilemma/controversy to our members - was not easy. Fortunately (after explaining this dilemma to the DYFS caseworkers), we were able to negotiate that we only needed to write quarterly reports for our individual cases and not for the members of the group. DYFS asked to be informed of the members’ attendance and to be notified of situations in which they needed to take action. Therefore, we were able to maintain confidentiality, which helped the members gain trust and become more open. At one point, however, one girl disclosed an incident of sexual abuse that we needed to report. After the disclosure, we discussed in supervision how to handle this information. Both, my co-facilitator and I knew what we had to do, but we were both concerned that this incident would destroy the trust that we had worked so hard on building. We asked to meet with the member individually and told her that it was necessary to take action, so that she (and potential future victims) would be safe from the perpetrator. We gave her a few days to mentally

prepare herself to tell her mother what had happened and then followed her wish to support her when she informed her mother. Her mother not only contacted the police immediately, but also discovered that the man had molested several other family members over the last 20 years. Our member was the first one to break the silence. The man was arrested and our member was not only relieved but proud that she had done such a brave thing. Nevertheless, as we had expected, this incident threatened the survival of the group. Despite knowing that there were some exceptions in which confidentiality needed to be broken by us, the members of the group felt betrayed by our actions and strongly voiced their anger and disappointment – which was a painful experience for us, the group leaders, but an extremely therapeutic one for our members. Processing their (and our) feelings around this, was difficult, but supervision (and the support of one brave member) helped us understand that, as much as our members saw our actions as a betrayal, had we not taken action, deep down they would have believed “not even they cared enough to keep us safe.”

#### 1.2.5. Premature Disclosure

Of course we want our members to disclose some information about themselves early on so the group can see what they have in common and cohere, and of course there is some anxiety around people not sharing any personal information. But there is actually one scenario that is worse than members not disclosing, which is members disclosing prematurely – sharing difficult, personal information before they established some trust in the other members and the facilitators and felt safe enough in the room.

If one or more members are very open from the beginning, leaders often are relieved that the group is getting off to a rich start. Buchele quotes Bernard (2002), saying that “the problem is that early disclosers sometimes get overwhelmed with feelings of shame and embarrassment after the fact, and in fact may be unable to face those whom they have disclosed so much (p. 109)”. Not only do we risk drop-outs but we run the risk of retraumatizing group members by metaphorically allowing them to “take off their clothes” and feel exposed and vulnerable. Hence, it is the group leaders’ responsibility to keep them safe from this experience. It is not the responsibility of the group members, as they often do not recognize or are used to others forcing them to cross their own boundaries. I found it extremely difficult on the one hand to invite members to be open while at the same time warning them from being “too” open.

- Remind them again about confidentiality and the limits of confidentiality.
- Teach them about trust and safety. Most of them will not know what that even feels like. Brainstorm in the group: How do you recognize when you feel safe and when you can trust someone?
- Psychoeducation re: defense mechanisms: What advantages and disadvantages does their distrust/suspicion/caution have? How has it protected them in the past and how may it hinder them at times?
- Have they ever regretted sharing something before? How did they and others handle it and how can we prevent this from happening in here?
- Tell them that it is a privilege for us to have them share something important with us but that they have all the time in the world and should not do so unless they feel confident that they are ready to disclose and would not regret it afterwards.



- Activities where they should be warned of disclosing prematurely: Genogram, Timeline, Circle-Icebreaker, Loss Activity. For the timeline activity, tell them that they may just make a little mark on the timeline, that indicates that “something happened” during that time period that made them particularly sad/angry but that they do not want to talk about it yet. Or they don’t have to mention it at all. As you introduce the activity with a fictional case example, make sure to include those options. For the circle-icebreaker they may just not take a step into the circle and for the loss activity, they may just not share what the loss was about afterwards.
- Interesting fact: In the MIA-group, we did the timeline-activity twice, once in the beginning of the group and once more than a year later, after several new members had been admitted into the group. A lot of members who had not been ready to disclose painful experiences the first time around were ready to add it to their second timeline, as it “felt right” to them the second time around. One member felt safe enough a few sessions before she left the group. It was wonderful to see these adolescents respect their own boundaries.

#### 1.2.6. Shifts in Group Composition

Helpful interventions when it comes to a shift in group composition:

- Use the family analogy (facilitators being parents, members being siblings, new members being newborns, terminating members being older siblings that move out).
- Introduce the open group model early on so that it does not come as a surprise.

- Find a balance between calming down and reassuring the existing members, valuing and mourning the departing members and welcoming and supporting the incoming members.
- When a member leaves, give the group a few sessions to process the termination and get some closure. Never admit a new member too soon.
- As most of your members have experienced some painful goodbyes and departures, their defense mechanisms might make them want to avoid the processing of yet another loss. If they push you to just “move on”, do not go along with it.
  - Explain the importance of the event and why they need to process it, even if it is painful.
  - Which memories get triggered, what feelings come up? Process this goodbye and explore the similarities and differences of prior goodbyes.
  - Invite opinions and the expression of feelings that deviate from the group norm. If everyone acts like they are “totally fine” with the departure/new arrival, bring a different viewpoint into the discussion.
  - Communicate that ambivalence is okay and that several feelings can coexist. We can love and be disappointed by the one that leaves us; and mourning can include sadness, appreciation and anger. And we can be both excited and scared/threatened by a new sibling.
  - Again, do not move on too early! If your sensitive group members see that you are capable of just moving on, they might interpret it as you not caring about the departing member and will conclude that it would be just as easy for you if they left. Even months or years later, continue to once in a while

mention memories of previous members to communicate to “your kids” that they will never be forgotten/they will continue to live in your heart.

- After the member departure has been processed properly, involve the members in the decision making process regarding the timing and the amount of new members.
  - Discuss their worries and excitement (pro’s and con’s) regarding the admission of new “siblings”.
  - Crucial: Incorporate empathy-building activities. Have them remember how they felt when they first entered the group. How have they felt in the past when they were “new” (after switching schools, foster homes etc.)? Switch perspectives to sensitize them: What do they assume are the worries and fears of the incoming members? How would they want to be welcomed if they were them?
  - Involve them in the problem-solving process and treat them like experts/big siblings. What are the potential risks that they see? How can the old and new members benefit from each other? How can subgrouping be prevented? How can we add something new without jeopardizing the already established trust and safety? What would they want to teach the new members about the goals, rules and culture of the group? How do we balance tradition and innovation? What are some good first activities? How should we go about old activities that were important, i.e. timeline and genograms (repeat, modify or skip them?)
- When the new members are added, the most important task is to create a connection between the old and the new members and show genuine appreciation for both.

- Implement the activities that you and the old members decided on.
- Have the old members welcome the new ones
- Activities:
  - Adjusted circle game to show commonalities
  - Activity about worries and excitement about the “family extension” → Process afterward! (Message: We are happy to have new members join and need to make sure that this remains a safe place)
- Group rules
- Ideas of new members?

#### 1.2.7. New Facilitators

You may also use the family analogy when a facilitator leaves the group. In order to prevent a loyalty conflict and make sure that the new facilitator gets a chance with the members, the terminating facilitator needs to give the members the permission to “like” the “step-parent.”

Of course, the termination needs to be introduced early on (ideally six months) and processed properly. Similarly, the new facilitator should be introduced early on and the group should give their input on whether or not they would like the new facilitator to attend a few (ideally two) sessions along with the old facilitators – to show her how the “family” works. This also gives the departing facilitator the opportunity to show appreciation for the new facilitator.

Also, it is important to communicate that the departure has nothing to do with the

members. I recommend having a goodbye ceremony, so that both the members and the facilitators have the opportunity to express their feelings. The new facilitator should not be part of this event. When I left the group, I wrote a letter in which I addressed the group as a whole, as well as every member (including co-facilitator and undergraduate student) individually. I read it out loud – and all participants read out theirs.

#### 1.2.8. Dealing with Upcoming Breaks

Helpful interventions when planning the breaks:

- Introduce the idea far in advance; surprises, unexpected disruptions are to be avoided.
- Talk about fears and expectations about the break
- Give a rationale for the importance of breaks and prepare the members for and educate them about possible/ reactions that might get triggered
- Give them as much control as possible in the decision-making process [i.e. length of break, planning of the last session before the break, such as a celebration, while still setting boundaries (having a break is not negotiable)].
- Process feelings in the moment and after including transference and countertransference issues (it can be therapeutic if you share some of your feelings); discuss/share the memories that get triggered.
- Discuss who they can reach out to in case of a crisis; provide them with emergency contact information.

### 1.2.9. Self-Disclosure

Find a balance between self-disclosure and setting boundaries in a non-rejecting way.

Always think about the purpose and the consequences of the disclosure and the reason for the question. (Why does the member want to know this? What does she really want to know/what lies behind the question? How would knowledge about it be helpful for her?)

If you choose not to disclose, explain why you think it would not be beneficial or address what you think stood behind the question. Motherwell and Shay (2005), Section VI: Self-Disclosure

- “How Far Should I Go?”, “Breaking Up the Family or the Fantasy?”, “If I Did It, Why Can’t You?”, “Sharing At The Exit”

⇒ View pp. 193

### 1.2.10. Treating a Child Individually and in the Group Setting

Seeing a member both in individual therapy and in group can be done as long as it is processed both with the individual and the entire group (confidentiality issues etc.).

### 1.2.11. Disciplining

- “Group Therapy with Children”, Sheppard (2008)

⇒ Sheppard, p. 30

### 1.2.12. Ethical Concerns and Diversity Issues

- “Group Work with Adolescents: Principles and Practice”, Malekoff (2004)
- “Group Therapy with Children”, Sheppard (2008), p. 47

### 1.2.13. Emphasis on Process Versus Content

- “Cognitive Behavioral Therapy in Groups”, Bieling, McCabe and Antony (2006):  
     ⇒ View pp. 22: “Group process in CBT: Using Group Dynamics productively”
- “Group Therapy with Children”, Sheppard (2008)  
     ⇒ View pp. 27

### 1.2.14. Other Issues of Group Leadership:

- Activity versus non-activity
- Balance between affect and cognition
- Transparency versus opaqueness
- Gratification versus frustration
- Historical, “here and now”, or future focus
- Group-as-a-whole, interpersonal, or individual focus
- Intra-group versus out-of-group interactions
- Combining insight with emotional participation in order to provide a corrective group experience
- Disagreement among co-leaders

## II. SUMMARY: FINAL WORDS OF ADVICE

Below you will find a summary of helpful points, so that you may enter the group well equipped and with the right mind-set.

- Empathy, compassion, acceptance and caring are the traits your emotionally deprived adolescents need the most from you. And do not just feel them, but show them.
- Authenticity: Be yourself. Do not wear a mask and do not attempt to be perfect. Nobody needs a perfect role model, they want REAL people.
- Congruence/credibility: Do not just talk the talk! There cannot be a discrepancy between what you communicate and how you behave. If you jeopardize your credibility, your members will condemn you as phony and will not only respect you less, but you actually put them in a double-bind where they can only fail, as they do not know whether to follow your words or your behavior. If you invite “the whole person” to participate and preach honesty, do not judge them if they display unpleasant sides; if you preach equality, do not treat members differently.
- Patience and perseverance: Their progress will take a long time and their testing will be hard to bear at times.
- Find a balance between playfulness/humor and seriousness/sophistication/psychological-mindedness. This needs to be a place where fun and profoundness are possible.
- Understanding/relating: Members sometimes hold the attitude of “how would you even know what I’m talking about” and wonder how you as a “privileged person” can even relate. Do not ever forget that you can understand them and feel sad for them without having experienced what your members have experienced. And you can communicate that. Give them an example (e.g., your sibling does not have to pass away for you to know that it must be one of the most painful things that one can experience).



- Make personal contact with each individual member; they all have to feel recognized by you. Making contact is the unspoken “I see you” (Carrell, p. 30).
- Positive regard: Find something good and likeable in all of your members, even if they act obnoxiously, give you a hard time and try their best to make you dislike them. Do not prove them right, do not step into that trap, do not act like all the other adults. Remember that their “nasty attitude” serves a purpose. → Take on an attitude of “People are basically good. No one sets out to be bad” (Carrell, p.35). Carrell recommends using self-talk techniques such as: “This teen is not a warrior, this teen is wounded”; “This teen has to be in love with himself because no one else is”; “This teen acts out because she was acted on”; or “This teen pretends to be fearless because she is so full of fear” in order for you to be able to keep up your respect and your caring (Carrell, p.31).
- Find a balance between self-disclosure and setting boundaries in a non-rejecting way. Always think about the purpose and the consequences of the disclosure and the reason for the question.
- Be in and make use of the moment and yourself.
- Use transference and countertransference. Be the “good-enough mother”.
- Everything that happens in group is grist for the mills.
- Look for parallel processes.
- Find a good mix between content (what members are talking about, the subject of the conversation, ‘there-and-then’) and process focus (what is going on in the room, behavior and communication among members and between facilitators and members; ‘here-and-now’).

- Withstand their testing.
- Do not take their reactions personally. Always remember the origin, function/purpose of their behaviors. Do not underestimate the strength and perseverance of their defense mechanisms.
- Do not take everything at face value. What they display may not be what they feel. Explore/discover what lies below.
- Look beyond the words. Is there a discrepancy between words and body language/behavior/mimic? (For instance, members who say that they “don’t care” but are present and on time every session)
- Metacommunication: Always pay attention to what members are trying to communicate to one another “underneath” the surface, even if they are talking about people outside of group. You may bring the outside-focus back into the room if it seems appropriate (for instance, “so you have been talking about your friends always spreading your business, I wonder what this means for us in here.”)
- Interpreting and Analyzing: When used to working with adults, therapists are sometimes afraid to make interpretations as they fear to just “point out the obvious”. Adolescents do not usually see it that way and your pointing out the obvious often can’t be obvious enough, as they may not be able to make simple connections or understand themselves. They need help identifying their own feelings and understanding their reactions. It can be a great relief if you help them make sense of things.

- Pay attention to and reinforce little things, do not expect big changes. Meaningful progress cannot be measured (gaining trust, learning to smile or developing hope etc.).
- Conflict is not bad but necessary. Resolving an argument is a new, therapeutic experience.
- Collaborative approach: Try to involve them in most decision-making processes. This is not only important for adolescent development but particularly for children in foster care who have had little control over things before.
- If you make decisions without their collaboration, ALWAYS give a rationale for why you are doing what you are doing.
- Pick activities that promote communication among them and increases empathy.
- The group was created for their benefit. Communicate that it is THEIR group and that the success of it depends on everyone's contributions. Shared responsibility → empowerment → correlation between ownership and level of investment of members.
- They determine the pace.
- Make room for ambivalence. Bring in opinions that deviate from the norm.
- Set limits out of love and care! Be consistent, predictable and fair when enforcing rules.
- Help them weep but do not forget to focus on resources, strengths and resiliency. Empower them to take control!
- Communicate that you understand why they are the way they are and that it has doubtlessly been a useful defense mechanism that kept them alive, but that it might now get in the way of them being able to form close relationships.

- Reflect/let them know how their hurtful comments towards you make you feel. Tell them that you can handle it and look beyond it but that others in the outside world may be hurt by it and ultimately reject them, which is what they feared and expected in the first place → Concept of the self-fulfilling prophecy!
- The underlying message should always be: “I will continue to love you no matter how difficult you are trying to make it for me. No matter how hard you are trying to test me and push me away, I will stay.”
- Be both spontaneous and predictable, flexible and structured. They need both.
- Come prepared and be ready to throw preparation overboard, if necessary.
- No surprises regarding vacations/leaves. Plan those far in advance.
- Anything unpredictable that occurs (drop-outs etc.) needs time for processing, even if the group says that they’re “over it”.
- Remember that they are not only foster kids but also teenagers: Not every “crisis” is actually a crisis.
- Countertransference: Be aware of your own issues/what you bring into the room. Analyze strong reactions, discuss them in your own therapy and supervision.
- Self care: If you burn out, you can’t help. Every helper needs helpers! Do not carry this burden alone. Talk about what “moves you”. Take breaks, turn your phone off, go on vacations.

### III. IMPLICATIONS OF THE DISSERTATION FOR TREATMENT AND TRAINING

#### 3.1. Applicability of This Manual at Other Agencies and Generalization to Other Populations

As this manual was customized for the specific and, in many ways, ideal conditions and circumstances of the FCCP, some suggestions might not be feasible or replicable at other settings where some of the mentioned resources are not available. For instance, only a few agencies will possess an attached undergraduate program that can provide transportation and mentoring services for the members, not many settings offer weekly trainings, individual, group and peer group supervision, not every setting receives continuous referrals from caseworkers, has multiple therapists to choose from, or has as much flexibility regarding therapy hours (late evenings), working space (group rooms) or the funding to offer low-cost services. While some of these issues can certainly be negotiated and, with some creativity, tailored to the needs and capabilities of the particular agency, there are some areas that should not be compromised when setting up a therapy group for this specific population. As such, essential components are frequent supervision and the need of a co-therapist – for ethical and self-care reasons. Similarly, some agencies may be under a lot of time (and financial) pressure and may therefore consider turning the ongoing/open-ended model into a short-term/time-limited one. One should be cautious about making these kinds of fundamental changes for the reasons mentioned in the section above “Time-Limited versus Open-Ended Groups”. Foa et al. (2009) mention, in their section on treatment management, that “patients with PTSD require dependable and steady therapeutic relationships because their symptoms do not remit completely and can exacerbate with anniversary reactions and trauma reminders”

(p.17) – which provides another rationale for a more long-term/open-ended model. They further state: “[...] many patients with PTSD symptoms have ongoing crises in their lives [which certainly is the case for many children in foster care] and may need to rely intermittently upon a supportive therapist” and “[...] it is important to assure the patient of the continued availability of his or her therapist” (p. 17), which would not be the case in a time-limited setting. For all these reasons, unless thoroughly thought through, an open-ended format is strongly recommended

On a similar note, some agencies may have difficulty justifying the need of concurrent individual and group therapy to the paying parties. In this case a careful assessment of the client is necessary to determine which modality is primarily indicated. If a client seems stable enough at intake, the treatment of choice would be group-therapy, since it appears that the interpersonal piece that group therapy can offer is the most beneficial aspect of treating adolescents in foster care (review chapter I for a rationale). If the patient is not stable enough or seems to need the sole attention from an adult first, the recommendation would be to start with individual therapy first and later transfer into the group setting. If members have the opportunity to attend both modalities (if there are no financial constraints, if there are no time barriers and if patients are motivated) simultaneous attendance would be the clear choice

While this manual was inspired by the author’s experience with traumatized adolescent females in foster care and was therefore primarily created to meet the therapeutic needs of this very specific population, many principles (i.e. stages of group development, theoretical background on adolescents, setting up a group, structure of sessions) and activities (icebreakers, rituals, teenage-related activities around family,

sexuality etc.) of this manual are applicable to a broader population. With a few modifications, most exercises are suitable for male members, as well as adolescent members that do not have a foster care background. Caution is urged, however, in utilizing this manual when working with younger individuals (below the age of 13), as they are going to be at a developmental level where they require a more structured setting with more breaks (due to a lower attention span), a different, more active and reinforcing leadership style (possibly with a reward/token system), and interventions that revolve around child-appropriate topics and encompass fewer open discussions and more play.

### 3.2. Limitations of the Manual and Suggestions for the Future

Having advocated for a continuous group model throughout this manual, one may argue how ongoing or continuous a set-up can be, in a setting where therapists may only stay for one year. Of course, the disruption that a shift in therapists (at the FCCP and many other agencies) brings about for the group is less than ideal and would be avoided in a consistent, "perfect world". Nevertheless, when it comes to building trust, there is a vast difference between a time-limited group that is designed to only meet for a few months versus one that is designed to continue, even if life circumstances (members being moved out of district, members having achieved their goals in group, conflicting after-school activities, signing out or aging out of DYFS, moving away to go to college, or facilitators starting another job/internship/practicum) bring about a shift in people. By processing the termination for many months in advance, by avoiding both facilitators (and undergraduates) leaving at the same time, by introducing the new facilitator early on, and by having a candle-ceremony or other ritual for the terminating person, facilitators

attempt to make the process as transparent and as minimally traumatizing as possible. Still, the inherent shift in beloved (and even not so loved) members and facilitators that goes along with group therapy and the subsequently increased risk for re-traumatization for this particular population mark a clear challenge for the group therapy modality and hence, this manual.

Another weakness of this manual and an area that should undoubtedly receive more attention from future facilitators or in future research is the lack of focus on evaluation processes. Because of the immense amount of time that was consumed by generating group exercises, making outlines, creating handouts, and assembling the materials needed for the next group (which can hopefully be circumvented by the creation of this manual), the progress/outcome measures of our members or the effectiveness of the group were never properly evaluated. For instance, the facilitators passed out an anonymous evaluation form ("Feedback Form", see appendix) at the end of every session, that assessed whether the group was useful for the member, gave the member the opportunity to propose new topics and write down additional comments. While every member's feedback was reviewed after each session, the form was mainly used to assess how the members were doing (if anyone needed follow up), if someone felt neglected, uneasy about a topic or recommended new topics. The facilitators got a general sense of whether or not a group was popular and productive. If necessary or beneficial, feedback, ideas or concerns were brought into the group (without giving away members' identities) and discussed. While the members knew that they were "heard" and that their feedback was taken seriously, the forms were not analyzed in-depth or looked at for correlations between different scales. It would have been helpful and important to



determine which topics or activities ranked high on the likeability scale (“I liked group today”), which ones were important to the members (“This was an important group session for me”) and which exercises promoted self-disclosure (“I shared something about myself in group”). Also, was there a correlation between the importance-scale (“This was an important group session for me”) and the self-disclosure one (“I shared something about myself in group”)”? Did the more popular group sessions (“I liked group today”) or the important ones (“This was an important group for me”) correlate higher with the fun-scale (“I had fun in group”), the self-disclosure-scale (“I shared something about myself in group”), self-learning (“I figured out something about myself/my family in group today”) or the learning about others-scale (“I learned something about another group member”)”? Were the group sessions that scored low on the likeability scale also the ones that scored low on the scale that asked members whether or not they felt supported by the group leader? Were the members who found the topic important more active or passive (“I talked in group today”). Hopefully, future group facilitators will be able to take better advantage of this form and build in a research component from the beginning of their work.

Similarly, it would have been helpful to formally assess and track the members’ progress regarding their level of impairment and functioning. Although various scales and questionnaires (Beck Depression Inventory, Ohio Scales, Trauma Symptom Checklist) were handed out for diagnostic purposes and progress evaluation during the first few group sessions and a second time at a later point, they were not used to track members’ progress or evaluate program effectiveness. Before starting the group, it should be discussed in supervision which measures will reflect individual and group progress the

best and how often the members should fill out the assessment-forms (in addition to pre- and post-group treatment). One of the scales that should be utilized in addition to regular symptom-based measures is the “Resiliency Scales for Children & Adolescents” (RSCA) by Sandra Prince-Embury, which consists of three stand-alone global scales (Sense of Mastery Scale, Sense of Relatedness Scale and Emotional Reactivity Scale). The great thing about this tool is that it provides the facilitator with a resiliency-profile of the member that can help the facilitator understand why some members who experienced difficult circumstances adjusted or recovered better than others, it helps make prognoses about how members might respond and how much care they require, it helps determining interventions, strategies and goals and adds a positive psychology aspect (by identifying the members’ strengths, optimism, self-efficacy and adaptability) to the usually quite deficit-oriented assessment-world. The second one of the three scales, which assesses the members’ levels of trust, support, comfort, and tolerance might be particularly useful in determining whether or not group therapy is effective in areas

The fact that the forms that had been distributed to the members were not evaluated, did not mean that the facilitators did not pay attention to the group members’ progress and the areas in which there was still room for growth and development, – but goals were not diagnosis/psychopathology-focused and the progress that was perceived often was difficult to quantify. Progress was seen in changing attitudes, enhanced emotion-regulation, the performance of new, more functional behaviors, enhanced interpersonal relationships with members and people outside of group, improvement of grades, the breaking of old patterns, an increase in trust, brave self-disclosures, the completion of college applications, increased levels of empathy, changes in

communication-styles, body-language and gestures...such as A. dropping her always happy-and-bubbly-mask and showing her authentic (often depressed, scared, disappointed and hopeless) face – first in individual therapy, then in group and then with her foster parents at home...or B., known for her stern, somewhat disengaged façade, suddenly sharing her first, big, beautiful smile with the group after realizing that we had not forgotten about her birthday and giving her the only birthday gift that she would receive that year...or C., the youngest and newest member, whose statement during every check-in had been “everything’s cool”, one day saying “I miss my mom”...or D. saying “I’m thinking about leaving group” instead of doing it the easy/learned way and just staying away/disappearing...or E. speaking up in group after having been completely silent in individual therapy for about half a year. Progress was A., who had never learned to set boundaries, after not including the traumatic incident of her sexual abuse on her first timeline (when she was not ready), including it on her second timeline a year later (when she was ready) – which not only showed that she was now able to talk about “less happy” things, but also that she had learned to set boundaries...or when B. actually waited in front of her house for the undergraduate student to pick her up for group as opposed to waiting inside without her shoes and coat on, as she expected every time that she would be forgotten about because deep down nobody actually cared about her...and C., having gained enough trust in the group to share that not everything was okay and that her uncle was touching her occasionally, and being brave enough to break the circle of silently-abused women in her family and report him to the police...D. giving herself and the group the gift of a non-traumatic goodbye by allowing enough time to process her departure and celebrate this event with our very first candle-ceremony...and E., who

never trusted this facilitator in individual therapy and also never seemed to trust us much in group, protecting the group facilitators from the other group members (who had experienced our reporting of C.'s sexual abuse as a betrayal), reminding them how much the facilitators had done for them and that we were just trying to protect them from people that hurt them – and then (after more than two years) sharing that she herself had been raped a few years ago.

As you see, while we did not formally track group members' progress, we observed their smiles, recognized their (at times clumsy) attempts to comfort each other, noticed and reinforced behavior changes that were displayed in group and then applied in the "real world", identified boundaries they set and risks that they took, observed the circle of seats becoming tighter (as the members no longer feared physical and emotional closeness), and noticed how the group went from "I don't want be here" to "I don't want this to end" and from "let's all agree so that this does not fall apart" to "disagreements won't make us fall apart". While I hope that future facilitators will formally quantify their members' progress in order to prove the effectiveness of the group approach described in this manual, comments such as the following that occurred at the end of the group must also be seen as evidence for the success of this treatment approach:

- "I love this group. At first I really didn't want to be here, but I really grew to love everyone. You did a really good job with this group. I wouldn't change a thing!"
- "I thank God that I joined this group and opened up to everyone. Hopefully we will grow off of this and keep in touch. Maybe this can benefit us all...but I mean we should keep this going. I don't know...it helped me, point blank."
- "I love group and I am so thankful that I got to meet such wonderful and strong people. I love you all and cannot wait until we have group again."
- "I'm not gonna say goodbye because goodbye means "I'll never see you again." I'm so glad that this group was created! I'm glad that I met you all!! Now I know

I'm not alone in this world anymore!! People outside of this group I didn't even want to be friends with, but all of you, I'm glad we're friends!! It feels good for a change because I believe you all are real and are good people! I wish this group wouldn't end because it feels like I just started knowing who you really are."

- "I really like this group because I don't have any female friends, but now I have plenty. This group was cool. I couldn't ask for anything different."
- "I'm so happy that I got to be in this group, it means the world to me. I could say that I learned a lot from this group. And this is not a good-bye."

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## APPENDICES

APPENDIX A: Supplemental Materials from Chapter II

APPENDIX B: Supplemental Materials from Chapter III

APPENDIX C: Supplemental Materials from Chapter IV

## APPENDIX A

### Supplemental Materials from Chapter II

GROUP FLYER

CONSENT FORM

## GROUP FLYER

Rutgers University  
Foster Care Counseling Project



## Psychotherapy Group for Adolescents in Foster Care

### Addressing Issues of:

- Adjustment
- Separation/Loss
- Emotional and Social Development
- Self-Esteem
- Anger Management

Ages 14-18

Limited space available (4-9 per group)

Weekly sessions on Thursdays from 4-5:30 p.m.

Starting date: January 24, 2008

Psychological Clinic at GSAPP

Busch Campus, Piscataway

For more info, contact Carolin:

732.445.7789 ext. 10

or [CaroH@Eden.Rutgers.edu](mailto:CaroH@Eden.Rutgers.edu)



## CONSENT FORM

I, \_\_\_\_\_, understand that in utilizing the services of the Foster Care Counseling Project, I am participating in the activities of a teaching program associated with the Psychological Clinic at the Graduate School of Applied Professional Psychology (GSAPP) at Rutgers University. As such, I understand that information obtained from questionnaires, group sessions, or interviews may be shared with clinical supervisors and with other clinicians-in-training during case conferences or consultations to help the group leaders provide the group members with the best possible service. I understand that information, which I provide in forms of surveys etc. may be used anonymously as part of ongoing research. I also understand that this information is kept under strict conditions of professional confidentiality. This also means that DYFS will not be provided with any of the information that will be shared in group by participating group members. Solely participation will be reported to DYFS for billing purposes only. Participation in the group is free of charge for me.

I agree to honor the following group rules:

### 1. Confidentiality among group members

To create a safe place where group members can feel comfortable sharing experiences, it is important that I don't talk outside of group about the things that other group members have shared. While it is okay to talk to people outside of group about my experience in group, it is important that I respect the privacy of others, which means that I don't share information (names, school etc.) or the experiences of other group members. I would not want group members to talk about me and will therefore not talk about them.

### 2. Attendance

I understand that participation in this group is optional (unless otherwise indicated by my DYFS caseworker). However, I agree to attend 4 group sessions to be able to make a good decision about whether or not I want to be a member of the group. After the 4<sup>th</sup> session I will let \_\_\_\_\_name and phone numbers of both group facilitators\_\_\_\_\_ and the group members know if I will continue to come. The group will meet every Monday from 6:00 until 8:00 PM at GSAPP. Transportation to the location is provided. If I cannot come to a session, I will notify \_\_\_\_\_name and phone number of transportation aid\_\_\_\_\_ 24 hours prior to the group. If I decide to leave this group, I will inform and meet with my group facilitator three weeks before I plan on leaving the group to give the group the chance to process my termination.

I have read, and I understand, the terms of this agreement. (For parents: I allow my child to participate in this group.)

\_\_\_\_\_  
Client Name (Please print)

\_\_\_\_\_  
Date and Signature of Client

\_\_\_\_\_  
Clinicians' Names (Please print)

\_\_\_\_\_  
Date and Signature of Clinicians

\_\_\_\_\_  
Parent / Caregiver's Name (Please print)

\_\_\_\_\_  
Date and Signature of Parent / Caregiver

## APPENDIX B

### Supplemental Materials from Chapter III

#### FEEDBACK FORM

Important Activities during the First Stage of Group Development:

I AM YOU

THE CIRCLE

BOWL OF QUESTIONS

MY SCAR

DREADING THE DARK WHILE REACHING FOR THE STARS

MY GOALS, OUR GOALS

CREATING OUR GROUP CONTRACT

OUR GROUP STATEMENT

FINDING A GROUP NAME

OUR TOPIC LIST

# FEEDBACK FORM<sup>4</sup>

Date of the group: \_\_\_\_\_

The topic for today was: \_\_\_\_\_

1 = *Strongly Disagree*      2 = *Disagree*      3 = *No Opinion*      4 = *Agree*      5 = *Strongly Agree*

- |  |           |
|--|-----------|
| 1. This was a good/important topic.                        | 1 2 3 4 5 |
| 2. I liked group today.                                    | 1 2 3 4 5 |
| No? Because_____   |           |
| 3. I learned something about myself in group today.        | 1 2 3 4 5 |
| 4. I figured out something about my family in group today. | 1 2 3 4 5 |
| 5. I learned something about another group member.         | 1 2 3 4 5 |
| I learned the most about: _____                            |           |
| I would like to learn more about_____                      |           |
| 6. I felt comfortable in this group.                       | 1 2 3 4 5 |
| No? Because_____   |           |
| 7. I shared something about myself in group.               | 1 2 3 4 5 |
| No? Because_____   |           |
| 8. This was an important group session for me.             | 1 2 3 4 5 |
| Because_____   |           |
| 9. I felt supported by the group leader.                   | 1 2 3 4 5 |
| No? Because_____   |           |
| 10. I had fun in group.                                    | 1 2 3 4 5 |
| 11. I'm looking forward to next week's group.              | 1 2 3 4 5 |
| No? Because_____   |           |
| 12. I talked in group today.                               | 1 2 3 4 5 |
| No? Because_____   |           |

The bravest member today was: \_\_\_\_\_

I was proud of myself because I\_\_\_\_\_

A topic I would like the group to discuss is: \_\_\_\_\_

My goals after this session are: \_\_\_\_\_

Other comments: \_\_\_\_\_

\_\_\_\_\_

<sup>4</sup> This form was inspired by Carrell (2000): "A Patient Satisfaction Survey" (p. 4).

## I AM YOU

### Description of Activity

- Members sit in a circle and are asked to break into pairs with their neighbor. If there are an odd number of members, the last person pairs up with the undergraduate student. Group facilitators (and possibly the undergraduate student) pair up with each other, if they choose to participate in the activity.
- The members are asked to take a few minutes to interview each other (four minutes per person) and find out general information (name, age, school etc.) and whatever else they would want to find out about their partner (hobbies, siblings, living situation, favorite music, something funny or unusual about themselves etc.). Also, ask them to share how they feel about being in this group.
- The interviewer tries to remember/memorize as much information about her partner as possible. Before the four minutes are up, the person who did the interviewing summarizes the information that she remembers to the interviewee.
- When the group facilitator gives a signal, the group members switch and the interviewer becomes the interviewee.
- When the pairs are done, they are asked to share the information that they found out about the other person in the following way:
  - Interviewer stand behind the chair of the interviewee, puts her hands on her partner's shoulders and introduces partner as if she was her: "My name is (name of partner), I love (hobbies of partner) and (sharing of information that she remembers about partner...)."
    - Afterwards interviewee is asked if interviewer did well or if she wants to add or correct anything.
    - Partners switch roles and positions.
- In order to take make it easier for the members and take the initial embarrassment off them, the group facilitators can start the process and either actually introduce the other facilitator/undergrad or just give a fictional example of what "I Am You" can look like.
- The group applauds after every presentation.

### Conclusion/Processing Activity

- Feedback after the last pair: What was it like to introduce someone else as if you were her? What was it like to have someone else introduce you without being able to interrupt?

### Rationale and Objective

- Good first icebreaker: sharing of basic (generally not too personal) information.

- Introducing self to entire group can be anxiety provoking; introduction to just one partner is easier.
- Learning to take other person's perspective → prerequisite of empathy-building process.
- Sharing of information from 'outside of group' and initial 'in-group focus' (how they feel about being there).
- Promotion of initial emotional (and physical) connections.
- By not utilizing notes, the members are asked to focus on what's important and actually listen.
- By participating in this activity, the group facilitator has the chance to set the tone of the group, show which kinds of disclosures are possible, introduce emotional language (expression of feelings) and model how to express ambivalence (coexistence of excitement and nervousness).
- Yalom's Curative Factor: development of socializing techniques

#### Materials

- No materials needed

#### Reminders to Group Leaders

- If you as the group facilitator decide to participate in this activity, be careful about the information that you disclose (age etc.).
  - I usually said something like: "My name is Carolin, I was born and raised in Germany (as you can tell by my big accent) and moved to Jersey two years ago. I'm currently a grad student at Rutgers and I love basketball, ice cream and being outside when it's sunny. Sometimes I'm very goofy (I'm sure you will find this out soon), but I'm also a good and serious listener. I like living here even though it's hard to be this far away from my brother (who by the way looks nothing like me as he is 6'6" tall) and I'm both super happy to see you all here and excited about the opportunity to get to know you all and really, really nervous, because I so much want this group to be a good experience for all of you."
- If you choose not to participate, still make sure to give them an example and just make up information (I'm Daisy Duck, I'm 15 years old and...).
- Communicate to the group that this activity is not about doing a perfect job and remembering everything but about being in the moment and actually listening.



## THE CIRCLE

### Description of Activity

- Group pushes chairs to the side and forms a small circle (so that their shoulders almost touch) standing up. The facilitators and undergrad mingle with the group but do not participate in the activity.
- One of the members is asked to read the following instructions out loud (See below: “The Circle – Instructions)
- Everyone takes a step out, group facilitators begin to slowly read the statements (See below: “The Circle – Statements”)

### Conclusion/Processing activity

- What did they think about this activity? What do they think was the purpose? Why did we choose this one?
- How do they feel? What was it like to take steps/not take steps? Was it hard to take a step in? Was there anything that made it easier to step in?
- What do they take away from it? Was there anything they were surprised about?

### Rationale and Objective

- One of the most valuable activities during the first few groups.
- Activity reveals important commonalities and interests that are meaningful to members but would not have gotten asked about in a more open question-format (like the “I Am You” activity).
- Promotes self-disclosure without pressure and without actually having to ‘talk’;
- A lot of statements do not disclose specific information but are worded in more general terms (e.g., “experiences” instead of “physical abuse”), which pushes their boundaries but keeps premature disclosure at minimal risk
- Simultaneous disclosures are less anxiety provoking and more healing than individual disclosures
- Challenges their fear of being alone with their experiences; members hear, see and even feel that they have company
- Decreases feelings of shame, guilt and self-blame around certain experiences
- Fear of being rejected and ‘standing alone’ after a personal disclosure gets contradicted by the symbolic taking-a-step-towards-each-other meeting in the inner circle. Thus, painful experience is not isolating but creates (emotional and physical) closeness.
- Yalom’s curative group factors that apply here:
  - Universality
  - Fosters early group cohesion
  - Instillation of hope
  - The corrective recapitulation of the primary family group
  - Imitative behavior
  - Interpersonal learning

### Materials

- One copy of “The Circle – Instructions” sheet for a member to read out loud.
- Three copies of “The Circle – Statements” (for both facilitators and the undergrad)

### Reminders for Group Leaders

- Should not be used as the very first ice breaker. The disclosure of more personal information requires at least a minimal level of trust or acquaintance with the other members.
- Group facilitators and undergraduate student should not participate in this activity. You should however be part of the circle and not just be a silent observer from the outside. The three of you should take turns reading the statements.
- The order of the statements should not be changed, as some of them build onto one another. Of course you can add new statements.
- This activity was one of my favorite activities. It was amazing to witness how the facial expressions of the girls went from looking scared, doubtful and hesitant to looking surprised and incredibly relieved once the first girl took a brave step inside of the circle. With a big sigh, most members then joined the courageous first one, who was equally relieved to see that she was not the only one. It was wonderful to process this experience and what it meant to the members after the activity. No matter who this activity was done with, I always felt like it made a huge difference and brought the group closer together immediately.

## The Circle – Instructions

This game is called “The Circle” – whenever we have something in common, we come together in a close circle.

It works like this: After I have read the instructions out to you, we are all going to take a step outside of the circle, making the small circle larger. (Names of facilitators) are then going to take turns in reading a list of statements out to us. We take a second to think about whether or not the statement applies to us. If my answer is YES (meaning if it applies to me or if I agree with the statement), I take a step inside the circle. If the answer is NO, I will stay in the same spot. I will remain in my spot for a few seconds and am then asked to take a step back out to the position where I started out from and the next statement will be read out to me.

Yes = In, No = Stay where I’m at.

Does everyone understand this?

Any questions?

Before we start, there is one more thing that is really important: If a statement applies to me but I’m not ready to share this about myself yet, I do not have to take a step into the circle but can stay in my place. I’m not forced to disclose anything about myself and I will neither feel pressured by the members taking a step inside nor the ones that are staying at the outside circle. I will push myself a little bit but not disclose anything that makes me feel uncomfortable or unsafe.

Questions?

Okay, let’s start and take a step out.”

## The Circle – Statements

1. I like chocolate.
2. I love to sleep in on the weekends.
3. I’ve had a crush on a movie star.
4. I’ve been in foster care for more than one year.

5. I am sometimes shy around people I don't know well.
6. Without knowing people well yet, it feels like there are some girls in this group that I think I'm going to like.
7. I consider myself to be part of a minority group.
8. Sometimes I worry about what other people think of me.
9. I'm both excited and nervous about being in this group.
10. I like going to the movies.
11. I've been in more than one foster home.
12. I don't like people who gossip.
13. I play a sport.
14. I've been separated from a sibling.
15. I don't know how to talk to people at school about being in foster care.
16. I like to watch MTV.
17. I've experienced things that I don't like to talk about.
18. Sometimes I'm scared of taking a step inside the circle because I wonder if I'm the only one.
19. I want to go to college in the future.
20. I have a boyfriend or girlfriend.
21. My life is different from the lives of most people I know.
22. I live with a family of a different race than mine.
23. I like going to the mall.
24. I know what it's like to have parents who drink a lot or use drugs.
25. Sometimes I feel caught between my foster parents and my biological parents.
26. I've been skinny dipping before.
27. It's been a while since I've seen my mom and dad.

- 28. I like funny movies.
- 29. There are things I want to change about myself.
- 30. I hope this group can help me with that.
- 31. I like it where I am living now.
- 32. I care about the upcoming presidential elections.
- 33. I like serious movies.
- 34. I'm a little scared but I want to give this group a chance.
- 35. I have relatives who have been in jail.
- 36. I've been in therapy before.
- 37. I like to eat pizza.

## BOWL OF QUESTIONS

### Description of Activity

- Each member receives a few cards and is asked to fill out at least two.
- On each card they are asked to anonymously write down a question that they would like the other members to answer and feel comfortable answering themselves.
- Give your members some examples.
- All cards are folded and placed in a bowl that already contains cards that were prepared beforehand by the group facilitators.
- The cards are drawn, read out loud and then put aside by the undergraduate student.
- Each member has to answer every question one at a time around the circle. If a person needs more time to think, you can get back to that person later.
- This activity is going to take quite a long time, especially if members fill out more than two cards. You may end the game at any point and continue to play it during the next session. You may choose if members can continue to add questions at the beginning of the next session.

### Conclusion/Processing Activity

- What did you like about this activity? What questions did you find the most interesting and why? How did people reply? Which answers stuck with you the most and why? What did you notice about the way that you answered your questions? Were your answers influenced by the answers of others? Who was brave?

### Rationale and Objective

- Enhancement of group identity through exchange of personal information
- Members can ask meaningful questions without having to disclose their names (which makes it safer to ask). Nevertheless, members are less likely to ask inappropriate or too personal questions, as they know that they have to answer their own questions.
- In contrast to “The Circle”, members share information verbally; disclosure does not take place by ‘taking a step’. Also, questions are open ended, meaning the members can decide where they want to go with them (happy, sad, personal etc.), how much they want to share and which parts of their personality and life they want to share.
- Feedback in the end increases awareness of self and others
- Carrell introduced a similar exercise to this one, although in her version members did not write down their own questions but only answered the ones that were prepared by the facilitator. Carrell called this activity a “nice breather”. She stated that the activity was a good one for newly formed groups, for groups that have just admitted new members and for ongoing groups that have had some intense sessions and need some ‘slowing down’.
- Yalom’s curative group factors that apply here:
  - The corrective recapitulation of the primary family group
  - Development of socializing techniques

- Interpersonal learning
- Group cohesiveness
- Catharsis

### Materials

- 1 Bowl
- Print out one copy of “The Bowl – Cards” (see below) on thick paper or cardboard, cut out cards and fold them once.
- Prepare blank cards (same paper) for members to fill out. Prepare about 5 cards per member.
- Pens that do not print through paper.

### Reminders for Group Leaders

- Have the undergraduate student and not the members read out the questions. This way, you have more control over the ‘appropriateness’ of the questions, no one finds out who asked the particular question, you avoid that potentially bad readers get embarrassed during the first group sessions and that members make fun of each others’ spelling.
- Make sure to brief the undergraduate student beforehand so that she can assess and determine the appropriateness of a question. If she is unsure, have her put the card back into the bowl, discuss it after group and get to it next time.
- If you feel like a question may be too personal or is worth a discussion during one of the following sessions, you may write down the particular question on the “Topic List” (see below) of the group.
- Regarding the ‘already prepared questions’: We took the following questions from Carrell’s manual (“Breaking The Ice”, p.45):
  - What is the best movie you’ve ever seen?
  - Who is the most important person to have lived during your lifetime?
  - What was the best day of your life?
  - What is your earliest memory?
  - What would you like to be doing five years from now?
  - If you had \$5000, what would you do with it?
  - What is one thing that you like about this group?
  - One of the things people like most about me is...
  - My favorite performer, actor or entertainer is...
  - The season I like best is... Why?
  - My role model is... Why?
  - The characteristics I most value in my friends are...

What is the best movie you've ever seen?	Who is the most important person to have lived during your lifetime?
What was the best day of your life?	What is your earliest memory?
What would you like to be doing 5 years from now?	If you had \$5000, what would you do with it?



<p>What is one thing that you like about this group?</p>	<p>One of the things people like most about me is...</p>
<p>My favorite performer, actor or entertainer is...</p>	<p>The season I like best is... Why?</p>
<p>My role model is... Why?</p>	<p>The characteristics I most value in my friends are...</p>

Figure 3. The bowl cards.

## MY SCAR

### Description of Activity

- Members are asked to tell the story of a scar on their body.
- Everyone needs to talk, no specific order.
- Leader can choose to leave the instructions at that or add the following sentence to 'specify' the instructions: "The scar can be visible or invisible, physical or emotional."

### Conclusion/Processing Activity

- How did it happen? Who healed your wounds? How did people react to the incident? Does the scar trigger happy, angry, fearful or sad memories? How often are they reminded of it? Did it heal well? Does it still hurt?
- How did the incident/accident that caused the scar affect them in the long run (be more cautious, avoid things etc.)?
- Do they have several scars? What made them pick this one? What made them not want to pick another one?
- Did they know which scar they want to present from the beginning and did the stories of others change their plan? Which one did they first want to share and why did they decide not to?

### Rationale and Objective

- Members practice telling a story about themselves.
- Instructions are very brief and somewhat vague (especially if leaders choose not to add the emotional and invisible part). Where members take it, whether they show the scar or not, whether they make a funny or sad story out of it, says a lot about their personalities, their roles within the group and what they want others to know about them.
- Yalom's curative group factors that apply here:
  - Altruism
  - Interpersonal learning
  - Group cohesiveness
  - Catharsis

### Materials

- No materials needed.

### Reminders for Group Leaders

- The discussion and processing of the stories afterwards is at least as important as the story itself.
- Pay attention to the first story. Are the other stories of a similar 'tone'?



## DREADING THE DARK WHILE REACHING FOR THE STARS

### Description of Activity

- Group facilitator asks members to take a few minutes to quietly think about their hopes and fears in regard to this group.
- Each member receives two cards that were prepared by the group facilitators beforehand (see below). Members are asked to spread out (leave the circle) and sit down on their own where they can be focused and write. Leaders participate in the activity.
- Members are asked to write down at least three concerns on the card that says “What I’m a little worried about in regard to this group” and three anticipations on the card that says “What I’m excited about/looking forward to in regard to this group”. Members can ask for more cards, should they need them.
- Ask members to take the activity seriously, as the group contract and group statement will be derived from it. Ensure your members that the activity is ‘anonymous.’
- When they are done, cards are folded in half and put in the bowl.

### Conclusion/Processing Activity

- When everyone is finished, group sits back down in circle.
- Undergraduate mixes cards and reads them out loud; a volunteer is asked to go to the board and record hopes and fears with the help of the other members.
- Group is invited to discuss and share feelings.
- Group organizes points (similar anxieties/which fears go together?), making clusters with headings and categorizing them in a way that allows them to later make rules for the group contract.

### Rationale and Objective

- This activity requests members’ anxieties and anticipations anonymously so they can voice their fears and desires without having to worry about what the other members may think about them.
- It communicates that ambivalence is normal and that anxiety and anticipation can coexist.
- It shows that others have similar hopes and fears and they are all ‘in the same boat.’
- They learn to collaborate and problem-solve and create something together, which enhances group identity.
- Yalom’s curative group factors that apply here:
  - Instillation of hope
  - Universality
  - Interpersonal learning
  - Group cohesiveness
  - Catharsis

## Materials

- “Dreading the Dark While Reaching for The Stars”-worksheet:
  - Make enough copies so that every member plus both facilitators and the undergraduate can have at least one “Worry” card and one “Excitement” card; Bring some extra ones in case members have more than three points they want to write down.
  - Cut out cards and make two piles out of them
- Pens for members, leaders and undergraduate
- 1 Bowl
- Chalkboard and chalk or whiteboard with pens

## Reminders for Group Leaders

- Explain to your members that this activity is an important one as it inquires what they need from the group in order to feel safe, enjoy it and ‘get something out of it’.
- Help your members understand the feelings that are behind their comments.
- Since you participate in the activity, you can write down important concerns that might not get voiced by your members (e.g., regarding boundaries, confidentiality in the car, creating a group that is both fun and serious, premature disclosure, side talks, leaving the group).
- Undergraduate student can write down worries unique to her role so that an open discussion about boundaries, responsibilities, limitations can derive from it. For example, “I’m worried that members will tell me something in the car and feel betrayed if I then tell the facilitators about it.”
- I would recommend doing the first part of the activity (the ‘writing down’ part) in one session and the ‘board’ part in the next session. (You can just take a picture of the board so that you can erase it and do not have to copy everything down before the group ends). This way, you have time to read through the cards, get prepared and possibly add some comments to your cards that did not get addressed by the members.
- Below you find the ‘unclustered’ comments that the younger girls of the TALK group . As you can see, most of their worries revolve around distrust, self-doubt and fear of being rejected, judged and getting hurt. They seek new relationships, validation, and being able to express themselves in a safe setting.

“Dreading the Dark While Reaching for The Stars”: Things we’re excited / concerned about in regard to this group.

WE’RE A LITTLE WORRIED ABOUT STARTING THIS GROUP FOR GIRLS IN  
FOSTER CARE  
BECAUSE...

“People might laugh at what I say.”  
 “People may dislike me.”  
 “I’m a little worried about what we will talk about.”  
 “No more members”  
 “Bad reactions”  
 “Hurt feelings”  
 “People will tell classmates what we talked about.”  
 “People might judge me.”  
 “People might talk about me in the car when I leave.”  
 “We will become close and then somebody leaves.”  
 “I might have to miss some days.”  
 “I’m shy.”

WE’RE EXCITED ABOUT STARTING THIS GROUP FOR GIRLS IN FOSTER  
CARE  
BECAUSE...

“I get to understand/communicate with people like me.”  
 “It’s good to meet new people.” (3x)  
 “Hanging out”, “(b-day) parties”, “games and activities”  
 “It’s a chance to talk about things and get new perspectives.”  
 “Starbursts!”  
 “Finding support from those who get me!”  
 “New friends” (3x)  
 “Talking about fun and serious things”  
 “Fun!” (2x)  
 “New way to express myself.”

<p>What I'm <u>excited</u> about/looking forward to in regard to this group:</p> <p>1.</p> <p>2.</p> <p>3.</p>	<p>What I'm a little <u>worried</u> about in regard to this group:</p> <p>1.</p> <p>2.</p> <p>3.</p>
<p>What I'm <u>excited</u> about/looking forward to in regard to this group:</p> <p>1.</p> <p>2.</p> <p>3.</p>	<p>What I'm a little <u>worried</u> about in regard to this group:</p> <p>1.</p> <p>2.</p> <p>3.</p>

Figure 4. Dreading the dark while reaching for the stars – worksheet.

## MY GOALS, OUR GOALS

### Description of Activity

- Members are asked to take a few minutes to think about:
  - Personal goals they want to achieve during the group (ask them to both write down long-term goals and short-term goals that they would like to work on in every session); and
  - Goals they want the group to work towards.
- If they have difficulty thinking of personal goals, the facilitator may assist them.
- They fill out the appropriate cards and cut them out.
- They then pair up with their neighbor and share their personal and group goals with each other.
- Every member then shares her partner's personal and group goals.
- Personal and group goals are then put in their binders (see below).
- After everyone is done, every member has the chance to write down one or more "secret goals" that they do not want to share with the group. They are asked to put the card in their wallet (or their binder) so they can be reminded of their own secret goals from time to time. They also have the option of writing their name and their secret goal down on the last card for the group facilitator to read (so the facilitator can assist the member in achieving her goal). This, however, is not a requirement.

### Conclusion/Processing Activity

- The group discusses personal goals of others that they liked.
- How can they 'measure'/assess whether or not they achieved their goal.
- The group collaboratively establishes common group goals on the board.
- Optional: The group can discuss why they did not want to share their secret goal WITHOUT saying what their secret goal is.

### Rationale and Objective

- Formulation of personal goals to remind self what one wants to work on.
- Increases empathy with other members by explaining partner's cards.
- Formulation of group goals enhances group identity and effectiveness of the group.
- Promotes team-work, collaboration, problem-solving.
- Yalom's curative group factors that apply here:
  - Instillation of hope
  - Universality
  - Imparting information
  - Development of socializing techniques
  - Imitative behavior
  - Interpersonal learning
  - Group cohesiveness

### Materials



- Enough copies of “My Goals, Our Goals”-Worksheet
- Pens
- Scissors
- Bowl
- Chalkboard and chalk or whiteboard with pens

#### Reminders for Group Leaders

- If members have difficulty finding personal goals, remind them what you talked about during the screening.
- Write down the group goals agreed on by all members, type them up and pass them out for them to put in the binders during the next session.
- Psychoeducation about SMART goals (give examples)
  - S – pecific
  - M – easurable
  - A – ttainable / Achievable
  - R – elevant / Realistic
  - T – imely (within a specific timeframe)

<p style="text-align: center;">My Personal Goals</p> <p>1.</p> <p>2.</p> <p>3.</p>	<p style="text-align: center;">My Group Goals</p> <p>1.</p> <p>2.</p> <p>3.</p>
<p style="text-align: center;">My Secret Goals</p> <p>1.</p> <p>2.</p> <p>3.</p>	<p style="text-align: center;">_____’s Secret Goals</p> <p>1.</p> <p>2.</p> <p>3.</p>

Figure 5. My goals, our goals – worksheet.

## CREATING OUR GROUP CONTRACT

### Description of Activity

- Members look at the clusters of the previous activity and collectively create rules that address each one.
- A contract is developed from the rules.
- Facilitators type up contract after the session and hand it out the following week for everyone to sign.
- Group can discuss if they would like to have some sort of symbolic ceremony to seal the contract.

### Conclusion/Processing Activity

- Discussion about the importance of the contract and the consequences of breaking the rules.

### Rationale and Objective

- This activity puts members in charge of creating the type of place they need and want.
- It gives a population with 'learned-helplessness tendencies' control over their situation.
- The rules create a structure in an otherwise unstructured world.
- Contract communicates what is expected from the members and provides common grounds to go by and refer to.
- Developmentally appropriate discussion about norms, values, boundaries etc.
- Enhances collaboration and communication, problem solving and conflict resolution skills.
- Promotion of self awareness (reflection about own needs and concerns) and empathy (learning about needs and concerns of others).
- Empowers members to take responsibility. Shared responsibility increases feelings of ownership and level of investment in the group.
- Creation of a group identity, promotion of bonding as a group.
- Yalom's curative group factors that apply here:
  - Universality
  - Imparting information
  - The corrective recapitulation of the primary family group
  - Development of socializing techniques
  - Imitative behavior
  - Group cohesiveness

### Materials

- Chalkboard and chalk or whiteboard with pens

### Reminders for Group Leaders

- Interfere as little as possible; only intervene if you feel like members might be missing something important.
- Please check theory-part of the manual, as it gives you important suggestions on what needs to be in the contract (confidentiality, attendance etc.).
- Below you will find a sample contract. Of course, yours can look completely different. The contract below was the one of the TALK group and was derived from the above posted list of their concerns and anticipations.

### Example of a Group Contract

(Developed in collaboration with group members, derived from “Dreading the Dark While Reaching for The Stars”; has to be signed by members and facilitators within the first 2-3 sessions).

### OUR GROUP CONTRACT

\* \* \*

Our worries: “People might laugh at what I say”, “People might judge me”, “People may dislike me”

⇒ Rule: We will be respectful to one another. We will not hurt each other’s feelings, judge or laugh at each other.

I know how painful it is to be laughed at and how difficult it is to talk about past experiences. I will, therefore, not laugh at or disrespect anyone who is brave enough to share personal information with me.

\* \* \*

Our worries: “Hurt feelings”, “Bad reactions”, “Arguments”

⇒ Rule: We will voice our difference of opinion in a respectful way.

Conflict is normal. We are different people, so it is normal to have different opinions. Our group is only valuable if we dare to speak up and disagree. What matters, is HOW we handle conflict. When I disagree, I will never intentionally hurt somebody else’s feelings. I will not yell, call someone names, make fun of the way anyone looks, or hit anybody in the group. I will try to let others finish their sentences and not interrupt.

\* \* \*

Our worries: “I’m a little worried about what we will talk about”, “I’m shy”

⇒ Rule: I will NEVER be forced to talk about anything that I do not want to talk about.

This group was put together to help ME, so I (along with the other group members) get to choose what kinds of topics we will talk about in here. Since a lot of us share similar experiences, it is likely that some of us are going to want to talk about similar things (for example: what it is like to be in foster care ). Still, at times some members may want to talk about something that makes me feel very uncomfortable. If this happens, I will inform \_\_\_names of group facilitators\_\_\_ and one of them will then keep me company in a different room, while the group discusses the topic. I decide IF, WHAT and WHEN I share personal information about myself with the group!

\* \* \*

Our worries: “This is a type of therapy”

⇒ This is both: a place where I can talk about difficult things AND where I can have fun!

Yes, this is a TYPE of therapy, but that does not mean that we will not have any fun together. It only means that I have the opportunity to talk about things in a SAFE and PROTECTED setting that I would not feel comfortable talking about in most other places (school etc.) because I would fear that people would not understand me.

\* \* \*

Our worries: “People will tell classmates what we talked about.”, “People might talk about me in the car when I leave.”

⇒ Rule: Everything that is being said in this room STAYS in this room!

This is the only way I can feel safe enough to open up to the other girls in the group. Therefore, this is the most important rule!

This rule means that I will not tell ANYONE (school, friends, parents, caseworkers etc.) the things that are being disclosed to me by the other group members. I can tell others about MY experience in group and the general topics that we talk about, but I will not talk about anybody else’s experience, nor will I mention anybody’s name or school. I will not gossip about the other girls or say hurtful things in their absence.

\_\_\_Names of group facilitators\_\_\_ will also keep everything that is being said confidential. I understand that the only time they have to share information is when I plan on hurting myself or others or when somebody else is hurting me – because \_\_\_names of group facilitators\_\_\_ care about me and want me to be safe. They will never do so without talking to me about it first.

\* \* \*

Our worries: “We will become close and then somebody leaves.”, “No more members”

⇒ Rule: I will never leave this group without a proper “goodbye ceremony”

I know how hard it is when people just disappear out of my life. I will, therefore, make sure that I will not hurt the girls by just leaving the group without any notice. If I have to or want to leave the group, I will inform the group three weeks in advance so they have enough time to say their goodbyes and so that a “candle-ceremony” can be held for me.

\* \* \*

Our worries: “I might have to miss some days”

⇒ Rule: I will come to all group sessions, unless I am sick or there is something very important going on in my life.

I know how tough it is to look forward to seeing someone and then that person does not show up. We are a group, and we are only complete if I’m there. I will, therefore, try not to schedule any appointments on Mondays between 3:30 and 6:30 P.M. If I do have to miss a group, I will notify \_\_\_names of group facilitators\_\_\_ 3 days in advance.

Sometimes I may not feel like coming because I’m upset or because of the topic of the group...that is very normal! But I will be brave enough to come anyway and tell the group why I did not feel like coming this week.

\* \* \*

I promise to obey this group contract. I will follow the rules above and thereby do my part in making everyone feel safe in this group.

---

(Date and Signature)

## OUR GROUP STATEMENT

### Description of Activity

- After values, norms, goals and rules have been discussed, the group can collaboratively come up with a group statement, poem, song, dance...
- They can use the group contract/personal and group goal-sheets for inspiration.
- Work on it on the board.

### Conclusion/Processing Activity

- Creation of a ritual. How and when do they want to use the statement? At the beginning of each group? At the end? Take turns on who reads it? Have everyone memorize it and 'declare' it together like the national anthem?

### Rationale and Objective

- Creation of a ritual helps create safety, increases group cohesion and group identity and a sense of belonging.
- Being 'part of something' is a healing experience for isolated foster kids.
- Reminds them of norms, values and rules every week.
- Yalom's curative group factors that apply here:
  - Universality
  - Imparting information
  - The corrective recapitulation of the primary family group
  - Imitative behavior
  - Group cohesiveness

### Materials

- Copy of group contract (if not in their binders already)
- Copy of personal and group goals (from their binders)
- Chalkboard and chalk or whiteboard with pens

### Reminders for Group Leaders

- Write down what they agreed on, type it up at home and pass it out for their binders in the next session.
- Implement new ritual/group statement in every session from now on.
- Below you will find an example of a group statement that Carrell (2000) posted in her manual.



### The Group Statement

This is our group. Its success or failure is up to us. We come together in search of ourselves. What we have to share is honesty; what we hope to gain is trust. Through expressing our feelings, hopes, and dreams, we can become known to one another. Friendship and self-understanding are the rewards. We will respect the privacy of each member by keeping group business within the group. What we see here, what we hear here, let it stay here. There are only two rules for this group: (a) No side conversations are allowed, and (b) we must be kind to one another.

(Carrell, p. 29)

## FINDING A GROUP NAME

### Description of Activity

- Members can develop some ideas as their homework and present them to the group in the following session; group can then discuss ideas and vote for the best one.
- In the alternative, members collaboratively develop ideas and create a group name they can identify with

### Conclusion/Processing Activity

- Members create a poster with group name on it.

### Rationale and Objective

- “The Group Name: From Stigma to Valued Identity” (Malekoff, p. 101)
- One of the most important activities, as it gives all members a symbolic ‘last name’, something everyone identifies with – a common self-reference.
- Enhances group identity.
- Practices collaboration skills, ‘presentation’ and communication skills, being assertive.
- Promotes creativity and ‘sophisticatedness’.
- Yalom’s curative group factors that apply here:
  - Universality
  - The corrective recapitulation of the primary family group
  - Development of socializing techniques
  - Group cohesiveness

### Materials

- Scrap sheets and pens to jot down ideas
- Chalkboard and chalk or whiteboard with pens
- Poster board
- Material to decorate poster with (glue, scissors, markers, magazines (collage), glitter etc.

### Reminders for Group Leaders

- If your adolescents lack ideas, give them some areas to think about. Their group name could be foster care-related (“Foster Group”), age-related (“Teen Group”), strength/resource-based (“Power”, “Resilience”), deficit-related (“The Crazy Mixed-Up Kids”, Malekoff, p.101), task/goal-related (“Social Skills Group”), symbolic/metaphoric (“The Stars”), acronyms, future-oriented, memory/past-related.
  - In my case neither of the groups wanted a reference to foster care in their group name. They wanted to be able to talk about the foster care experience but not be condensed/reduced to just being a ‘foster kid’. Even though foster

care took up the most space in their lives, they knew they were much more than that. It seems they did not want to be limited by their group name as they knew they would one day rise above it.

- Process with your group why they chose the name that they chose, and why they chose not to go with other names. This might start a discussion about the foster care experience, about who they identify with and what they are hoping for.
- Make connections between members, show them what they have in common.
- During the discussion, pay attention to members' activity level and their roles. Who takes the lead? Who is passive? Does the one who is in control enjoy the role or just take on the responsibility because she feels obligated? Who withdraws? Who is the peace maker? Who wants attention? How do they deal with conflict? Is there a class clown? Who uses humor when things get serious? Who can't handle silence?
- Both of my groups came up with very sophisticated group names and neither group facilitators or undergraduates needed to give any sort of input – even with the younger girls. In both cases they had creative discussions, introduced different ideas, went back and forth and were quite undecided but as soon as the name was brought up, it was absolutely clear that this was going to be THEIR NAME. It was amazing how from that day on, they exclusively referred to themselves as MIA and TALK. (They wrote it on their binders, answered the phone saying “I’m on way my to MIA” or labels CDs with “MIA-Mix”.)
  - By the way, MIA stands for both “Missing In Action” and “Misunderstood Individuals Associating”; TALK stands for “Talking Actively, Listen Kindly”.

## OUR TOPIC LIST

### Description of Activity

- Similar to the above mentioned activities, members are asked to first think of potential group topics on their own and write down their ideas.
- When everyone is done, one volunteer writes the ideas that are being read out by each member down on the board.
- The members then determine which ones are similar and categorize them, just like they did when they developed the group contract.
- They then decide on the order of the topics based on their priorities. Most ranking decisions will come naturally, while some might be more difficult to determine. The following approach helps your members rank your topics.
  - Each member gets six votes. They can use all 6 votes on one topic or split up their votes. The volunteer makes a mark behind every topic that receives a vote. In the end, the votes are counted and the topics are ranked accordingly. Not every topic needs to be numbered. The first three to four are enough, as the order will most likely change anyway and a re-ranking will be sought by the members.

### Rationale and Objective

- Democratic decision-making as a group
- Expression of own needs
- Negotiation of group needs
- Creation of group agenda → Giving members control
- Yalom's curative group factors that apply here:
  - Instillation of hope
  - Universality
  - Development of socializing techniques
  - Interpersonal learning
  - Group cohesiveness
  - Catharsis

### Materials

- Scrap sheets and pens to jot down ideas
- Chalkboard and chalk or whiteboard with pens

### Reminders for Group Leaders

- There may be topics that your members would like to discuss in the group setting but do not feel comfortable bringing it up in front of everyone. Ask your members to write those down in the last section of their feedback form at the end of the session.

The group facilitators then add these topics to the group list without mentioning who suggested them.

- 
- 

## APPENDIX C

### Supplemental Materials from Chapter IV

Important Activities during Stage 3 (The Working Stage) of Group Development:

Cluster: My Life-Story

- MY LIFE-LINE \*
- OLD ME, THEN ME

Cluster: Me – My Interests, Self-Perception, Identity and Values

- PAPER BAG-ACTIVITY \*
- OBJECTS LIKE ME
- FISH FOR A THOUGHT
- PERSONAL VALUE SYSTEM AND SELF-ESTEEM
- MY THEME SONG \*

Cluster: My Family

- MY FAMILY GENOGRAM (FAMILY TREE) \*
- THE FAMILY FLOOR PLAN
- FAMILY SCULPTING \*
- FAMILY CHOREOGRAPHY
- SURVIVAL ROLES IN A FAMILY: A PSYCHODRAMA \*
- FAMILY MEMORIES

Cluster: My Feelings

- CARD GAME \*
- THE WIZARD: A GUIDED IMAGERY EXERCISE \*
- THE LOSS CYCLE: A MODEL FOR DISCUSSING DEPRESSION AND SUICIDE \*
- THE SHAME GAME
- WORDS THAT WOUND \*
- LOVE LETTERS

Cluster: My Sexuality

- SEX TALK-ICEBREAKER \*
- LET'S TALK ABOUT SEX, BABY \*
- SEX: EVERYTHING YOU WERE AFRAID TO ASK \*
- ROLE PLAYING DIFFICULT SITUATIONS \*

- HEARTACHE

Cluster: My Trauma

- MY LOSS \*
- CBT IN GROUP
- OPRAH SHOW \*

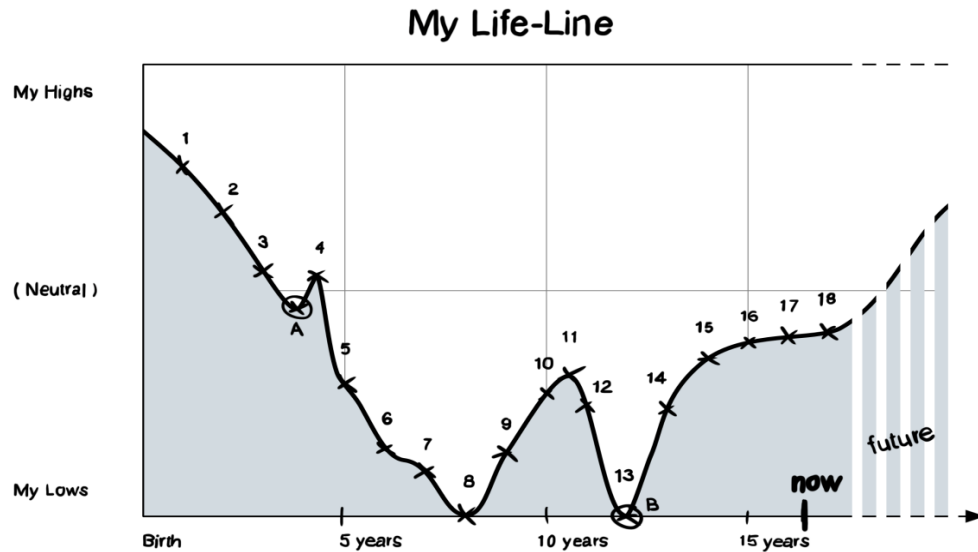
Important Activities during Stage 4 (The Separation Stage) of Group Development:

- OLD VERSUS NEW GOODBYES \*
- WALKING DOWN MEMORY LANE \*
- OLD ME, THEN ME, NOW ME, FUTURE ME \*
- WHEN THE SEASON COMES TO A END
- A FAREWELL CIRCLE \*
- TRANSITIONAL SPACES AND PLACES
- ROCK AND REFLECTIVE GARDENS AND RITUALS FOR BUS RIDE \*
- CANDLE CEREMONY \*\*

## MY LIFE-LINE \*

## Description of Activity

- Explain to your members that everyone experiences happy and sad times throughout their lives – highs and lows. Show your members an example of a timeline like the one below (“My Life-Line”) and tell them that the following activity involves drawing a diagram of their life, indicating their ‘highs’ and their ‘lows’ from their birth throughout the present on to the future.



- Explain the basics of the diagram: Y-axis = their mood: from their lows (bottom, where the “0” would be) to their highs (top, where the “10” would be); X-axis = time: from their birth, to age 5, 10, 15, to now, on to their future (dashed line).
- In order to explain the idea of a time/life-line, you can make up a story to the above posted life-line or use the example below. If you choose to pick the one below, have a volunteer read the story out loud.



### My Life-Line

This is my Life-Line. Obviously I don't remember my birth and I do not remember much about the time when I was very little, but I believe that everything was pretty good at home. I was a happy, bouncy kid and I remember going to parks with my mom and having sleepovers and baking cookies at my grandma's place.

Life was okay, although I started noticing that my parents were fighting more and more. My mother kept telling my father that he needed to stop drinking so much – back then I had no idea why 'drinking' was a bad thing.

My first most memorable early childhood memory (indicated by an "A" in the Life-Line) was of the time when I was 3 ½ years old. I remember my dad coming home from work, he smelled, walked, talked and acted weird and then he told mom that he had been fired. The next thing I remember was that my mom and dad were yelling, beating each other and throwing things...until grandma came and took me home with her. That was the first day that I really did not feel okay anymore. When I turned 4, I met my friend Kyla at Kindergarten, which helped me a little bit because I had someone I could play with when things got too noisy at my house. Still, things at home got worse and the neighbors started noticing that something was wrong and called the police a few times. When I was 6 I started school, which was hard because I had trouble staying focused. I kept falling asleep because I never slept at night. During that time some things happened that I don't want to talk about, but it was a rough time.

Anyway, when I was 8, the police picked me up from school one day and told me that I couldn't go home anymore. I stayed in this office for a night and was scared and had to answer questions that I didn't want to answer to the police and this woman. Back then I thought her name was "DYFS", now I know better. I remember that being the worst night of my life so far, because no one told me anything. The next day, my grandma came and I lived with her from that day on. I liked living with my grandma, but I had to switch schools, lived far away from Kyla and did poorly in school. I missed mom, but she never came to see me. After a while I started getting used to some things and it went uphill a little but I was never fully happy. When I turned 11, I made it into the basketball team, which was nice because I met some new people there that I liked. But after my 12<sup>th</sup> birthday, I injured my knee and was not able to play for the rest of the season. But I still met with my friends from the team.

The second time I hit rock bottom ("B") was when I turned 13. I walked home from school one day and found my dead grandmother on the kitchen floor. The ambulance and police came...and I ended up in that same office again, "Mrs. DYFS" was there again. Only this time my grandma did not come to pick me up the next day. I was told that they were trying to find 'a new home' for me, so I ended up with this foster family that lived so far away that I couldn't attend my grandma's funeral. And of course I had to switch schools again and didn't know anyone. Again. I missed my grandma, I still missed my mom and I felt like a stranger in this new house, even though the foster family was pretty nice. The first year there was hell and I did some things that I probably shouldn't have done. I was sure that my foster family would kick me out and maybe part of me wanted that. But then I decided to join the basketball team at my new school, met some nice people and things got better since then.

Today I'm feeling okay, but I still have trouble sleeping because I remember bad things when I go to bed. And I miss having close friends, but am sick of making 'real' friends because I'm so sick of having to leave them all the time. I think my future is going to be good because I will graduate soon and then I can be on my own. Don't know yet if I want to have a family – not really interested in relationships right now. And college seems impossible for me because I have never been a good student. I still think my future will be good. I mean, can't be much worse than my past...

- Ask your members to think about their lives and make at least one mark (a dot or an 'x') per year plus additional marks for every significant or not so significant event (e.g., Kindergarten, breaking a leg, finding first friend, starting school, joining a sports team, parents fighting, death of a grandparent, getting involved with DYFS, moving) in the appropriate spot of their diagram until now, indicating whether they felt more 'high' or more 'low' during this time. On the dashed line they are then asked to 'foresee' their future how they imagine it to be.
- Ask them to first use a pencil, so they can make changes and add points later.
- They can either write down the event above the mark on the diagram or just put a number next to the mark and write down the key below their timeline. Have them write down as many memories as possible so that the diagram reflects the 'richness' of their actual lives.
- Inform your members that there may be some life events that they may not want to write down, as they might not be ready yet to share it with the group. In this case, they have two options: they can either leave the event out completely and move on to the next occurrence on the timeline, or they can make a mark but not provide the group with the key. This option lets the group know that 'something' happened at a given time that affected the member, even though we don't know what exactly it was. Whenever the member is ready (later on in group), she can share it with the group.
- Ask your members to take their timelines home with them, so they can decide whether or not they want to add or erase some points before they present their timelines to the other members.
- During the next sessions, members are asked to connect the dots on their timelines with a marker. This line then represents their "Life-Line".

#### Conclusion/Processing Activity

- Most members (especially the first ones and the shy ones) are going to want to rush through the presentation of their timelines. Ask them to go slowly to give members the opportunity to take in all the information. . Every member should state beforehand whether they would like the members to ask questions during their presentation, ask them afterwards or not ask questions at all.
- Many members may not ask questions even if they are invited to do so by the presenter. It is extremely important to process the reasons for this, as the presenter may very likely take the lack of questions as a sign of disinterest ("Nobody is interested.", "I probably bored them", "They were probably shocked to hear my story"). Reveal that many members do not ask questions because they do not want to make the presenter feel uncomfortable or are scared that they will in turn be asked 'uncomfortable' questions when it's their turn to present.

- Whether or not the members volunteer to answer questions, make sure that you process the experience of sharing their lives with each other afterwards. What was it like to think about the different stages in your lives? Was it easier to think of high's or low's? What was it like to connect the dots and actually see your Life-Line? Were you surprised about the number of high's and low's? What was it like to share? What was it like to hear about others? Were you surprised to see commonalities? What did you appreciate? What are you taking away from this?

### Rationale and Objective

- Increases cohesiveness and empathy
- Shows commonalities
- 'Safe' amount of self-disclosure
- Encourages members to think about different stages of their lives
- Forces members to think about their future
- Shows members different models and ideas of the future that they may not have thought about or thought might be possible for them otherwise (college etc.)

### Materials

- Copies (for all members to put in their binders) of:
  - My Life-Line - Diagram
  - My Life-Line - Story
- Big poster boards for each member (2 per person, as they are probably going to make some mistakes)
- Colored markers
- Decoration material
- Rubber bands to roll posters up.

### Reminders for Group Leaders

- Assess: Which topics still cause emotional reactions? (Which areas did they rush through)? How was their affect? (Was it congruent with the event that they talked about)? How much information did they disclose?
- Incorporate strength-based approach: Which experiences made them stronger?
- Remind members of confidentiality and ask them to respect it, if members choose not to talk about certain experiences.
- Be aware: The types of experiences that you include in your exemplary timeline will influence the type of information that your members will disclose about themselves. Similarly, the timelines of 'earlier' presenters will influence those of later ones (domino effect). In order to prevent members from disclosing too personal information prematurely, do include potentially traumatizing information on it (e.g., domestic violence) but leave out sexual abuse issues. Instead put down an "x" to indicate that something happened that cannot be shared just yet.



## OLD ME, THEN ME

### Description of Activity

- Ask your members to draw a line through the middle of their (horizontally positioned) construction paper. On the left top they write “Old Me”, on the right side they write “Then Me”, indicating the changes (in personality, appearance, behavior, hobbies, attitudes, relationships) they noticed in themselves before versus after the ‘significant event’ (e.g., separation, parental substance abuse).
- They do not have to share what the significant event was.
- They can draw pictures of themselves, cut words or pictures out of magazines, write down words from the “Feeling Words” list – whatever they want to do to represent the changes.

### Conclusion/Processing Activity

- Members present their collages to each other.
- Process: Are there commonalities? Were all changes bad or did some good things come out of the experience? What did they like about the “Old Me”? What do they like about the “Then Me”? How would they like to be?

### Rationale and Objective

- Helps members think about the impact of their trauma and how they would like to be.
- Fosters creativity.

### Materials

- Construction paper
- Magazines/Collage materials
- Colored markers and pens
- Copies of “Feeling Words” (see appendix)
- Glue, Scissors
- Decoration material

### Reminder for Group Leaders:

- Make sure to let your members know that the “Then Me” does not necessarily reflect how they are NOW, but how they were after the event. Tell your members that they will be adding a third part – the “Now Me” - before they leave the group.

## PAPER BAG-ACTIVITY \*

### Description of Activity

- Talk to your members about the discrepancy between what we show on the outside versus what we keep on the inside/to ourselves. Talk about the reasons why people might wear a mask or maintain a poker face.
- Explain that this next activity encourages us think about how we portray ourselves to others and what we choose to keep buried inside. The second part of the activity allows us to see how we are perceived by others and what they ‘see in us’ or believe lies within us.
- Explain that the paper bag in this activity represents our body. The outside of the bag is visible to everyone – our ‘appearance’, hobbies, what we talk about, the feelings we display. The inside of our bag only comes to the surface if we choose to share it with others.
- Ask your members to take two paper bags: The first one is for them to decorate; the second one will later be decorated by the other members.
- Members take 15 minutes to quietly look through magazines, brainstorm words, ideas, memories, quotes, and draw pictures that represent both their “outside” and their “inside.” Explain why it is important that they do this in silence. They can be as creative as they want, changing the outside of their bag as much as they would like, using all of the materials on the table (see below). The things that represent their “outside” get glued onto the outside of the bag, the “inside” things can either be folded up and thrown into the bag or be glued onto a third bag that then gets put inside the other one.
- Remind your members that they may share everything that they put inside the bag, some things that they put inside the bag, or nothing at all. They can also be vague about the things that they disclose (e.g., just write the word ‘feelings’ or ‘memories’).
- When they are done, ask them to grab the other paper bag and write their name on the bottom of it. Set your timer and tell them that they will soon pass their bag to the person on their right. On your go, they have one minute to write down what they see on the outside of the person whose bag they are holding in their hands. What was the first thing you saw? How do they portray themselves? Tell them to go with their gut but make sure that they are not hurtful. Ask them to not read what others before them wrote on the bag, otherwise they will be influenced when they write their words on the outside of the bag. They have to write down at least two words. After a minute, they are asked to grab flashcards and write down what they think the person is keeping on the inside (again, at least two words on separate flashcards). They then put the flashcards inside the bag and pass the bag on to the person on their right after the facilitator tells them to do so (after one minute). They repeat this procedure until everyone has their bag back.
- After they have their bag back, they can take a few minutes to look at it. Ask them to compare the inside and the outside of both bags – the one they produced and the one that was produced for them. What are the similarities? Where are the differences?
- Below you will find an example of a paper bag that was filled out by one of my members and a paper bag that was filled out by others for that member.

### Conclusion/Processing Activity

- Members then present the bag that they produced themselves to the group. They can choose whether they would like to share the inside as well and it is also up to them whether they would like to present the bag that was produced FOR them to the group.
- Process the following points with your members:
  - What was it like to produce their own bag? What did they struggle with?
  - What was it like to fill out the bags of the other members?
  - What was it like to read what was written about them? Were they surprised about anything? How were the two bags similar and different? (Why did they choose not to share the second bag with the group?)
  - What is it that makes them keep certain things to themselves? After this activity, are there some things that they would like to portray differently or are there some things that they would like to work on revealing? If so, they can write it down on their personal goal card (in their wallets or binders)

### Rationale and Objective

- Increases self-awareness (what they portray and how they are perceived)
- Increases empathy and cohesion amongst the members
- Forces members to make conscious decisions about the things they would like to keep to themselves and the ones that they are ready to disclose. The paper bag activity prepares the members for subsequent activities, which evolve around self-disclosure.

### Materials

- Paper bags (2-3 per member)
- Magazines
- Colored pens and markers
- Glue
- Scissors
- Flashcards



Figure 8. The member's outside- paper-bag (what the member portrays to others).





Figure 9.

- Her insecurities about her body -
- Her wish to find a 'good man' who treats her well -

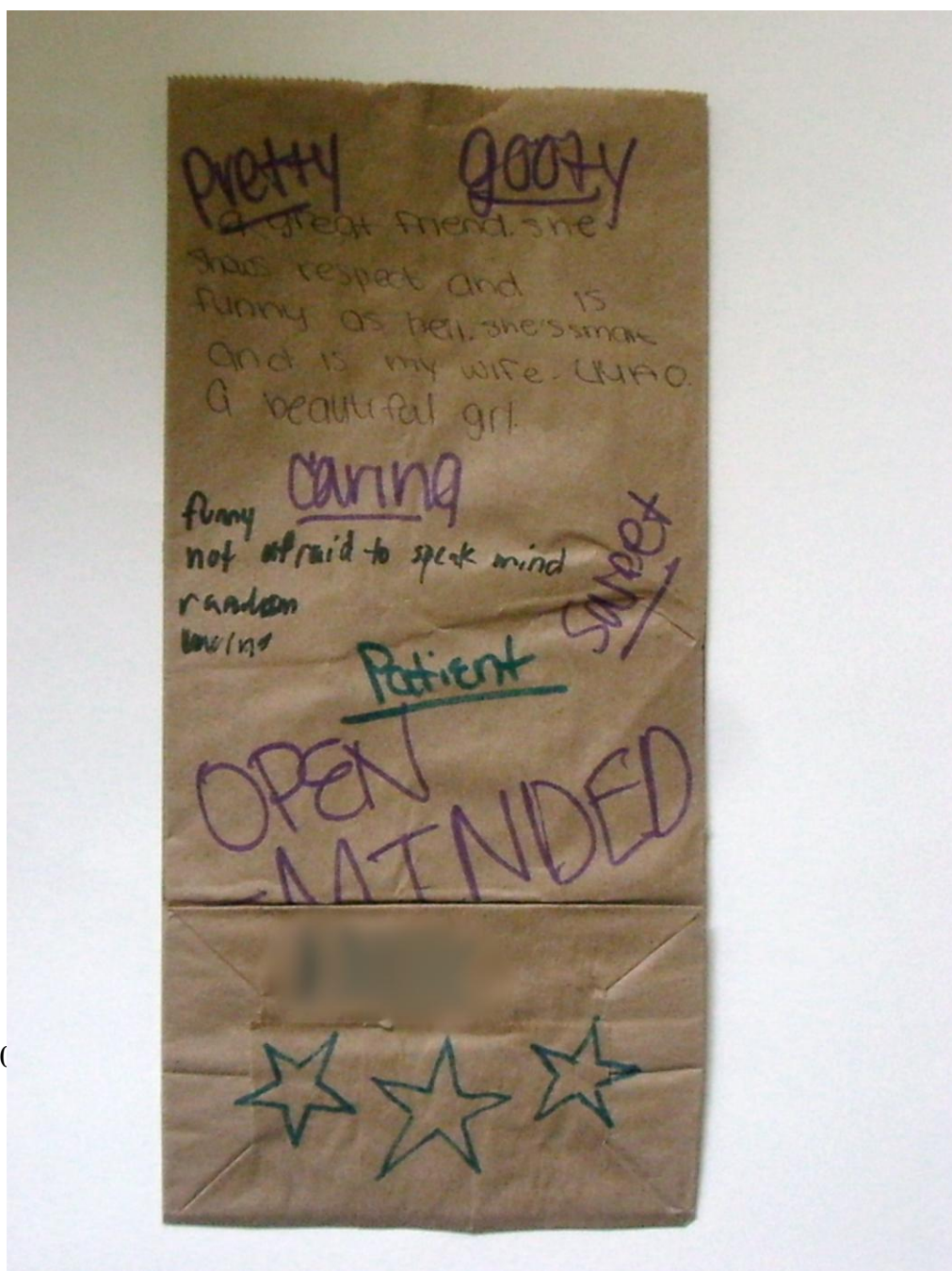
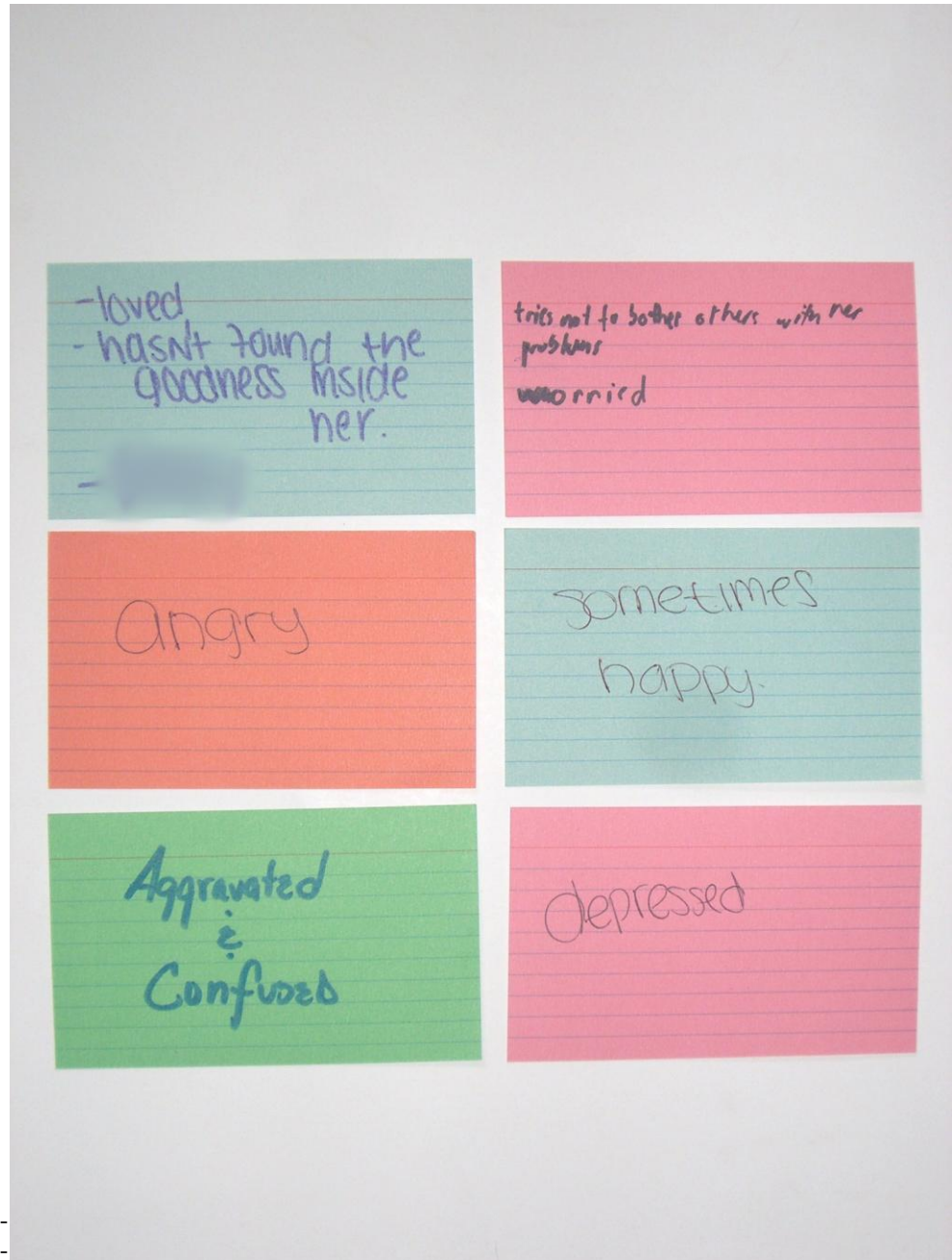


Figure 10



- Not wanting to burden others with her problems -
- Allusion to her mask: being happy 'only sometimes' -

## OBJECTS LIKE ME

- Reference: Carrell (2000), p. 70

## FISH FOR A THOUGHT

- Reference: Carrell (2000), p. 73

## PERSONAL VALUE SYSTEM AND SELF-ESTEEM

- Reference: Carrell (2000), p. 82

## MY THEME SONG \*

- Reference: Carrell (2000), “Hit Parade”, p. 85.
- Slightly different version recommended:
  - In this case, members are not asked to bring their ‘favorite song’, but one that they like and is ‘meaningful’ to them. They play it to the other members without commenting about it. Group analyzes which aspect of the song the particular member can relate to/identifies with. After everyone is done with their interpretation, member explains why she picked the particular song.

## MY FAMILY GENOGRAM (FAMILY TREE) \*

Reference: McGoldrick & Gerson (1985)

### Description of Activity

- Members are asked to draw a genogram – a graphic picture of their family history which reveals the basic structure and demographics of about three generations, using the symbols shown below (“Genogram Symbols”).
- Show your members the genogram below (“Exemplary Genogram of Rosie O’Donnell”) and also provide them with the key (Genogram Symbols) they need in order to understand the biological relationships, occurrences and emotional relationships/dynamics between the family members.
- Explain the basics: circles represent females, squares represent males, the number inside represents the age of the person; people can be connected through lines, which indicate their relationship etc.
- Then find someone who volunteers to ‘translate’ Rosie O’Donnell’s genogram with the help of the other members. Do not pass out the key below (“Key: Rosie O’Donnell’s Genogram”) until later.

### Key: Rosie O’Donnell’s Genogram:

- Rosie O’Donnell, (who back then was 44 years old female) is married to Kelli Carpenter. They got married in 2004. The dashed, orange line around them indicates the family members that currently live together. Rosie and Kelli own a pet named Zoe and used to provide a home to a 9-year-old foster child (dotted line) named Mia, who appears to no longer live with them. They adopted (dashed lines) 3 foster children: Parker (11), Chelsea (9) and Blake (7). In 2002, Rosie’s wife Kelli gave birth to Vivienne, whose biological father was a sperm donor. Rosie is the third child of Edward and Roseann, who got married in 1959. Rosie’s oldest brother is Edward, her second brother Daniel is married to John, her two younger siblings are Maureen and Timothy. She does not seem to be in touch with her father (cutoff, dashed line). Her mother, who she had a close relationship with (several lines), passed away (of breast cancer, I believe) when Rosie was only 11 years old.
- Once everyone understands the procedure, sit down on tables and ask them to start working on their own genograms (first biological then foster family) on scratch paper with pencils. Go around and offer your help. You may play music while they work, as long as they stay focused.
- Ask your members to finish their genograms at home and bring them to the next session. If they run into problems at home, they can finish it at the beginning of the next session. During this session, all members copy their genograms from their scratch papers onto their poster boards.



- One member at a time then presents her genograms (biological and foster family/current setting) to the other members. Members may ask questions if the presenter gives permission. Group applauds after every presentation.

#### Conclusion/Processing Activity

- Process afterwards what it was like to present and what it was like to listen. What were their worries beforehand? How do they feel now?

#### Rationale and Objective

- Great diagnostic tool that provides an enormous amount of compressed data at one glimpse
- Gives therapist an idea of important emotional relationships, family dynamics, traumatizing separations, estranged relationships etc.
- Forces members to think about their family of origin
- Provides members and therapists insight about connections, inherited diseases, addictions, behaviors, psychological disorders and common patterns across generations; shows members that sick or abusive parents often had sick or abusive parents themselves – which does not excuse but can help explain certain behaviors and habits.
- Sometimes the activity helps members gain an understanding of and have empathy for parents. Sometimes it decreases the member's feeling of 'being responsible'.
- Shows members that they run the risk of following similar patterns but that they now have the opportunity to break the cycle.
- Most members will feel very ambivalent about this activity: On the one hand they are embarrassed to talk about their untraditional families, on the other hand they are excited about the opportunity to be able to talk about their families, as foster families/caseworkers etc. sometimes suggest that they are supposed to 'forget about'/not talk about their family of origin. Also, members usually are excited to find out about each others' backgrounds.
- Learning about similar backgrounds of other members, having facilitators react in a non-judgmental way and seeing the exemplary genogram of a nontraditional family such as Rosie O'Donnell's, is a validating experience (Yalom's concept of 'universality') that decreases feelings of shame and guilt about their own family constellations.

#### Materials

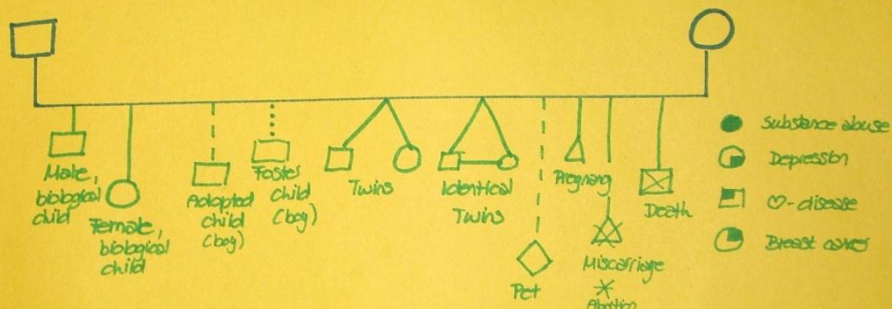
- Copies (for each member to put in their binders) of:
  - Genogram Symbols
  - Example: Genogram of Rosie O'Donnell
  - Key: Rosie O'Donnell's Genogram
- Scratch paper
- Big colored poster boards
- Pencils

- Colored markers and pens

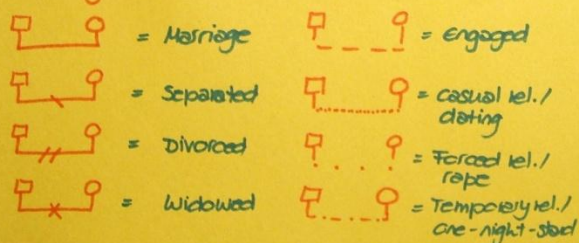
#### Reminders for Group Leaders

- A lot of children in foster care come from family constellations that are extremely challenging to draw (such as many marriages and divorces, children from open relationships and different fathers). Make sure to draw some genograms for yourself beforehand, so you will be able to assist your members as much as possible.
- One of my members told me that her grandfather had more than 70 grandchildren. Obviously, there is no way that all of them have room on the genogram. Ask your members to only put 'relevant' members on their genogram.
- It is absolutely crucial that you maintain a very open-minded, nonjudgmental attitude when you help your members draw their genograms. Remember that this might be the very first time they talk about their families. Most children in foster care hide their untraditional, chaotic family backgrounds from everybody, so you can expect them to be embarrassed to talk to you about drug abusing, incarcerated parents. Most of your members expect to be judged by you and others, as they assume that you come from perfectly functional and traditional family constellations. Do not make assumptions about anything. Keep in mind that they may know very little about their families, and show them that there is no such thing as a 'normal' family. I remember how relieved one of my members was when I simply asked her, "Do you and your sister have the same or different fathers? Different ones? Okay, so do you know the name of your sister's dad? Do you know your father's name?" After I tried to help her with her challenging genogram, she smiled at me and said: "Thanks for not making me feel weird about this."

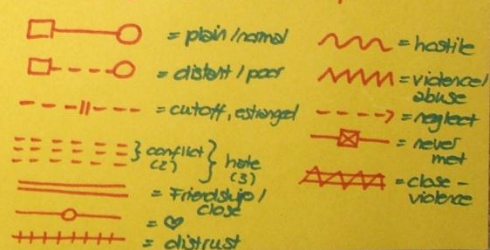
# GENOGRAM-SYMBOLS



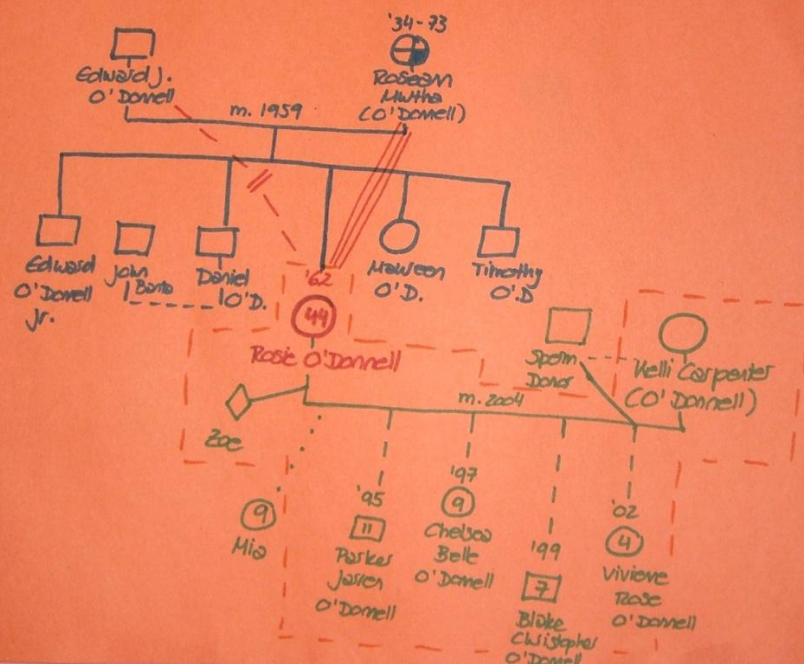
## Family Relationships:



## Emotional Relationships:



# ROSIE O'DONNELL



## THE FAMILY FLOOR PLAN

- Reference: Coppersmith (1980)
- Great diagnostic tool; less threatening than “Family Sculpting”
- Group members draw the plan of their nuclear family (family of origin) and a second one of their current living situation (foster home, kinship care, shelter etc.).
- Spaces between the people on the floor plan/different territories indicate levels of comfort/conflict between different parties. Indications of differentiation, operating family triangles, and subsystems often become evident.

## FAMILY SCULPTING \*

- Originally developed by Duhl, Kantor, and Duhl (1973);
- For detailed instructions, see Carrell (2000), p. 99.

### Description of Activity

- In family sculpting, the family systems (biological or current placement) of the group member gets recreated.
- One member ('sculptor') at a time is asked to assign group members to represent/stand for her family members and herself.
- After assigning the members, sculptor physically (silently) arranges them in a way in the room that reflects her family system according to her own experience.
- Sculptor is asked not to 'think' about the set-up beforehand but to arrange members on a more 'emotional' basis in the moment. Sculptor can make use of the equipment in the room (tables and chairs) as needed.
- The set-up symbolizes family dynamics and nonverbally communicates the thoughts and feelings the sculptor carries about the family and her position within.

### Conclusion/Processing Activity

- After the family system is 'replicated', facilitator can
  - ask group members who are not part of the sculpture, what they see/how they feel when they look at the set-up,
  - ask participants how they feel in their role/position ("How does you position feel?", "Who do you feel close to?", "What power do you have?", "What do you do for the family?") and
  - ask sculptor what it feels like to look at the family 'from the outside'.

### Rationale and Objective

- Family sculpting is a very helpful activity as it serves as a diagnostic tool and provides insight for therapists and other group members, fosters empathy and understanding amongst members, increases self-awareness of sculptor regarding "dynamics that may not have been recognized consciously", enhances "self-observation by determining [her] own "position" in [her] family", confronts the sculptor with difficult issues (loss etc.) that can then be addressed in therapy, and identifies "possibilities for change by altering or rearranging the sculpt" (Carrell, p.99).

### Materials

- No materials needed
- Room set-up: tables and chairs need to be pushed out of the way

### Reminders for Group Leaders

- This activity can be an incredibly valuable but painful experience for the members. Therapists need to prepare themselves and members carefully beforehand.
- Important: This brief description is not sufficient to familiarize facilitator with this very delicate technique. Please prepare yourself thoroughly!

## FAMILY CHOREOGRAPHY

### Description of Activity

- The family sculpting activity typically does not involve the resculpting of the family set-up into a preferred scenario, though Carrell (2000) included this procedure into her version of the activity. In family choreography, arrangements go beyond initial sculpting: The family members can position themselves in a way that would make it 'more comfortable' for them and the sculptor can arrange the family in the desired way.

### Reminders to Group Leaders

- When incorporating family choreography into the family sculpting activity, therapists need to be very cautious to not provide members with 'false hope' or give into the wishful thinking of the members. As much as your members wish to change the realities in their families, they can simply change 'themselves' – their positions, their viewpoints or angles. Addicted mothers will not be healed, violent dads will not be tamed, and arguing parents will not make up by employing this activity – but the sculptor can take a step outside (of the triangle) and thereby possibly change the experience.
- In some cases, it may be more constructive to utilize this technique with the members' current as opposed to past/family-of-origin living situations. It can bring some movement into a seemingly 'stuck' family system and shows the member what they can do to feel better within their current setting. \*

### SURVIVAL ROLES IN A FAMILY: A PSYCHODRAMA \*

- Reference: Carrell (2000), p. 103
- This activity is highly recommended, as it both educates members about typical survival roles (alcoholic father / ignorant, blind mother / caring, responsible, overachieving, good first child / troublemaking, scapegoated second child / invisible, lost third child / sick fourth child / 'happy', family-mascot baby-child) that family members of troubled families often take on in order to keep up the homeostasis and helps members identify their own roles, functions and defense mechanisms within their family setting.



## FAMILY MEMORIES

- Reference: Carrell, p. 109

## CARD GAME \*

- Reference: Carrel (2000), p. 150
- Members are asked to complete sentences, such as:
  - “It is wrong to...”, “I wish...”, “My mother...”, “I despise...”, “I wish my father...”, “Someday I”, “I am ashamed...”, “The big difference between mother and dad is...”, “Most of my friends don’t know that I’m afraid of...”, “My greatest mistake”, “My family treats me like...”, “I could be perfectly happy if I...”, “My most vivid childhood memory...” etc. (Carrell, pp.152)
- Quick replies provide access to unconscious feelings.
- Good as a first activity in the feelings category, as it gives members and facilitators an idea of where strong (hidden) affect may be.

### THE WIZARD: A GUIDED IMAGERY EXERCISE \*

- Reference: Carrell (2000), p. 145
- Activity identifies members' greatest personal desires and explores their self-worth by identifying a personal asset

THE LOSS CYCLE: A MODEL FOR DISCUSSING DEPRESSION AND  
SUICIDE \*

- Reference: Carrell (2000), p. 127
- Extremely valuable as this activity balances the experiential part of sharing a significant loss with the psychoeducation component about loss, depression and suicide.
- The Loss Circle: Old Life → Loss → Denial (shock, disbelief) → Bartering (If you'll, I'll) → Anger (at self, at person, at others, at god) → Depression (hopeless, helpless, grief, thoughts about suicide) → Acceptance → New Life → Stronger (Carrell, p.131)

### THE SHAME GAME

- Reference: Carrell (2000), p. 132
- Exposure-activity followed by psychoeducation about shame and guilt (Are shame and guilt helpful or harmful?)

### WORDS THAT WOUND \*

- Reference: Carrell (2000), p. 135
- Through guided imagery, members recall hurtful words of the past and through the help of other group members transform words of the past into empowering ones.

## LOVE LETTERS

- Reference: Carrell (2000)p. 140
- Members write love/appreciation letters to one another

## Intro to “My Sexuality”-Cluster

I’ve often wondered what it would be like if we taught young people swimming in the same way we teach sexuality. If we told them that swimming was an important adult activity, one they will all have to be skilled at when they grow up, but we never talked to them about it.. ...Suddenly, when they would turn 18, we would fling open to the doors to the swimming pool, and they would jump in. Miraculously, some might learn to tread water, but many would drown.

(Robert, 1983, p. 10; In: Malekoff, 20004)

Figure 13. Intro to “My Sexuality”-Cluster.

Discussing adolescent sexuality in group can be challenging for both you and the members. Make sure to address this ‘elephant in the room’ and process the reasons for it (see “Sex Talk-Icebreaker”). In order to prepare yourself for the upcoming sessions, I would recommend reading Malekoff’s (2004) chapter 14: “Adolescent Sexuality and Group Work: Variations on a Theme” (pp. 275), as he provides statistics, practice principles for addressing this subject with your members, addresses important issues around teen pregnancy, the coming-out process and offers case examples and structured group approaches/activities.

Another extremely valuable reference for you and the members is ‘Sex, Etc.’, as the webpage provides “comprehensive sexuality education to young people and the adults who teach them” (<http://www.sexetc.org/>).

Below you will find four activities that target adolescent sexuality. I recommend carrying out the first three in the below posted order, as they build on one another.



## SEX TALK-ICEBREAKER \*

### Materials

- Facilitators prepare posters beforehand and put them up on different walls in the room with different colored markers under each poster.
  - Each one of the 5 posters has one of the following words on it: “PENIS” “VAGINA”, “TESTICLES”, “BREAST”, “SEXUAL INTERCOURSE”

### Description of Activity

- Members are asked to grab markers in different colors and write down synonyms of the word on the poster. Tell your members that it can be ANY word they have ever heard, no matter if they find it ‘inappropriate’.

### Conclusion/Processing Activity

- After they are done, sit down in the middle of the room and have your members read the words out loud. What do they notice? (Usually, the male body parts represent strength and pride, the female one often involve shame. Discuss this with the group.) What is it like to read those words out loud? What do they think is the reason behind the activity? What is it like to talk about sex in this setting? What is it like to talk about it in general? Why do people not talk about it and what are the disadvantages? Why could it be important to talk about it?

### Rationale and Objective

- Helps members talk about something ‘uncomfortable’ in a playful way.
- Gives rationale for the importance of sex ed.

### Reminders for Group Leaders

- When talking about sex/relationships/dating, address both homosexual and heterosexual members

## LET'S TALK ABOUT SEX, BABY \*

### Description of Activity

- Members split up into three groups and take 15 minutes to answer the questionnaire “Let’s Talk About Sex” (“Questionnaire: Let’s Talk About Sex”, see appendix) collaboratively. This gets them used to talking about sex in a smaller group.
- When they are done, they share with the group, how many times they marked a YES and how many times they marked a NO.
- Facilitator then shares that the answer to all of the questions is YES.
- Group goes through each one and discusses all of the questions; Facilitator provides them with the key (“Key: Let’s Talk About Sex”, see appendix)

### Conclusion/Processing Activity

- What were they surprised about? What does this mean to them?

### Rationale and Objective

- Corrects misconceptions about sex.

### Materials

- Pens
- Copies (for everyone) of:
  - “Key: Let’s Talk About Sex”
  - “Questionnaire: Let’s Talk About Sex”

### SEX: EVERYTHING YOU WERE AFRAID TO ASK \*

- Reference: Carrell (2000), p. 116
- Very important activity! Members anonymously write down all the questions they have about sex. I would recommend doing this activity at the end of your session, so you can take their questions home with you and get prepared (as you may not know all of the answers either).

## ROLE PLAYING DIFFICULT SITUATIONS \*

Brief description:

- Adolescents often do not possess the self-esteem and communication-skills to be able to assert themselves in sexual situations. A lot of adolescent girls report that they 'go along' with it' because they do not know how to stop things in the moment. They feel like they do not have the right to stop once they have started. Some girls reported that they did not want to be a party-pooper, others stated that the guys gave them a 'guilt trip'. Particularly members who experienced acts of sexual abuse in the past often do not know how to set boundaries. They may go along with sexual acts because they do not feel like they have the right to say no.
- Ask your members to talk about (or write down) difficult situations they have encountered or envision and role play the different ways to get out of them.

## HEARTACHE

### Brief description:

- The handout below (“How to Cope When a Relationship Ends”) can be passed out if your members are dealing with breakups. They can also come up with their own list or revise the one below.
- You can also listen to songs that dealt with breakups (see below, “Girl Power Music Mix”) and discuss how the women in the songs dealt with their pain.

## How to Cope When a Relationship Ends

- Remember that there are other people in your life (friends, siblings, family members, foster parents) who care about you.
- Remind yourself that you will meet other people who you will love and who will love you.
- Acknowledge your feelings, but do not spend too much thinking about the relationship; listening to sad music and looking at pictures of the two of you together will only make you sadder.
- Distract yourself; try to stay busy spending time with other people and doing other things.
- Reflect on what you've learned from the relationship and how it made you a stronger person.
- Identify friends and other people in your life who you can call when you are upset and who you can rely upon for support.
- Remember your own value and self-worth.
- Focus on yourself and your priorities (i.e. schoolwork, applying to college, sports, jobs, other activities).
- Listen to music that is upbeat and energizing (i.e. the "Girl Power Music Mix")
- Write a letter expressing your feelings, but don't send it.
- Distance yourself from the person you miss; it is harder to get over someone if you continue to see them and communicate with them.
- Do not repeatedly check your ex's MySpace page or Facebook profile.
- Remember that you've faced other challenges, have dealt with other hard times, and that things have gotten better. Rely on your inner strength. Although healing after being hurt can be a slow process, sad feelings don't last forever.
- Call the MIA girls for support.
- Do not turn to alcohol or drugs to help make the pain go away.
- Treat yourself (i.e. get a manicure, enjoy an ice cream sundae, take a bubble bath).
- Spend time doing the things that you enjoy.
- Get involved in something new (i.e. learn a new hobby, join a new club or organization).
- Volunteer; helping other people can be a great way to help yourself feel better.
- Do not try to get revenge or make him/her jealous. You will probably end up feeling worse.
- Don't be afraid to meet someone new, but don't compare everyone you meet to your ex.
- Go out on dates when you think you are ready; you aren't being disloyal.
- Exercise; it releases endorphins that naturally lift your mood.
- Flirt!



## Girl Power Music Mix

- A Woman's Worth – Alicia Keys
- Before He Cheats – Carrie Underwood
- You Make Me Sick – Pink
- Hit 'Em Up Style – Blu Cantrell
- Fighter – Christina Aguilera
- Independent Woman – Missy Elliott
- Respect – Aretha Franklin
- Can't Hold Us Down – Christina Aguilera
- Express Yourself – Madonna
- Ladies' Night – Lil Kim
- Survivor – Destiny's Child
- There You Go – Pink
- Any Man of Mine – Shania Twain
- No Scrubs – TLC
- Since You've Been Gone – Kelly Clarkson
- I Will Survive – Gloria Gaynor
- Ring the Alarm – Beyonce
- Big Girls Don't Cry – Fergie
- You and Your Hand – Pink
- What Goes Around Comes Around – Justin Timberlake



Make sure to provide your members with the 'Sex, Etc.' link!

Ask them to write it in their binders!

[www.sexetc.org](http://www.sexetc.org)

## Introduction to “My Trauma” Cluster

Since this area is one of the most important but most likely also *the* most sensitive area of treatment, it is absolutely crucial that you know which interventions are effective. Please read chapter IV in the theoretical part of the manual for a more detailed description of the mechanisms of action underlying the following activities.

### MY LOSS \*

#### Materials

- Print out worksheet: “Grief and Loss”
- White paper
- Art material: scissors, glue, colored construction and transparent paper, markers, tissues, water color, paint, feathers, sand...and whatever else you find.
- I would not put any magazines out. Ideas/words should come from inside of the participants and not be inspired by external cues.
- When it comes to markers/papers, make sure that there are plenty of dark and light colors for them to use.

#### Description of Activity

- All members sit around a big table. The art supplies are placed in the middle of the table so that everyone can access them.
- Each member has a sheet of plain white paper in front of her.
- The following instructions are read to them:

This activity is called “My Loss”. Please take a minute for yourself and then put a hole in the paper in front of you. The hole (or holes) represents your loss. It can be ANY type of loss. You can then use any of the art supplies in the middle of the table to put your inner world on paper. Try not to think things through. Just be in the moment and concentrate on yourself for the next 20 to 30 minutes. Afterwards you can share your work with others or keep it to yourself, whatever you want.

#### Conclusion/Processing Activity

- After 30 minutes (or earlier, if your members need less time), everyone leaves the table and retreats to the circle.
- They can then decide whether they would like to: a) keep their work to themselves, b) show their work but not comment on it or have others comment on it, or c) share what the holes represent.
- If members are open for questions and feedback, the group can comment what they see on the picture (what stand out, what they noticed, how it makes them feel etc.)
- After discussing the art work itself, please process what it was like to do the activity. If processed properly (What was it like to do the activity? What feelings came up? Why do you think we chose this activity? For those of you who shared your work,

- what was it like to talk about your loss with the other members? For those who did not, what were the reasons? What are the advantages and disadvantages of keeping those memories in?), the Loss Activity will provide a great opportunity and stepping-stone into the next, psychoeducational part of the trauma treatment.
- Pass out the handout below (“Grief and Loss”) and choose a member to read it out loud. The following week, you will then be able to link the two activities together and discuss PTSD symptoms, avoidance and its function and consequences, the need for exposure against anxiety, the need of cognitive restructuring against feelings of guilt and shame, etc.

### Rationale and Objective

- According to the CBT model, people “whose post-trauma reactions have persisted over time can extinguish their conditioned responses by systematically exposing themselves to trauma triggers. This is one of the mechanisms of action presumed to underlie exposure” (Foa et. al., p. 15).
- This activity is a good first activity into the trauma-cluster, as it represents the first, systematic step into the exposure world without overwhelming the members. “My Loss” does not force members to talk about traumatic experiences in detail (flooding) but represents a milder form of exposure (gradual exposure), as the members are asked to confront themselves with painful memories and paint a picture of their inner world.

### Reminders for Group Leaders

- The instructions are purposefully brief, so that your members can go with whatever comes to mind. If they ask questions to specify the instructions (“Can I make more than one hole?”, “What kind of loss?” etc.) tell them that they can do whatever they would like, as long as they do not destroy the paper.
- It will be interesting to see what they make of the assignment.
  - Is the hole big or little? Are there several or just one and how do they differ in size? Does one overshadow the others? Did they tear the hole or cut it out and what could that mean? Did they cover up the holes? What did they do with the pieces they cut/tore out?
  - What did they lose? Friendships, family members, trust, virginity, a soccer game, faith...?
  - How did they make use of the art supplies? What are the colors they used? What emotions come across?
- The activity may be a very emotional experience for some of your members, as many will have avoided the memories of their losses for a while.
- Below you see the work of one of the members of our group, who was extremely emotional during the process.



Figure 14. My Loss-Activity: Example of a Member.

# Grief and Loss

- Grief is a process, not an event. That means that when people experience a loss, it can be a long time before they start feeling better. The process of grieving can go on for months or even years.
- Grief is a natural process. Everyone who experiences a loss, goes through a process of grieving.
- Grief is part of the solution, not part of the problem. Only by allowing ourselves to grieve can we heal.
- Many feelings are associated with grief and loss; these include, but aren't limited to, helplessness, fear, sadness, guilt, and anger.
- A common response to loss is denial. It's often easier to not think about something so painful. However, although this makes things better in the short term, when grief is not dealt with or gets buried, it usually comes back later in even more painful ways.
- Sometimes the pain after a loss is cutting, it is so intense. Other times people feel nothing, they just feel numb.
- The process of grieving is unique for everyone; don't judge yourself based upon how others react to loss or death.

- After experiencing a loss it can be common to be afraid to get close to anyone again. This is especially true for people who have experienced more than one loss.
- Even though you have experienced a loss you still have a right to enjoy life. It's okay to laugh and have fun.

## CBT IN GROUP \*

### Materials/Preparation Beforehand

- Print worksheets below.
- Facilitators need to be familiar with the cognitive behavioral theory and treatment of PTSD. Providing a detailed outline of how the disorder is conceptualized in CBT would go beyond the scope of this manual, nevertheless you will find a brief summary of the treatment and its efficacy in chapter IV of the manual.
- For a thorough preparation, I strongly recommend:
  - Completing the trauma-focused CBT online course (<http://tfcbt.musc.edu/>),
  - Reading the book “Cognitive-Behavioral Therapy for PTSD: A Case Formulation Approach” by Zayfert and Black Becker, as it provides very practical advice on how to do psychoeducation, exposure, and cognitive restructuring in regard to PTSD and
  - Skimming Zayfert’s book, as it gives an outline of effective PTSD treatments

### Rationale and Objective

- In order for your members to understand why they should give up their avoidance behaviors and expose themselves to feared stimuli or talk about secrets that they have kept to themselves, you need to be able to communicate the CBT conceptualization of PTSD, the treatment approach and its efficacy.
- Below you will find a list of bullet points that should be raised in your session – separated into the three most important components of CBT: psychoeducation, exposure and cognitive restructuring.
- This is a great activity to follow the “My Loss” activity. “My Loss” sensitized the members and gave them an initial idea of how important it is to talk about their loss. This activity gives them a rationale for why it is therapeutic to further expose themselves to anxiety-provoking memories and the next activity provides the exposure component.

### Description/Outline of Sessions

- First Part: Psychoeducation (takes about 2 sessions, some worksheets can be filled out at home)
  - define trauma/traumatic situations with the group
  - list typical trauma symptoms and assess which symptoms are experienced by your members
  - explore the different ways they re-experience the traumatic situations
    - ⇒ see worksheet below: “How the Trauma Comes Back to Me”  
(individuals fill out their own forms, then one member gathers information on the board, discussion afterwards)
  - talk about the criteria of the PTSD diagnosis
  - teach about comorbid disorders and why they develop;
  - teach how anxiety disorders are conceptualized; explain the relationship between physical sensations, thoughts and behaviors when it comes to fear

(and how the cognition-physiology-behavior triangle applies to other disorders like depression)

- ⇒ see worksheet below: “Trauma Triggers & Reactions”  
(individuals fill out their own forms, then one member gathers information on the board, discussion afterwards)
- explain why fear persists even though the danger is past.
  1. avoidance → exposure
  2. unhelpful ways of thinking → cognitive restructuring
- talk about fight and flight behaviors, the function of avoidance and the long- and short-term consequences (short-term: relief; long-term: perpetuation of the disorder)
  - ⇒ see worksheet below: “How Trauma Has Impacted Our Lives”
- explore the type of places, things, people, activities, sounds, smells and sensations that trigger fear and what their fear reactions are
  - ⇒ see worksheet below: “Trauma-Triggers & Reactions”
- explore what it is they avoid
  - ⇒ see worksheet below: “How Trauma Has Impacted Our Lives”  
(separate group into two subgroups to fill out form, then one member gathers information on the board, discussion afterwards)
- explore how trauma has affected their lives and let them think about what kind of life they would like to live and how they can get there. This activity will motivate members to take control (and you can remind them of those goals when their anxiety during the following exposure activities makes them want to give up)
  - ⇒ see worksheet below: “Taking Control of My Life” (motivating, goal setting (each member fills out left/“goal”-side of the form, group then helps member fill out right/“solution” side))

For more information:  
See Zayfert and Black Becker’s chapter on Psychoeducation (pp. 73)



- How the Trauma Comes Back to Me -  
My Re-experience through:

<b>My Pictures, Flashbacks &amp; Images</b>	<b>My Feelings</b>
<b>My Dreams</b>	<b>My Thoughts</b>

Figure 15. How the trauma comes back to me – worksheet.

### Trauma Triggers & Reactions

What Triggers My Fear	How I React When Confronted
Places:	Body Sensations:  Thoughts:  Feelings:  Behaviors/Consequences:
People:	Body Sensations:  Thoughts:  Feelings:  Behaviors/Consequences:
Activities:	Body Sensations:  Thoughts:  Feelings:  Behaviors/Consequences:
Sounds, smells, sensations:	Body Sensations:  Thoughts:  Feelings:  Behaviors/Consequences:
Other:	Body Sensations:  Thoughts:  Feelings:  Behaviors/Consequences:

Figure 16. Trauma triggers and reactions – worksheet.

### How Trauma Has Impacted Our Lives

What We Avoid	How We Avoid (active and passive, e.g., numbing)	Short-Term Consequences	Long-Term Consequences
Places			
People/ Relationships			
Activities (incl. pleasurable ones)			
Things			
Thoughts			
Feelings			
Memories			
Conversations			
Other			
<i>Example: Avoiding closeness</i>	<i>Start arguments, Act out, Act like I don't care, Keep to self, Be unapproachable</i>	<i>Less anxiety; Relieved, Do not have to tell people my story; Rejecting others before I get rejected.</i>	<i>Ultimately I still get rejected (foster parents...), No friends, Loneliness, Depression</i>

Figure 17. How trauma impacted our lives – worksheet.

Taking Control of My Life

What kind of a life do I want, What are my goals?	What do I need to change in order to get there?
1.	→
2.	→
3.	→
4.	→
5.	→

Figure 18. Taking control of my life – worksheet.

**Second Part: Rationale for Exposure** (can take a few sessions, some worksheets can be filled out at home)

- Explain to your members that they need to face the fear in order for it to go away. If they withdraw, they give into their fear and let the traumatic event/their perpetrator take control of their lives. If they want freedom, they need to push back: the bigger they get, the smaller the fear gets and vice versa.
- Draw and explain the theory behind the habituation curve: When you stick with an anxiety-provoking situation for an extended period of time, you learn that it is safe, and the fear goes down automatically.
- Explain that withdrawal/avoidance is understandable but counterproductive as it perpetuates the disorder. Avoiding painful memories, emotions or places may make them feel better in the short-run but perpetuate the disorder long-term and prevent them from feeling better and forming healthy relationships;
  - ⇒ See worksheet above: “How Trauma Has Impacted Our Lives”
  - ⇒ You can also make them find other examples of behaviors that have positive short-term and negative long-term consequences (e.g., eating chocolate → gaining weight, taking a drink to feel less anxiety → developing an addiction, sleeping in because you are tired → failing your classes);
- Use form above “How Trauma Has Impacted Our Lives” to see what kinds of things they avoid to help them develop their individual exposure hierarchies (least to most anxiety-provoking stimuli)
  - ⇒ See worksheet below: “My Exposure Hierarchy”
- How could they utilize the group setting to confront their fears? What could they practice with their individual therapist? What should they change at home?

For more information on exposures, see Zayfert and Black Becker:

In Vivo Exposure, pp. 78  
&  
Imaginal Exposure, pp. 119

### My Exposure Hierarchy

Feared Situations, People, Places... (From Least to Worst)		SUDS (0-100)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Feared Situation	Exposure Ideas For:		
	Individual Sessions:	Group Session	Outside of Therapy
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Figure 19. My exposure hierarchy – worksheet.

- **Week 3: Cognitive Restructuring**

- Explain past processing failures and the rationale behind cognitive restructuring.
- Explore with your group what it is that makes it challenging to talk about traumatic events and help them uncover that – besides anxiety, it's often feelings of guilt, embarrassment, shame, and false responsibility that make it difficult.
- Help them understand the origin of these feelings. Did they talk to anyone about the trauma or keep it to themselves? If they chose to deal with it on their own, what expectations and assumptions led them to make that decision? How did they explain to themselves what happened to them? Talk about the not fully developed cognitive abilities as a child, the lack of corrective input, the benefit of talking about such events in order to process and make sense of them, about the need for predictability and control and the lack thereof when it comes to most traumatic events, about the attempt to make sense of things and gain control by blaming oneself ("Everyone makes choices and is in control of what happens to them", "When bad things happen to you, it's because you made bad choices", Zayfert and Black Becker, p. 17), which causes guilt and shame as a result. If they decided to share with others what happened, how did those people react? Did the reaction of those they told (such as disregard, indifference, overwhelm, anger, disbelief, annoyance) contribute to the way they processed the experience?
- Explain that while exposure is effective when it comes to eliminating pathological anxiety, cognitive restructuring/reprocessing is necessary when it comes to overcoming inaccurate/dysfunctional belief systems that are responsible for pathological non-anxiety emotions such as guilt, shame or anger.
- In cognitive restructuring, unhelpful/dysfunctional thoughts are identified and then systemically replaced with more helpful and realistic thoughts; common styles of thinking (all-or-nothing, arbitrary inference, over-generalization, personalization, selective abstraction, magnification of negatives and minimization of positives, etc.) are detected; and underlying/core beliefs are explored. Teach the members how to detect their own (and each other's) dysfunctional thoughts. If they are stuck in their thinking patterns and are not able to raise more empathy for themselves (if they, for instance, continue to blame themselves for a sexual assault), ask them what they would tell member XYZ if she had been in that situation.
- Explain the 6 steps of cognitive restructuring and have them log these:
  1. Notice the situation
  2. Notice/track your emotions
  3. Identify your automatic thoughts
  4. Challenge your automatic thoughts
  5. Respond to unhelpful thoughts
  6. Notice/track your emotions

⇒ See cognitive restructuring-worksheet: Zayfert, p. 198

<p>For more information on cognitive restructuring: See Zayfert and Black Becker, pp. 157</p>
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#### Reminders for Group Leaders

- You need to determine when it is useful for your members to fill out their own forms and when they could benefit from you turning an activity into a group or subgroup activity.
- Please be sure to inform your members' individual therapists about the kinds of things that you are working on. Since your members may be more sensitive, needy, rejecting, or withdrawing during this time, their individual therapists need to be involved. Also, since in vivo exposure often goes beyond what is practicable in group therapy, individual sessions might be utilized for those interventions.



## OPRAH SHOW \*

### Materials/Preparation

- Print script (see below)
- Something that looks like a microphone
- Room set up like a TV-studio: 2 chairs for host and guest, chairs for people in the audience
- Introduction beforehand: introduce this activity briefly to your members one week in advance:
  - Tell them that next week you will be playing the “Oprah Show”, where you are going to need one “guest” that will be interviewed by Oprah about a traumatic event in her life. The rest of the members are going to be “experts” and people who have experienced traumatic events themselves ( “survivors”). The audience can ask questions, make comments, share their expert knowledge or share a little bit about their own experiences.
  - Remind them of the theory behind this activity (see above, rationale for exposure-interventions) and tell them that you will not be assigning anyone for the role as the guest but that you need volunteers that feel “ready” for this activity. The most appropriate “guest” is one that has already talked about her story in individual therapy.
- Preparation beforehand: undergraduate student needs to prepare herself for the role (as the host/Oprah), read the script, prepare questions, and feel comfortable “interviewing” a member about her traumatic experience.

### Description of Activity

- Theme: Oprah Show about trauma
- Roles:
  - Oprah: if possible, played by undergraduate student (to break the therapy setup, in which it’s always the facilitators asking questions). If undergraduate does not feel comfortable with this or feels overwhelmed, one of the facilitators takes the role.
  - Trauma guest: a member who volunteers, trusts the group and is ready for the challenge.
  - Audience: consists of trauma experts and people who have experienced trauma themselves. Members can be both, experts and “survivors” and can enrich the show with comments and questions whenever they would like. Facilitators are experts.
- Host can follow the script below, but the more spontaneous, flexible and creative she is in the moment, the better. It is important that she interviews the guest about her experiences and is not afraid to ask anxiety-provoking questions but incorporates and gently “pushes” the audience as much as possible so that the activity is not only an exposure intervention for the guest. Host encourages interactive conversations among the members, promotes their asking questions and sharing experiences.

- Host is responsible for increasing the amount of anxiety (exposure) for each member without pushing too hard. If host has difficulties with this challenging task, group facilitators can help out in the role as experts.
- In addition to exposure components, host needs to incorporate psychoeducational elements (give members the opportunity to show what they already know and insert additional/correct false information) as well as cognitive restructuring pieces (members detect each other's thinking errors, etc.)

### Rationale and Objective

- This activity is an advanced activity in the trauma cluster. Your members should already have received psychoeducation about trauma, understand the rationale for exposure, have learned about cognitive restructuring, be able to detect dysfunctional thoughts, and have done some exposure activities – as all of this will be incorporated in this activity.
- The goal is for your members to talk about an entire or parts of a traumatic event (depending on their roles) so they can reprocess their trauma narrative in a supportive group environment to decrease high levels of anxiety, shame, guilt/self-blame, embarrassment and feelings of isolation regarding the event.
- Curative factors/mechanism of change:
  - *Control:* The great thing about this activity is that each member can control the amount of exposure that she wants to undergo. The Oprah Game is equally suited for members who are ready to talk about their traumatic experience in depth and for those who are not. It is their choice if they play a big or small role in this activity. Depending on how much anxiety a member can tolerate, she can be
    - the guest (highest level of exposure) → guest talks about a traumatic experience in much greater detail than in any of the other activities before (the Loss, Lifeline or Genogram activities, for instance). Exposure gets intensified through additional questions by the host and audience.
    - a trauma survivor in the audience → Has the chance to bring in her own experiences and control her level of exposure (depending on how much she can tolerate).
    - a trauma expert → someone who primarily brings in own knowledge, detects dysfunctional thinking patterns, or asks questions but shares nothing about her own experience, or
    - a silent listener in the audience (lowest level of exposure) → experiences exposure by listening to and sitting through someone else's trauma report.
 → Later, activity can be repeated with switched roles so that everyone who feels ready can experience the highest level of exposure.
  - *Objectivity:* Traumatized patients are often much more empathic and less critical with others than with themselves. Therefore, they are more objective and better at detecting other people's thinking errors/dysfunctional thoughts – and can, therefore, be very helpful to one another (“It's my fault that my 18-

year-old brother touched me when I was five years old because I slept in his bed when I had a nightmare” when it’s about one’s own experience, as opposed to “XYZ was only a little girl! A 5-year-old is never, EVER responsible!” when it comes to others).

- *Interpersonal learning*: Even the silent member who is not ready to talk yet can internalize or apply aspects that she learned through the stories of others to own story (“if XYZ was not responsible, then maybe I’m not, either”).
- *Reprocessing/catharsis*: Being able to talk about the traumatic event, its meanings and consequences in the presence of people who can detect old, dysfunctional processing failures and help make sense of something that had been kept to self.
- *Corrective recapitulation of the primary family group*: Experiencing a “holding environment”/“good enough mother [family]” that reacts adequately in a holding way and is not overwhelmed by the disclosure (“I’m not being rejected”, “This is being taken seriously”, “I do not feel responsible/like a family burden”...)
- *Installation of hope and imitative behavior*: “If it helped XYZ to talk about her experience, then maybe it will make me feel better, too.”
- *Universality and group cohesiveness*: “I’m not alone with this experience.”
- *Altruism/imparting information*: The activity gives victims of trauma the opportunity to be helpful, empathic, listen to others, give advice, and show what they have learned.

#### Processing Activity

- What was it like to be the guest/host/in the audience? What was it like to listen/talk? What did they anticipate and how did it turn out? What was difficult and why? What was helpful? What was surprising? What did they learn? What are they taking with them? What are their goals? What did they appreciate about each other? What do they have in common?

#### Reminders for Group Leaders

- Please be sure NOT to assign the role of the guest. It is imperative that the member volunteers, as it would be retraumatizing to force a member to disclose. If no one volunteers, normalize the experience of anxiety and explore what their hesitation is about. If someone then volunteers, make sure that this person does not “step in” because she feels pressured or responsible (often the “good” member who had a similar caretaking role within the nuclear family system). If no one volunteers, postpone activity. If several volunteer, have them negotiate who goes first, the other one gets to be the guest in the “second show” (in which a member can then play the role of Oprah).
- Be sure to inform your members in the audience that they can leave the room if it gets too tough for them. One of the facilitators should follow the member and keep her company outside.

- Before the session ends, carefully assess where your members stand and if you need to follow up with anyone. This activity can evoke a lot of emotions – even for those who are “just listening” (including yourself and the undergraduate).

### Script for Oprah Show:

Hello everybody and welcome to the Oprah Show. In today's show we will be talking about trauma. We have a special guest here. Her name is \_\_\_\_\_. \_\_\_\_\_ will be sharing her experience with us today.

We also have a lot of special guests in the audience today. Some of them are trauma experts, some of them have been victims of trauma themselves. Throughout this show, we will be asking the audience a lot for their opinions, input and knowledge and they are welcome to jump in and ask \_\_\_\_\_ questions or add comments. Is that okay for you, \_\_\_\_\_?

Before we ask \_\_\_\_\_ to talk about her experience, maybe the audience can name a few different traumatizing situations.

*Members name examples (physical, emotional and sexual abuse, car accident, being in an earthquake, witnessing domestic violence...)*

Thank you for your examples.

\_\_\_\_\_, was your traumatic mentioned by the audience or did you experience something different? Are you ready to talk about it?

\_\_\_\_\_ *shares her story.*

Thank you for sharing your story with us. It must be very tough for you to talk about it. Is it still okay for me and the audience to ask you some more questions about your experience?

*Oprah asks audience for questions or comments and asks additional questions herself. Facilitators can intervene in their roles as experts.*

What are some of the symptoms that you experienced as a result of the trauma?

...

Can the audience tell us what other symptoms are pretty common and does anyone know the name of the diagnosis that often comes up after traumatic experiences? What other diagnoses co-occur and why do they develop?

*...audience lists PTSD symptoms (flashbacks, sleeping difficulties, avoidance etc.) and other diagnoses such as depression, substance abuse (drinking alcohol to avoid sleeplessness, flashbacks, depression because of isolation etc.)*

How does the experience affect a victim's personality and life? What experiences does the audience have with this? What do your friendships/relationships with others look like?

*Audience can talk about mistrust, dysfunctional relationships, testing tendencies, isolation, core beliefs...*

Why do most people not talk about their experiences? What makes it hard to talk about it?

*Shame, guilt, mistrust, development of core beliefs...*

*For instance, for someone who's parents did drugs and therefore lost custody, the automatic thought and core belief might be: "Obviously I was not important enough to make her stop" → I'm worthless; "maybe this was all my fault" → I'm a bad person/guilty/responsible, "everyone is always judging my mom, therefore I feel like I need to stick up for her and protect her from everybody" → I need to rescue.*

Why do people often feel guilty and ashamed?

*Reaction of family members, pressure from perpetrator, processing failures, lack of input from stable adults, lack of cognitive capacity during childhood...*

*Have members give examples!*

Does anyone know what traumatized people need to do to feel better?

*PTSD treatment, rationale for exposure and cognitive restructuring against anxiety and guilt/shame, avoid avoidance, reprocessing, avoid isolation, talking about it...*

\_\_\_\_\_ What is it like to talk about it?

...

Have you talked about it before? (If no, why not?)

...

Why did you choose to talk about it now?

How does the audience feel about what we heard from \_\_\_\_\_? How should people around her have reacted?

We have talked a lot about trauma today. What are some POSITIVE and NEGATIVE aspects about talking about trauma? \_\_\_\_\_? Audience?

Before we end today's show, do you \_\_\_\_\_, or does the audience have any final comments or questions?

\_\_\_\_\_, what is your feedback to the audience; audience, what is your feedback to \_\_\_\_\_?

I want to thank you, \_\_\_\_\_, and everyone else who has shared something personal about themselves so very much for being brave enough to talk about this with us. I'm sure you have inspired a lot of viewers at home. They now know that they are not alone with their experiences and that there is help out there for them.

And also, a big THANK YOU to all the helpful experts in the audience.

For more ideas on creative interventions, see:  
“Creative Interventions with Traumatized Children” (2008) by Cathy A. Malchiodi who  
wrote an entire chapter on “Creative Interventions with Families and Groups”.

## OLD VERSUS NEW GOODBYES \*

- See manual-part for description of activity
- Members fill out table below.



OLD VERSUS NEW GOODBYES

Problem: What made previous goodbyes painful	Solution: What we can do to make this goodbye less painful

Figure 20. Old vs. new goodbyes – worksheet.

## WALKING DOWN MEMORY LANE \*

## Description of Activity:

- Members are asked to bring items, music and pictures that remind them of group/have come up during the process of the group. Most members possess plenty of pictures of the members that they took during group sessions. Ask them to pick a few nice ones and make enough copies for each member. During the session, group sits on the floor, listens to music, scrapbooks and shares stories, memories and 'remember when'-moments. Facilitators, do not forget to bring music equipment, a camera and scrapbook materials!

## OLD ME, THEN ME, NOW ME, FUTURE ME \*

### Description of Activity:

- This is the second part of the above described activity “Old Me, Then Me”.
- Follow the same instructions as above – only this time, terminating members write “Old Me” and “New Me” on the top part of the construction paper and produce illustration, picture or collage below accordingly.
- Departing members then present ALL 4 parts to the group, demonstrating the progress they have made, the different challenges and stages they have gone through and their future goals and plans.
- Members then talk about the changes they have noticed in the member and explores the ways in which they believe the group was helpful.

## WHEN THE SEASON COMES TO A END

- Reference: Malekoff (2004), p. 196

### A FAREWELL CIRCLE \*

- Reference: Malekoff (2004), p. 197

#### Brief Description of Activity:

- Members stand up and form a circle with their backs facing each other; when instructed, they take a step (forward or backwards) symbolizing the group development and the upcoming ending.
- During the activity, they express their feelings verbally and finally turn around – facing each other, standing still and reflecting/taking the situation in for a minute.
- Then debrief or let experience speak for itself.

## TRANSITIONAL SPACES AND PLACES

- Reference: Malekoff (2004), p. 197

Rationale:

- Meeting outside the agency to “help make the connection to the world beyond group”

## ROCK AND REFLECTIVE GARDENS AND RITUALS FOR REMEMBERING

- Reference: Malekoff (2004), p. 200

## BUS RIDE \*

- Reference: Carrell (2000), p. 61



## CANDLE CEREMONY \*\*

### Reminder for Group Leaders:

- This one is NOT optional! Each member signed a contract that asked them not terminate without a proper goodbye ceremony to allow self and others some time for closure.

### Example of our Goodbye Ceremony/Description of Activity:

- We decided to call our goodbye ceremony “Candle Ceremony”, but of course you can create a new tradition (termination ritual) with a new name. In our case, every member was asked to prepare a dish (maybe the favorite ones of the departing member or own favorite) and a letter for the departing member at home and bring it to group. The letter could contain memories, thank you’s, wishes for or ways in which the departing member had impacted the life of the one who wrote the letter. It is also nice, if they write down what they are most likely going to remember about the departing member in the future (“Every time I hear the song XYZ” or “Every time I see a shy smile I will think of you” etc.) so that the member knows that she will not be forgotten but left footprints in the hearts of the MIAs. The departing member is also asked to compose a goodbye letter to the group – and maybe mention the impact of the group and the individual members. The facilitators and undergraduates of course also wrote letters and prepared a little goodbye gift (a framed picture of the MIA’s and a card). As a goodbye ritual, we turned off the lights and everybody sat down in a very close circle, holding candles in our hands as everyone read their goodbye letter to the departing MIA-member, who read her letter out last. These sessions always were extremely emotional – but as sad as they were, they were also very healing, as this type of goodbye created closeness and comfort as opposed to unanswered questions, unspoken words and a feeling of abandonment and loneliness. Make sure to take pictures of the terminating member with all the MIA’s and be sure to have an extensive check-out, to assess where the members are at emotionally and if you need to follow-up with any of them. At the end we held hands and send the member off with a wish from the group.