

# **Group Therapy for Abused and Neglected Youth: Therapeutic and Child Advocacy Challenges**

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*Although group therapy for abused and neglected youth is a viable and efficacious treatment option, facilitation is challenging. Group leaders must contain intense affect, manage multiple transferences, and advocate for their clients within the larger social welfare system. Using a case study of a group for sexually abused girls, this paper explores some of these issues and discusses ways in which therapists recognize and deal with the dual challenge of advocating for and treating children.*

Group therapy is an effective treatment strategy for abused and neglected youth (Carter and van Dalen, 1998; Corder, Haizlip, & DeBoer, 1990; deYoung & Corbin, 1994; Foy & Eriksson, 2001; Heiman & Ettin, 2001; Kweller & Ray, 1992; Zamanian & Adams, 1997). It provides a unique opportunity for self and interpersonal learning (Nolan et al., 2002), allowing members to address the effects of interpersonal victimization identified by Gil (1991) and Briere and Elliott (1997). Members benefit from the understanding and support of peers who have had similar experiences (Foy & Eriksson).

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Normalization of shame, isolation, helplessness, powerlessness, and betrayal can be achieved (Heiman & Ettin). Additionally, group interventions may be structured and focused to maximize skills associated with resiliency, leading to improved treatment outcomes for traumatized children.

While most practitioners readily comprehend the benefit of group treatment for abused and neglected youth, facilitation is challenging. Some challenges revolve around the therapist's joint role of group facilitator and child advocate. As group facilitators, therapists must manage chaotic interpersonal interactions, intense affect, boundary issues, group defenses, and transference and countertransference reactions. Therapists are constantly exposed to repeated stories of traumatic victimization, yet must maintain a healthy, hopeful perspective. Group leaders also must work to advocate for their clients within the child welfare system. They have a legal and ethical obligation to report suspicion or evidence of abuse and neglect. Such reports may occur in opposition to a child's wishes, creating friction, amplifying mistrust, and exacerbating hostility between the therapist and group member. Additionally, inadequate or limited system responses to a client's needs often leave therapists as the target for the child's frustration and helplessness. The multiplicity of purposes served by the group compound the therapist's challenges, since the group provides an opportunity for psychoeducation about abuse, neglect, and family dynamics, yet becomes the container for traditional interpersonal psychotherapeutic work. This paper will discuss ways in which therapists can effectively deal with the challenges of being group facilitators and advocates for abused and neglected youth. Specifically, a group conducted by the first author will be used to illuminate the aforementioned challenges and their resolution.

## **CASE STUDY**

The therapy group for this paper consisted of 8–12 girls between the ages of 10–14. All were victims of incest by male perpetrators (e.g., brothers, fathers, grandfathers, uncles, etc.), and the majority had family members receiving treatment at the same facility. Most of their families were court ordered into treatment following an investigation and eventual substantiation of sexual abuse by Child Protective Services (CPS). All group members were required to be in individual therapy; therefore, attending group was voluntary and served as an adjunctive therapy rather than the primary treatment modality (although some group members reported attending individual therapy on an infrequent basis). Group meetings occurred weekly for

approximately 1.5 hours. There was no fee. New members could be added at any time, although core membership remained fairly constant for roughly two months at a time. Some problems with absenteeism occurred due to changes in the child's primary residence (e.g., new foster placement), shifts in the child's legal status (e.g., state custody v. custody of biological parents), transportation difficulties, and conflicting school activities.

Group members displayed a range of presenting problems. Though all had experienced some form of incest, their psychosocial histories and life circumstances were quite varied. Approximately half of the group members reported repeated victimization from more than one perpetrator. The remaining members were victims of a single perpetrator, with either one reported incident or several incidents over a period of years. Some disclosed the incest themselves, while others were identified through CPS investigations of other family members. The group members presented with a range of symptoms and diagnoses (e.g., PTSD, Major Depression, ADHD, Conduct Disorder). Most exhibited signs of anxiety. Symptom severity often corresponded with the intensity and duration of their abuse, although some members were remarkably resilient.

Family support of group members was as varied as the girls' symptom presentation. A few members had a parent who was outraged about the abuse and acted quickly in a protective and supportive manner. The majority of the group, however, had family members who directly participated in the abuse, denied such events occurred, minimized the offenses, or blamed the victims. Obviously, how families responded had a profound effect on the victim's conceptualization of the abuse, emotional state, life circumstances, and recovery from the trauma.

The group leaders consisted of a male and female, both with moderate levels (4–8 years) of experience with this population. The therapists worked well together, and the ease, humor, and affinity with which they related were often the subject of group remarks. The therapists had four objectives for the group: 1) Provide emotional support for group members going through a difficult period. For example, many girls joined the group shortly after the disclosure of incest and/or initial CPS involvement; 2) Provide a place for these girls to work through their victimization. For instance, group members discovered ways to label and appropriately express feelings associated with their abuse; 3) Provide a place to discuss normal developmental concerns (e.g., school, peer struggles, interests); 4) Build skills associated with resiliency, such as improving self-esteem, developing interpersonal supports, and fostering adaptive coping strategies.

While the primary focus of the intervention was to provide group psychotherapy, or in other words, to treat psychological trauma in

an interpersonal context, the goals of the group also incorporated important aspects of psychoeducational and group counseling approaches (Association for Specialists in Group Work, 1992). For example, the group members needed a clear understanding of what constitutes abuse/neglect to help them guard against re-offenses by family members. Members also needed a place to explore typical developmental concerns of adolescents such as peer relationships and school adjustment. Assisting the group members with current issues resulting from their trauma, such as foster placements and court experiences provided a chance to enhance problem-solving skills and to develop social support. Although complex to facilitate, the group leaders believed that such a multifaceted treatment approach would best serve the group. The group approach focused on multiple levels of the girls' experiences and developmental needs, hoping to repair the effects of trauma and facilitate normal adolescent development.

In reviewing these goals, it should not be assumed that this group ran smoothly. It was difficult to maintain focus, establish a safe affective container, manage transferences, and counter the pervasive mood of helplessness and blame that permeated some group meetings. Away from group, the therapists struggled to give their clients a voice in the child welfare system. Oftentimes, phone calls to CPS caseworkers were not returned, foster care placements were changed without warning, and decisions were made about disposition that placed the child at risk. Conflicting opinions about how best to serve each child frequently appeared among group therapists, individual therapists, caseworkers, court evaluators, and guardians ad litem. Funding limitations and lack of available, qualified foster placements also influenced decisions. Unfortunately, the challenges described herein are not unique to this group and have been described elsewhere (England & Connors, 2005; Tower, 2002).

### **THERAPIST AS GROUP FACILITATOR**

All groups present challenges for the group leader. Common problems include establishing cohesion and healthy norms, encouraging interaction, and moving the group into the here-and-now (Yalom, 1995). These challenges also exist in groups for abused and neglected youth; however, there are other problems specific to this population. For organizational purposes, these challenges will be discussed under two main headings: therapist as container and therapist as transference object. It should be noted, however, that these roles substantially overlap in a practice setting. This overlap is evident in the group examples provided.

## **Therapist as Container**

Abused and neglected children experience a fundamental lack of personal safety. Often, the very people designated as their protectors have violated personal boundaries. The emotional upheaval, intrusiveness, and betrayal that accompany incest are disorienting and interfere with the child's self-development. As stated by one group member:

Who am I now? I'm not the same, but I am. I am still Lisa, I guess. Is my grandpa still my grandpa? I know he hurt me, but, so what? I still love him. People tell me that he is a bad person because he touched me like that. I don't really care. Am I bad, too? After all, I touched him. I don't know what's going on. Nothing is the same. Mom isn't speaking to Grandpa. I don't even know where Grandpa is. No one will tell me what is going on. All I know is ever since that stupid caseworker came into the picture, my life is horrible. Now, mom's even talking about moving to another state. How do I feel about that? Pissed as hell.

As a result of the abuse she experienced, Lisa's internal and external worlds changed dramatically. Her main affective expression in the group was anger, directed primarily at her mother, the CPS worker, a group peer, and the female leader. She presented as emotionally entangled with her grandfather, who at one time served as a primary parental figure. Lisa's contact with her grandfather was severed, without a goodbye or sufficient explanation. Her concept of family was challenged, her sense of good/bad was blurred, and her world no longer made sense. She felt abandoned by parental figures and alienated from her previous life. Her sense of self was jarred, and she defended against her vulnerability with anger. Initially, she could not consider the source or impact of her rage. She rejected group members' attempts to understand. She devalued structured group activity. Yet, despite her alleged hatred and dislike of the "stupid group," she returned, week after week, because she had "nothing better to do on a Thursday night."

Lisa's emotional intensity created chain reactions in the group. As Lisa raged, Nicole experienced terror, and Leslie felt overwhelming guilt. Lisa distanced herself from group affect with nasty, hurtful missives. Mona fell asleep. Leslie stopped talking because her thoughts were "too bad to talk about." Lisa became increasingly agitated and yelled at the group leader to "do something." Clearly, this raw, unprocessed emotional intensity did not serve the group and represented a traumatic reenactment for many of the group members. The therapists needed to modulate, contain, and interpret Lisa's anger and other group affects.

Several researchers have defined therapeutic containment. Mathews and Gerrity (2002) associated the therapeutic container with

client/therapist boundaries. Specifically, therapists facilitate member self-exploration by not crowding or burdening the group with inappropriate disclosures. Briere (1996) discussed monitoring the “therapeutic window” for a client and group as a whole. In other words, the therapist serves as an emotional pacemaker, challenging clients towards therapeutic growth while not overwhelming them with too much traumatic stimuli. The therapist assists clients in creating a coherent narrative of their fragmented, emotionally charged experiences. Likewise, the therapists must not underestimate group members’ capabilities, which can lead to avoidance of any discussion of a traumatic event.

According to Yalom (1995), a safe container begins with the pre-group interview. During this meeting, the therapist provides information on how the group works, explores client expectations and group fit, and establishes “rules” for participation. Additionally, the therapist facilitates the beginning of a therapeutic alliance and assesses the member’s readiness to participate. Although containment starts with the pre-group interview, it necessitates careful, ongoing attention by the group therapists and members to promote therapeutic growth throughout the group experience.

In working through trauma, clients tend to either avoid or flood themselves with traumatic stimuli. They are limited in their ability to regulate emotional exposure to traumatic content. Effective containment involves finding a balance between avoidance and flooding. In the example above, Mona avoided affectively charged material by sleeping. Lisa could not stop her rage, thereby alienating her from others and eventuating in self-mutilation. Consequently, the therapists nudged Mona into more affect by having her describe specific (vs. global) details of her traumatic encounters. For instance, Mona was asked to describe the room where an abusive incident took place. This helped place Mona in the event, thereby eliciting the affect previously silenced with sleep. Additionally, the leaders drew attention to Mona’s sleepiness, challenging her to look at what she might be avoiding in that moment. In contrast, Lisa needed more cognitive understanding of her rage. This was accomplished by asking factual questions requiring an evaluative response. For example, the therapist queried, “When was the first time your grandpa touched you in a sexual manner? Who alerted CPS? Where were you interviewed?” Such questions facilitated a specific, cognitive response, and Lisa had to step back from her anger to retrieve the information. The leaders also helped Lisa examine how she used anger to distance, thereby avoiding closeness with and potential hurt by other group members. These types of interventions helped the members experience greater safety and understanding as they worked through their trauma.

Providing structure is another way therapists can maintain safety in an affectively charged setting. For instance, at one point the therapists used a fairly common group activity of having group members construct masks. The outside of the mask represented the qualities and traits shown to others. The inside of the mask revealed their inner self. Members used markers, paint, and magazine cutouts to create their masks. They laughed at themselves, helped one another, and chatted about less serious matters. Once the mask was completed, they were able to talk about their feelings with more safety than before. In essence, the mask served a concrete containing function, allowing members to approach their abuse and its consequences. One member, Shauna, said her external self was perfect, as indicated by the flawless model's face on the outside of the mask. However, the inside of her mask contained sloppily attached cut-up faces, thereby revealing a more fragmented, conflicted self-representation. The value of the exercise was exhibited in Shauna's ability to put words to this split between her external and internal self-representations.

In addition to containing overwhelming affect, structured activity can also draw out groups who collude in downplaying trauma and emotional pain. For instance, in another exercise, the therapists asked the girls to write a letter to a family member. Mona decided to write a letter to a younger sister who was also abused by an older brother. She wrote the letter hoping to provide some support and comfort to her sibling. As she read this letter to the group, Mona began to cry, leading to some disclosure about her own pain and sense of betrayal. Another effective activity was to have group members describe another member's role in the group. For example, Lisa told Shauna that she acted like one of the group leaders. "You take care of people when they're upset. I think that's because you want to help them, but I also think it's so we won't ask you about your abuse." Lisa's feedback helped Shauna examine her own fears and take more group focus.

Containment also requires careful consideration and use of therapist self-disclosure. Too much disclosure may detract from the client's own self-exploration and impede the development of useful transference reactions. For example, a client asked the female therapist where she purchased her sandals. The therapist chose not to respond to the question, primarily because it occurred just after another group member, Shauna, described seeing her dad outside the courtroom. Instead, the group leader asked the member if she felt uncomfortable listening to what Shauna was describing. The patient acknowledged that the thought of seeing her perpetrator was anxiety provoking, thereby prompting her to change the subject. If the therapist had answered the question directly, she would have colluded with the client's resistance.

Since this was a group for incest survivors, member comments often contained sexual content. For example, when the group first started, a member asked the male therapist, "Does your wife know?" All the girls giggled. The therapist asked for clarification. The group member refused to answer. The male group leader gently but firmly persisted with his request, and eventually the client said she assumed the co-therapists were having an affair. She believed that this was true because the leaders appeared to be emotionally close and good friends. Careful not to shame the questioner, the therapists invited the group to talk about impressions of the therapists' relationship. This discussion led to an important insight that emotional closeness and sexual intimacy are not synonymous, a foreign yet welcome concept to group members.

Safeguarding appropriate boundaries within the group served as another form of containment. On several occasions, the group leaders had to set limits on physical touch, inappropriate dress, and sexualized behavior. For instance, Lisa dressed provocatively and typically sat right next to the male group leader. One night she came to group late, sat on the table across from the male group leader, and spread her legs so her underwear was quite visible. Initially, he ignored her behavior, but her sexual acting out became more pronounced. Stating she had cut herself shaving, Lisa moved her skirt upward to expose the wound (and her underwear). The male group leader gently suggested she put her skirt down and sit in a chair next to the other members. Skillfully, he explored what she wanted through her seductive behavior. Initially, Lisa was angry and defensive, denying any sexual intent and suggesting the group leader must be "some sort of perp." As the session progressed, however, Lisa admitted she missed her grandfather and wanted some attention. The group leader helped Lisa talk about rather than act out her painful feelings. This facilitated a constructive group discussion about how group members sexualized their clothes, body, and behavior to meet a variety of social, emotional, and non-sexual physical needs.

### **Therapist as Transference Object**

Abused and neglected children typically experience harm at the hand of an adult, frequently someone in a powerful family role. Not surprisingly, these victims often replay aspects of their traumatic abuse within the group therapy setting. Therapists often become transference objects, arguably a necessary component in working through traumatic events. Whether or not such encounters are therapeutic depends on the skill of the therapist, particularly in managing countertransference reactions. As Heiman and Ettin (2001, p. 267)

explain, "By responding to messages underneath children's behaviors, rather than suppressing them, an opportunity exists to respond and transform the function of children's actions." Though many transference/countertransference exchanges could be examined, this paper will focus on four common themes found in an abused/neglected population: helpless victim, exploitive perpetrator, silent partner, and perfect parent.

## **Helpless Victim**

Consider the familiar, but never easily addressed, refrain captured by one group member: I don't know why I come to this group. You can't really help me, no one can. No matter what you say, it doesn't change what happened. You can't make me normal. I'm like a dress with a permanent stain. Who wants that? Oh, you can try to make me feel better, but I'm already ruined. Stains can't be washed out. . . get it? There's nothing you can do. (Becca, age 13.)

All therapists working with sexually abused girls find themselves the focus of remarks similar to this one, and there is some truth in each statement. A therapist cannot prevent what has already happened and can only work with the resultant trauma. The shame, humiliation, powerlessness, sadness, and paralyzing helplessness experienced during episodes of abuse are projected onto the therapist.

Many therapists are made uncomfortable by helplessness, someone else's or their own. Armed with an advanced education, a title, and years of clinical experience, therapists may think of themselves as potent change agents. Encountering helplessness, consequently, can evoke quite a range of countertransference and other defensive responses. For instance, therapists may try to rescue the client (and themselves) through a demonstration of power (e.g., becoming an overzealous advocate and demanding the caseworker do something on their client's behalf). A therapist may also intellectualize the client's experience to alter the former's sense of helplessness. For example, suppose the therapist told Becca her true self lies underneath the stained dress. While this may be helpful to separate the abuse from Becca's sense of self, to deny that such an event had changed Becca amounts to an emotional dismissal. It also sends the message to the client that such feelings are intolerable to the therapist and blocks the client from working through them.

So how can a therapist best manage these feeling of helplessness? Simply recognizing and interpreting the transference reaction is often enough. As Ryan (1996, p. 308) stated, "If the therapist's helplessness can be understood as a reaction to the trauma or as a transference

reaction rather than a personalized issue, then the therapist may feel less restricted by this feeling.”

## **Exploitive Perpetrator**

Another common transference reaction by abused youth is captured in the following statement:

What’s wrong with you? Do you get off on people’s pain or something? You keep asking her about every detail. Don’t you get what happened to her? (Sarcastically, she mimics the therapist) “How do you feel? Then what happened? What did he say?” Geez, enough! You’re hurting her. Don’t you get it? (Cindy, age 11)

The perpetrator role can be extremely uncomfortable for a therapist. As Cindy expressed, a client may perceive a therapist as intrusive, persecutory, opportunistic, and yet another example of a powerful adult exploiting a child. A therapist’s well-intentioned questions may appear voyeuristic, if not an attempt to satisfy his or her curiosity. Even empathy can be viewed as an intrusive attempt to amplify the pain of the experience. Certainly, Cindy’s comments exemplify this projective process, necessitating that the therapist absorb the assault, recognize its defensive function, and assist Cindy in metabolizing her own feelings about her traumatic abuse.

In another group session, a client asked the male therapist if he had any children. He answered her query, and then asked what prompted her question. This led to a discussion of the client’s fear that all fathers wished to sexually abuse their daughters, a view shared by many group members. They simply could not envision a normal father-daughter relationship, as evidenced by their transference responses to the male therapist. Exploration and interpretation of these responses assisted these young clients in working through their traumatic experiences and negative views of men.

Disgust, denial, and defensiveness often accompany a therapist’s placement in the perpetrator role. The first author of this paper recalls being told she was “like a pimp,” leading her to immediately want to clarify and defend her intentions. While such a defense may have alleviated the therapist’s discomfort, it would not have served the client. This group member needed the therapist to “hold” the perpetrator role. This allowed the client to face emotions she was unable to express at the time of her abuse and to express rage at a safe person that would neither need to be rescued nor impose punishment. Holding the perpetrator role requires a therapist to tolerate reprehensible misattributions, even when they might stimulate one’s most despised or disowned parts of self.

## **Silent Partner**

Lisa refused to interact with the female therapist. If the therapist spoke to her, Lisa pretended she did not hear. Lisa sat next to the male therapist, chatted with him after group, and attempted to engage him sexually. She evidenced cold, dismissive disdain toward the female therapist, almost as if to announce, “You don’t matter.”

One might expect that a female/male therapist team would receive different reactions from incest victims, depending on the nature of their abuse. In this group of all female victims, the male leader was prepared to be rejected and viewed as a threatening, untrustworthy figure. Occasionally, he experienced such characterizations, but the female therapist was a much more frequent target of group hostility. Characterized as the mother who stood by while her child was victimized, the female therapist was either dismissed as useless or attacked for not protecting group members. Additionally, the female therapist represented a disowned part of the victim’s self who was a passive partner in the abuse.

A therapist who is rendered useless may feel angry or inadequate. Anger is one response to not being seen. For example, Lisa’s absolute dismissal of the female therapist generated a countertransference response of dislike. The therapist had to be careful not to punish Lisa as a means of retaliation. The therapist needed to recognize Lisa’s own anger and self-hatred that she projected into the therapist. At some level, Lisa believed she should be punished for her “seductive” behavior, pulling for a rejecting response from the therapist. Blamed and rejected by her mother, Lisa enacted the same scenario with the therapist. Their transference and countertransference responses provided a window into Lisa’s experiences, allowing her to put words to her self-hatred and abandonment.

## **Perfect Parent**

Younger children tend to be quite blatant in their idealized parental transference. The message is the same with older children, “If I lived with you, I would be taken care of.” Consider the following from Mindy, a 10-year old girl:

I wish you were my mom. You would never let dad hurt me. I know you would take care of me. We kinda look alike, and sometimes I pretend that I am going to live with you. Then I think that you probably already have a daughter, and you don’t want another.

For Mindy, projecting this role onto the therapist allowed her to attach and believe in a nurturing adult. However, it also presented

a dilemma. Her endorsement of the idealized therapist was a condemnation of her biological mother, who was struggling to repair her relationship with her daughter. Additionally, Mindy's view of the therapist as perfect created a fear of rejection. She assumed the therapist would not want a damaged child. She tried hard to please the therapist and avoided expressing any negative feelings. In response, the therapist gently encouraged Mindy to be herself and reminded her she was still accepted and cared for, even when at odds with the therapist. As Mindy gradually reworked her idealized view of the therapist, she was able to see the positive and negative qualities in her mother and herself.

Unlike the others, the idealized role may be seductive and appealing to the therapist. Who doesn't wish to be seen as the perfect parent who can make everything right? Common countertransference responses can include enmeshment, rescuing behavior, competitiveness (with the parent), and distancing. For instance, because the client is idealizing and affirming, a therapist may collude with the client through emotional enmeshment. Like parents who cannot see their child's misbehavior, a therapist may refrain from confronting the client, even inappropriately protecting her from other members' constructive feedback. Alternatively, therapists may feel worn out by the child's unending need for affirmation and support, distancing themselves from the child in a way that recapitulates feelings of rejection and abandonment.

Certainly, there are other transference/countertransference combinations; however, those explored previously illustrate the importance of examining such responses in depth. Processing group interactions as co-leaders and seeking clinical supervision may assist group leaders in deciphering these sometimes complex transference/counter transference exchanges and using them to benefit their young clients.

## **THERAPIST AS CHILD ADVOCATE**

The treatment of abused and neglected youth does not end with the group therapy hour. Therapists have an ethical and legal responsibility to advocate for their clients. In addition to working through trauma, therapists are advocates within the child welfare system. This role may include intervention at the individual, community, and societal level.

Therapists are ethically and legally required to report to the proper authorities any suspicion or knowledge of abuse. For the group therapist, this is an ongoing process. An initial report to CPS often precedes the client's entrance into treatment. Group members often disclose

additional incidences of abuse during group sessions. Often this necessitates another call to CPS, perhaps naming additional perpetrators. Typically, therapists are the most likely party to hear about violations of court no-contact orders or retaliatory family events that threaten the child's safety and therapeutic progress. Such information is often relevant to decisions about case disposition and placement, and it is important for therapists to maintain contact with child welfare workers and other professionals in order to best protect and serve the client.

Many therapists do not like to interact with the judicial system. They argue that a client is best served when therapy remains separate from court considerations and caution against dual relationships (e.g., court evaluator and psychotherapist). While clarity and boundaries regarding the therapist's role are very important, therapists often have greater access to the child than others involved. Besides reporting suspected abuse/neglect, the therapist must consider what information is relevant to child treatment and placement decisions.

For instance, two members of this group were placed in foster care because their mothers were viewed as unable or unwilling to adequately protect them from further abuse. Once the mothers complied (albeit minimally) with CPS treatment plans, the agency workers recommended the girls return home. Hearing this information in group, the leaders were concerned such a move was premature. Neither of the girls had participated in any joint therapy session with their mothers to discuss abuse issues. After securing consent from the two clients and making certain no confidentiality issues were breached, the therapists contacted the involved caseworkers. To their surprise, both caseworkers were unaware family therapy was not underway. Once they had the therapists' information, the caseworkers delayed their recommendations to send the girls home and arranged for family treatment. Therapists must not assume someone else is managing these kinds of issues. Active participation in all aspects of treatment, including events outside the group room, is required.

Certainly, child advocacy has many challenges. Some happen within the group. A client, for instance, may be frustrated by the therapist's legal responsibilities around reporting, bringing friction to the therapeutic alliance. The child may disagree with the therapist's recommendations to CPS or the guardian ad litem. Although these events may prompt anger, resistance, and lack of cooperation, they also present an opportunity for growth. For example, a child's wish to return home can be acknowledged, and the therapists can discuss their concern for the child's safety and well-being. This provides the client with information about dysfunctional family dynamics. It is also another opportunity for the therapist to absorb the client's negative

affects and demonstrate that difficult emotions and conflict can be worked through. A child who initially disagrees with the therapist's recommendations may eventually see the value of the therapist's cautions, much like the adolescent who rebels against yet finds comfort in the parent's restrictions. Whether the child agrees or not, however, the therapist must advocate for the child's safety and well-being.

Another challenge is the sense of powerlessness therapists feel when confronted by the enormity and bureaucracy of the child welfare system. By working as part of a team, therapists can more effectively confront this challenge. Child advocates expect to fight for their clients, sometimes erupting into battle with the very people they need to work on behalf of their clients. Group therapists need to be able to view themselves as members of a community working to assist a child.

In order to do this, the group therapist must create or join a community network. Both informal and formal organizations can be initiated or maintained. For example, a therapist can build relationships with CPS workers, guardians ad litem, and other treatment providers. This network can then be accessed when problems arise. Therapists may also establish formalized networks, such as joining or beginning a private provider group to address specific child treatment issues, funding problems, and other child welfare concerns. Obviously, this kind of advocacy takes time, but once established, can assure some of the aforementioned issues are efficiently remedied.

The second task is to identify pathways for problem solving. Are the issues encountered by the group therapist a single case problem or a thematic concern? In the instance where the therapist's concern focuses on an individual case, the therapist has the option of contacting specific individuals who are directly involved in the child's care (e.g., caseworker, foster parent, etc.). If this does not solve the problem, it may be appropriate to contact a supervisor or oversight committee. Therapists should inquire about proper avenues for making complaints and resolving differences of opinion. When the problem is more systemic, another strategy may be indicated. For example, when mandated reporters confront voicemail, busy signals, or a delinquent reply, they may need to contact a CPS administrator, a state legislator, or child advocacy group in order to remedy the problem.

Finally, prevention is the best solution to child welfare problems. Usually, a group therapist takes part in prevention at the tertiary level, entering into the picture after the abuse has taken place. Therapists must work to mitigate potentially damaging consequences of abusive acts and to prevent further abusive incidents. Group therapy is one avenue for an abused youth to work through trauma and psychologically adjust. A therapist may also participate in other

primary and secondary levels of prevention, such as leading a parenting group or giving PTA presentations on sexual abuse. What is significant is not the therapist's particular chosen course of action, but rather the partnering with others to advocate for the needs of children. Such partnerships tend to reduce therapists' feelings of helplessness, isolation, and futility, allowing them to impact the child welfare system more effectively.

## CONCLUSION

This paper has presented ways in which group therapists recognize and deal with the dual challenges of group facilitator and child advocate. As group facilitators, therapists must be able to contain affect, to assist their clients in making sense of their trauma and working through negative emotions, and to teach them healthy and adaptive coping strategies. Therapists must also learn to recognize and manage difficult transference/countertransference reactions. Common themes that abused children project onto the therapist are helpless victim, exploitive perpetrator, silent partner, and perfect parent. Therapists must be able to hold these roles, allowing their clients to work through projected aspects of their traumatic experiences. Finally, effective group therapists must advocate for their clients within the child welfare system as powerful change agents who intervene at individual, community, and societal levels. Therapists can facilitate communication between all parties trying to assist the abused child, including individual therapists, CPS caseworkers, and guardians ad litem. Such collaboration reflects advocacy at the tertiary prevention level, helping those who have already been victimized. Therapists can also intervene at primary and secondary prevention levels through community outreach and problem solving, identifying at risk groups and facilitating educational initiatives. Given the potential benefits of group therapy for abused and neglected youth, it is vital for researchers and clinicians to understand and discuss ways in which more effective group facilitation and child advocacy can be achieved.

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