The Group Circle

Fall 2013

The Newsletter of the
American Group Psychotherapy Association
and the International Board for Certification of
Group Psychotherapists

Maximizing Group Psychotherapy Training for Population Health

Donna Markham, PhD, ABPP, CGP

In the United States, adequate cost-effective treatment for those suffering from mental illness is sorely lacking. This is especially disturbing when the uninsured and underinsured are in need of treatment. According to the Substance Abuse and Mental Health Services Administration, one in 20 Americans suffers from serious mental illness—that is nearly 17 million people. If we included the full range of mental illness affecting people today, the number of Americans affected would be much higher. The Bureau of Labor Statistics estimated in 2010 that access to mental health professionals is worse than for other types of doctors with 89.3 million Americans living in federally designated Mental Health Professional Shortage Areas. (This is compared with 55.3 million living in Primary Health Professional Shortage Areas.) Group psychotherapy across the continuum of care is a financially feasible and effective modality that could enhance access to mental health care, and ultimately improve the health of our communities.

Response to the Need: Group Therapy Treatment Implementation

Recent research conducted by Gary Burlingame, PhD, CGP, FAGPA, Bernhard Strauss, PhD, and Anthony Joyce, PhD, supports what many group psychotherapists have long known: Groups are a powerful force in the treatment of most mental disorders. This research acknowledges that while there are some disorders where individual psychotherapy may be more promising (e.g., specific trauma-related disorders) comparisons between individual and group psychotherapy for the majority of mental disorders generally produced equivalent treatment outcomes (Burlingame, Strauss, & Joyce, 2013).

It would seem logical, given current research findings, that third-party payers would see value in reimbursement schedules that would cover group therapy, not only as cost effective, but as producing effective outcomes. Sadly, many third-party payers do not cover group treatment. As a result, many practitioners across all behavioral health disciplines have not pursued in-depth training and supervision in the provision of group treatment, opting instead to develop their practices based on providing reimbursable, yet more costly individual psychotherapy. Given the growing needs of the population for mental health care and the clear cost-effectiveness and treatment outcome efficacy of group therapy, it seems more important than ever to train practitioners in group treatment and to work with payers to cover group psychotherapy in health insurance plans.

Given the realization that mental health issues place significant demands on the health system and contribute to the overutilization of Emergency Department services, Catholic Health Partners (CHP), a large U.S. Midwest health system encompassing Ohio and parts of Kentucky, undertook a visionary initiative in 2012 to address aggressively the transformation of the current delivery system across the seven geographic regions of the organization. Included in this vision was: a) intensifying partial hospitalization and intensive outpatient programs; b) embedding behavioral health clinicians in primary care practices; c) using treatment outcome measures to determine effectiveness of changes implemented across the continuum of care; and d) engaging the state Departments of Mental Health. To realize this change, sizeable financial resources were allocated, and a multidisciplinary leadership team was hired to direct the transformation process. Central to implementation of this vision was to train clinicians in group psychotherapy.

Training Challenges

Like many health providers, CHP had a lack of trained, Certified Group Psychotherapists (CGPs) needed to implement such an intensive, group-based treatment model. Given the dearth of group clinicians, it became critical to develop an intensive training model that would prepare as many clinicians as possible in a short time to allow the treatment program to be implemented and to prepare clinicians to meet criteria for International Board for the Certification of Group Psychotherapists (IBCGP) group psychotherapy certification. This entailed creating the possibility for therapists to take part in the intensive training required for certification. In addition to a minimum of a Master's degree in a mental health field and State Licensure, Group Certification requires completion of a 12-hour course in group therapy, 300 hours of group psychotherapy experience as a leader or co-leader, and 75 hours of supervision by a qualified group therapy

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From the President

Kathleen Ulman, PhD, CGP, FAGPA

As the weather changes and days shorten, I greet the fall and anticipate the winter with great ambivalence. I mourn the loss of light and warm evenings but also find the cooler weather invigorating. It beckons me to get back to business with new initiative and energy for the tasks at hand. The approaching holidays reminds me that the AGPA Annual Meeting is right around the corner, which enlivens me. Thoughts of seeing old friends, meeting new ones, and learning cutting-edge ideas about group therapy buoy me. This year, the meeting in my hometown of Boston will be special for me. I am eager to share my city with you.

We are in the final stages of the new website, testing its new features and making adjustments. So many in our organization helped us implement this enormous task. Many thanks to CEO Marsha Block, CAE, CFRE, who along with the AGPA staff, and President-Elect Les Greene, PhD, CGP, FAGPA, have devoted many months to this task. Many others contributed to this endeavor, including Committee and Task Force Chairs, the Group Foundation, and the International Board for Certification of Group Psychotherapists. It took a village, and I want to express my appreciation to them all.

This summer we again participated in Camp Galaxy, a day of programs for military children of the 106th Airborne Division at West Hampton Beach in New York. Once again Community Outreach Task Force Co-Chair Suzanne Phillips, PsyD, ABPP, CGP, FAGPA, headed the team, this year with the help of her family. We owe our gratitude to Suzanne for her supreme efforts for this program. As a result of her dedication and skill, AGPA was awarded a Certificate of Appreciation by the Commander of the 106th Airborne Division for our support through the years.

The Community Outreach Task Force reached out to affiliate organizations affected by the recent crises created by the floods in Colorado and the mass shootings in Washington, DC, providing disaster response group materials and support.

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What's Inside

The Group Circle is published four times a year by the American Group Psychotherapy Association, Inc. and the International Board for Certification of Group Psychotherapists.

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From the Editor

Steven Van Wagoner, PhD, CGP, FAGPA

Excitement brews in me before each AGPA Annual Meeting when we publish interviews with some of the many fascinating speakers. In this issue, we present some of the major advances in the science of group psychotherapy, without losing the personal, relational, and intersubjective nature of the work we do.

In the past year, I mentioned to a number of colleagues a California researcher who was creating virtual reality systems for treating PTSD, among other trauma-based syndromes. I found the research compelling and innovative. Albert "Skip" Rizzo, PhD, who will present the Mitchell Hochberg Memorial Public Education Event, discusses this cutting-edge science with Paul Kaye, PhD, CGP, FAGPA. Instead of the computer nerd I imagined, I found Skip relatable, charming, and funny. His sense of humility pervades this interview while not detracting from the brilliance of the science in which he engages.

In her interview with Alexis Abernethy, PhD, CGP, Special Institute presenter Susan Gantt, PhD, ABPP, CGP, FAGPA, FAPA, honors Yvonne Agazarian, EdD, DLFAGPA, her mentor, while charting new territory in connecting Systems-Centered Therapy to the latest advances in neurobiology.

The article by Donna Markham, PhD, CGP, ABPP, addresses how a regional mental health delivery system introduced a programmatic, evidence-based group psychotherapy to the treatment of the severely mentally ill. This serendipitous follow-up to the evidence-based group treatment discussion in the last issue of *The Group Circle* is not intended to create a monolith to the research gods, but to acknowledge that many group therapists are engaging in evidence-based practices, intentionally or otherwise with some exciting results.

I sadly draw your attention to recent deaths of some giants in our field. In this issue, we are treated to memories of K. Roy Mackenzie, MD, CGP, DFAGPA, by Gary Burlingame, PhD, CGP, FAGPA, and his colleagues. Our next issue will recognize the passing of Saul Tuttman, MD, PhD, DFAGPA.

When my now college-aged children were younger, we loved watching the Lion King together. The movie's theme of the circle of life is echoed in AGPA. Our teachers, therapists, and mentors live in us, and as the Annual Meeting approaches, I hope that we all attend to the youngest and newest in our ranks, for they will be tomorrow's leaders, innovators, and among them, a few giants. ●

In Memoriam

Recollections About K. Roy MacKenzie, MD, CGP, DFAGPA— One of the Leaders in Our Field

Gary Burlingame, PhD, CGP, FAGPA

As I thought about the core characteristics of K. Roy MacKenzie, MD, CGP, DFAGPA, it seemed fitting to call on the group to share its thoughts about who he was and how he affected our personal and professional lives. Denise Wilfley, PhD, is a co-author of Roy's second most cited publication. Roy made a significant impact on group treatment in Europe. Steinar Lorentzen, MD, and Per Anders Øien, MD, describe Roy's impact in Norway. I hope those who knew him are reminded of how delightful and rare a human being he was. For those who didn't, I hope these comments bring a perspective to an author, clinician, and researcher who you will undoubtedly read as you explore the group literature.

Gary Burlingame—Roy became an AGPA member in 1970, serving in a number of roles including Secretary, Executive Committee member, Board member, and in the mid-1990s as President. He was a Professor of Psychiatry at the Universities of British Columbia, Calgary, and Texas and was active in the Canadian Group Psychotherapy Association, where he also served as President. He was a prolific writer, a careful scholar, and effective clinician. I met Roy in 1980 when I attended an AGPA Annual Meeting for the first time. I'd already heard his name and read his work, but when we met at the Research Special Interest Group, I was struck with the importance Roy gave to integrating clinical practice and clinical research. As a graduate student, I was keen on both, and Roy graciously took me under his wing as an equal—a life-changing experience for an inexperienced graduate student. Indeed, the friendly, inviting, and encouraging relationship that he developed with me helped set my own professional course. I've seen Roy's keen intellect help groups get unstuck, produce an inspired solution to a gnarly set of research findings, and creatively lead a chorus of psychotherapists in gleefully singing a German song celebrating the city of Ulm. When Roy retired, he passed along decades of group journals to me that still sit on my shelves, but more importantly he passed along his passion for group psychotherapy, both as a powerful treatment and as a worthy object of scientific study. We've lost one of our giants.

Denise Wilfley—In the late winter of 1997, Roy sought me out to work on a book project that later became *Interpersonal Psychotherapy for Group*. Roy and his wife, Carol, came to San Diego in the summer of 1998 so Roy could work extensively with my husband (Rob) and me on this project. I will always look back on that special time with fond memories. Not only did we spend many hours on the book, but also much pleasurable time getting to know them. While rollerblading around Mission Bay one afternoon, we learned that Roy was a champion speed skater in Canada. We also learned of Roy's love for the outdoors and for his family. What was most impressive was his passion for his work. He was willing to be a student with us, while at the same time serving as mentor. As time went on, I realized how rare it was to be mentored by a such a genuine, gentle, gracious, humble, passionate, persistent, and diligent human being. It was a once-in-a-lifetime opportunity for me to learn from such a master and special person. I feel honored to have known him professionally and personally.

Steinar Lorentzen (SL) and Per Anders Øien (PAØ)—I (SL) met Roy for the first time at the 1987 AGPA Annual Meeting. He and Robert Dies conducted a workshop on the use of AGPA's *Core Battery*. The quality of this test battery and the simplicity in Roy's arguments for its clinical usefulness convinced me to integrate it into my own clinical practice. In 1994, Roy was invited by the Institute of Group Analysis to a seminar on clinical research in groups in Oslo. As usual, his input was clear, up-to-date, and valuable, and many participants started to use clinical measures in their group practices.

This was the first time I (PAØ) met Roy, and I was caught by his presentation on the therapist's role in a group. "Do you want to look like mummies?" he exclaimed, advocating the active therapist who was tuned in with everyone in his group, followed their needs, spoke in a way that all could understand, but all the time challenging the group members on problematic aspects of their lives. I invited Roy to come back and spend some weeks in Norway to teach and supervise staff at the Modum Psychiatric Clinic, where I am the Clinical Director, in the use of group oriented interpersonal therapy. Roy's work with our patients with social phobia helped them to relax and focus on how their phobia influenced their lives. His impact on the professional milieu in Norway consisted of a combination of the lectures and workshops he gave there, his books and papers, his stay at Modum Psychiatric Clinic, and not the least, the personal friendships that were built. He was a warm person, open about important existential questions, and engaged in important issues in society and culture, including music.

Member News

Long Island University awarded **Elliott Schuman, PhD, ABPP, CGP**, the David Newton Award for Excellence in Teaching. In two of the courses he teaches (Group Dynamics to undergraduates and Group Process and Techniques to graduate students), he introduces promising students to the specialty of group methods, ushering potential new members to AGPA.

Functional Subgrouping and Its Neurobiology:

An Interview with Susan Gantt, PhD, ABPP, CGP, FAGPA, FAPA, 2014 Special Institute Presenter

Alexis Abernethy, PhD, CGP

Editor's note: Because this is an interview, and not a scholarly publication, many of Dr. Gantt's specific literature references to published works were eliminated due to space and format considerations, but I have provided a bibliography supplied by Dr. Gantt for those wanting to study this topic and the major influences in greater depth.

AA: What is the focus of your Special Institute?

SG: *Systems-Centered's Functional Subgrouping and Its Neurobiology: Lowering Scapegoating and Enhancing Emotional Regulation* will introduce the systems-centered approach to group, and in particular, will focus on its core method-functional subgrouping. The day will be largely experiential with theory and discussion interwoven between periods of using functional subgrouping in both small groups and the large group.

AA: How did you get interested in these topics and why do they continue to hold your interest?

SG: Actually, my interest in both systems-centered training (SCT) and neurobiology has been significantly kindled and fueled by my experiences at AGPA. I first became interested in group therapy in college where I had a chance to attend trainings through the Mid-Atlantic Training Conference affiliated with the National Training Laboratory (NTL), so group has been important to me for some time. In the 1980s and early 90s, I was in an ongoing training group led by David Hawkins, MD, CGP, DLFAGPA, and he suggested I attend an AGPA Institute led by Yvonne Agazarian, EdD, DLFAGPA. A year later, I did, and discovered a very new and exciting approach to group. I still remember bits from that Institute.

At that time, Yvonne was working with the group-as-a-whole and was still in the process of developing the systems-centered approach as a coherent theory with its core method of functional subgrouping. In the Institute, I was struck with the freedom I experienced when I could hear my voice and my experience as belonging to the group and not just to me. This was my first experience of being encouraged not to take myself just personally. This opened a doorway for me, enabling me to more freely contribute my experience to the group's work. Within a year, I became committed to the systems-centered training process, attending workshops whenever I could, and regularly attended Yvonne's Institute at AGPA each year.

I have certainly been transformed personally and professionally from my work in SCT; it truly transformed how I see groups and work as a group leader. Being able to recognize subgroups as members clustered together around similarities has enabled me to introduce groups to the functional subgrouping process to explore and resolve conflicts, that if not explored, are often enacted or lead to scapegoating. Learning to subgroup, by building first on the other's contribution with something similar to one's own, develops a climate different than the familiar pattern of 'yes, but,' which introduces a difference rather than a similarity.

One other aspect of SCT has strongly attracted me: All of its methods link to a coherent systems theory. In developing SCT, Agazarian took each construct in the theory, operationally defined it, and then established the methods and techniques that put the theory into practice. SCT's theory is one of living human systems, which can be used to conceptualize any theory or practice, as it is a comprehensive and integrative systems theory. This integrative aspect also drew me to SCT. For example, once functional subgrouping is established, SCT works in the early phases of group development to undo the cognitive defenses much the same way that Cognitive Behavioral Therapy does. As the group gains skill in doing this and develops its capacity to reality-test, it can then work with restoring the connection to the body in ways reminiscent of Gestalt techniques and sensory awareness work. As the group transitions from flight to the fight phase, the work is similar to short-term dynamic approaches using techniques that weaken the tendency to turn the retaliatory impulse back on the self.

Some years ago I began reading interpersonal neurobiology (IPNB) and was spurred to read even more after Daniel Siegel's presentation at AGPA in 2006. I recognized the strong similarity between what SCT does with its systems orientation and the neurobiological principles. I have been significantly influenced by not only Siegel's work and his emphasis on the mind as both an intrapsychic function and an interpersonal process, but also Allan Schore's emphasis on implicit emotional regulation as the central change process in therapy, Jaak Panksepp's formulation of fundamental emotional patterns in all animals, Iain McGilchirst's understanding of right brain function and its central role in human experience, Stephen Porges's understanding of the ventral vagal as a regulating social engagement system, Bonnie Badenoch's emphasis on relational neuroscience, and Marianne Bentzen's and Susan Hart's work with neuroaffective development.

In all of these, I have been drawn to understanding more deeply how group therapy and group experience bring about change that is initiated in the interpersonal context and impacts the neurobiological level. It makes sense to me that group has a unique capacity, through its interpersonal processes and emphasis on here-and-now experience, to support and promote neurobiological change, which then significantly impacts human emotional functioning at both the explicit and implicit levels. Or as Bonnie Badenoch, PhD, LMFT, and I put it in our book, *The Interpersonal Neurobiology of Group Therapy and Group Process*, "might it be possible that neuroscience, in particular interpersonal neurobiology, can illuminate the unique ways that group processes collaborate with and enhance the brain's natural developmental and repairing processes?" This commitment to fostering the integration of IPNB into group therapy has led me to edit not only our book but also a special issue of the *International Journal of Group Psychotherapy* on this topic in 2010.

AA: What do you expect to cover in your Special Institute?

SG: The Special Institute will be heavily experiential. We will use SCT's functional subgrouping to experience and explore the ways in which functional subgrouping builds emotional regulating systems that make it easier to explore the differences that every group encounters. Subgrouping makes it more likely that these differences can be integrated as resources rather than scapegoated and attacked.

AA: How has your thinking on this topic evolved over time?

SG: Fortunately, it is always evolving. Most recently in SCT, we have been focusing on the difference between the person system and personalizing. Personalizing is inherent in human experience particularly when a difference is 'too different.' Personalizing leads to reactivity and commonly to sympathetic arousal or dorsal vagal activation at the neurobiological level. In these states, little new learning or development can happen; we are much closer at these times to survival states. In contrast, activating the exploratory drive enables toleration of small differences in the context of enough similarity. This is the very process that functional subgrouping introduces: joining on similarity first so that we can open up to exploring and discovering the just tolerable differences.

SCT discriminates between the person system as the energy source for all groups and the member system which is oriented to the group's goals. This is always ongoing work in SCT groups; the process of functional subgrouping supports this discrimination.

In terms of integrating IPNB and SCT, my most recent focus has been on the ways in which functional subgrouping both becomes an emotional regulating mechanism for the group and for its members, and simultaneously develops the capacity for implicit emotional regulation in the members and, in turn, in their person systems.

AA: How do you feel that the learning will be relevant for participants? Will this be useful for people of all levels of experience?

SG: This Institute will give participants of all levels a chance to experience and experiment with SCT's functional subgrouping, in effect, trying it out to see what happens when a group uses this method. At its heart, SCT is very much devoted to action research, so testing out functional subgrouping and finding out how it impacts the group, its climate, and its members in terms of neurobiology will be the major focus. Participants will learn the basics of

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The Birth of Interactive Virtual Humans for Clinical Assessment and Intervention *An Interview with Albert Rizzo, PhD*

Paul Kaye, PhD, CGP, FAGPA, Annual Meeting Committee Co-Chair

Albert "Skip" Rizzo, PhD, is a Research Scientist at the University of Southern California Institute for Creative Technologies and conducts research on the design, development and evaluation of virtual reality systems targeting the areas of clinical assessment, treatment and rehabilitation. He will present the Mitchell Hochberg Memorial Public Education Event at AGPA's 2014 Annual Meeting.

PK: Could you describe how virtual reality (VR) technology has been used in clinical settings and provide several examples of the type of patient populations that have benefited from this modality of treatment?

AR: By its nature, VR applications can be designed to simulate naturalistic environments. Within these virtual environments, researchers and clinicians can present ecologically relevant stimuli embedded in a meaningful and familiar simulated context. VR simulation technology also offers the potential to create systematic human testing, training, and treatment environments that allow for the precise control of complex, immersive, dynamic 3D stimulus presentations, within which sophisticated interaction, behavioral tracking, user response, and performance recording is possible. When combining these assets within the context of functionally relevant, ecologically enhanced VR scenarios, a fundamental advancement emerges in how human assessment and intervention can be addressed in many clinical and research disciplines. VR-based testing, training, and treatment approaches that would be difficult, if not impossible, to deliver using traditional methods are now being developed to take advantage of the assets available with VR technology. There is an expanding group of researchers and clinicians who have recognized the potential impact of VR technology and have generated a significant research literature documenting the many clinical and research targets where VR can add value over traditional assessment and intervention.

A short list of areas where clinical VR has been usefully applied includes fear reduction in persons with specific phobias; treatment for PTSD; stress management in cancer patients; acute pain reduction during wound care and physical therapy with burn patients; body image disturbances in patients with eating disorders; navigation and spatial training in children and adults with motor impairments; functional skill training and motor rehabilitation with patients having central nervous system dysfunction (e.g., stroke, TBI, SCI, cerebral palsy, multiple sclerosis, etc.); and for the assessment and rehabilitation of attention, memory, spatial skills, and other cognitive functions in both clinical and unimpaired populations. To do this, VR scientists have constructed virtual airplanes, skyscrapers, spiders, battlefields, social settings, beaches, fantasy worlds, and the mundane (but highly relevant) functional environments of the schoolroom, office, home, street and supermarket. Emerging R&D is also producing artificially intelligent virtual human patients that are being used to train clinical skills to health professionals; and as anonymously accessible, online healthcare guides. VR has now emerged as a promising tool in many domains of clinical care and research.

PK: Could you briefly trace the training path that led to your expertise in the application of virtual reality technology in clinical treatment and training?

AR: I received my PhD in clinical psychology at the State University of New York at Binghamton, a program that is known for its rigorous scientist-practitioner model. I learned quite a bit about clinical research, and along the way I also became interested in neuropsychology, particularly cognitive rehabilitation with persons who have suffered some form of CNS dysfunction (traumatic brain injury, stroke, disease processes, etc.). After my internship, I wanted a break from the intensive research focus and to spend more time doing direct clinical practice. I took a position in a Traumatic Brain Injury (TBI) rehabilitation center and a few years later added some general private practice work. I did that for about nine years, pretty much casting a blind eye to research, but always with the feeling that someday I would come back to it when I found a set of problems that I wanted to study. I felt that the process of conducting good research required a devotion to a problem area that had to come from within. Otherwise, a research career struck me as a lot of passionless hard work that I likely would not be very good at. So I waited.

It was in the early 90s that the research light bulb started to go off. At the time, handheld Gameboys had emerged onto the digital landscape, and many of my younger TBI clients seemed obsessed with gaming. They were intensively focused on the task, played regularly, received instant performance feedback, and got much better at the games over time. I remember thinking that if only we could engage clients in the rehab process as intensively, then perhaps we could really make some progress. Serendipitously, at Christmas I was given a Nintendo 64 with the game SimCity, which is one of the most ultimate executive function exercises ever created, and after playing it to death myself, I brought it into the clinic for some of my clients to try. It was amazing to see that some of these young TBI clients, who had difficulty maintaining concentration on traditional cognitive rehabilitation tasks for more than 20 minutes, would now easily spend hours at a time exercising cognitive processes in the course of building cities within this video game simulation.

At the same time, virtual reality had popped into the public conciousness, and as I learned more about it, I found my clinical research passion activated again. The technology at the time, however, was costly and primitive, and I realized that it couldn't be successfully developed within a clinical setting without significant computer science resources. Moreover, a lot of people thought that clinical VR was a hairbrained idea. So, I wrote some conference papers on the concept of applying VR for TBI rehab and took a post-doctoral position within the University of Southern California's (USC) Alzheimer's Disease Research Center. That allowed me to translate my clinical neuropsychological skills from TBI to Alzheimer's disease, while collaborating with USC computer scientists to begin building a clinical VR research program. I was lucky to meet a few computer scientists who found the idea interesting, and we started a collaborative interdisciplinary research program that has evolved since 1996 into a comprehensive scientific effort. Over the years, I have had the opportunity to create VR systems that have addressed a wide spectrum of psychological, cognitive, and sensorimotor research questions and clinical targets. More recently, I had the opportunity to work with scientists on the cutting edge of computer science with the development of virtual human characters that I believe will have a significant impact on clinical science, training, and practice. I see my work as centrally focused on how we can create engaging user experiences with interactive and immersive digital technology to support a therapeutic process and to study how to do that more effectively, efficiently, and at the lowest possible cost.

PK: When did it become apparent that the use of virtual reality technology could be as effective, if not more so, than the use of imaginal processes in the treatment of phobic symptoms associated with PTSD?

AR: What attracted me in the first place to the use of VR in psychology and rehabilitation was my dissatisfaction with the state of the existing tools that were in common clinical use. Working as a clinician in the trenches for nine years prior to coming to academia, I saw firsthand the limitations that existed for assessment and treatment, whether it was based on paper and pencils tests, contrived rehabilitation exercise tasks, or if it relied exclusively upon the client's unknowable world of imagination, like what is used in CBT exposure therapy for anxiety disorders. In fact, prolonged exposure therapy is a clinical approach that most clearly illustrates what VR has to offer clinical practice and research. While the efficacy of imaginal exposure has been established in multiple studies with diverse trauma populations, many patients are unwilling or unable to effectively visualize the

traumatic event. In fact, avoidance of reminders of the trauma is inherent in PTSD and is one of the cardinal symptoms of the disorder.

Clinical researchers use VR to deliver exposure therapy (VRET) by immersing users in simulations of trauma-relevant environments in which the emotional intensity of the scenes can be precisely controlled by the clinician in collaboration with the patient's wishes. In this fashion, VRET offers a way to circumvent the natural avoidance tendency by directly delivering evocative, multi-sensory, and context-relevant cues that aid in the confrontation and processing of traumatic memories. VRET has documented success with persons with other anxiety disorders, such as specific phobias. These ideas have also been supported by three reports in which patients with PTSD were unresponsive to previous imaginal exposure treatments, but went on to respond successfully to VR exposure therapy. VRET used with service members with PTSD produced positive clinical outcomes in at least two open clinical trials, one small RCT and there are currently five randomized controlled trials in progress funded by the Department of Defense.

PK: Could you describe the Virtual Human Project and the use of the SimCoach?

AR: For over a decade, we have been building virtual humans (VHs) at the USC Institute for Creative Technologies (ICT). Ultimately, we want to be able to create virtual humans that look like real people, are autonomous, think to some degree on their own, and model and display emotions and interact in a fluid, natural way using verbal and non-verbal communication. It is already possible to build characters that realize parts of this vision—characters that can be practically incorporated into a variety of useful systems. Because they mimic the behavior of real people, virtual humans can add a rich social dimension to computer interactions that could be used to engage people in discussion and provide information on a specific topic, or as a means to support credible training of a range of social and occupational interaction skills. Such inherently human interactions can serve to increase user engagement and one's sense of connection to the virtual character. Studies repeatedly show that people respond to virtual humans in much the same way as they do to real people.

At ICT, with significant funding from the U.S. Army and the Department of Defense, we focused on creating VHs that could act as replacements for human role players in training and learning exercises (e.g., leadership training, negotiation tactics, cultural sensitivity, etc.). From this we developed virtual patients for clinical training purposes, including VH characters that included resistant teenagers, sexual assault victims, and military personnel with PTSD. We have now been funded to create an open access virtual patient toolkit that will allow clinical educators to author training and evaluation cases. The challenging part is to create software that a clinical expert could easily learn and use without needing computer programming skills. We aim to make the complex activity of authoring VH client dialog and behavior as easy as programming a good Powerpoint slideshow, and then grow a crowd-sourced library of well-vetted VH cases created by clinical experts that could be accessed online!

A second project, SimCoach, developed virtual human support agents to serve as online guides for promoting access to psychological healthcare information and for assisting military personnel, veterans, and family members—particularly those who might not otherwise seek help—in breaking down barriers to initiating care, including mental health support. The SimCoach goal is to motivate users to take the first step toward seeking information and advice with respect to their psychological health, traumatic brain injury, and addiction, all within a private discussion with a VH health guide. SimCoach characters are able to solicit anonymous background information about the user's history and clinical/psychosocial concerns, and with this information they can provide advice and support, direct the user to relevant online content, and potentially facilitate the process of seeking appropriate care with a live clinical provider. While much of the information provided by SimCoach is similar to what could be obtained from websites such as WebMD or AfterDeployment, the use of conversational interaction with a highly approachable virtual character allows us to create rapport, establish trust, and encourage people to find the help they need. The SimCoach virtual support agents do not deliver diagnosis or treatment, nor do they aim to replace human providers and experts, rather they provide people who may initially be hesitant to seek care with a live provider an accessible and anonymous way to engage in a dialogue about their mental health care concerns.

PK: What do you foresee as some of the future applications of VR including its use in the field of group psychotherapy?

AR: Group psychotherapy could benefit from the advances I have already enumerated. As the technology continues to improve giving us the ability to program increasingly complex interactions, training in group therapy processes could perhaps be delivered using a group of virtual patients that can interact with each other as well as with the therapist. New advances in VR creation tools could allow clients to author virtual worlds or interactions with virtual people of relevance to promote sharing of their personal experiences that could foster empathy or group cohesiveness.

Group therapy has already been conducted online in avatar-based virtual worlds like Second Life that can bring people together in a computer mediated setting in spite of the limits of geography or transportation. In this format, some of my colleagues have conducted substance abuse groups where clients can create and control a virtual avatar representation of themselves and drive the character to meet and interact with other avatar representations of real people in an online virtual clinic. These online virtual worlds have also been used to provide a gathering space for support group activities, as in the Asperger's oriented space on Second Life called Brigadoon and other virtual locations where people with various clinical health conditions (e.g., stroke, MS, HIV) can gather and interact together, albeit from the privacy of their own home.

One issue cited as a barrier for implementating computerized therapies is the potential impact on the sanctity of patient-therapist relationship. Joe Weizenbaum, an artificial intelligence (AI) researcher who wrote a language analysis program called ELIZA that was initially designed to imitate a Rogerian psychotherapist, concluded that it would be immoral to substitute a computer for human functions that "involves interpersonal respect, understanding, and love." Although supporters of clinical VR approaches are quick to point out that these applications are simply tools that extend the therapist's expertise or increase a client's access to care, there still exists a view in some clinical quarters that any technology serves to subvert the clinical relationship. The intensity of this debate will likely increase as more believable and autonomous AI virtual humans begin to populate VR applications. Perhaps some of the valid concerns and points brought up on both sides of this issue will be understood more clearly when good science and ethical practice come together to show both clinical benefit as well as areas where continued concern is warranted.

So far, rational minds have prevailed among clinical VR developers and clinicians, most of whom have approached this area with a measure of enthusiastic vision, good science and healthy skepticism. Thus, any rush to adopt VR should not disregard principles of evidence-based and ethical clinical practice. In the end, technology is really no more than a tool. There are practical clinical and ethical issues that will always need to be addressed thoughtfully during times of great technologic changes. We must modulate the tension between those yearning for the good old days of face-to-face talk therapy and those those who march to technologize every aspect of human life without regard to the unintended consequences that can occur with unbridalled technological advances, regardless of the nobility of the intent. On this front, I am optimistic that we will find the right balance to advance the care of those we serve. ●

Maximizing Group Psychotherapy Training

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supervisor. Also of importance, certification renewal is dependent on continuing education hours with content specific to group therapy.

All master's level (or above) clinicians who would be conducting group therapy were required to attend an intensive three-day training institute during which they participated in the required 12-hour group psychotherapy course and exam and specifically practiced leading the Agenda Group as developed by Irvin Yalom, MD, DLFAGPA, and Molyn Leszcz, MD, FRCPC, CGP, DFAGPA (2005). CHP selected the Agenda Group format for a number of reasons. First, the structured process of the group decreases the anxiety level of patients who are seriously mentally ill; second, the structure allows therapists of all levels of professional experience to learn effective short-term group intervention easily; and third, the model is resilient to the reality of very short-term lengths of stay and a constantly changing and diagnostically heterogeneous membership constellation.

Additionally, behavioral health unit directors and managers were prepared to administer the Lambert Outcome Questionnaire-30.2 as an overall measure of treatment program outcome. The Lambert OQ-30.2 is an easy-to-use, validated self-report measure, which is approachable to many patients with a limited reading capacity, and places limited demands on an already taxed staff. Baseline measures were collated prior to the implementation of a comprehensive therapeutic program that included psychotherapy groups, psycho-educational groups, occupational therapy groups, and other activities groups. Because multiple group modalities were introduced at once, it was not possible to isolate the specific effect that the Agenda Group played on treatment effectiveness. Aggregated comparative data pre-intervention and post-intervention will be analyzed in a year's time. Meanwhile, once therapists have become sufficiently comfortable and adept with leading the Agenda Group, further research will be proposed to measure the effectiveness of the Agenda Group alone.

The 12-hour course was videotaped and made available on the CHP intranet for future staff members to prepare for certification. The exam will be retained in the corporate office and administered electronically when staff members have completed the course. To overcome the distance barrier, each acute care site was provided an iPad to transmit group therapy sessions to the supervisor for live consultation. Face-to-face meetings through the iPads obviates the need for time spent commuting to various sites. It also supports the development of an adult learning community that supports therapists as they work in a demanding and challenging environment.

Group supervision was conducted with therapists participating from across the system's seven regions. Weekly supervision and consultation was thus possible using face-to-face groups with practitioners able to view and critique one another's work and gain insights from the Certified Group Psychotherapist conducting the supervision.

To capitalize on peer support and opportunities for shared learning, a standard daily schedule was developed and followed across all acute behavioral health facilities. A similar standard daily schedule is being developed for the partial hospitalization and intensive outpatient programs. This allows therapists across multiple sites to observe one another's work and have set times for peer consultation. Further, this process provides therapists a reflective space to evaluate their work and facilitate comfort with transparency with colleagues. Drawing further on the therapists' expertise and best practices, a standardized manual, including content and delivery of psychoeducation groups, is being developed.

Our major goal for 2013 focused on the implementation of a quality, group-based acute care treatment model led by trained and Certified Group Psychotherapists. During 2013, clinicians working in post-acute care programs were prepared to deliver appropriate group treatment, with training in cognitive group therapy, interpersonal group therapy, and dialectical behavioral group therapy. The full implementation of group treatment in post-acute care is envisioned by 2014. Concurrently, an effort is underway to prepare behavioral health practitioners to work within primary care practices based on contemporary collaborative care model research. If headway is made with third-party payers, this model will be greatly enhanced through group modalities.

Metrics and Anecdotal Support

To support the case for funding group treatments by public and private insurers, various metrics are being employed to assess the effectiveness of group-based psychotherapeutic treatment. In the acute setting and in the partial hospitalization programs, the two measures used to measure patient satisfaction and treatment outcome are the Press-Ganey Patient Satisfaction measures and the Lambert OQ-30.2 (2005). Scores gathered pre-group program intensification serve as a baseline against which to measure success. Additionally, two measures of staff job satisfaction, pre- and post-group program intensification have been initiated: the Gallup Survey and the Maslach Burnout Inventory for mental health workers (1996). At this time, it is premature to examine the effect a solid, group therapy based focus is having on the patients and on the staff.

There have been numerous comments made by patients and clinicians expressing how much they appreciate the opportunity to engage in meaningful treatment. Patients' comments attest to feeling not alone; feeling supported and mutually helpful; discovering that group therapy worked; and hoping they could continue progressing after they left the acute unit. Therapists' comments focused on observations: that they were finally able to engage in the work they were trained to do; that administrative leadership was making it possible for them to deliver the kind of care that caused them to want to enter the field initially; and that they felt valued valued as clinicians and not simply as custodial care-providers. Many staff acknowledged they felt eager to come to work and that they were finding their work more meaningful.

Moving beyond acute care and partial hospitalization programs, further inroads toward improving the behavioral dimension of population health are being initiated as behavioral health clinicians become collaborators in primary care physician practices across the health system. Such opportunities to enhance the health of our communities are richly supported through the provision of group treatment. Group therapists provide leadership in wellness groups directed toward smoking cessation, health management, weight management, grief support, mild depressive conditions, and many more. Measures are currently being investigated that will provide treatment outcome information for these groups.

Conclusions

While the hard data on the effect of this transformation initiative have yet to be collected and analyzed, we have learned that it is possible to overcome barriers to training practitioners and implementing a quality group psychotherapy treatment program across a large geographic area with a paucity of Certified Group Psychotherapists. As a larger cadre of certified clinicians becomes available, a significant portion of peer supervision and consultation will be obtained at the various sites. In the meantime, the journey toward population health through the use of group intervention can begin with a healthy dose of creativity and with the commitment and passion of groups of therapists who believe in the incredible power of the group therapy to heal. ●

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Consultation, Please

Dear Consultant:

I have been leading a mixed-gender group for four years. There has been relatively little turnover in membership, and until recently, all five members of the original group remained. There are now eight members in the group, and one of the original members is set to leave the group at the end of next month. Joanne has been a beloved member of the group, and her departure has been a difficult but rewarding process for the group and for me as the leader. How long should I wait before I bring a new member into the group? I don't know whether to bring in someone else right away, or wait a while until the group has had a chance to absorb and process Joanne's leaving. I wonder what is an appropriate amount of time to wait?

Sincerely,
Stumped

Dear Stumped:

It sounds like you have built a cohesive group, and that is wonderful. A few thoughts come to mind with regard to timing the transitioning of specific group members. First, I would suggest that you be attentive to differentiating your own needs and feelings from that of the other group members. In terms of working through your own feelings related to the departing group member, I suggest that you discuss these with a trusted mentor, supervisor, or your own therapist. If you would be comfortable working with a smaller group for an extended period of time, for example, then there is less of an urgency to add a new group member. If having a full group is important to you, then you might want to expedite the process of birthing a new group member.

It might be helpful to give the group a month after the departure of the long-time group member to work though feelings associated with this change. Depending upon how democratic you want the decision-making process to be, you might want to include the remaining group members in a discussion about when to bring in someone new. However, once the decision is made, allow three to four weeks between when you notify the group about the new group member and his/her actual start date. This will allow time for the group to assimilate the information in anticipation of welcoming the new group member.

Groups, even long-term cohesive groups such as yours, are transitory in nature. The departure of a beloved long-time member offers an opportunity for the group to work through issues related to growth and change, as well as loss. Obviously, these are highly transferrable phenomena, so please keep in mind that this event in the group's life offers a rich opportunity for personal growth for the remaining group members. Most importantly, there are no hard and fast rules about timing this transition. Trust your instincts and embrace the shift as a great opportunity.

Barney Straus, LCSW, CGP
Chicago, Illinois

Dear Stumped:

There is no rule that dictates the appropriate amount of time to introduce a new member after a long-time member has departed, however, there are a few factors to be considered. Your group is four years in existence, 50% of the remaining members have been there since its beginning, and you report that the group has been capable of processing its feelings about the member's departure. All of this bodes well for the introduction of a new member. A mature, well-functioning group such as yours should be able to welcome a new member when you, as the leader, are ready to do so.

A group is like a family, and the leader is its symbolic parent. Any attentive parent prepares a family for a new arrival. The fact that you are anxious about the timing of the introduction not only indicates how much you want to do the right thing for your group family, but it also makes me wonder if some of your concern is induced by the group. Are the members wondering if you will do the right thing? Getting them to talk about their anxiety in the group may relieve you of yours. When you feel ready, the time is right, and that could be sooner rather than later.

To help the group talk about a new arrival, you could employ a prognostic intervention. After announcing that you are thinking about or planning to introduce a new member (your choice of words), you might ask how the group is planning to make the member feel welcome or unwelcome. By suggesting that someone in the group might want to make the new member feel unwelcome, you are giving them permission to have all their feelings—pleasant and unpleasant—about the anticipated arrival. It will be interesting to watch how group members who were the oldest of their siblings in their families of origin react to your invitation to talk about an addition to the family. Most importantly, continue to enjoy your group.

Jacqueline Fish, LCSW, CASAC, CGP
New York, New York

Members are invited to contact Michael Hegener, MA, LCP, CGP, FAGPA, the Editor of the Consultation, Please column, about issues and/or questions that arise in your group psychotherapy practices. They will be presented anonymously, as in the question here, and two members of AGPA will be asked to respond to your dilemma. In this way, we all benefit from members' consultation from an objective point of view. SIG members are also encouraged to send cases that pertain to your particular field of interest. Michael can be reached by fax at 512-524-1852 or e-mail at mhegener@sbcglobal.net.

Functional Subgrouping and Its Neurobiology

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functional subgrouping, how subgrouping changes as a group develops from early phases to later phases, and how subgrouping impacts neurobiological processing in each phase of system development.

Functional subgrouping has been integrated and adapted to a variety of groups and can be used whenever there is group conflict to lower the potential of scapegoating. Learning to use functional subgrouping will make it possible for participants to enable their groups to explore differences and use them as resources rather than ammunition for fighting.

AA: What advice can you offer participants for getting the most out of this experience with you?

SG: Come with your curiosity and willingness to explore and experiment and, as much as you can, place your preconceptions and what you already know to the side so that you can be open to whatever we discover together before you integrate it with what you already know. ●

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The Group Circle

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See *Group Assets* insert

Affiliate Society News

Visit AGPA's website at www.agpa.org/mtgs/affiliatemtgs.html for updated Affiliate Society meeting information. For space considerations, events announced in previous issues are included in *Group Connections.*

The **Eastern Group Psychotherapy Society** (EGPS) Fall Conference—*Out of the Comfort Zone: Taking Risks and Embracing Turbulence in Groups*—to be held November 22–23, features Earl Hopper, PhD, CGP, FAGPA, as the plenary speaker. Sherry Breslau, PhD, CGP, and Hilary Levine, PhD, CGP, are Co-Chairs of the Conference. Earlier this summer, EGPS celebrated the many contributions of members Chera Finnis, PsyD, CGP, FAGPA, Bernard Frankel, PhD, LCSW, ABPP, LFAGPA, and Lena Furgeri, EdD, CGP, LFAGPA.

The **Houston Group Psychotherapy Society** sponsored two recent programs—a brown bag session on *Boundary Considerations in Group Therapy*, presented by Victoria Jones, MEd, MA, LPC; Michele Lees, MA, BC-DMT, LPC; and Richard Newman, MEd, CGP, FAGPA; and a joint dinner meeting with the Houston Psychiatric Society on *Why Group Therapy?*, presented by Patricia Barth, PhD, CGP, DLFAGPA; Aaron Fink, MD, CGP, FAGPA; Cindy Hearne, PhD, CGP; Elizabeth Knight, MSW, CGP, DFAGPA; Carol Vaughan, LCSW, CGP, LFAGPA; and Robert White, MD, CGP, LFAGPA.

The **Mid-Atlantic Group Psychotherapy Society's** Fall 2013 Conference—*Interplay Between Envy, Competition, and Shame: Its Impact on Intimacy in Groups*—featured guest presenter Steven Van Wagoner, PhD, CGP, FAGPA, Editor of *The Group Circle*. Through the leader's containment of these powerful experiences and modeling, participants identify and analyze various ways of constructing intimacy, as well as verbalize passionately held feelings of envy, rejection, and perceived loss of power as a way of neutralizing its destructive potential.

The **Puget Sound Group Psychotherapy Network** (PSGPN) is working with the theme of *Building the Culture of Engagement* with a commitment to expanding its membership through educational opportunities for current members and recruitment and nurturing the next generation of group therapists. PSGPN elected two new board members—Tom Buffington, MA, LMHCA as Secretary, and Beth Shields, MA, LMHC, as President. Paul Berkelhammer, MA, LMHC, CGP, continues as Treasurer and Robert Berley, PhD, CGP, FAGPA, serves as Past President. Two new committees were created—the Membership Committee and Program Committee. PSGPN sponsored *How to Construct a Group in Private Practice* with Elana Clark-Faler, LCSW, CGP.

The **Westchester Group Psychotherapy Society** hosted two workshops this fall. Elisabeth Mayer-Riekh presented *Mindfulness-Based Stress Reduction Within a Group Setting*, focusing on specific mindfulness practices designed to support self-regulation and to calm the anxious mind. Gregory MacColl, LCSW, CGP, FAGPA, presented *A Group Therapist's Countertransference: Hindrance or Aide in Resolving Group Resistance*.

Please note: Affiliate Societies may submit news and updates on their activities to Kathy Reedy, MSW, MFT, BCD, CADC, CGP, Editor of the Affiliate Society News column, by e-mail to: Kreedy57@gmail.com.

President

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Additionally, the Task Force, with the help of Co-Chair Cecil Rice, PhD, CGP, DLFAGPA, and the Northeastern Society for Group Psychotherapy's Disaster Response Committee, is building on the Distance Learning event held last spring related to the effects of the Boston Marathon bombings by planning a series of four events over the next six months for therapists in the greater Boston area who have been treating patients affected by the bombings and, perhaps, experiencing aftereffects themselves. The final event will coincide with the first anniversary of the bombings next spring. We plan to involve some local organizations in the presentations.

Jeffrey Kleinberg, PhD, CGP, FAGPA, Marsha Block, and I took AGPA abroad by attending the International Standards Committee meeting in Lake Iseo, Italy, in late August. Each program and organization brought its own particular history and culture about training and certification, making our task challenging. In this fourth meeting of the group, however, we agreed on shared goals and are developing a process to find areas of commonality in each other's programs related to credentials, so we can develop some collaboration regarding training.

Here at home, we are pleased to report that we have received an increased number of requests for customized training this year. AGPA has completed a year–long training at the Debakey Veterans Medical Center in Houston and is now consulting for them. We also completed a one-day training for the Georgia Department of Mental Health, and are considering other training requests. We encourage members with contacts in agency settings to connect AGPA with those who make the agency's training decisions. We can bring the 12-hour Principles of Group Psychotherapy course, other curricula, training groups and/or consultation to the agency to support its group program and staff, and ultimately serve as a resource to improve the group services offered. We need your help to make these contacts.

The Annual Meeting program is now completed and up on the website. As always, I am amazed at the wide array and depth of offerings our Annual Meeting Committee has developed. There are tantalizing programs for everyone, encompassing varied theoretical orientations and applications of group treatment. This year's Special Institute (*The Body Keeps Score: Integration of Mind, Brain, and Body in the Treatment of Trauma*), to be led by Bessel van der Kolk, MD, will be live-streamed to those who cannot be at the meeting in person. The video also will be available at a later date for training and consultation.

I look forward to seeing you all in Boston. ●