

The Group Circle

Winter 2014

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

Social Connectedness as a Biological Imperative: A Polyvagal Perspective *An Interview with Stephen Porges, PhD*

Hank Fallon, PhD, CGP, FAGPA, Co-Chair, Annual Meeting Committee

Editor's note: Stephen Porges, PhD, will deliver the Opening Plenary Address on March 6 at AGPA's Annual Meeting. Dr. Porges is Professor of Psychiatry at the University of North Carolina and Professor Emeriti at the University of Illinois at Chicago, where he directed the Brain-Body Center and the University of Maryland, where he chaired the Department of Human Development. He is the former President of the Federation of Behavioral, Psychological and Cognitive Sciences and the Society for Psychophysiological Research. A Fellow of Division 6 and 7 of the American Psychological Association and a Charter Fellow of the Association for Psychological Science, he is a former recipient of a Research Scientist Development Award from the National Institute of Mental Health. In 1994, he proposed the Polyvagal Theory, which links the evolution of the vertebrate autonomic nervous system to the emergence of social behavior. The theory provides insights into the mechanisms mediating symptoms observed in several behavioral, psychiatric, and physical disorders. Professor Porges has authored The Polyvagal Theory: Neurophysiological Foundations of Emotions, Attachment, Communication, and Self-Regulation (Norton, 2011). His book Clinical Applications of the Polyvagal Theory: The Transformative Power of Feeling Safe is scheduled for publication this year.

HF: How did you first become interested in psychophysiological research?

SP: I was always curious about what was going on behind a person's smile, behind his overt behavior. Even in high school, I observed faces. Adolescence was an interesting period. When I was growing up, I recall trying to interpret other people's cues. I was an intuitive psychophysiologicalist before I knew it was a scientific area. I was curious about how one can use facial, behavioral, and physiological indicators of intentionality to understand the behavior of people.

HF: So you were curious from the very beginning.

SP: I was interested in psychophysiology as a strategy to function as an unbiased observer. I stumbled onto the notion that physiological state was a very important mediator of how we behaved and interacted with other people.

HF: Can you provide a brief overview of your Polyvagal Theory of the tenth cranial nerve to orient our readers?*

SP: The Polyvagal Theory proposes that the evolution of

the mammalian autonomic nervous system provides the neurophysiological substrates for the emotional experiences and affective processes that are major components of social behavior. According to the Polyvagal Theory, the well-documented phylogenetic shift in neural regulation of the autonomic nervous system passes through three global stages, each with an associated behavioral strategy.

The first stage is characterized by a primitive unmyelinated visceral vagus that fosters digestion and responds to threat by depressing metabolic activity. Behaviorally, the first stage is associated with immobilization behaviors.

The second stage is characterized by the sympathetic nervous system that is capable of increasing metabolic output and inhibiting the visceral vagus to foster mobilization behaviors necessary for fight or flight.

The third stage, unique to mammals, is characterized by a myelinated vagus that can rapidly regulate cardiac output to foster engagement and disengagement with the environment.

The mammalian vagus is neuroanatomically linked to the cranial nerves that regulate social engagement via facial expression and vocalization. As the autonomic nervous system changed through the process of evolution, so did the interplay between the autonomic nervous system and the other physiological systems that respond to stress, including the cortex, the hypothalamic-pituitary-adrenal axis, the neuropeptides of oxytocin and vasopressin, and the immune system.

The theory proposes that physiological state limits the range of behavior and psychological experience. In this context, the evolution of the nervous system determines the range of emotional expression, quality of communication, and the ability to regulate bodily and behavioral state. The Polyvagal Theory links the evolution of the autonomic nervous system to affective experience, emotional expression, facial gestures, vocal communication, and contingent social behavior. Thus, the theory provides a plausible explanation of several social, emotional and communication behaviors and disorders. From this phylogenetic orientation, the Polyvagal Theory proposes a biological basis for social behavior and an intervention strategy to enhance positive social behavior.

HF: Was your early research with neonates and respiratory sinus arrhythmia (RSA) very applied?



From the President

Kathleen Ulman, PhD, CGP, FAGPA

The return to my regular routine after the holidays is always a signal to me that the AGPA Annual Meeting is not far off, and that soon I will be together with



colleagues and friends learning new ideas about group psychotherapy and in meetings tending to the business of the organization and planning for the future. The Annual Meeting Committee and the staff have been working on the details since last spring in order to prepare the best possible meeting for us. However, after January 1 the pace picked up for us all, and Annual Meeting preparations began to take precedence over everything else! This energy is catching as the tempo ramps up in the AGPA office, and I feel the anticipation and excitement of things to come.

I am particularly pleased this year to be welcoming you to my hometown of Boston with a strong program that has both depth and breadth. There will be something interesting and challenging for everyone. In addition, after the institutes and workshops are finished, Boston offers museums, theater, universities, history, and great restaurants. The Local Hosting Task Force has been hard at work for the past six months planning ways to welcome you and make your stay in Boston enjoyable. This will be a Conference not to be missed.

In the past few months, our focus has been completing our revamped website. It is a beauty. Many thanks to those in governance who have participated in this effort and our CEO Marsha Block, CAE, CFRE and the staff who have coordinated every facet of the site's construction. Under Marsha's careful coordination and invitation, it truly has been a village delivering this tremendous member benefit. By the time you get this newsletter, you will have had access to the new website and, I am sure, admired its clarity, resources, good looks, and user friendliness. It has been a long, but pro-

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Editor

Steven Van Wagoner, PhD, CGP, FAGPA

Editorial Staff

Hank Fallon, PhD, CGP, FAGPA
Michael Hegener, MA, LCP, FAGPA
Kathy Reedy, MSW, MFT, BCD, CADC, CGP

Managing Editor

Marsha Block, CAE, CFRE

Editorial/Production Managers

Nicole Millman-Falk, CAE
Angela Stephens, CAE

AGPA

25 East 21st Street, 6th floor
New York, NY 10010
phone: 212-477-2677
toll-free: 877-668-AGPA
fax: 212-979-6627

e-mail: info@agpa.org

www.agpa.org

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President

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ductive process.

In spite of the time devoted to the website, many other things were accomplished at AGPA this fall. Several Affiliate Societies in collaboration with the Group Foundation and AGPA held events for local members and supporters. The Austin GPS held a workshop led by Philip Flores, PhD, ABPP, CGP, LFAGPA, and a reception at which Lisa Mahon, PhD, CGP, FAGPA, Chair of the Group Foundation, spoke. Houston held a very successful wine tasting. Kathleen Ulman, PhD, CGP, FAGPA, and Jeffrey Hudson, MEd, LPC, CGP, FAGPA, attended the GPALA Society's annual member reception in Los Angeles. As part of the preparation for the Annual Meeting in Boston, AGPA and NSGP held a Museum Walk organized by Lise

From the Editor

Steven Van Wagoner, PhD, CGP, FAGPA

The countdown to the Annual Meeting is well underway. In this issue, we have three interviews from our major presenters to complete a taste of what's in store for you in Boston. Eleanor Counselman, EdD, CGP, LFAGPA, takes you on a voyage with Institute Opening Plenary Speaker Cecil Rice, PhD, CGP, DFAGPA, who makes connections between his own personal and professional journey and that of a member of a therapy group. Hank Fallon, PhD, CGP, FAGPA, distills Stephen Porges', PhD, Polyvagal Theory into an understandable narrative, and together they explore its clinical applications to

IBCGP Recognizes Outstanding Training: The Harold S. Bernard Group Psychotherapy Training Award

The International Board for Certification of Group Psychotherapists (IBCGP) will present Donna Markham OP, PhD, ABPP, CGP with the Harold S. Bernard Group Psychotherapy Training Award for 2014. This award was established in 2001 and is given annually to an individual or organization whose work in group training and/or education contributes to excellence in the practice of group psychotherapy.

It was renamed last year through a legacy gift provided to the Group Foundation for Advancing Mental Health by Dr. Bernard's estate for the purpose of endowing the award. Throughout his lifetime, training in group psychotherapy was near and dear to Dr. Bernard's heart. His legacy bequest and this award insure that individuals and programs meeting a high standard of training quality be identified and honored for their contributions to the field in developing the next generation of clinicians who use group psychotherapy to help people. All are invited to attend.

Motherwell, PhD, PsyD, CGP, FAGPA, in my honor.

To celebrate its 30th anniversary, the Group Foundation had a retreat for the Board and donors in Santa Fe, New Mexico. A fund-raising consultant who worked with the group received rave reviews and will return to work with the Group Foundation going forward. Away from the demands of home and work, the group was able to relax and to concentrate creating a compelling story about all that our organizations have to offer.

It is hard for me to believe that this is my last newsletter column. My time as President has been rewarding and exhilarating. The accomplishments have been made possible by the support and diligence of those in governance who have worked side by side with me. I want to express much appre-

individual and group psychotherapy. You will want to hear Dr. Porges' Conference Opening Plenary Address as he unpacks the complexities of neurophysiological research as applied to clinical practice. Finally, Special Institute presenter Bessel van der Kolk, MD, in his interview with Martha Gilmore, PhD, CGP, FAGPA, gives us a glimpse into how neuroscience is sharpening our understanding of how the brain regulates emotional experience, and how people with traumatic experiences benefit from body oriented practices (e.g. yoga, theater, EMDR), which help to create associative practices that allow patients to locate and tolerate traumatic experiences that have been locked up and contribute to deregulated emotional states.

I have included two memorial testimonies for the passing of Saul Tuttman, MD, PhD, CGP, DFAGPA, AGPA President from 1994-96, one from his

colleague Leonard Horwitz, PhD, CGP, DFAGPA, and one from Alice Byrne, LCSW, CGP, FAGPA, who speaks about his mentorship to her. It is also sad to learn that Fern Cramer-Azima, PhD, DLFAGPA, passed away in December, as did Irene Harwood, PsyD, MFT, MSW, CGP, LFAGPA. Both will be memorialized in the next issue of *The Group Circle*. It is always a poignant tribute to publish these pieces from people in whom these valuable colleagues and mentors reside, and we usually do not benefit from two different perspectives.

I would like to invite you to submit your articles for the spring issue. In particular, I would like to challenge new members, students, scholarship recipients, or new professionals to submit an article on a topic of interest, or perhaps your first experience at an AGPA Annual Meeting. While I cannot publish them all, I would love to provide a space for your written voice to find expression. Call or write me with your ideas.

AGPA Elects New Officers and Directors

Jeffrey Kleinberg, PhD, CGP, FAGPA, Chair, Nominating Committee

I am pleased to announce the 2014 AGPA Election results for the Officers, Board Members and Nominating Committee Members. I would like to take this opportunity to thank all the candidates who were willing to step forward and be part of the election process that shapes the future of the AGPA. It is a big contribution to building leadership in AGPA, and this year's slate was a strong and vital one. Congratulations to our newly elected candidates.

Officers

President-Elect: Eleanor Counselman, EdD, CGP, LFAGPA
Treasurer: Lise Motherwell, PhD, PsyD, CGP, FAGPA
Secretary: Anne McEaney, PhD, CGP, FAGPA

Board of Directors

Robert Hsiung, MD
Paul Kaye, PhD, CGP, FAGPA
Nancy Kelly, PhD, MSSW, CGP
Farooq Mohyuddin, MD, CGP
Dayne Narretta, MSW, LCSW, BCD, CGP
Darryl Pure, PhD, ABPP, FAGPA

Board of Directors Affiliate Society Representatives

(elected by Affiliate Assembly)
Chair-Elect: Mary Krueger, LCPC, CGP
Member-at-Large: Paul Berkelhammer, MA, LMHC, CGP

Nominating Committee

Elected Board Members
Francis Kaklauskas, PsyD, CGP, FAGPA
Suzanne Phillips, PsyD, ABPP, CGP, FAGPA

General Membership
Mary Dluhy, MSW, CGP, FAGPA
David Hawkins, MD, CGP, DLFAGPA

ciation to the Executive Committee—Les Greene, PhD, CGP, LFAGPA, Anne McEaney, PhD, CGP, FAGPA, Lise Motherwell, PhD, PsyD, CGP, FAGPA, Katie Griffin, MA, LPC, CGP, Lisa Mahon, PhD, CGP, FAGPA, and Sherrie Smith, LCSW-R, CGP, FAGPA—for their consistent presence, the thoughtfulness they have brought to the business at hand and for their openness to forming a well-functioning work group. I also want to thank the Board members for their conscientious participation in the Board meetings and the work of the organization. The wider perspective they bring to the tasks before us is invaluable. Additional thanks go to the Committee and Task Force Chairs and the Special Interest Group Chairs for their contributions to the workings of AGPA. The work of these groups is essential to the vitality of the organi-

zation, and it goes on all year largely unnoticed by the membership. Many thanks to Lisa Mahon, Chair of the Group Foundation for Advancing Mental Health, and Sherrie Smith, Chair of the International Board for Certification of Group Psychotherapists, for their assistance in making the work of all three Boards go smoothly.

In particular, I want to thank Marsha Block, Angela Stephens, Diane Feirman, Leah Penny, Helen Li, and Katarina Lizon for their extraordinary dedication to AGPA. They are always there with their expertise and a warm pleasant response. They are magicians who have done the job of at least 10 people and made the office and organization run seamlessly all the while appearing as if there is no strain.

I look forward to seeing you all in Boston in March.

The Body Keeps the Score: Integration of Mind, Brain, and Body in the Treatment of Trauma

An Interview with Bessel van der Kolk, MD, Special Institute Presenter

Martha Gilmore, PhD, CGP, FAGPA, Annual Meeting Committee Co-Chair Designate



Editor's note: Bessel van der Kolk, MD, has been the Medical Director of The Trauma Center in Boston for the past 30 years. He is a Professor of Psychiatry at Boston University Medical School and serves as the Director of the National Center for Child Traumatic Stress Complex Trauma Network. He is past President of the International Society for Traumatic Stress Studies. Though he identifies himself primarily as a clinician, he has published well over 100 peer reviewed scientific articles on various aspects of trauma, including his current projects: yoga for treating PTSD, funded by the National Institutes of Health; the use of theater for violence prevention in the Boston public schools, funded by the CDC; the mechanisms of EMDR; sensory integration; and the use of neurofeedback in PTSD. Dr. van der Kolk participated in the first neuroimaging study of PTSD, which was also the first study to link Borderline Personality Disorder with childhood trauma; was co-principal investigator of the DSM IV Field Trial for PTSD, and is Chair of the NCTSN DSM V Workgroup on Developmental Trauma Disorder. He has written extensively about using neuroscience research to identify appropriate treatments for PTSD and completed the first NIMH-funded study of EMDR. He has taught at universities and hospitals around the world.

MG: What do you consider the most significant changes in the treatment of trauma in the last decade?

BvdK: The biggest thing is EMDR (Eye Movement Desensitization and Reprocessing) developed by Francine Shapiro, PhD, which allows us to do things we could never do before like process traumatic memories. EMDR is a very strange technique that allows for an associative process to take place in the brain. What ordinarily happens is that people get stuck in trauma; it doesn't move through time; almost as if something is actually preventing the process so the brain can no longer update itself. EMDR and other later techniques are associative processes, which provide ways of putting the mind into a trancelike state where things that are in a fixed and locked position can be opened up again.

MG: How have EMDR and other techniques influenced your practice in the treatment of trauma?

BvdK: It really showed the importance of creating associative processes. One way it's affected my practice is that now I can cure my patients, which is great! Not all of them, but many can be helped very dramatically. It's also opened up my mind to other methods, techniques, and investigations into the brain.

I think many people that know trauma intimately; they know that trauma itself is a dissociative process. The traumatic imprints don't get associated within the mind and brain. The images, body sensations, thoughts, and feelings that lead to the past get stuck and don't get updated or integrated with newer information. EMDR is one method to help people to create their own associative process. Apparently tapping, neurofeedback, and hypnosis can do the same thing. Dreams also can unstick it, but the problem is that oftentimes with traumatic stress you'll wake yourself after the dream so that the natural healing process of the dream cannot be utilized.

MG: How has the influence of neuroscience research on the treatment of trauma contributed to your understanding of the importance of these new techniques?

BvdK: In the last 10 years, we have learned that, after trauma, certain parts of the brain that have to do with filtering out irrelevant information get messed up, giving that material too much value.

Trauma disturbs the normal secretion of stress hormones and disrupts the process by which people try to down-regulate their sensitivity. In an attempt to deal with recurrent intrusive images, people try to shut down their experience of themselves and their internal world. As a result, we can look for ways for patients to safely increase bodily awareness without becoming overwhelmed. That legitimizes any number of body-oriented therapies like what Peter Levine does in somatic experiencing or Pat Ogden's sensorimotor therapy. I have found that yoga has been very important. Our NIMH-funded studies on how the brain changes through yoga found that the traumatized people who study yoga benefit from it as much as they can from any medication or any cognitive therapy that exists right now.

MG: Is there evidence that some of the mindfulness practices have a similar effect?

BvdK: Mindfulness is at the foundation of everything. You cannot change your life without becoming mindful. The difficulty with people who are traumatized is that both the brain areas that are involved in mindfulness often become quite dysfunctional, so the cultivation of mindfulness with traumatized people requires special attention.

MG: Are people taking the research on EMDR and yoga and other techniques seriously, or are they skeptical?

BvdK: There's no question that if facts matter, clinical practice will shift in the direction of more body-oriented treatments and more facilitation of associative processes. But facts oftentimes don't matter because most people are more religious than they are fact-based. What I have observed is that people learn a particular orientation and then become very invested in that particular orientation, even when it might not help. Our job is to get our patients better, so sometimes our religious/ideological/professional orientation gets in the way of facing facts.

MG: It seems to me that people within AGPA predominantly are doing talk therapy in groups with only a few using any kind of body-oriented or action techniques. There is certainly live practice using emotional communication in groups but it is talking practice, not movement.

BvdK: I have some very serious doubts about

whether you can get there by understanding and talking. Neuroscience research doesn't support that the areas of the brain involved in insight and understanding have much connection with areas where emotions are generated and stored. We can understand why we feel so bad or why we do the crazy things that we do, but understanding doesn't change our feelings. In order to change our feelings we have to do other things, and those other things tend to be more experiential.

MG: I see group therapy as quite experiential even in terms of rewiring the brain, since people are doing different things and relating in different ways, but for most practitioners one still sits in the chair even if there is an emphasis on the sensory aspects of the body.

BvdK: I'm also stuck in the paradigm that I was raised in. I still sit in the chair. I'm much more hypnotic than I used to be; much more body-focused than I used to be; much more interoceptive than before. But I'm still immobilized sitting in my chair, and if you really take everything we've learned about the brain seriously you might not necessarily want to do that. For example, I'm very interested in the role of theater, from both a personal and a research perspective. In theater people assume different roles and feel those roles very deeply. Switching between different roles can help people open up to new possibilities. But all of us who were educated to sit in the chair and talk to people tend not to do that sort of thing. I am learning from theater directors how to help people be emotionally in a role.

MG: How do you weave these techniques into an ongoing therapy? How do you view the therapeutic relationship?

BvdK: You cannot be a human being without a relationship. Our brain is wired for relationships. My big beef with our diagnostic systems, both the DSM system and the new NIMH research foci, is that there's no room for relationships. We are relational creatures; every form of mental illness is a relational illness. Trauma also is a relational disturbance. It causes you to not be tuned into others, to be preoccupied with things other than the people around you, and to not get comforted by the people around you. At the AGPA Annual Meeting, I'll be talking about

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The Body Keeps Score

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neuroscience research—mine and others—which shows that you can actually rewire the brain so it becomes more focused and attentive and less dissociative.

MG: Forming a therapeutic relationship might take an extended period of time with someone traumatized. Do you advocate a stage-related treatment, where safety and the relationship are addressed first?

BvdK: Not anymore. You are always doing trauma processing from the beginning because trauma is always in the room, and you always work with safety simultaneously. The thing that I learned while treating people with dissociative disorders with neurofeedback is that people cannot have a relationship as long as they are dissociated. We need to ask ourselves as clinicians, “Is this person, in his current state, capable of relaxing enough to trust and see another person?” We need to find a way of calming peoples’ brains enough so they can start noticing what’s going on interpersonally between themselves and the people around them. There’s a videotape I hope to show at the AGPA Annual Meeting of therapy with a homeless person who has DID. She had a terrific therapist who started doing neurofeedback to calm and organize her brain. The patient said when her brain became organized she could actually begin to see who that person was sitting in the room with her.

MG: Are you saying the brain must be calmed down enough to really participate in the therapy?

BvdK: Yes. The core clinical goal is self-regulation. Life is all about learning to become a regulated creature, and trauma is about becoming dysregulated. Treatment is all about finding ways to regulate people. That’s why it’s important to get away from ideological attitudes and ask “What the hell can I learn in order to help this person to calm down?” There are many ways of doing this, but very few of these have a long-standing Western tradition. There’s a much longer tradition of focusing on self-regulatory techniques in China, India, and Japan than in European-derived cultures, which mainly rely on yakking and alcohol to calm down or regulate. With globalization, we are learning about other cultures where traditions are focused on moving the body and focusing on one’s breathing, and really engaging with other people in Karate and other interesting things that foster the executive system.

MG: How can group psychotherapy be helpful in the recovery from trauma?

BvdK: When I first went to the VA and learned about trauma, I found it was enormously liberating for returning soldiers to sit with other soldiers and hear that they were not alone in their experiences. Having other people share their hurt, pain, and history with you is a powerful experience. But what I found in my groups, and my good friend Judy Herman found in her incest groups as well, is that if you keep these groups going people get stuck in their victim identity. So about 25 years ago, we came to the conclusion that these groups need to be short-term.

MG: I think it’s a fairly accepted practice that a homogeneous group is useful as an initial part of dealing with trauma but then moving into a heterogeneous group is an important step in helping patients leave that victim identity and become integrated back into society.

BvdK: I’m a student of Anne Alonso, PhD, DFAGPA, and J. Scott Rutan, PhD, CGP, DFAGPA, who taught me how to lead groups, and I was a devoted member of AGPA for many years. I ran groups all the time. I was actually Director of Group Psychotherapy at one of Harvard’s hospitals. I ran one group for 17 years, and at some point I realized the group wasn’t moving; the patients were really stuck and dependent on the group just to keep them stable. So that’s what got me into theater, yoga, and movement because it became very clear to me that in order to change you have to move. I’m not a big fan of sitting around talking about how bad you feel anymore.

My sense is that the best thing you can use groups for is for people to have fun because being traumatized means not having fun; being traumatized means feeling out of sync with other people. It makes you feel superfluous, unwanted, unneeded, and unloved. When you do something like a theater piece you get

engaged and move. You become an essential part of the program, so you get to see what it feels like to be something other than that frozen, rejected, hurt person who you’ve grown up to be. I think groups are where people have reparative experiences.

MG: What specialized skills do you think are needed in order to treat trauma?

BvdK: I have a list of competencies one should have in order to call oneself a trauma therapist. First, I think you need to have specialized training in dealing with traumatic memories, and in my mind that’s either hypnosis or EMDR. There are probably many other ways but learning how to associate dissociated traumatic memories is primary.

Second, I think you need to know about the life of the body and how trauma is stored as somatic experiences and unbearable feelings. You need to have training in sensorimotor therapy or Feldenkrais, or Peter Levine’s work or Hakomi or something to help people to shift bodily states.

The third requirement is mindfulness. Everybody needs to learn to meditate, be still, do yoga, Qigong, Tai Chi—something that helps one to be very deeply embodied with an internal focus. Again, the neuroscience behind it is that the only way you can modify your emotional brain is through the activation of the interoceptive part of the brain (I’ll address this more at the AGPA Annual Meeting). We change not by figuring things out, or talking, or even relating to people, but by going deep inside. That’s why I think mindfulness is a critical experience.

MG: How do you keep yourself from becoming vicariously traumatized (VT)?

BvdK: I think vicarious traumatization is a function of being disrespected by the institution or being a private practitioner who sees too many patients. The worst VT I see is in people who work in institutions that don’t believe in

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American Society of Group Psychotherapy and Psychodrama

72ND ANNUAL CONFERENCE

April 3 - 7, 2014
Oakland Marriott City Center, Oakland, CA

SATURDAY KEYNOTE SPEAKER:
Dare to be Happy: Psychodrama and the Power of Positive Psychology
DANIEL J. TOMASULO, PhD, TEP, MFA, MAPP
Daniel Tomasulo, psychologist, psychodrama trainer, award winning writer of *Dare to Be Happy*, is recognized internationally for development of the Interactive-Behavioral Model (IBT) of group psychotherapy for people with intellectual and psychiatric disabilities.

SUNDAY KEYNOTE SPEAKER:
Honoring the Past, Dreaming the Future:
JENNIFER SASSER, PhD
Jennifer Sasser, Chair of Department of Human Sciences and Director of the Gerontology at Marylhurst University, has been involved in inquiry in the areas of creativity in later life; older women’s embodiment; sexuality and aging; critical gerontological theory; and transformational adult learning practices. She co-authored the textbook *Aging Concepts and Controversies*.

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FOR ADDITIONAL INFORMATION, CONTACT:
ASGPP / 301 N. Harrison Street, Suite 508, Princeton, NJ 08540
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www.ASGPP.org



Dear Consultant:

Tom has been in my men's group for two years. After struggling with alcohol for many years, he has been sober for three months. He attends two AA meetings daily in an effort to maintain his sobriety. The group has been supportive of his efforts to remain sober, but lately he has been taking a lot of group time talking about his progress in sobriety. He has become the "expert" on healthy living and often gives advice to other members. At other times, he just talks a lot, and I look around the room to see other group members staring at the carpet, looking out the window, etc. I am glad to see his progress, but sometimes this group doesn't feel like a group. How can I get my group back?

**Signed,
Frustrated**

Dear Frustrated:

I can certainly empathize with you and your group feeling conflicted about a member who has struggled with addiction and yet now is dominating the group. I think all of us who lead groups have faced the dilemma of thinking that the group has been monopolized by a particular member.

I am wondering what you feel when Tom starts talking and how you could use that awareness in your interventions. Your countertransference to Tom could be useful information as to what the rest of the group is experiencing. Do you know what has kept you silent as this situation has been unfolding? What did you feel toward the rest of the group? My perspective on group is that the goal is for progressive emotional communication between the members. Given that, what needs to happen is for the other group members to begin to take their space while allowing Tom to continue feeling safe enough to talk.

You may want to ask Tom a simple question to help him with progressive emotional communication such as, "What are you feeling as you are talking right now, Tom?" You could also ask what he is feeling toward the person to whom he has been speaking. Similarly, when he begins one of his speeches ask what he thinks the other person or people may be feeling as he is talking. This could compel other group members to share their feelings of both support and frustration. By asking Tom to notice the other members reminds him that there are other people in the room.

Another idea would be to make a prognostic intervention as the group session begins, by saying something like, "How will we help Tom to talk about his sobriety today?" This could invite members to voice that they would like some other topic, or that one of them may have an issue they would like to address. It would be important to ask this question in a light tone, not being accusatory, but inviting the other voices in the group to speak while protecting Tom's ego and his budding sobriety.

Perhaps you could ask the group-as-a whole a question like, "Am I helping all of you talk as much as you may need?" This could allow the group to focus their aggressive feelings that are being aroused by Tom's monopolization of the group toward you as the leader. This could allow them to voice their feelings while protecting Tom's likely fragile ego. Once the group begins to talk again to each other, I'm sure it will once again function as a group.

*Jay Erwin-Grotsky, LCSW, CGP
Austin, Texas*

Dear Frustrated:

As a modern analytic group therapist, my goal for the group is to promote progressive communication, i.e., to have group members put their immediate thoughts and feelings toward the other folks in the room into words. As members do so, they regress back to their developmental deficits and begin the process of psychological maturation.

Let's start with Tom. As with the other members, he is doing what he can as best he can. So, we need to join him before we nudge him. As the group therapist, it is up to you to insulate him, to give him as much external protection and boundaries as he needs. (In fact, his fervor might be a communication to you that he needs more from you). He is newly sober and needs to authenticate his own experience externally with his words, more so out loud to himself than necessarily in relationship to other people. His experience needs to be validated and joined, if by no one else, at least by you. "Sounds like you are feeling stronger and confident in your own recovery." "Tom is excited about his sobriety and wants to share that enthusiasm with you, his group members." Or even, "Tom is doing exactly what he is supposed to be doing; he is putting his thoughts and feelings into words." Such a joining with him prevents him

from becoming and/or setting himself up to become the scapegoat. It is permission granting in that you are telling him (as well as telling the other group members) that all of their parts are welcome here.

As his insulation solidifies and he can hold his esteem, you can begin to work with him on being open to having other forms of interactions within the group. This is the nudge. Can he become curious about what he is communicating to the group with his "preaching"? Can he allow himself to think about how he is protecting himself with his words? Can he identify what he is feeling in a certain moment when he resorts to lecturing or hyper verbal discourse? Can he recognize that he is having a feeling and identify what it might be toward another member? This is the prodding along his growth edge or developmental trajectory, to help him move from a narcissistic position to one that is more object-oriented.

Obviously, the group consists of more than just Tom. Withdrawing, looking at the carpet, and not putting thoughts and feelings into words is not only a breach of the contract but a form of acting out that is communicative in itself. As the group therapist, it is your job to get members to be curious about their silence and their underlying anxiety about putting their thoughts and feelings into the room.

After adequately shoring up Tom, see if you can get group members to either talk more or to be curious about their resistance to talking. Do others, like Tom, have something they want to say. You might wonder aloud what is not being said in the room or turn to a quiet member and ask if he is getting enough tonight? How come? Would he like more? What is keeping him from getting more? Ask why people are not talking about their experience in the room with the other members. Are they protecting someone? Are they afraid that you might not protect someone? You might ask a particular member what you are doing (or not doing) to not encourage people to speak more freely about what they are feeling in the room toward each other. Assuming that they are feeling aggressive toward Tom, you might ask them why they are more interested in suicide than homicide. You might bridge by consulting with a member about what you can do to get another member to speak.

As people begin to talk more freely, keep a pulse on Tom. Is he protected enough? Can he hear what is being said without feeling attacked? Is he ready to hear how others experience him and can he take it in and make use of it? Do you need to jump in to shelter Tom so that he is not swallowed by toxic shame?

You are dancing as fast as you can to craft and hold the space for all the varying family members to have a voice and a genuine presence, all the while being induced with Tom's and the group's feelings of powerlessness. Tom is powerless over alcohol, as well as his fragile but determined defense of preaching with too many words. The group is powerless over getting Tom to stop without making him the scapegoat and possibly pushing him off the wagon. You have been induced to feel powerless such that you are not sure how to return the group to more mature functioning.

*Ginger Sullivan, MA, LPC, CGP
Washington DC*

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 hegener.michael@gmail.com.

Sailing Into the Unknown

An Interview with Cecil Rice, PhD, CGP, DLFAGPA, Institute Plenary Speaker

Eleanor Counselman, EdD, CGP, LFAGPA, Institute Co-Chair

Editor's note: Cecil Rice, PhD, CGP, DLFAGPA, will give the Opening Plenary to introduce the two-day Institute (March 4-5), at AGPA's Annual Meeting in Boston. Dr. Cecil Rice is a co-founder of the Boston Threshold Group (Northern Ireland Group Psychotherapy Conference). He teaches at Harvard Medical School and has a private practice in Needham, Massachusetts. He has written widely in the field of group psychotherapy, and he is currently studying and writing about the effects of Northern Ireland's 30 years of civic strife on therapy groups, their members and leaders. Dr. Rice served as the Associate Editor of the International Journal for Group Psychotherapy from 2003-2013.



EC: What is the title of your Plenary Address?

CR: The title is *Sailing into the Unknown*. I will link my personal experience sailing from Northern Ireland to America with that of experiencing an Institute group.

EC: Can you tell me about that voyage? What led you to make such a huge life-changing decision?

CR: The context is important. Remember that this was back in the 1960s. Things were not so good in the whole UK. Many people were leaving; in fact, in my seminary class, nine of 10 members ended up emigrating. Some people called it the “brain drain;” others called it rats leaving a sinking ship. So one interpretation was flattery, while the other one was guilt!

I had been a pastor for several years. In that role, I would go and visit people in their homes. I often had a sense of something wrong in these families, but I didn't know what. That led me to decide I wanted more training in psychology. One of my university professors had studied at Harvard, and he recommended Boston as a good place for me to study. So that is why I came here.

Pastors made very little money. The joke was that when a new pastor arrived at a church, the congregation would pray “Dear Lord, please keep him humble, and we'll keep him poor.” Also the congregation didn't necessarily respect your boundaries. One time, some people came to inspect the manse (our home) and while we were fixing tea to offer them, they went through the whole house without any “by your leave.”

I had to borrow the money for the trip to the U.S. because I couldn't afford to fly, so I found a way to book passage on a tramp steamer with my wife and baby daughter. For 10 days, sometimes surrounded by waves higher than the boat, we were part of a small group of passengers that I will describe in my plenary. This was my first experience group—quite a collection of characters!

For insurance reasons, passengers had to get off tramp steamers at the first port, which in this case was Norfolk, Virginia. This is a big Navy port, and so our first experience of America was the Navy fleet—quite a powerful sight. We then made our way to Boston via Greyhound bus, and I began to discover that Americans and I did not share the same language. For example, I asked a man to help me get our daughter's pram out of the luggage compartment, and he gave me a blank look. Using sign language and descriptions, I finally got across what I wanted, and he smiled and said, “Oh, you mean a baby buggy!”

EC: In groups, people also have trouble understanding what others mean even though everyone supposedly speaks the same language. Sometimes it takes effort to get to the real meaning, and sometimes sign or body language is where the real meaning gets conveyed. What other similarities do you see between your voyage to Boston and the Institute experience?

CR: You are taking a gamble joining a group of strangers without much structure. If you are attending a lecture, you can sit back, listen, and even hide. In an Institute, you are in a circle with people you have never met before. You are taking a voyage into the unknown, together, and you are pretty exposed. You really can't hide.

EC: It speaks to the necessity of making connections with the people who are there with you.

CR: Yes, we had to find a way to deal with each other, to engage. This was true on the ship and, of course, once we settled in Boston. You find all sorts of connections. For example, I discovered that a neighbor in Boston, a man from Rhodesia (now Zimbabwe) and I had a common bond in that his pastor had been the best man in my father's wedding!

It is important to remember that in those days we did not have computers, and long-distance phone calls were very expensive. So we had only letters between our families and ourselves. That meant that the here-and-now relationships were very important.

I had to rely on the kindness of strangers on many occasions. I had to have someone in America vouch for me in order to secure a visa. A cousin of my father whom I had never met vouched for me, and I didn't even meet him for two more years.

EC: In an Institute experience, you are making another kind of voyage as well, into your own inner unknown parts.

CR: Yes, and that is part of what is so exciting about being in a group. You can learn so much about yourself from the mirroring back from the others. Also, you can explore your fear of strangers and your imaginings about them and what they tell you about yourself.

EC: Would you be willing to share something that you learned on your voyage to Boston?

CR: My biggest discovery was how desperate I was. Once on the ship, I realized how important this decision was in a way that I hadn't before. So that

was a part of myself that I only got in touch with while I was on the journey. That is what happens in groups, as well; you access a part of yourself more fully during the journey.

EC: You wanted further training in order to understand people and families better. What influenced you to become a group therapist?

CR: I think what probably had the greatest influence on becoming a group therapist was being part of a large family. As a child, I learned about group by trying to find my way through my large family: two parents, five kids, four grandparents (two living with us), 16 aunts and uncles, and 30 first cousins—and that was just on my father's side! Like so many large groups, we had many subgroups; for example my mother (an only child) and her parents were a small subgroup compared to my father's vastly larger subgroup. We had a religious subgroup (my paternal grandmother would cover the television set with a blanket to avoid associating with the devil), and a rakish subgroup centering around local pubs. I also learned about the power of the other group as a container of one's internal projections. The Nazis, who bombed Belfast when I was a small child, were my first experience with the other. I called them Germs so I could hate them. Later, of course, I became familiar with the painful tensions between the Protestant and Catholic subgroups. Group was what I knew, so when I first led groups at the Danielson Center I felt I was home. I have described the effect of these early experiences on my identity as a group therapist more fully in my essay “Arriving Where I Started” (Author's note: See Group, Vol. 32, June 2008, 136-144.)

The tragic events in my family further taught me about the power of group to heal group leaders as well as members. As a result of those experiences, my career shifted to a greater focus on healing trauma through group work. Kathy Ulman, PhD, CGP, FAGPA, Patricia Doherty, EdD, CGP, FAGPA, and I started the Boston Threshold Group, which organized group conferences in Northern Ireland to help mental health workers dealing with traumatized individuals while struggling with feeling traumatized themselves by the ongoing violence. Pat Doherty and Walker Shields, Jr., MD, CGP, FAGPA, invited my wife Shirley and me to start the Rice Memorial Fund at NSGP (to study the role of groups in understanding and addressing violence) and were honored that the Rice Center for Young Children and Families at the Boston Institute for Psychotherapy (to prevent violence in families) was named for our family.

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In Memoriam: Saul Tuttman, MD, PhD, CGP, DFAGPA AGPA President, 1996–98

Saul was an important contributor to the group psychotherapy literature and an accomplished teacher who inspired many students at the New York University Department of Psychiatry, as well as the AGPA. He assembled an important collection of articles in honor of his friend Saul Scheidlinger, PhD, CGP, DFAGPA in 1991 entitled *Psychoanalytic Group Theory and Therapy*.

Saul had an international presence and was one of AGPA's chief ambassadors to the Japanese psychiatric community. He was much esteemed by this country's leaders in the field and I recall a conversation with an important Japanese psychiatrist who said she highly valued Saul's frequent visits and his contributions to her staff, but also viewed him as a kind and supportive presence to her personally. As a testimony to the love he created, his friend Takashi Yamaguchi made a special trip to see him before he died.

He was a broadly cultured person who collected art, particularly from countries in Asia and Africa. His home was a veritable museum of fascinating sculptures from these areas and he enthusiastically described each of his pieces and what they represented historically.

I always valued my contacts with Saul. He was not only a companionable person, but he was eager to hear about you, your family, and your activities. In his younger days he was an inveterate traveler and happily shared his experiences from many exotic places. He was a warm empathic person who will be missed. He is survived by his devoted partner, Gregory Siskind, and his sons, Michael and David.

Leonard Horwitz, PhD, CGP, DFAGPA

*I first met Saul as a member of a team of teachers in a semester-long group therapy class through New York University. His charm, charisma, sparkle, and imagination were a sharp contrast to other, more desiccated intellects on that team. After I finished the two-year group therapy program in psychodynamic/analytic training at the

Postgraduate Center for Mental Health, about five or six of the graduates enlisted Saul as supervisor. I also met with him individually for supervision.

Many apocryphal tales exist about Saul and his generosity, including one (not verified) that he paid a patient/ex-patient's college tuition. It seems possible to me. I learned from Saul the wonderful Harry Stack Sullivan quote, "We are all more alike than not." Saul explained that Sullivan meant even psychotic patients in the back wards. Saul's intent was to be empathic to the range of human emotion.

Saul described poetically what he felt the inner experience of a borderline patient of mine might be as he made a case that I see her three times a week at a lowered fee. "Borderlines live with these endless eternal storms, winds blowing, loving and hating all at once." Another time while discussing fees, Saul licked his middle finger, held it high in the air, perhaps sailor-like, and said, "Always see which way the wind is blowing before making any decision about enforcement."

One summer, he invited a co-supervisee, Lois Kennedy, PsyD, CGP, and me to a party at his exquisite country home and horse farm. Saul's love of horses and riding was another accomplishment of this erudite man. We spoke of horseback riding, as I too enjoyed the sport. Riding ended when Saul contracted Lyme's disease, which was a heartbreak for him.

Saul's disease eventually had him wheelchair-bound. The last time I had contact was several years ago. A mutual friend and colleague told me how limited Saul's world had become, and that she was sure he'd welcome a call. I called and was told he'd call back. He never did. I feel the power and colorful fireworks of this man, now gone, deeply.

Alice Byrne, MSW, CGP, FAGPA

*A version of this article appeared originally in *GROUP*, Volume 37, Issue 2.

Saling into the Unknown

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EC: Have you ever missed your previous vocation?

CR: This is a part of a broader question about what it means to be an emigrant/immigrant. At one level the answer is yes, I miss it, but would I want to do it now? Probably not. Although paradoxically, I've also been doing a central function of the clergy for over 40 years by being a therapist.

When people left County Donegal during the Famine, funerals were held, because everyone knew that those who were leaving would never be back. Part of being an immigrant is grief, sometimes called homesickness, for what you left. If you plan to return, that grief/homesickness is modified. If you stay, then it becomes mourning, and that is always a part of you.

A friend of mine from Belfast who emigrated to Canada wrote a poem about this experience a part of which reads: *Deny me if you dare. I've left, / my imprint on every aspect, / of your being. / The Shankill, Lisburn Road, / Roden Street, Portadown are / more powerful markings than / tattooed prison numbers.* (Noel Rea, personal communication).

EC: Do you have advice for Institute participants?

CR: My advice is to enjoy your voyage into the unknown and trust the group. ●

Social Connectedness

continued from page 1

SP: My path didn't start with neonates; it originally started with looking at physiological responses during sustained attention. Using physiological measures to tap into intentionality and mental effort processing paralleled my earlier interest in faces and intentionality of behavior. Over time, my interests shifted into affective and social processing. When I started graduate school, studying emotional processes wasn't a viable research area. When I was invited to speak at the AGPA Annual Meeting, I smiled, because it is nice to know that people can see how my work is related to human interactions. My biological and physiological models are about features of being a human, and the importance of interacting with another human being to regulate state. Most clinical interactions are functionally neural exercises, which involve an integrated biobehavioral system that I label the social engagement system. Consistent with this conceptualization of social interaction as the interaction among individual social engagement systems, a group therapy model is similar to a musician in an orchestra or a vocalist in a choir—the individual's social engagement system is choreographing responses and detecting other people's cues and facilitating complex interactions. Interaction of multiple social engagement systems constitute more than

overt behavior and include visceral changes as well listening and inhibiting activity.

HF: Can you clarify what you mean by the concepts vagal tone and vagal brake that you refer to in your work?*

SP: Unique to mammals, the primary vagal regulation of the heart shifted during evolution from the unmyelinated pathways originating in the dorsal motor nucleus of the vagus to include myelinated pathways originating in the nucleus ambiguus. The myelinated vagus functions as an active vagal brake in which rapid inhibition and disinhibition of vagal tone to the heart can rapidly mobilize or calm an individual. The myelinated vagus actively inhibits the sympathetic nervous system's influences on the heart and dampens hypothalamic-pituitary adrenal (HPA) axis activity. Functionally, and this is what group therapists might be most interested in, the vagal brake, by modulating visceral state, enables the individual to rapidly engage and disengage with objects and other individuals and to promote self-soothing behaviors and calm states. Thus, deficits in the regulation of the vagal brake may cause deficits in social communication observed early in development. Basically, the expression of social engagement behavior is dependent upon the regulation of visceral state by the vagal brake. If visceral homeostasis is challenged and the vagal brake is unable to regu-

late visceral homeostasis, then social engagement behaviors will be minimized.

The mammalian heart is characterized by a relatively strong vagal influence, via the myelinated pathways, on the heart's pacemaker (i.e., sino-atrial node). Due to the tonic vagal influences on this pacemaker, resting heart rate is substantially lower than the intrinsic rate of the pacemaker. When the vagal tone to the pacemaker is high, the vagus acts as a restraint or brake limiting the rate the heart is beating. When vagal tone to the pacemaker is low, there is little or no inhibition of the pacemaker. Thus, the brake metaphor is a useful construct to describe the functional modulation of heart rate by the myelinated vagal efferent pathways. The vagal brake provides a neural mechanism to rapidly change visceral state by slowing or speeding heart rate. ●

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- Porges, S.W. (2001). The polyvagal theory: Phylogenetic substrates of a social nervous system. *International Journal of Psychophysiology*, 42(2) 123-46.

*Author's note: Answers to these questions were taken verbatim directly from the writings of Dr. Porges noted on his website with his permission and references are cited. The rest of the interview is from a Skype interview.

This interview is part of a larger conversation that was held with Dr. Porges. The complete interview can be viewed on the AGPA website: www.agpa.org.



American Group Psychotherapy Association, Inc.
25 East 21st Street, 6th floor
New York, NY 10010

See Group Assets insert

Affiliate Society News

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

The Atlanta Group Psychotherapy Society (AGPS) hosted Paul Earley, MD, FASAM in January for the workshop on *Brain Models, Healing, and Empathy: What A Therapist Must Know about Neurophysiology*. AGPS had an energetic response to the Fall Conference: *Unbearable States of Mind: Working with Dissociation in Group*, presented by K. Brynolf Lyon PhD, CGP and Karis Klassen MA, CGP, with Philip Flores, PhD, ABPP, CGP, L FAGPA, as Discussant.

The Eastern Group Psychotherapy Society (EGPS) had a very successful Annual Conference in November. The theme was *Out of the Comfort Zone: Taking Risks and Embracing Turbulence in Groups*. Co-chaired by Sherry Breslau, PhD, CGP, and Hilary Levine, PhD, CGP, the Conference featured Plenary Speaker Earl Hopper, PhD, CGP, FAGPA, who also led a supervisory workshop the day after the Conference. *Group: The Journal of the Eastern Group Psychotherapy Society* is now online. Harville Hendrix will be the featured presenter at EGPS's Spring Event, to be held May 16. Contact Jan Vadell: egps@optonline.net.

Ryan Spencer, MFT, CGP, President of the Group Psychotherapy Association of Los Angeles (GPALA) has passed the baton to John Chebultz, MFT, who will lead GPALA as President in 2014 and 2015. GPALA will hold its two-day Annual Conference on May 16-17, featuring Molyn Leszcz, MD, FRCPC, CGP, DFAGPA. On October 15, Alexis Abernethy, PhD, CGP, will lead a conference on spirituality and group therapy. In addition, William Whitney, GPALA's newsletter Editor interviewed Elliot Zeisel, PhD, LCSW, CGP, DFAGPA, in its latest newsletter which can be viewed on www.gpala.org.

The Illinois Group Psychotherapy Society (IGPS) will present Ronnie Levine, PhD, ABPP, CGP, FAGPA, on April 4-5, speaking on *Welcoming Love and Hate: Expanding the Emotional Range of the Therapeutic Process in Groups and More* and Harold Rice-Erso, PhD, CGP, on October 24-25, speaking on *The Stories that Enslave Us, The Stories that Liberate Us, and How We Work with Both in Group*. Contact the IGPS Office: igpsinfo@aol.com to register. IGPS's newly elected officers include: James O'Keefe, MS, CGP, President; Sarah Kallick, PsyD, CGP, President-Elect; and Board Members: Hylene Dublin, MSW, CGP, L FAGPA, and Paige LaCava, MA, LCPC, CGP. Lawrence Viers, PhD, CGP, a former IGPS President, has been appointed to fill Sarah's unexpired one-year term as Secretary. IGPS will be celebrating its 50th anniversary this year, and plans for a celebratory event are underway.

The Mid-Atlantic Group Psychotherapy Society's Spring Conference will be held April 26-27. Featured Speaker Catherine Nugent, LCPC, TEP, will address *Care for the Heart and Soul of the Psychotherapist: Psychodramatic Explorations*. Nugent is a licensed clinical professional counselor and Board-certified trainer, educator, and practitioner of psychodrama, sociometry, and group psychotherapy.

The Philadelphia Area Group Psychotherapy Society's Spring Workshop on May 9 will feature Craig Haen, PhD, RDT, CGP, FAGPA, speaking on *Group Therapy on the Edge: Adolescence, Creativity and the Anti-Group*.

New officers for the Tri-State Group Psychotherapy Society are: Catherine Reedy, MSW, LCSW, LMFT, CGP, President; David Moore, MSSW, PhD, CGP, President-Elect; Jack Niehaus, LICSW, CGP, Secretary; and Chris Stewart, MD, CGP, Treasurer. Molyn Leszcz, MD, FRCPC, CGP, DFAGPA, will speak at its Fall Conference. Dr. Leszcz is the Psychiatrist-in-Chief at Mount Sinai Hospital and Professor and Head of the Group Psychotherapy Program, Department of Psychiatry, University of Toronto.

Heidi Landis, RDT, LCAT, CP, CGP, spoke at the Westchester Group Psychotherapy Society in January on *Playing the Unspeakable: Story and Drama in Group Process*. Drama therapists believe that the therapist must be the most spontaneous person in the room. They also believe that helping clients access their spontaneity and creativity can help lessen anxiety and allow clients to imagine new possibilities and expand their role repertoires. This experiential workshop looked at how using metaphor and play can help clients find their voice and their story. Participants explored their own creativity and spontaneity, as well as learned hands-on exercises to use in group therapy settings.

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.

The Body Keeps Score *continued from page 4*

dissociation or don't believe in EMDR. People are forbidden to talk about concepts like dissociation, or the use of EMDR, and that contributes to VT. Then, of course, it certainly helps to know some effective therapies and to see your patients get better. The biggest defense against vicarious traumatization is to see your patients improve. Having a supportive group of colleagues and friends is also critical.

MG: What do you find meaningful and important to you in working with trauma?

BvdK: Everything about it is important. It's about learning to survive as a human being; what's not meaningful about that? Do you like Othello or King Lear? If Shakespeare's tragedies don't appeal to you then working with trauma might not be for you. We work with Shakespearean tragedies all the time in treating trauma, and oftentimes with happier endings. ●