Group Therapy Through the Lens of Attachment Theory: An Interview with David Wallin, PhD

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

David Wallin, PhD, is a clinical psychologist in private practice in Albany and Mill Valley, California. Dr. Wallin has been practicing, teaching, and writing about psychotherapy for nearly three decades. His most recent book, Attachment in Psychotherapy (©2007, The Guilford Press), has been translated into nine languages. He is also co-author (with Stephen Goldbart, PhD) of Mapping the Terrain of the Heart: Passion, Tenderness, and The Capacity to Love (©1996, Jason Aronson). He has lectured on attachment and psychotherapy in Australia, Europe, Canada, and throughout the United States. Dr. Wallin will present the Anne and Ramon Alonso Plenary Address at the AGPA Annual Meeting in New Orleans on March 1, 2013.

PK: In your book, Attachment in Psychotherapy, you state, “...the stance of the self toward experience predicts attachment security better than the facts of personal history themselves.” Could you define what the stance of the self toward experience refers to and describe how a clinician would go about assessing it?

DW: The stance of the self toward experience refers to the ways in which we respond to and process our own experience and that of others. In my book, I describe three such stances, suggesting that we can be embedded in experience, we can be reflective (in other words, we can mentalize), or we can be mindful. When embedded in our experience, we simply believe everything we think and (especially) feel. When we reflect or mentalize, we make sense of experience and behavior in light of the underlying mental states that shape them. When we’re mindful, we’re deliberately present and fully aware of whatever experience arises in the immediacy of the moment.

I want to make sure I give the concept embeddedness its due. This stance is probably just what’s called for when we’re immersed in the pleasures of music, or skiing, or making love. On the other hand, embeddedness is a problem when it’s regularly our only option. Then we’re on autopilot—prisoners of our own internal world—with little ability to regulate our emotions, or to understand ourselves or others. With such a stance we can’t interpret experience; we’re just defined by it.

In contrast, I’ve referred to mentalizing and mindfulness as “the double helix of psychological liberation.” Why? Because each of these stances fosters the de-embedding that loosens the grip of automatic response patterns. Each stance is also affect-regulating, contributes to insight and empathy, and helps promote the integration of dissociated experience that’s key to therapeutic change.

In working with our patients, it is critical to gauge the patient’s capacity to mentalize. We often make this assessment on the fly, and sometimes it shifts on a dime. The extent to which patients can mentalize helps us choose our interventions. For assessment purposes, three questions are key: a) At any particular moment, can the patient see that reality might be other than he thinks or feels it is? b) Can he see that different people might legitimately regard the same reality in different ways? and c) Can he appreciate that his own estimate of what he now regards as reality might well change? The idea here is that mentalizing involves the capacity to consider multiple perspectives on experience, rather than being trapped in the presumed reality of a single view. Because mentalizing capability is both developmentally determined and context-dependent, its strength varies; hence, the importance of keeping in mind the inverse relationship between the intensity of feelings—or the rigidity of defenses against feeling—and the degree to which we’re able to take a step back from experience in order to make sense of it. The more freaked out we are, or the more rigidly detached, the less we’re able to mentalize.

If you think of a hierarchy of interventions with empathy and support at the top and interpretations of motivational dynamics (especially as these involve transference-countertransference) at the bottom, then it’s the intensity of the patient’s emotion, or defenses against same, that should determine the depth of our intervention: The more mental space available to the patient, the deeper the intervention should be. On the other hand, there’s also a kind of horizontal differentiation to be made between highly emotional patients with a hyper-activating attachment strategy and emotionally detached patients with a de-activating strategy. The former may need more in the way of ongoing empathy and support from the therapist, while the latter may need the therapist to show some emotion, to lead the way, to offer more in the way of confrontation and self-disclosure.

From the President

Kathleen Ulman, PhD, CGP, FAGPA

As the leaves start to fall and the days grow shorter, I remember my excitement and anticipation of new challenges with the onset of the new school year that marked the beginning of the rhythm of the coming academic year. AGPA also has its own yearly rhythm. For me, the fall brings thoughts of scheduling Board meetings, encouraging scholarship applications, beginning preparations for the Annual Meeting, anticipation of Distance Learning participation, and the start of many goings-on outside of the awareness of many AGPA members. I would like to take this opportunity to share with you the activities that have been taking place on behalf of AGPA over the summer while most of us have been on vacation, as well as more recently.

The Annual Meeting Program is completed, the Special Institute and Two-Day Institute Programs can be viewed on the website, and the rest of the program will soon be available. This is the time of year to encourage trainees and new professionals to apply for scholarships. Your help is essential. The Scholarship Program has been a vital source of new attendees and members. In June, the Board approved a pilot to simulcast a limited number of Annual Meeting events. This is an exciting innovation that means that group therapists around the world will be able to observe in real time these events, as well as interact and ask questions. These simulcasts will also be stored and available following the Annual Meeting.

The Annual Meeting Committee surveyed the 2011 attendees who did not return in 2012 to the Annual Meeting in New York City. The results showed that the major reason for not returning was determined by considerations of time and money and was not related to satisfaction with attendees’ experiences. The Annual Meeting Committee has also been using participant evaluations to help guide them in designing...
from page 1

this year's and future meetings.

I am pleased to announce that the Board approved the Westin Copley Place for their Annual Meeting. A contract has been

signed with the Westin Copley Place for March 3-8, 2014.

In August, the American Psychological Association cited AGPA’s Practice Guidelines for Group Psychotherapy several times in their new Resolution on the Effectiveness of Psychotherapy. It was very good news, and satisfying to see AGPA’s Practice Guidelines, developed by the Science to Services Task Force, recognized.

Now that we have a new Editor—Dominick Grundy, PhD, CGP—for the International Journal of Group Psychotherapy, the Journal Search Committee has sent out separate surveys to the Editorial Committee, readership, and authors to obtain feedback about the quality of articles and authors experiences to provide information for recommendations to the new Editor.

In July, Jeffrey Kleinberg, PhD, CGP, FAGPA, Marsha Block, CAE, CFRE, CEO, and I traveled to the IAGP meeting in Cartagena, Colombia, and participated in the meeting of the International Standards Committee that continued the work that was begun in New York in March. The agenda was very full, with each group organization presenting its point of view. The meetings culminated in the development of a draft for basic standards for international certification of group therapists. The Committee work will continue at the AGPA Annual Meeting in New York.

The development of a new website has been the major undertaking of the organization that began this summer and will continue to be through the fall and winter. The design is drawing on both member input and the expertise of many branches of the organization; we have been using the results of the membership survey and the input developed at the Tri-Organizational Board Meeting in March for overall website development. The current and past Special Interest Group Task Force Co-Chairs and AGPA Secretary have been reviewing new software as an alternative to E-Communities. The Annual Meeting Committee undertook the time-consuming task of developing the taxonomy for tagging Annual Meeting and Distance Learning presentations so that continuing education will be searchable on the website. The Science to Services Task Force is taking a final look at the taxonomy to make sure it reflects the state of the art in group psychotherapy. The Task Force is also looking at videotapes that could be put on the site to demonstrate what a group looks like in action. The Certification Board is consulting with the office to redesign the directory to make sure it reflects member comments for changes and that it’s user friendly. As we move through the website plans, we will also be contacting members to test the site with us to insure functionality and ease of use.

The redesign of the website is a massive undertaking that will involve many committees, as well as a large portion of the office staff’s time. As you can see, it takes a village to build the AGPA website. I want to thank everyone who has been involved in this monumental effort and to give special thanks to Marsha Block and the office staff who have put in many long hours getting this effort off the ground.

I am keenly felt in the AGPA community. I again urge you to send me your ideas for an article on a topic of interest in group psychotherapy. So many of you have offered stellar workshops and institutes that you might want to turn into an article for The Group Circle. Do not hesitate to contact me with your ideas.

Call Nicole Millman-Falk at 201-652-1887 for further details.

IBCGP Looking for Outstanding Contributions in Education and Training

The International Board for Certification of Group Psychotherapists (IBCGP) is accepting nominations for the Harold S. Bernard Group Psychotherapy Training Award. IBCGP is greatly honored that the award will now carry Dr. Bernard’s name. Dr. Bernard was a Past President and Distinguished Fellow of AGPA and was a prolific and outstanding contributor to the field of group psychotherapy through his many years of teaching, training, and writing.

The award will be presented at the AGPA 2013 Annual Meeting (February 25–March 2) to an individual or organization whose work in training and/or education contributes to excellence in the practice of group psychotherapy. Examples of contributions that will be considered include the creation of a curriculum, monographs, manuals or programs for the development of psychotherapists; provisions of continuing education and/or training of practicing group psychotherapists; or advocacy for quality in the provision of group psychotherapy services.

Anyone can submit a nominee. An applicant may be self-nominated. Priority is given to CGPs and AGPA members. The application must include the name, address, curriculum vita (if it applies to an individual) and a detailed reason for the award nomination. Additional letters of recommendation will be encouraged to accompany the award nomination.

The application should be sent to Sherrie Smith, LCSW-R, CGP, FAGPA, Chairwoman IBCGP Board of Directors, sherrrie_smith@urmc.rochester.edu, and Leah Penney, Membership and Credentials Associate, leahpenney@agpa.org. Due to Hurricane Sandy, the deadline has been extended to November 30.

Call for Nominations for AGPA Election 2013

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

The Nominating Committee is pleased to invite nominations for Officer and Board of Director positions of the American Group Psychotherapy Association. All nominations should be directed to the Chair of this Committee, Jeffrey Kleinberg at jkleinberg@usl.com.

At this stage, we are simply accepting nominations. As the pool of potential applicants grows, the Nominating Committee will exercise its charge to put together a slate of candidates that is as diverse as possible to faithfully and most fully represent our membership. A nomination to the Committee does not guarantee candidacy, but does ensure a deep pool of potential candidates for the 2013 elections. It should be noted that nominations for President-Elect should have previously served on the AGPA Board of Directors.

always love the Fall edition because for me, it stirs excitement and anticipation for the Annual Meeting, which is only a few months away. Reading the fine interviews with David Wallin, PhD, Morris Nitsan, PhD, and Jerry Gans, PhD, CGP, DFAGPA, is like getting a taste of the menu before making my choices. At times, I could imagine myself in dialogue with each of them, generating my own questions in anticipation of rich responses.

As is occasionally the case in our organization, enthusiasm for the activities AGPA offers coincides with the periodic loss of our community’s precious members. Bercy MacLennan, PhD, CGP, DFAGPA, and F. Theodore (Ted) Reid, PhD, CGP, DFAGPA, two of our Distinguished Fellows and generous contributors to the field of group psychotherapy, died recently. We honor the life of Dr. MacLennan in this issue’s In Memoriam, and we will do the same for Dr. Reid in the next issue. Their loss is keenly felt in the AGPA community.

Gil Spielberg, PhD, ABPP, CGP, FAGPA, gave a presentation to the Institute of Contemporary Psychoanalysis in Los Angeles, California, on Building Immediacy in Group Using the Adjacent Possible. This was the first-ever group-oriented presentation for this analytic institute.
In Memoriam: Beryce Winifred MacLennan, PhD, CGP, FAPA, DFAGPA

2012 Annual Meeting Non-Attendees Survey-Results Overview
Hank Fallon, PhD, CGP, FAGPA and Paul Kaye, PhD, CGP, FAGPA
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Introduction and Survey Demographics
We have tabulated the results of our survey of people who attended the 2011 AGPA Annual Meeting, who did not return for the 2012 Annual Meeting. Out of 78 respondents, 69% were female 31% male. Members accounted for 73% of respondents, non-members 27%. We found that 37% of those surveyed were AGPA members for 0-5 years; 19% for 6-10 years; 22% for 11-15 years; 4% for 16-20 years; and 19% for 20 or more years. Twenty five percent attended the Annual Meeting for the first time in 2011; 41% attended 2-5 meetings; 13% attended 6-10 meetings; 12% attended 11-15, and 4% attended 16 or more meetings. Similar to the overall composition of the meetings, 40% were psychologists; 31% were social workers; 13% were psychiatrists; and 29% comprised all remaining disciplines.

Possible Reasons for Missing 2012
Cost of travel (33% very important; 30% somewhat important), cost of hotel (38% very important; 29% somewhat important), and time considerations (30% very important; 32% somewhat important) were cited as reasons for not attending the 2012 meeting. The location of the conference (20% very important; 15% somewhat important) and the fact that it was held in the same city two years in a row (20% very important; 12% somewhat important respectively) were not as influential.

Interest in program offerings (0% very important; 15% somewhat important), a negative experience in 2011 (0% very important; 6% somewhat important), and rejection of a proposal (2% very important; 0% somewhat important) had less impact on respondent’s decision to attend.

When asked to choose the chief reasons for not attending the conference, time considerations (29%) and travel costs (23%), followed by cost of hotel (12%) were the most prominent. Also of note was that 19% indicated they normally did not attend yearly.

From this sample of 2012 Non-Attendees, 27% were interested, 40% not interested, and 33% unsure about whether they would use remote access to the conference if it were offered. We believe that this question may have confused respondents, and the survey should have been clearer about what remote access actually meant.

Conclusions
Most of those not attending the 2012 Annual Meeting appear to be satisfied with what the Meeting offers and do not cite negative experience or rejection of a proposal as a key reason for not attending.

Twenty-nine percent of our non-attendees had under five years of group experience. A review of the comments suggests that we need to be more sensitive to early career professionals. A clearly defined track at the meeting for those with less than five years group therapy experience could enhance their meeting experience and improve their overall perception of the organization.

Given that 29% had less than five years as a member in AGPA and 65% of the respondents had five or less prior conferences, we might hypothesize that these are newer professionals who are in the process of establishing themselves in their career. They are the individuals who will likely be most importan by the expense and time factors, although none of us are immune to those pressures. For those in private practice, taking time off is of significant cost in lost revenue. For those working in agencies, professional development leave or vacation leave might be limited, also adding to the overall cost of attending meetings. The AGPA Scholarship Program remains a significant resource to those for whom cost is a serious impediment.

Newer members also are more likely to have younger children who easily become an issue when trying to decide whether to attend the meeting for a week, and this was cited in the comments by some respondents. Finally, newer members might need greater assistance finding a professional and social home in the organization, so that attention to ways in which we can make them feel more included might positively enhance their initial perception of the organization.

The information on remote access needs to be explored further as AGPA moves toward offering remote access to the conference.
The Making of a Group Therapist:
An Interview with Jerome Gans, MD, CGP, DFAGPA

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

The theme of personal experience will permeate the Special Institute to be led by Jerome Gans, MD, CGP, DFAGPA, at the upcoming AGPA Annual Meeting in New Orleans. The Role of Personal Experience in the Making of a Group Therapist will be the focus of his morning session, and The Courage of the Group Therapist is the focus of the afternoon. A private practitioner in Wellesley, Massachusetts, he is an Associate Clinical Professor of Psychiatry at Harvard Medical School at the Massachusetts General Hospital. The author of more than 23 refereed articles and the book Difficult Topics in Group Psychotherapy: My Journey from Shame to Courage, Dr. Gans also served as Editor of The Group Circle.

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

JG: On a hot day in July 1968, along with 27 other psychiatric residents, I began my training at the Massachusetts Mental Health Center. Crowded into the second floor library, we listened to Dr. Elvin Semmel, a renowned teacher of psychotherapy. Of the many things he said that morning that stayed with me all these years was: “The one thing that all of you have that no one else has is your experience as you experienced it. You may not have elected it; you may think it stinks, but it is yours; so value it and use it.” That statement has served me well over time. Initially, when I had little patient experience and even less theoretical knowledge, it was reassuring to know that my personal experience counted for something. In the next phase of my career, I overvalued theory; it became a transitional object that contained my anxiety. With more clinical experience, I realized that major theorists were also just people whose personal experience influenced the theories they developed. This realization helped me lower these theories between expected therapeutic competence and leader courage. I anticipate that the demonstration group will illustrate that the concept of leader courage is more complicated than it appears on the surface. But then again, with demonstration groups and the energy infused in them by the unconscious, who can predict what will transpire?

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

JG: I plan to focus on how personal experience inevitably becomes part of one’s therapeutic presence. I will discuss several personal experiences from which I have culled important lessons for therapy—and life—and provide clinical examples for each. I will emphasize that I highly value theory, supervision, clinical experience, mentorship, and one’s own therapy as crucial to the making of a psychotherapist. Our basic personhood is at the heart of our therapeutic efforts and efficacy.

The role that our personal experience contributes to our therapeutic efficacy has been overlooked. I hope this Special Institute will help participants take stock of their personal experience and value it as an important and valid part of their therapeutic presence. I want to be sure, on the other hand, that participants relatively new to the field realize that basic grounding in theory, clinical experience, supervision, and one’s own therapy all contribute to the development of our professional selves. A balance is needed. The personal without the professional runs the risk of being solipsistic where therapists believe they need be aware of nothing but their experience and their emotional states. The professional without the personal lacks inspiration, conviction, and authenticity.

The afternoon session will delve into the differences between expected therapeutic competence and leader courage. I anticipate that the demonstration group will illustrate that the concept of leader courage is more complicated than it appears on the surface. But then again, with demonstration groups and the energy infused in them by the unconscious, who can predict what will transpire?

EC: Has your thinking on this topic evolved over time and if so, how?

JG: The complexity of group dynamics and the healing process has always impressed me. It has never made sense that one theory or approach can do justice to the variety of human experience and the countless unique contexts in which such experience occurs. I have never subscribed to identifying oneself as a self-psychologist, object relations therapist, or a Freudian. I have always been a pluralist, a clinician who believes that I should know all the theories and employ their methods with a given patient—or group—at a given time, where doing so made therapeutic sense. Certain occurrences also made me realize that, under this pluralist umbrella, I needed to include the personal as well as the professional, as the following example will explain.

Twenty or so years ago, I was invited to speak to Lou Ormont’s group in New York City about my development as a group therapist. I remember speaking about my medical experience at the University of Rochester Medical School, where I was exposed to giants in the field like Drs. John Romano and George Engel. I then spoke about what I learned about group therapy from Drs. Elvin Semmel and Max Day at the Massachusetts Mental Health Center. I touched on my early life-altering T-group experience, as well as things I learned from participating in AGPA Institutes. During the reception after my talk, many people graciously commented on my talk. What I will never forget is that 90 percent of those comments addressed a personal, family experience that I recounted, not the professional experiences I enumerated.

I come from a lower-middle-class Conservative Jewish home. My parents had relatively little formal education. When I attended Harvard College and was dazzled by the preppy, WASP culture that I never knew existed, I took a 15-year sabbatical from Judaism. After I married and we had three children, I slowly returned to my Jewish heritage. We began to stay home on Friday nights, and my wife would prepare a beautiful Shabbos meal, replete with a white tablecloth and our finest dishes. We would light the candles, bless the children, and sing the blessings over the wine and the bread. I would look at my wife and children with love and appreciation, ready for a relaxing meal and special family time. Before we knew it, the children were spilling the wine, bickering with each other, or dissatisfied with the food. One of them might leave the table, I would look at my wife, all of her efforts apparently in vain, and wonder with her why we were expending all this energy on a ritual that the kids didn’t seem to appreciate. Following three or four such disheartening Sabbath evenings, to our surprise and seemingly out of nowhere, our children would initiate a discussion about the meaning of community, or justice, or the importance of welcoming the stranger. After dinner my wife and I would wonder why such wonderful Shabbos dinners didn’t happen every week. We finally realized that it was in the nature of things to have to put up with four such evenings in order to get the fifth.

More than anything I read in a textbook or was told by a supervisor, this highly personal experience helped me realize that the same pattern often emerged in my therapy groups. Just when I was ready to conclude that my groups were unproductive and not worth the time and energy, the next session was remarkably productive. It was many experiences like this one that made me appreciate how central my personal experience is to my therapeutic presence. In 2006, I wrote a paper—"My Abiding Therapeutic Core: Its Emergence Over continued on page 6
The Group as an Object of Desire: Exploring Sexuality in Group Psychotherapy with Morris Nitsun, PhD

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

Morris Nitsun, PhD, will be a Special Institute presenter at the AGPA Annual Meeting on Monday, February 25, 2013, in New Orleans. Dr. Nitsun is a consultant clinical psychologist at the NHS Mental Health Trust in England, a training analyst at the Institute of Group Analysis, and a member of the Group Analytic Practice. His numerous publications include The Anti-Group: Destructive Forces in the Group and Their Creative Potential, and his most recent book The Group as an Object of Desire: Exploring Sexuality in Group Therapy. His Institute will cover material from this latest book. He graciously took time to answer some questions regarding his book and provide us with insight into his upcoming Institute. You will also be able to register for a live simulcast of this Institute.

HF: It has been about six years since the publication of your book on sexuality. Do you think that the field of group psychotherapy is more open to engaging in a discourse regarding desire and sexuality in group and is moving away from the marginalization of these topics you noted at the beginning of your book?

MN: Overall, the field is a bit more open to engaging in a sexual discourse, as you put it, but I still detect uncertainty and defensiveness. This sometimes takes the form of “Why are you making such an issue of it?” The much greater openness about sexuality in society-at-large, partly stimulated by the Internet, is not reflected in commensurate changes in group psychotherapy. This does not alter the fact that there are, of course, some very open group practitioners who work creatively and directly with sexuality and desire, but they appear to be the minority.

HF: In the book, you discuss the different facets of the sexual self (individual, relational, and social sexual self) and how often sexuality is experienced as a difficult, awkward, and incomplete part of the self. If the work of therapy is to uncover the hidden stories of desire beneath the presenting issues and symptoms, what allows the group to understand and integrate the importance of these in the group process rather than minimize them?

MN: The culture of the group is all-important. It is important that there is trust in talking about the diversities and intimacies of sex and a recognition that, for many people, sex is not all that it is cracked out to be. Even people who have good sex lives experience periods of anxiety and self-doubt. In addition, sexual desire in some ways knows no bounds, often harboring wishes for transgression or the breaking of boundaries, even if this is not enacted. The group requires openness, a non-judgmental stance, and an absence of pathologizing. It also requires a large element of play, so that sex can be spoken about in a spontaneous, experimen-tal way. The excitement of sex should not be lost in too serious or anxious an approach. In my book, I refer to the erotic imagination of the group, which includes a playful approach to sexuality expressed through the exploration of fantasy and sharing of desires in all their subjectivity.

HF: You talk about sexuality becoming a property of the group and the group being able to discuss aspects of the experience that are normally kept hidden due to shame and/or hurt. What is the leader's role in the development of this culture of curiosity and willingness to risk? What do we do that can be counterproductive to this process?

MN: The leader's role is crucial. The leader sets the tone when it comes to sexuality, and the group will consciously or unconsciously be alert to the his or her attitudes and feelings and be guided by them. It is important for the leader to be clear with him/herself and where he/she stands on important current issues such as sexual orientation, promiscuity, Internet sex, and the wide range of alternative sexual interests and practices. It is insufficient to assume as a group conductor that one has a liberal view of sexual matters. It requires close questioning of oneself, one's knowledge about sexual diversity, and one's morality. It would be counterproductive if the therapist is closed to these issues or if he/she thinks he/she is open, but is inwardly guarded and self-protective. Of course, we all have anxieties and prejudices in this area, and I am not suggesting that these can simply be eradicated.

HF: I believe you see the therapist's sexual orientation as offering both opportunities and potential roadblocks to desire and sexuality discourse in group. Please talk about some of the complex dynamics involved and how we can increase our awareness of these forces.

MN: It is probably less complex when the therapist is heterosexual because this is mostly what is assumed, and probably what most clients expect. However, being straight in itself doesn’t resolve all of the challenges, and a straight therapist may well have difficulty understanding and appreciating gay and lesbian sexuality. How well homosexual therapists facilitate discourse on sexuality may be complicated by whether or not they are out, whether clients know they are gay, and so on. They may also be uncertain of their ground when it comes to straight sex or may be perceived as such by clients. In both cases, however, an erotic imagination can overcome biases. Additionally, therapists can benefit from focused training on sexuality and desire and dealing with it in group. In the UK, group therapy courses include very little about this. Either the courses have to add sexuality training to their approaches or practitioners will need to go elsewhere for this specialized training.

HF: Dealing with recognition of the body, embodied relationships, and non-verbal communication are important features of some group work. How does attention to these issues enhance the understanding of group process as it relates to desire and sexuality in the group?

MN: The difficulties people have with their sexuality are always in some way related to their bodies, the body in fantasy, and, of course, other people’s bodies. Therefore, there can hardly be a sexual discourse without attention and sensitivity to the body. Again this needs openness, playfulness, and a non-judgmental position in the group so that people can feel free to talk about bodily matters, including intimate ones. Direct attention to the body and non-verbal in-group interaction, generally and not only in relation to sexuality, facilitates this position. This is another area that may merit greater emphasis in training courses since group psychotherapy is a largely verbal medium and lip service is often paid to non-verbal expression.

HF: You suggest that the private sexual self may contain all the hidden desires and impulses that are at odds with social standards and norms, and the risk of exposure may be why people fear joining groups. With the exponential growth of the Internet, people are now able to join groups in an unexposed way and talk about and engage around hidden desires and impulses with others. How is this form of connection different than desire and sexuality in groups that you discuss? What can group therapy offer, if anything, to those addicted to this type of engagement?

MN: The Internet connection you describe is very different from most therapy groups in so far as people participating in Internet groups usually join for very specific reasons having to do with sexual preference and sexual liaisons. So the Internet group is a group of like-minded people with very similar interests and an either implicit or explicit behavioral agenda. Most therapy groups do not represent such specific interests and do not have this kind of behavioral purpose. Internet activities have become very important in people’s sex lives offering forms of direct sexual stimulation with the possibility of satisfaction, and also have the advantage of anonymity, which again is very different from therapy groups. Addiction to Internet pornography and other forms of sexual material is a huge issue in the current world. A psychotherapy group may be of assistance if members with addiction issues are able to address these in the group. Again trust is vital. A therapy group may be able to challenge...
PK: How might attachment theory be helpful to the group psychotherapist working with a mixed group of men and women who bring into the group a variety of life struggles in maintaining intimacy in their relationships?

DW: Attachment theory research has three key implications for therapy: highlighting the centrality of the relationship; nonverbal experience; and the stance of the self toward experience.

Patients often seek group therapy because they have problems in relationships, and attachment research is largely research about childhood relationships. This research identifies the ingredients of those relationships that most effectively foster security, resilience, and flexibility. It suggests that as individual or group therapists we should aim to generate relationships with our patients that are inclusive (they make maximum room for patients’ feelings, views, desires), that upgrade the dialogue to higher levels of awareness and complexity, in which disruptions are recognized and repaired, and in which the therapist is willing to actively engage and struggle with patients.

Attachment research also suggests, by implication, that our ability as therapists to implement these guidelines will have a great deal to do with our own psychology. How effectively parents can impart security to the child depends largely on their freedom to recall and reflect upon their own attachment experience. When we are able to read our own minds, we can more easily read the mind of the child. Similarly, what we can include in the relationship with the patient depends on what we can allow ourselves to recognize and tolerate in our own experience. And our ability to upgrade the dialogue will depend on the strength of our own capacities to regulate our emotions, to mentalize, to be mindful, and so on.

PK: You write, “Because our first crucial experiences are mainly lived outside the domain of language, our crucial internalizations of early relationships register as representations, rules, and models that cannot be linguistically retrieved….

for old working models to be updated they must be accessed, that is, experientially engaged.”

What resources are available to the clinician for helping patient’s access nonverbal experience?

DW: That’s a perfect lead-in to the third key implication of attachment research, which is that we need to prioritize the nonverbal subtext of the therapeutic conversation. So how do we tune in to that channel? It turns out that what human beings can’t put into words they tend to evoke in others, enact with others, and/or embody. The implication for the therapist is that to access the realm of unverbalized experience, which is often also the domain of dissociated experience, we need to attend to our own subjective experience as we relate to our patients, we need to work with the transference-countertransference enactments we co-create with our patients, and we need to try to read the language of emotion and the body, for these are all routes to accessing and eventually integrating preverbal, disowned, and/or dissociated experience.

I’m most interested in enactments. I see these arising when and where the attachment patterns of the therapist interlock with those of the patient. In group therapy, these ongoing, mini-psydodramas will engage the attachment patterns of group members as they enact with one another, as well as the attachment patterns of the therapist as these are activated in the group.

PK: You mention “intersubjectivity…as the best umbrella term for an invaluable body of clinical research that has taken shape in the last 20 years, that both echoes and extends the clinically fertile insights of attachment theory and infant-patient research.” With the above in mind, how does the intersubjectivity model serve to provide this link with attachment theory and developmentally based research?

DW: Lots of researchers and clinicians have used the term intersubjectivity to mean different things. I’m using it to refer to what’s been called the “relational turn” in psychoanalysis, which happens to parallel the relational emphasis in attachment theory. Both in the clinical and the attachment research settings it’s become clear that we come to know ourselves as we are known by others, and our experience is created in our interaction with others. The clinical and research findings echo and may thus confirm each other, but intersubjectivity adds therapeutic innovations to attachment theory’s developmental and diagnostic insights. Specifically, it rejects any standard technique in favor of a kind of creative clinical pluralism. It also allows for the option of deliberate self-disclosure. Lastly, it prioritizes a focus on enactments, not only as a key route to insight and new experience, but as potential barriers to both.

PK: You emphasize the importance of humanizing the therapist role, advocating the need for a paradigm shift from a one-person psychology to a two-person psychology. Could you expound on this?

DW: I’m a big fan of both humanizing and democratizing the therapeutic relationship. Therapists and patients alike are inescapably more human than anything else—more alike than different, though one is there primarily to help and the other to be helped. For better and worse, therapists affect and are affected by their patients. All of us are embedded in the relational context.

Unfortunately for generations of patients and therapists, the long-prevalent one-person psychology failed to appreciate these realities. Trained in this model, many of us were encouraged to adopt some pretty crazy assumptions. One was the idea (contradicted by experience) that the therapist could be entirely neutral and objective. Another was the notion that the patient’s psyche could be understood only if it were isolated from the contaminating influence of the therapist’s real personality, hence the prescription that the therapist should aim (impossibly) to be a blank screen. In contrast, two-person psychology recognizes the reality of mutual reciprocal influence and the fallacy of objectivity. It makes room for a dialogue in which therapists and patients work together to understand primarily the patient, but also the therapist. In this framework, therapists, like patients, are influenced by factors outside awareness, and patients are respected as potential interpreters of the therapist’s experience.

We no longer have the unearned authority vested in us by a destructive old model. Now we can still have authority, but it has a completely different and sounder basis. We are (or should hope to be) experts at changing the system from within. This means being expert in knowing and using ourselves to co-create new attachment relationships with, and for, our patients.

PK: Do you feel that your efforts at integrating attachment, relational, and developmental theories have a place within the context of group psychotherapy?

DW: Very much so. Integrating attachment research and relational theory creates what is, at least for me, an extraordinarily useful framework for clinical intervention whether the therapy is that of the individual, the couple, or the group.
Dear Tiger:

When one member monopolizes a group for multiple sessions, I presume the group is in collusion to avoid really relating. John’s role as affable entertainer can be quite seductive, to you as well as the group. You brought him in thinking he would change the group by role modeling more engagement. Well, the group changed all right; but instead of more interaction, there is less.

Since no one else feels safe or strong enough to confront his monopolizing, it falls to you to do so. How you do it is important, so that he doesn’t get scapegoated. I would tell the group that it feels as if “we” have been colluding with John, to avoid really working, and really relating with one another.

The first reaction may simply be silence; sit with it a while. The tension will be great, and John will be tempted to take over. If so, stop him. The anger toward John for taking over the group needs to emerge. If necessary, redirect it toward you. Acknowledge “The John Show,” but remind them they all have been co-producers, encouraging members to own why they let it go on so long. You might even admit how you went along with it so long. If the therapist can say how he got stuck, sometimes that will make it easier for the members to also do so.

Dave Cooperberg MA, CGP San Francisco, California

Dear Tiger:

This is such a great example of a frequent situation that all of us continue to encounter. No matter how many times this kind of resistance arises in a group, it is never a slam dunk as to what kind of intervention will help resolve it. You can understand wanting to add a more active member to a group of depressed or repressed people. On the one hand, it seems like a good idea that oftentimes works to the benefit of the group; the active member will catalyze the group, and the group will move forward with newfound energy. Or, our worse fears are realized, and the opposite happens. The depressed/repressed members get overwhelmed with additional envy and aggression, and it increases their resistance. This seems to be what is happening with your group in response to John and maybe even in response to you for bringing him in.

I want to start out by thinking about your choice of signature and what it may tell us about the group. As I’m sure you know, I’ve Got A Tiger By The Tail is the name of a song by Buck Owens. A definition of the phrase is that of a situation too difficult to handle. In the song, Owens sings “I’m about as helpless as a leaf in a gale and it looks like I’ve got a tiger by the tail.” My first thought addresses the issue of induced countertransference and how your group was able to get you to experience their helplessness and their own feelings of having a tiger by the tail. My guess is that group members are feeling overwhelmed with their own frightening and shameful impulses, particularly anger. They are afraid to confront John for any number of any number of reasons (fear of loss of control of their impulses, fear of rejection or retaliation, to name a few.) They are inducing you to experience the helplessness they feel in the face of their own overwhelming feelings.

I also wonder how you introduced John to the group. Did they pick up on your hope for something different to happen and are silently expressing their resentment towards you for bringing in a “ringer” or a favored child for that matter? Do they secretly feel they are letting you down and are paying you back for it? These are all issues to ponder as you continue to study your own feelings and the group’s resistance. If this continues to go on much longer, it could become a group destructive resistance, which could drive away the helpless feeling members, thereby threatening the viability of the group. This may call for strong measures.

The goal here is to help your other group members to find their voice and be able to put their thoughts and feelings into words, not into behaviors like silent and sullen withdrawal. Have you noticed any of the other group members rolling their eyes or tapping their foot or some other subtle behavioral reaction to John? If so, you could ask (let’s call him Joe) what he thinks Paul is trying to say when he looks at the ceiling or taps his foot. This is a fairly benign intervention that may or may not help group members speak up. You might also ask a more courageous member whether or not he feels satisfied or dissatisfied with how the group is going lately. If he is dissatisfied, ask how you have been contributing to his dissatisfaction.

If these approaches fall flat and they continue to accommodate (or avoid) John, you might consider using what Leslie Rosenthal (1971) developed and Lou Ormont later (1990) coined “The Prognostic Intervention.” David Rosenthal, (1993) in his paper “The Prognostic Intervention in Group Therapy: A Tool for Managing Group-Destructive Resistance,” wrote that the term ‘prognostic’ refers to “the therapist’s efforts to head off potential impact of treatment-destructive resistances before the damaging effects are realized.” According to David Rosenthal, the modern group analyst has a number of tools and techniques to deal with group-destructive resistance, and the prognostic intervention is particularly useful to address monopolization, sexual, and aggressive acting out.

You might consider starting the next session by asking the group, “What aspect of John’s life would you like him to talk about today for the entire session, and how is John going to accommodate you in doing so?” Although spoken with concern, this kind of intervention may evoke anger toward you, a safer target than John may be. This is a hoped for outcome as it could help resolve the resistance to aggression and free up the energy in the room. If they are angry with you for bringing in a new person or for a favored new person, it will be easier for them to direct their anger at you and hopefully loosen up their resistance to stopping John from monopolizing the group. Or, they may take it as a criticism and feel freer to complain to you. All this is meant to diminish their resistance to the expression of their anger and aggression. By doing so, the group members may be able to confront, contain and otherwise explore their own feelings in relation to John and get back to the business of making more meaningful contact with one another, as well as help John in exploring the anxiety that lurches behind his monopolizing of the group.

Brian Ashin, MSW, CGP Ann Arbor, Michigan

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 512-472-2880 or e-mail at mhegener@sbcglobal.net.
GPALA offered a one-day training program. In October, The Group Unseen: Bion’s Perspective of and for fall are Los Angeles. Among the programs scheduled MFT, CGP, at its annual summer garden party Los Angeles (GPALA) honored Nancy Fawcett, Jan Morris, PhD, CGP. AGPS’s 2012 programming will end with its. At the Tri-State Group Psychotherapy Society presented its Fall 2012 conference—a master class with Gail Brown, MA, on Maximizing the Use of the Here and Now Working with Groups. The Tri-State Group Psychotherapy Society continues to enjoy its recent renaissance with attendance doubling at its two most recent conferences. These conferences bring together interested professionals from the Ohio, Kentucky, and Indiana region.

The Group Psychotherapy Association of Los Angeles (GPALA) honored Nancy Fawcett, MFT, CGP, at its annual summer garden party for her long-term dedication to group therapy in Los Angeles. Among the programs scheduled for fall are Treating Addiction in Group Therapy and The Group Unseen: Bion’s Perspective of the Unconscious Group Process. In October, GPALA offered a one-day training program on Integrating Art Therapy into Your Group Psychotherapy Practice: An Introduction for Clinicians, presented by Jane Schulman, ATR, LMFT, and Gail Goldstein, ATR, LMFT. Justin Hecht, PhD, CGP, presented the Fall Conference Becoming Who We Are in Groups: A Jungian Approach to Group Psychotherapy.

The Illinois Group Psychotherapy Society (IGPS) hosted a gathering in the Chicago area to promote social networking and communication of ideas relating to current groups, training opportunities, as well as feedback on programming ideas. Shelley Korshak, MD, CGP, spoke informally about her use of psychodrama in groups, which kicked off the discussion. Members were invited to share resources by bringing business cards and fliers. The event was organized by the newly formed Social Committee, co-chaired by Paige LaCava, LCPC, and Elyssa Fink, LCSW. IGPS hosted Hylene Dublin, LCSW, BCD, CGP, FAGPA, and Paul Kaye, PhD, CGP, FAGPA, at a two-day experimental Institute at Argosy University Chicago Loop Campus. The Institute—Men and Women: Separate and Together—included opportunities for men and women to observe each other in uni-gendered groups, as well as combined group experiences to examine similarities and differences in group behavior. Contact IGPS at igpsinfo@aol.

The Westchester Group Psychotherapy Society sponsored two special workshops: Bernard Frankel, PhD, ABPP, LCSW, BCD, FAGPA, presented on Couples Therapy: A Generic Design and Gloria Bartkin Kahn, EdD, ABPP, CGP, FAGPA, presented on Group Psychotherapy as a Training Ground for Effective Management of Conflict. On December 14, Peter Taylor, PhD, SEP, CGP, FAGPA, will present The Threat Response Cycle: Understanding and Supporting Effective Survival Responses in Group. The location for these workshops is the Westchester Medical Center in Valhalla, New York.

Please note: Affiliate Societies may submit news and updates on their activities to Tammy Brown, MSSW, CGP, Editor of the Affiliate Society News column, by e-mail to: tammybrown@austin.rr.com.

Nitsun continued from page 5

the problems and losses involved in Internet addiction, as well as the complexities of self-perception (what self-injuries or disappointments may be concealed in the addiction?). Relational issues can also be addressed: What frustrated relationship needs lie behind the addiction and what might need to change in order to give up the addiction?

HF: You point out that sexuality is an integral part of group life, whether we acknowledge it or not. You also note that it is highly charged and there are ethical issues involved, such as safety, that are dealt with differently depending on the therapist and the position that he or she takes. Can you elaborate?

MN: Ethics usually relate to boundaries and boundary violations. There are various boundaries that may be broken in a group. There may be undue pressure to reveal sexuality; there may be unfair judgments of sexual behavior; and there may be precocious sexualization in the group. So, when I encourage a more playful exploration of sexuality, I am aware of the possible risks and the ways that openness can be abused. Also, excessive, misplaced, or voyeuristic openness may itself be abusive. The biggest boundary violation is probably the enactment of a sexual relationship by members outside the group, and this can include a relationship between therapist and client. All these examples require an ethical stance. The therapist must be prepared to take a position and hopefully a fair position that protects the group members and him or herself. Most professional associations like AGPA have guidelines in these areas, and it is important that therapists are familiar with these guidelines.

HF: Presenting at AGPA’s 2013 Annual Meeting in New Orleans is exciting for the organization. What is your desire for attendees of your Special Institute?

MN: I find that I learn something different in each situation, especially about sexuality, which is such a complex subject. I am aware that it is a complex subject for me, as it is for most others. I appreciate attendees’ openness and willingness to go on a journey rather than expecting fixed ways of seeing and doing things. Sexuality is about diversity, and I hope that we can join in a celebration of diversity.