Black Lives Matter in Therapy Groups Too: How Do Therapists Defang Racial Microaggressions?

Aziza Belcher Platt, PhD

Cultural diversity within therapy groups has greater potential for interpersonal exploration and development (Chen, Kakadi, & Balaban, 2009). Within groups, there are many possible combinations of interactions and fields, thus creating the potential for racial-cultural events in multiple directions and levels of interaction (Chen, Theombs, & Costa, 2019). Racial-cultural events can be defined as incidents, interactions, or processes in the counseling group that therapists believe were related to, or influenced by, visible racial dimensions, and any stereotypes and assumptions pertaining to those dimensions (Zaharopoulos & Chen, 2018).

In the wake of ongoing Black Lives Matter antiracism protests and COVID-19 and the racial disparities therein, racial microaggressions may emerge as a common racial-cultural event in therapy groups. Now more than ever, group therapists are required to identify preventative and intervention strategies. Dissecting microaggressions in therapy groups (Belcher Platt, 2020), first named by Chester Pierce (1970), are further defined by Sue et al. (2007) as “brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostility, derogatory, or negative racial slights and insults toward people of color” (Sue et al., 2007, p. 273). Racial microaggressions occur in multiple subtypes, and my research has yielded several additional subtypes within the small group context (Belcher Platt, 2017). Describing each type of microaggression is beyond the scope of this article; however, detailed descriptions and examples are available in Sue et al. (2007), Sue et al. (2008), and Belcher Platt (2017).

Prevention

Our work to address microaggressions commences before we convene our groups. Given the group as a social microcosm, we need to examine the macrocosm of the geographic context within which the group functions by exploring a few questions: What is the racial composition of your area? What is the history and status of race relations? Is your office in an area of town where Black people might feel unwelcome or be considered out of place by others? How are Black people received in your building, on your campus, in your institution? What are the direct or indirect ways in which the environment you have invited them into communicates that they are not welcome or welcome only in a subservient role? What in your environment, despite your personal beliefs, will compounded whatever harm has led them to seek treatment?

Case Example: In 2014, there was a period of uprising in New York City in response to the grand jury’s decision not to indict former police officer Daniel Pantaleo for the choking murder of Eric Garner. During this period, I worked at a community hospital outpatient program, and one of my patients was a Black single mother of a 10-year-old boy. She attended weekly therapy sessions after working full-time, picking up her son from school, and trudging from the Bronx to the Lower East Side. I considered so many of the individual factors and stresses in her microsystem and accommodated these structural barriers as much as possible. I often switched my night to align with her schedule. During sessions, her son completed homework or played video games in our open lobby area. One night, a white therapist who did not normally stay late was leaving, noticed my patient’s son, and inquired why he was sitting there. Despite the boy’s explaining his presence and numerous means by which to verify this, he insisted the boy accompany him downstairs to security who called the police. After frantically checking restrooms and nearby areas, my patient, found him frightened, in tears, and terrified of the impending police arrival. Assumption of criminality, another subtype of microaggression, led to the mistrust of this well-behaved child and his treatment as a delinquent. While the child did nothing wrong, I failed to consider the systemic context of my fellow therapists with whom I engaged in group supervision. The perpetrating therapist was oblivious to, or unconcerned about, the macrosystem in which racism and a corollary profiting and brutality of Black individuals by police is the reality. Hence, our preventative efforts regarding microaggressions are not limited to the group within but must extend to the group without.
Midst of Systemic Racism and Social Injustice, ABPP, CGP, FAGPA, provides:
In companion articles in with Zindel Segal, PhD Special Institute at AGPA Connect 2021. McEneaney, PhD, ABPP, CGP, FAGPA provides: need to understand the impact of microaggressions in groups. Comprehensive overview of the literature, relevance, and need to understand the impact of microaggressions in groups. AGAGA Connect 2021 Institute Co-Chair Anne Slocum McEneaney, PhD, ABPP, CGP, FAGPA provides: Treating Racial Trauma: Science, Art and Spirituality with the Anne and Ramon Adler Institute for Intergroup Education and Training. Treating Racial Trauma: Science, Art and Spirituality with the Anne and Ramon Adler Institute for Intergroup Education and Training. AGAGA Connect 2021 Institute Co-Chair Joe Sho, PhD, CGP, LFAGPA, overview of Dr. Segal’s Special Institute at AGPA Connect 2021. In companion articles in Group Assets, AGAGA Connect 2021 Conference Co-Chair Thomas Stone, Jr., PhD, ABPP, CGP, FAGPA provides: Treating Introspection and Group Composition Another important preventative consideration is racial identity development, ours and our potential members. A comprehensive overview of the literature, relevance, and need to understand the impact of microaggressions in groups. AGAGA Connect 2021 Institute Co-Chair Anne Slocum McEneaney, PhD, ABPP, CGP, FAGPA provides: Treating Racial Trauma: Science, Art and Spirituality with the Anne and Ramon Adler Institute for Intergroup Education and Training. Treating Racial Trauma: Science, Art and Spirituality with the Anne and Ramon Adler Institute for Intergroup Education and Training.

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marginalization was demonstrated on the AGPA listserv and the impact of supporting others who are also dealing with racism, and attempts to help those who want to be allies. A recent experience served as a motivator. I sat aside American/Black young professionals and shared stories of racism, prejudice, and micro aggressions that I have encountered in my personal work and trauma experienced within AGPA. Personal stories and information have been expressed, and public examples have been apparent for all to see. Yet, systems that allowed for this harm have gone largely uncategorized. Individuals who have perpetrated harm have been allowed organizationally to continue to serve in situations that lead to continuation of that harm. At times, the impact goes unrecognized, is minimized, or is handled by perpetuating cycles of harm, with little attempt at repair. Lack of attention to inclusivity of BIPOC and those holding marginalized identities to repeatedly reinforce institutionally devaluing these individuals and sanctioning the behaviors. These are also indicative of macroaggressions (Sue et al., 2019).

Another example is the hierarchical leadership structure that requires certain years of service to move up the ladder with limited inclusion of BIPOC and those who hold marginalized identities. It is reinforced by those who hold the belief that this is the frame of how things operate and it is a good frame, and will allow some adjustments within it, yet are reluctant to examine the frame itself to determine if it has caused hurt and/or harm to those who have felt it. It is also a frame that allows those who push back on a broader frame of BIPOC, those holding marginalized identities, and allies who point out the problem and advocate for change. These individuals safeguard the status quo. This institutionalizes prevention of BIPOC and those holding marginalized identities from having a true seat at the decision-making table to address institutionalized racism, marginalization, and full inclusion. It keeps in place systems that contribute to harm. It also serves to maintain power and privilege by those who have historically held it, while disentrenching others.

**Where Does AGPA Go from Here?**

Many at AGPA are trying to take steps toward addressing institutional racism and attending to inclusivity. These steps are valuable, yet the systemic racism in AGPA cannot be isolated or eradicated without acknowledging the impact of BIPOC and those holding marginalized identities. Acknowledging the impact of systemic racism within AGPA allows individuals to take greater ownership for attention to this and prevent harm to the clients, students/trainees/interns, and colleagues. It also serves to maintain power and privilege by those who have historically held it, while disentrenching others.

A recent example of institutionalized racism and marginalization was demonstrated on the AGPA listserv and the response from AGPA leadership. For a significant period of time, BIPOC and allies on the listserv addressed the harm, trauma, and safety issues they experienced, particularly those identifying as Black/African American. Subsequently, they experienced the impact of individuals being aggressive, transphobic, racist, abusive speech and behavior, with limited visible organizational intervention. Detailed accounting and recommendations were given regarding addressing the problem, yet there were challenges with implementation. Although there was condemnation of harm toward BIPOC, attempts at private mitigating, and an expressed goal of work on more comprehensive action, the ultimate temporary solution was to prohibit and moderate social justice posts with a reported goal of protecting BIPOC from harm. It excluded posts tied to their identities, yet still allowed for freedom of the requested refrains on referrals, resources, and consultation. BIPOC and allies were moderated for crossing these boundaries, without the same attention to moderation of those who posted content harmful to BIPOC. This reinforced discrimination, marginalization, and devaluing of BIPOC. It also reinforced the silencing of BIPOC that occurs within AGPA and leadership positions and the membership. The personal and micro level) and its clinical impact. This includes published material by US organizations, such as the Human Rights Campaign, and academic and clinical training programs. My heart sank toward goals in the midst of experiencing racism from professionals and heard the stories of resilience and working toward goals in the midst of experiencing racism from professors, advisors, supervisors, clients, and peers in their academic and professional training.

Where Does AGPA Go from Here? (Diangelo & Dyson 2019). Also consider when you encounter these issues in general, whether you need additional skills, whether you experience resistance or hold stringently to the frame, whether you’ve done personal work to address the concerns, or whether you’ve insulated yourself from these issues. I’ve heard some colleagues ask, “How do I avoid the backlash? Someone referring to me or viewing me as a racist, transphobic, or sexist?” “Good people are being villainized,” they say. This question (How can I have the appearance of being inclusive to continue to be seen as good, acceptable?) is part of the problem. Our ultimate response: I will not tell you how to pass. I will, however, support you in doing the personal work that is transformative in addressing personal racism, as well as the work that is required of each of us to create clinical work that is attentive to ethical considerations of addressing bias, blind spots, and areas where we lack competency relevant to BIPOC and those holding marginalized identities. I will welcome your active allyship in dismantling institutional racism, decreasing and preventing harm to the clients, students/trainees/interns, colleagues, and communities we impact, so that future generations can have a different experience than those of the past. By the time this is published, my hope is that AGPA will be in a healthier place on the path to institutional change.

**References**


Microaggressions and Group Psychotherapy
Francis Kaklaukas, PsyD, CGP, FAGPA

Intercultural aggression and oppression have existed between groups throughout history. While some are overt, such acts of violence, genocide, the withholding of needed resources, and the separation of families, other forms, such as biased historical narratives, the silencing of dissenting views, and allocation of power or resources. Narratives, overt and subtle, are held by many that influence our ideas and behaviors towards people in different groups.

Chester Pierce (1970) provided a framework and language for one powerful aspect of oppression. Peite claimed that microaggressions can be defined in this way: “Black-white racial interactions are characterized by white put-downs, done in an automatic, preconscious, or unconscious fashion” (p. 515). Regrettably, his ideas received only marginal attention. Sue and colleagues’ work (2007) and the ensuing 12,000 related papers (Freeman, 2020) have furthered our understanding of microaggressions.

The foundational descriptions of microaggressions centered on race but broadened over time. Group psychotherapists Lefforge, Melaunchin, Goates-Jones, & Mejia (2020) indicated that “Microaggressions are subtle forms of discrimination, often unintentional and unacknowledged that send negative and damaging messages to a person or group based on an identity that has historically been marginalized” (p. 3). Microaggressions occur across race, gender, sexual orientation, ethnicity, religion, ability, class, age, immigration status, intersectional, and other identities. Microaggressions are a smaller form of violence, oppression, and aggression (Sue, 2016).

Many feel tremendous personal, experiential, and philosophical resonance with this concept; however, Sue (2016) noted that “When people of color talk racism, Whites seem to interpret statements as a personal accusation, . . . even statements of racial facts/statistics, such as definitions of racism, disparities in income and education, segregation of neighborhoods, hate crime figures, and so forth arouse defensiveness.” (Sue, 2016, p. 140). Lui and Quezada (2019) described the ongoing pushback and popular mass war waged against addressing microaggressions and exploring our differences. Others have described the reluctance to embrace microaggression conversations as gilding marginalized positions (Fatima, 2017), a way to preserve domination, discrimination, and racism (Montenegro, 2018), and continued discounting of non-privileged or non-dominant identities (O’Dowd, 2018).

The critics report concerns about the increasing influence of critical social justice theory, highlighting examples of excessive punitive reactions, a culture of victimhood, or increased divisiveness (Campbell, & Manning, 2016; Hadi & Lukianoff, 2018). Use minimization, satanism, labeling, distorted stories, and even violence to minimize these conversations.

Academically, Littenfeld (2017, 2020) critiqued microaggressions for inconsistent operationalized definitions, reliance on subjective reports, and causal interpretation from correlational data. These criticisms are addressed by Kanter et al. (2017), Williams (2020), McClure and Rini (2020), and Freeman (2020), and suggest that microaggression research has focused on contextual and not laboratory settings, and that microaggressions have rater-reliability, and rigorous widely used interpretive methodologies including strong Consensual Qualitative Research (CQR) findings. Some researchers do acknowledge difficulty in discriminating between overt discrimination and microaggressions as both are often present (Lui, 2020).

Akin to the central foci of group psychotherapy, microaggressions arise in the world of identity, relationships, feelings, subjectivity, and dynamic actions. As group leaders, we value these subjective, interpersonnal, and systemic processes. While some scientific ideologies privilege observable content and highly controlled experimental designs, group leaders and researchers illuminate the potential deeper messages and impacts of unfolding interchanges. The best social science research is more complex, nuanced, historical, and interdisciplinary. The microaggression construct shares a similar journey of theory-building and research examination as central psychotherapy concepts, including depression and addiction, psychoanalytic constructs, and group therapeutic factors.

The microaggression information provided from clients, research participants, and historical accounts are rationally triangulated with observable, biological, longitudinal interdisciplinary data, and peer-reviewed evaluations.

The scholarly literature on microaggressions is more robust than empirically supported treatment protocols and dwarts the canon of most popular group psychotherapy approaches. The interdisciplinary research demonstrates the impact of microaggressions on physical and mental wellness, adaptation to life changes, and feelings of value and is scientifically undeniable, unless one’s viewpoint is prejudiced (Lui & Quezada, 2019; Owen, Tao & Dintrane, 2019). This is not to say that our knowledge of microaggressions is complete, and theoretical exploration, research, rational analysis, and practical application continues enthusiastically.

Qualitative methodologies have furthered group psychotherapists’ understanding of group dynamics and curative factors. Zabropoulo and Chen (2010) employed grounded theory with group leaders of different racial backgrounds to study reactions and behaviors related to group-racial-cultural events (RCES). This resulted in a taxonomy of helpful, mixed, or hindering RCES. Helpful events move the group along through addressing racial-cultural interchanges. Working with diversity as a relationship helps members to connect across racial-cultural differences. Working with diversity as a process supports difficult dialogues while holding the container of the group; this process allows for true cohesion by acknowledging heterogeneous identities. Mixed events include racial-cultural events that were cut short or unfulfilled but could be revisited. Hindering events included ignoring or minimizing racial cultural differences, unexplored bias, and one-sided racial-cultural inquiry. Generally, leaders of color encouraged discussing the complexity of racial-cultural differences, whereas white therapists favored highlighting perceived universal similarities.

Aziza Belcher Platt (2017) studied the other side of the experience with racially diverse group members. The transcriptions exhibited painful microaggressions against group members of color. Oppressive structures, dynamics, and outcomes that exist in society are often mimicked in the group. Belcher Platt identified inhibited and impeding dynamics related to the mishandling of microaggressions that prevented members from acknowledging, validating, or fully discussing differences. Completed events were often difficult or incomplete dialogues but allowed for the group to move forward in real acknowledgment of difference and were launching points activating many therapeutic factors (i.e., interpersonal learning, vicarious learning, and cohesion). Belcher Platt (2017) described the bystander effect as when people freeze in the ambiguity and subtlety of microaggressions, fearful that these conversations are not welcome, and/or will not be handled well. The group response can be anti-therapeutic, non-therapeutic, or therapeutic. She used the metaphors of cultural refugees to illustrate the potential cultural and spiritual transformation of events embraced difference, and these discussions embodied active listening, seeking to understand, and when needed, commitments to change behaviors to increase inclusivity.

Microaggression research has often focused on one demographic variable, and when researching individuals with intersectional identities, multiple measures are often used. Building on the work of Cole (2009), Fattorucci, Revels-Macalino, and Hoyt’s (2020) research found increased validity with the piloted Interpersonal Microaggression Scale (IMS). The significance of this research for group leaders lies in holding complex ideological conceptualizations rather than blindly following nomothetic or more simplified demographic viewpoints. Often leaders build group culture around linking, bridging, or relating through identity demographics (i.e., gender, age, location, history). We should be vigilant in some instances that this bridging can be experienced as a microaggression. This bridging may privilege the more common aspects of the member’s identity while oppressing other parts or their intersectional identities.

When microaggressions occur between members, leaders could attend to the injured member and allow other members to provide support, eventually helping the perpetrator reflect on their experience, learn, and stay connected to the group (Hahn & Brooks, 2019). Leaders should not and need not push for universality at the cost of individuality (Belcher Platt, 2020).

When the leader(s) perceive a microaggression, Brooks and Hahn (2019) suggested that the group therapist maintain a non-defensive stance, explore the impact of their behavior, invite members to share their reactions, and acknowledge their failibility. While the inclination may be to defensively explain that the action was not meant or intended in an aggressive manner, this is not helpful and may ask group members to further minimize their own experience to forgive the person in power. Hahn & Brooks (2019) suggested that the leader must understand that microaggressions create a therapeutic rupture that decreases trust in the leader and potentially the larger mental health system. Committing a microaggression does not condemn you as a bad group therapist, but handling such incidents with care, reflection, collaboration, and our own continued work is essential.

Overstreet, Pomerantze, Sigrist, and Ro (2020) examined response options when a therapist perpetrates a microaggression. Three vignettes (therapist microaggression with apologies, therapist microaggression without apologies, and therapist avoided microagg) were examined for perceived multicultural competency, client retention, and overall impression of the therapist. Not surprisingly, results suggested that avoiding microaggressions scored the highest across all three variables; however, the results also suggested no significant difference with or without apology. For group leaders, the general consensus is clear that it is best to avoid microaggressions; apologizing does not circumvent the impact.

Sue (2016) repeatedly said that often it is well intentioned people who commit microaggressions, and that these acts should be seen as opportunities to learn, dialogue, and
Mindfulness-based Cognitive Therapy and Emotion Regulation: An Interview with Zindel Segal, PhD

By Joe Shay, PhD, CGP, LFAGPA, AGPA Connect 2021 Institute Co-Chair

EDITOR’S NOTE: Zindel Segal, a cognitive psychologist, a specialist on depression, and one of the founders of Mindfulness-based Cognitive Therapy (MBCT). A Professor of Psychology at the University of Toronto, Segal combines mindfulness with conventional cognitive behavioral therapy, which teaches patients to develop a different relationship to their thoughts and emotions.

Anne McEneaney, PhD, CGP, LFAGPA, AGPA Connect 2021 Institute Co-Chair

Anne McEneaney, PhD, CGP, LFAGPA, AGPA Connect 2021 Institute Co-Chair

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

ZS: There are two major topics that I will cover. The first addresses how mindfulness meditation can be taught in a clinical context to promote enhanced emotion regulation. I will use the eight-session group treatment that my colleagues and I developed, Mindfulness-Based Cognitive Therapy (MBCT), to illustrate this in concrete ways, including the theoretical rationale, efficacy data, and neurobiology behind this work. The site qua non of this work is that we learn through the experience of doing, so a good deal of our time will be spent engaging in the practice of mindfulness and then unpacking the experience as a group.

The second focus will be on the nature of group process in MBCT compared to traditional group therapy. We will be looking at areas of overlap between therapeutic mechanisms, such as normalization, de-stigmatization, and common humanity. We will also discuss which group process features in one approach but are absent in the other.

JS: Can you briefly trace the path you took to get to MBCT as your preferred modality?

ZS: I started my professional career as a clinical researcher employing cognitive therapy to treat mood and anxiety disorders. My interest was in understanding the nature of relapse vulnerability, and there was a lot of research pointing to the fact that patients could maintain a higher level of functioning over time if they continued to employ the skills they learned in individual therapy, once they were on their own. So, for patients in CBT, if they could continue to fill out thought records or schedule activities their rates of relapse over two years were on par with the level of protection afforded by antidepressant medication.

I received a small grant from the McArthur Foundation to develop a depression relapse prevention version of CBT and used the funds to host a series of meetings with two colleagues, John Teasdale, PhD, and Mark Williams, PhD, to write the treatment manual. In our discussions, we discovered that we all shared the belief that metacognitive awareness was a central mechanism of change in CBT. That in effect, we were helping patients learn to stand back and witness their experience, rather than being fully identified with it.

We had also heard that mindfulness meditation offered a way to directly train metacognitive awareness, not just of the breath or bodily sensations, but also of thoughts and emotions. In the end, we decided that our version of relapse prevention CBT for depression would feature mindfulness meditation at its core and be delivered in a group format.

JS: Is there a special sauce in MBCT that differentiates it from other models, i.e., that makes something we should all be paying attention to?

ZS: I think so, but then again I am not exactly impartial. My view is based on the recognition that nearly all forms of psychotherapy succeed in providing patients with the opportunity to step outside their world and view it from a meta-perspective. The problem is that this can be haphazard, happening some of the time and sometimes not at all. In MBCT, the practice of mindfulness meditation is central to each treatment session and home practice. In this way, participants have the opportunity to build their metacognitive capacities on a daily basis. Once they have developed a platform or ability to attend to, welcome, and describe their affective experiences, they are in a better position to choose adaptive responses to what they are feeling.

JS: I assume you have typically presented in person on this topic. Do you have any thoughts about how presenting it virtually to a large group will create a different experience, or does the mindfulness component help maintain the richness of the experience?

ZS: This can be a challenge, especially if the presentation is very content heavy. My approach to virtual presentation will be to mix periods of presenting content with practice and group unpacking of what was noticed. This rotation of modes of attending and participating has proven to be very effective in maintaining engagement with the material. There is a saying in the mindfulness community ‘You learn by doing,’ so practicing mindfulness is essential. In a clinical learning context such as this, it is important to have a theoretical grounding as to why a particular practice has been selected, the teaching points it can address, and how to invite into a client’s experience of practice that leaves the greatest room for discovery and encountering the unexpected.

JS: What advice can you offer participants for getting the most out of this experience with you or any authors or books you would recommend for participants to read to become familiar with your work, if they are not already?

ZS: I would suggest wearing clothing that is not too restrictive and sitting in a chair that offers support and comfort.

There are several books and papers that provide a good background to our mindfulness-based cognitive therapy with individuals, couples, and groups, and provides supervision and consultation to other mental health professionals. He will present the Special Institute at AGPA Connect 2021, to be held virtually in February.

Treating Insecure Attachment in Group Therapy

Anne McEneaney, PhD, ABPP, CGP, FAGPA, AGPA Connect 2021 Institute Co-Chair

EDITOR’S NOTE: Aaron Black, PhD, CGP, FAGPA, has practiced for more than 20 years in Rochester, New York. He is on the faculty of the Center for Group Studies in New York City. Dr. Black has conducted numerous group workshop trainings for AGPA, as well as in St. Petersburg, Russia, and Rochester, New York. Dr. Black maintains a psychotherapy practice with individuals, couples, and groups, and provides supervision and consultation to other mental health professionals. He will present the Special Institute at AGPA Connect 2021, to be held virtually in February.

AM: What is the title and topic of your Special Institute?

AB: The title of the Institute is Treating Insecure Attachment in Group Psychotherapy. I’m hoping to create a wide-ranging exploration of attachment theory as applied to psychotherapy.

AM: How do you plan to structure your discussions in the Institute?

AB: Approaches to group psychotherapy often use training manuals and have limited flexibility. For this Special Institute, we will use the collaborative evidence-based practice model that has been developed in our training institute. Delegating the teaching points it can address, and how to invite into a client’s experience of practice that leaves the greatest room for discovery and encountering the unexpected.

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

AB: The key concept of insecure attachment is the sine qua non of group process. The model of insecure attachment is highly dynamic.Attachment theory offers a way to describe the development and process of insecure attachment and how these concepts can add precision to our interventions. I’ll also be talking about the group leader’s internal process and what I (and others) refer to as the “internalized secure base.”
build stronger non-oppressive relationships. Microaggressions may be inevitable in groups, as everyone has implicit bias and cultural indoctrination, but actively engaging with these dynamics will make our groups more welcoming for all members. Few leaders are cognizant of all forms of marginalization, and we can create an allyship group culture where members highlight and explore these interactions as they recognize them.

Currently, great opportunities exist to meet the realities of oppression in our culture and in our groups. Critical integrative work is calling us, regardless of our theoretical orientations. We need to earnestly examine our therapeutic approach and interventions as many were created in a context of and out of a history of racism and heterosexism: Intersectional microaggressions toward racial/ethnic and sexual minority group members. Cultural Diversity and Ethnic Minority Psychology; 14(4), 239-250. doi:10.1037/ceh0000150

References


Dear Baffled:

This month’s dilemma and responses are supplied by the Racial and Ethnic Diversity (RED) SIG. The RED SIG is charged with addressing the unique needs of historically racially and ethnically marginalized populations in the field of group psychotherapy. This includes engaging members from these groups and others to dialogue about issues related to group psychotherapy and advocating for and encouraging participation in diverse group psychotherapy programming that promotes social justice and equity. Co-Chairs are Sheremika Brooks, PsyD, CGP (drshemikabrooks@gmail.com), Latasha Smith, PhD, LCSW, CGP (smithlatasha@gmail.com), and Marcel Turner, PhD, CGP (mturner4@alumni.nd.edu). To join the RED SIG, email agpamemberservices@agpa.org. For questions about the SIG, contact the Co-Chairs at their emails above.

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This dilemma brings up a number of considerations that run the gamut from co-leadership dynamics, to the interpersonal, to the in immediacy of gender and social forces that arise in group. By the seventh session, enough group cohesion has developed to allow the African American woman to name how she feels judged in the group by White members. Making a disclosure of this kind in a majority-White group places her in a vulnerable position. Bearing witness to difficult feelings and remaining open to dialogue while in group is no easy task. In this instance, rather than helping the group grapple with this powerful disclosure, the Latinx co-leader re-directed attention.

In this example, members can both differ and share characteristics regarding gender, race, or ethnicity. As the group leader, choosing an intervention demands that you balance multiple viewpoints and help members voice their predicament. Groups benefit when social justice and equity issues arise by establishing norms that include guidance on how to name microaggressions and by creating a brave space versus a safe space. While at first glance it appears important to explore interpersonal factors for the seven to blame the Black woman for putting up barriers that make her difficult to approach. The White members co-create with the trainee (and by extension, you, the more experienced facilitator) the prototype of an angry or difficult Black woman. Internalized White superiority and Black inferiority are reflected in the leadership team. You give undue authority to the inexperienced trainee. A scapegoating phenomenon emerges when the trainee boldly assumes that the Black woman’s experience of being judged derives from her defenses rather than from in vivo experience in the group, lived experience in society-at-large, and impacts of historical trauma.

Displays of humility and rupture-and-repair work need to ensue. You and your co-leader could self-reflect, own that you colluded in projecting a racist stereotype onto the Black woman, and acknowledge that you unconsciously acted out power and privilege dynamics. You could make amends for exposing the women of color to yet another microaggression by your novice co-leader. You could inform the group that you and the trainee will pursue antiracism training to become more attuned to oppressive themes. You and your co-leader could self-disclose about your own racial identity development processes and about your misses and failures in the group. You could make space for the Black and Latinx women to share feelings, including anger toward the leaders, members, and group-as-a-whole. Importantly, both leaders could explicitly name microaggressions you committed or enabled. You could invite the women of color to share any slights, judgments, and harms from leaders or members. Feelings toward the leaders could be explored in the context of authority relationships in a White-dominated society.

The Latinx woman could be invited to share what moved her to object when White members confronted the Black woman about unapproachability. You and your co-leader could acknowledge burdening the Latinx woman with the role of intervening in the scapegoating dynamic. In a teaching moment, you could point out how often in White society people of color will support one another while Whites exit, become angry or defensive, claim good intentions, or display White fragility. Once antiracist group norms are under discussion, you and your co-leader could encourage a differentiation process, with all members sharing feelings about the group and about parallel process with American White society.

Courageously, the Black female member discloses that she feels vulnerable in groups with few BIPOC members and judged by White members of this group. Rather than recognizing her significant risk, especially given repeated microaggressions by the trainee, you and your co-leader act complicitly in marginalizing her. You make space for the seven to blame the Black woman for putting up barriers that make her difficult to approach. The White members co-create with the trainee (and by extension, you, the more experienced facilitator) the prototype of an angry or difficult Black woman. Internalized White superiority and Black inferiority are reflected in the leadership team. You give undue authority to the inexperienced trainee. A scapegoating phenomenon emerges when the trainee boldly assumes that the Black woman’s experience of being judged derives from her defenses rather than from in vivo experience in the group, lived experience in society-at-large, and impacts of historical trauma.

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Chicago, Illinois
In February 2019, I became the Editor of GROUP, the scholarly journal of the Eastern Group Psychotherapy Society (EGPS). The first issue under my editorship was dedicated to social justice. Christine Schmidt was Guest Editor. The issue featured articles by Kathleen Isaac, PhD, and Alice Shepard, PhD, on the work they do in groups with underrepresented minority students. It also included a piece by Joseph Hovey, LCSW, on how our political discourse has become corrupted by noise, in SCT terminology, and how the communication model utilized in SCT led to a great deal of misunderstanding and tolerance of difference. The issue also included reviews of three books that critiqued the standard clinical approaches of CBT, psychosynthesis and addiction treatment. It made the point that the unmet needs of the marginalized are not met by simply asking the group why so and so feels this way, for more clinically beneficial to address people in moments of emotional activation, when the person is actually living out an insecurely attached state in the group. A relatively simple, but common, example is when one member experiences another in literal, concrete terms. For example, ‘I’m scared of you because you are exactly like my abusive father.’ We know from mentalization theory that this person’s capacity for using their symbolic mind is partially impaired. Feelings are being experienced as facts, which is a primitive mental state where outer and inner realities are equated. When the leader helps the group get curious about this missing symbolic capacity, more mature mentalizing can be restored. This might be as simple as asking the group why so and so feels this way, which is an indirect invitation to restore symbolic thinking in the group. The therapeutic process typically involves the breakdown and restoration of mentalization, which invites primitive mental states to be verbally processed and integrated in the members and group-as-a-whole. For scholarly writing, there are additional barriers, such as not having the right connections or the right degree from the right school. Full-time clinicians, supervisors, and administrators who do not labor within the academic, who in fact work on the front lines in prisons, hospitals, clinics, and many other institutions, must spend their days navigating their clients through an endless series of obstacle courses created by the very system that oppresses them. This leaves them little time or energy to pause and reflect on the work that they do in a broader sense, let alone write about it. At EGPS, we have committed ourselves and the journal to not having the right writing has been extremely meaningful to me personally and is probably the most satisfying aspect of my position. We have a responsibility to ourselves and to the future of our profession to record and document the heroic struggles of practitioners, as well as the people they serve, creating a space to amplify and immortalize their voices.

### Eastern Group Psychotherapy Society’s Journal Centers BIPOC Writers and Themes through Scholarly Writing

Jonah Schwartz, LCSW, GROUP Editor, Eastern Group Psychotherapy Society

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### TREATING INSECURE ATTACHMENT IN GROUP THERAPY

Dynamics of secure attachment are expanded within it over time. A person who seems capable of secure attachment when dealing with grief, for example, may look entirely different when dealing with aggression or sexuality. It’s more clinically beneficial to address people in moments of emotional activation, when the person is actually living out an insecurely attached state in the group. A relatively simple, but common, example is when one member experiences another in literal, concrete terms. For example, ‘I’m scared of you because you are exactly like my abusive father.’ We know from mentalization theory that this person’s capacity for using their symbolic mind is partially impaired. Feelings are being experienced as facts, which is a primitive mental state where outer and inner realities are equated. When the leader helps the group get curious about this missing symbolic capacity, more mature mentalizing can be restored. This might be as simple as asking the group why so and so feels this way, which is an indirect invitation to restore symbolic thinking in the group. The therapeutic process typically involves the breakdown and restoration of mentalization, which invites primitive mental states to be verbally processed and integrated in the members and group-as-a-whole. In other words, the group can provide the missing component of mentalization for a regressed member or subgroup, who can then slowly internalize this function.

**AM:** Who are some of the group therapists whose ideas and work impacted and influenced you?

**AB:** I immediately think of Anne Alvarez, PhD, CGP, DFAGPA, and Lou Ormrod, PhD, DFAGPA. I’m so glad that I got to experience their work in SCT at conferences and at AGPA Connect and not just in their writing. They both had such a command of theory, technique, and their own emotional process. My training group leaders, mentors, colleagues, and students at the Center for Group Studies have had an enormous influence on me. And though not group therapists, John Bowlby, Mary Ainsworth, Mary Main, and Peter Fonagy’s elaborations of attachment theory have helped me enormously in all my clinical activities.

**AM:** How do you feel that the learning will be relevant for participants?

**AB:** Despite my love of teaching and training, most of the groups I facilitate are long-term therapy groups, with members who are in combined treatment (individual and group therapy). My group leadership style always considers the individual development of each group member along with group since I’m working with most of my clients in both modalities. If you think about how group practices develop in private practice, combined treatment is the clearest pathway, and this orients my group leadership style to incorporate (or at least attend to) the details of each member’s intrapsychic process. This is also how I work with demonstration groups. I’m hoping there’s something about my leadership style that participants will be able to identify with and apply to their practice.

**AM:** Will this be useful for people of all levels of experience?

**AB:** I always do my best to make my work accessible and useful to anyone running groups. While I’m keenly interested in the minutiae of theory and technique, I try to keep my interventions emotionally grounded and simple in the use of language. In the Special Institute, I think it’s especially useful for participants to have a rich enough experience that they can focus on whatever elements are of particular individual interest. For some, this might mean hearing about mentalization for the first time. For others, it’s the chance to experience the language I use to make an intervention they would also make, although I may come at it from an unfamiliar angle. Still, for others, observing how my mistakes affect the group process, for better or worse, will be most compelling. Fortunately, when presenting at a place like AGPA, the participants have enough experience already, that whatever is going to happen is likely to be rich and interesting. I’m sure to learn a lot myself!