Group Psychotherapy on the Global Stage

Jeffrey Kleinberg, PhD, CGP, MPH, DFAGPA

Editor’s Note: Dr. Kleinberg received the Group Foundation’s 2018 Social Responsibility Award for his international outreach work. Inaugurated in 2010, the Award is presented annually to an AGPA member or group of members who has performed an exceptional service that ultimately benefits the public at large, nationally or internationally.

In the last few years, I have been invited to teach and supervise group therapy in the Republic of Georgia, China, and most recently Grenada in the Eastern Caribbean. Support for this work has come from the International Association of Group Psychotherapy and Group Processes (IAGP), AGPA, the Global Health Program of Mt. Sinai Medical School, and sometimes from the professionals directly receiving the training. In every case, the trainees were enthusiastically working on ways to apply their newly acquired group leadership skills in a variety of settings, ranging from the rubble of a disaster area left by an earthquake, to the inpatient unit of a large hospital. I have trained various helping professionals, such as nurses, social workers, psychiatrists, surgeons, psychologists, and school counselors. I have addressed English-speakers, as well as Chinese- (Mandarin), Georgian-, and French-speaking students with the help of translators who have served as cultural navigators for me, informing me about cultural and language nuances and reading between the lines to convey subtle emotional tones.

As I bowled the group photos that seem to be a requisite part of each meeting around the world, I have tried to figure out why I wanted to go and what was the local enthusiasm all about? I have been motivated to advance the cause of talk therapy in places where medication was the only previously available treatment. The trainees have been looking for new ways of treating those with mental illness and new and enjoyable methods for learning these interventions. They are particularly excited by experiential learning, which, of course, is an effective part of training group therapists. Policy makers and managers welcome the visiting teachers as they seek to serve their constituents in a cost-effective way. Also important to all stakeholders are the personal relationships that form—we are collaborators, friends, and advocates—between colleagues across borders.

I have to thank the Eastern Group Psychotherapy Society (EGPS) and AGPA for introducing me to and immersing me in community mental health care in the aftermath of 9/11.

Word quickly spread through professional workshops, testimony from those affected by terrorism or natural disasters, and professional and organizational outreach, that groups were helpful in dealing with recovery from disasters and other community trauma. Moreover, mental health professionals in many parts of the world began to appreciate the applicability of group therapy to mental health needs in general. Groups addressed the gap from wars, genocide, famine, floods, and earthquakes rises from mental illness and new and enjoyable methods for learning these interventions. They are particularly excited by experiential learning, which, of course, is an effective part of training group therapists. Policy makers and managers welcome the visiting teachers as they seek to serve their constituents in a cost-effective way. Also important to all stakeholders are the personal relationships that form—we are collaborators, friends, and advocates—between colleagues across borders.

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Republic of Georgia

Psychodynamic treatment was not permitted during the Soviet era. Since the breakup of the Soviet Union, the population has experienced significant trauma (civil war, invasion, and floods). Camps for citizens displaced from their communities are in need of mental health services. Outside of these camps, residents of earlier conflicts have also left their mark. The brief war between Georgia and Russia in 2008 retraumatized thousands who suffered 18 years earlier in the conflict between Georgian Interior Ministry units and the paramilitary of South Ossetia, a breakaway territory. Universities today are graduating counselors and psychologists who are hungry to learn how to lead groups. Our liaison there, Rezo Koritseteli, MD, CGP, FAGPA, a member of AGPA and IAGP, is a strong supporter of group, and along with committed new professionals, has made major progress in upgrading therapy services in Tbilisi. For example, the International Red Cross and other agencies working in the refugee camps are providing group treatment for posttraumatic stress. One of the leaders of this effort was trained in workshops supported by IAGP that added what she had already learned by attending AGPA Annual Meetings on scholarship.

China

China, too, has now reconnected with mental health professionals in Western countries. In the aftermath of the earthquake and amid the rapid change in the economy and urban areas as new factories and buildings seem to be constructed overnight, the Chinese people have experienced increasing levels of stress. Working with our liaison, Xu Yong, MD, also a member of IAGP and AGPA, Nina Thomas, PhD, ABPP, CGP, and I planned outreach workshops that have each attracted more than 60 mental health professionals. In fact, people have had to be turned away. The need is so great. Trained group leaders have been addressing the needs of employees in stressful work settings, while expanding the mental health services in Tbilisi. For example, the International Red Cross and other agencies working in the refugee camps are providing group treatment for posttraumatic stress. One of the leaders of this effort was trained in workshops supported by IAGP that added what she had already learned by attending AGPA Annual Meetings on scholarship.

Continued on page 2
Steve Van Wagoner, PhD, CGP, FAGPA

Peaches are arriving, my tomato plants are producing fruit (for the chipmunks and squirrels mostly), and summer is well underway with cycling, hiking and Ultimate Frisbee (and accompanying injuries). So, it seems odd to be reading about the Special Institute from the President – 2.75 x 3.125  $    110
Sixth Page - 2.75 x 6.75  $   210
Quarter Page - 4.25 x 6.75  $   325
Full Page - 8.75 x 13.75 $ 1,250

FROM THE PRESIDENT

continued from page 1

STRATEGIC PLANNING MEMBERSHIP DISCUSSION

CURRENT

Officers: 1 (even years)
Board Members: 12
ASA Officers: 3
GF Chair: 1
IBCGP Chair: 1
Total: 12

Election Eligibility: Fellows, Clinical Members, Academic Members, Research Members

SCENARIO 1

Officers: 1 (even years)
Board Members: 6
Student/New Professional Board Members: 2
ASA Officers: 2
GF Chair: 1
IBCGP Chair: 1
Total: 9-16
Election Eligibility: Fellows, Clinical Members, Academic Members, Research Members, New Professional/Student Members for two designated positions

SCENARIO 2

Officers: 1 (even years)
Board Members: 6
Student/New Professional Board Members: 2
ASA Officers: 2
GF Chair: 1
IBCGP Chair: 1
Total: 16-17
Election Eligibility: Fellows, Clinical Members, Academic Members, Research Members, New Professional/Student Members for two designated positions; ASA Officers voted in as part of general membership election

feedback. Your participation and our transparency are most crucial.
Why is there a need for change? A smaller Board can be rambler and better able to maximize its effectiveness. Board exit interviews have indicated that Board members would like to have more opportunities to contribute, and a smaller size will allow for more participation. There is also a desire to retain a slate with more than one candidate for open positions, and the Nominating Committee’s task of recruiting as many as 20 individuals for Officers and Board positions has become quite challenging. Additionally, there is a desire to include new professionals and students in the decision-making of our organization to attract and retain early career professionals who have a fresh perspective. Consequently, we need to add and to subtract at the same time.

Membership voting rights is also a focus of our discussions. The organization has been structured so that those licensed for independent practice, teaching, or publishing are eligible to vote. Currently, Fellows, Clinical Members, Academic Members, and Research Members can vote. There have been numerous conversations about whether other membership categories—Associate Clinical, Adjunct, New Professionals, and Students—should also be offered the opportunity to vote in elections and other membership ballots, such as bylaw revisions. It should be noted that opening the voting opportunity is more democratic, but because AGPA is the parent organization of the International Board for Certification of Group Psychotherapists, the membership oversees our Certified Group Psychotherapist (CGP) credential, an unintended consequence is that the CGP or other practice/standard issues could be altered.

Membership category changes have been the trickiest to consider. We are examining whether to include the Certified Group Psychotherapist credential as a membership category to further the recognition of CGPs among our members. We are also considering whether all of the other membership categories are relevant if we offer voting rights across the board. Additionally, there is conversation about whether the membership categories are more of a barrier to membership than useful. Your thoughts on this area in particular would be welcomed.

Membership in general is a challenge, and we need the entire organization’s support to bring in new members and retain the ones we have. Renewed members were offered the opportunity to extend a Gift of Membership to a colleague, student, or supervisee; take advantage of this offer and invite a colleague to join us and then stay engaged with those you bring into the organization. The entire AGPA Board is taking on this challenging and also bringing along AGPA membership materials to meetings where they speak, teach, or consult. I hope that all members will help out and strengthen us as an organization by doing the same. If you have an engagement where you can talk about AGPA, please call the office and you will be sent easy-to-carry information to distribute.

We want membership to be a collaborative initiative with all of you, the Membership Committee, and the governance. Please weigh in with your thoughts and suggestions, and if you are interested in further participation, let us know and we will find a place for you to contribute. We appreciate and value your involvement.
See you next edition.
Clinical Applications of Attachment and Interpersonal Theories to Group Psychotherapy: Two Sides of the Same Coin
Anne Slocum McEneaney, PhD, ABPP, CGP, FAGPA, Co-Chair, Institute Committee

In my early clinical work, I was looking for a road map to my patients, including myself, experienced. When someone in the group is acting aggressively or completely detached, it helps me look beneath the surface to a painful childhood that would explain these behaviors. It allows me to have more empathy and compassion for members who learned to survive by engaging in protective strategies. The links between attachment theory, Fong's mentalization, and the neuroscience of Shote and Porges, also help me understand what I can do to help members in the group and why they can intellectually understand their interpersonal difficulties yet still struggle to change them. Even though change may come more slowly for some group members, the theory offers hope that change is possible.

MWE: In my early clinical work, I was looking for a road map that could really guide me through my clinical decision-making process. Finding new interpersonal circumstances in an article by Kivlighan and Angelone (1992) was a real aha moment, and I began researching it more deeply. Once I understood the core constructs, it just seemed to explain so much of what I saw in groups. Focused Brief Group Therapy (FBGT) also emphasizes a strengths-based approach that avoids blame, shame, and guilt as core principles. The idea that people are ready for a fun and challenging day. CM: I have learned a great deal from demonstration groups that I can apply to my group work (and my life). The similarities between the two are that the interpersonal dynamics that unfold in the demonstration groups are the same ones that unfold in therapy. The conflict, the transference, the internal representations, the activation of unconscious meanings, the cohesion are all the same. There is a lot we can learn from observing them.

AM: What advice can you offer participants for getting the most out of this experience with you?
CM: All group leaders are open to learning more techniques and approaches to working with challenging members in their groups. This will definitely help them identify their own blind spots and distinguish between transference and countertransference in groups. It will also foster their compassion for group members. Martyn and I will focus on how two theories can guide interventions that will be useful in their everyday practice. It will be accessible to clinicians at all levels of experience.

CM: I am a licensed psychologist in Ohio and an adjunct faculty at Xavier University and the Professional School of Psychology in California. When an Associate Professor at Wright State University, I founded Focused Brief Group Therapy (FBGT), now featured in the Sage Encyclopedia of Theory in Counseling and Psychotherapy. I have presented nationally and internationally on FBGT, most recently as part of the Yalom Institute in Beijing, China, and in Singapore for the Institute of Mental Health. I have authored numerous book chapters and articles, including the chapter on "Group Therapy in University Counseling Centers" for the Handbook of Group Counseling and Psychotherapy (2010). In 2012, he was awarded the Group Practice Award by the Association for Specialists in Group Work for excellence and innovation in group therapy. He was also awarded the Wright State University School of Professional Psychology's Teacher of the Year Award in 2014 and the African American Women in Professional Psychology's Faculty of the Year in 2015. As Chief of Clinical Integration and Research at Mercy Health (Ohio and Kentucky), he developed an evidence-based group therapy program for six inpatient units serving 13,000 patients per year. Dr. Whittingham is President-Elect of APA Division 49 and will assume the presidency in January; Co-Chair of AGPA's Science to Service Task Force; on the Editorial Board of the International Journal of Group Psychotherapy; and was a prior Research Chair for the Association for Specialists in Group Work.

References

MWE: When I was in graduate school, I observed Jack (John G.) Conczinis' PhD therapy group and saw what helped people change. Jack had a unique way of facilitating members' sense of security within the group, which allowed them to take interpersonal risks for the first time. Members relied on him and the group to feel secure. Jack was not afraid of painful emotions and could help members experience them in the room while linking the struggles they had in the group to the painful experiences with their early caregivers. I often left sessions in tears, touched by the members' honesty, genuineness, and courage. Years later, when I started reading the attachment literature and its application to individual therapy, I realized that Jack provided a secure base within the group and new relational experiences to challenge early internal representations of self and other. At the time, few people were writing about attachment in group therapy.

Attachment theory has held my interest over the years because it uniquely explains the interpersonal struggles many of my patients, including myself, experienced. When someone in the group is acting aggressively or completely detached, it helps me look beneath the surface to a painful childhood that would explain these behaviors. It allows me to have more empathy and compassion for members who learned to survive by engaging in protective strategies. The links between attachment theory, Fong's mentalization, and the neuroscience of Shote and Porges, also help me understand what I can do to help members in the group and why they can intellectually understand their interpersonal difficulties yet still struggle to change them. Even though change may come more slowly for some group members, the theory offers hope that change is possible.

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To me, the difference is in the safety. These groups have no confidentiality, no screening, and no preparation. For that reason, there are risks and there will be exceptions. The group must not unfold in therapy. The conflict, the transference, the internal representations, the activation of unconscious meanings, the cohesion are all the same. There is a lot we can learn from observing them.

AM: What is your expectation of participants? Will this be useful for people of all levels of experience?
CM: All group leaders are open to learning more techniques and approaches to working with challenging members in their groups. This will definitely help them identify their own blind spots and distinguish between transference and countertransference in groups. It will also foster their compassion for group members. Martyn and I will focus on how two theories can guide interventions that will be useful in their everyday practice. It will be accessible to clinicians at all levels of experience.

AM: What advice can you offer participants for getting the most out of this experience with you?
CM: Come to our Institute ready to apply attachment theory and interpersonal theory to your groups. Being an open mind, questions that you have been struggling with regarding your groups, and if you are like me, lots of coffee in the morning! MW: The Institute will be multimodal, so come prepared to think and engage intellectually but also to participate in watching video, seeing role plays, answering questions, and working in groups. We will be covering a lot of ground, so be ready for a fun and challenging day.

References
About his technique, our openness to feedback about our other surgeons into his operating room seeking feedback surgeon who described in to deliberate practice that harvests the full benefit of our maintaining a rigorous, reflective approach to our work and engaging in deliberate practice. It is the commitment and evidence-supported group therapist practices by reference effectively. We can ensure that we implement these evidence-supported group therapist practices by client outcome to the lowest 20% of therapists, we see that those clients who saw the more effective therapists measured by client outcome to the lowest 20% of therapists, 72% improved, 7% deteriorat...
Honing Emotional Intelligence in Group Psychotherapy: A Brief Illustration

Robert Pepper, CSW, CGP, PhD, FAGPA

Who hasn’t had some problem with relationships, either personal, professional, or both at some points in their lives? Many of us act out, often at the risk to their own physical well-being as well, by their volcanic rage at their own emotional expense and the object, the pre-oedipal patient protects the other from it. He believed that out of a self-defeating form of love for directed back onto an immature ego, thereby shattering the publication of that book, however, “Peter” suffered a

unconventional interventions in group psychotherapy

communication is taking place and when it’s not.

emotional intelligence. More than 20 years ago, Daniel Goleman popularized the term “emotional intelligence.” It can be defined as the capability of individuals to recognize their own feelings and those of others, discern between different feelings and label them appropriately, and use emotional information to guide thinking and behavior.

Some say it’s a gift. Some say it’s a skill. I say it’s most likely a combination of both, and it can be honed in a psychotherapy group, but it can only be enhanced with a leader who understands how to foster progressive emotional communication in interactions between group members. To foster progressive emotional communication between members, a group leader must be trained in the skill of having a quick ear to discern when progressive emotional communication is taking place and when it’s not.

In some people don’t want what they say they want: 100 unconventional interventions in group psychotherapy (2017), I described the recovery through progressive emotional communication in group psychotherapy, of a gay, pre-psychotic, young man. In the months following the publication of that book, however, “Peter” suffered a relapse. He was enacting a narcissistic defense, a term and concept coined by the founder of modern psychoanalysis, Hyman Spornitz (Spornitz, 1985). Spornitz took issue with Freud’s notion that pre-oedipal patients—schizophrenics, psychotics, psychotics, borderline, and those with character disorders—were suffering from a re-direction of libido away from the outside world and back onto themselves. In Spornitz’s view, it was not libido but aggression that was directed back onto an immature ego, thereby shattering it. He believed that out of a self-defeating form of love for the object, the pre-oedipal patient protects the other from their volcanic rage at their own emotional expense and often at the risk to their own physical well-being as well, by directing the aggression back on his fragile ego.

A Brief Illustration

My interventions in the example that followed were guided by this principle of aggression turned against the self. As a consequence, I worked to relieve the stress of a regressed group member’s shattered ego by redirecting the aggression off the self and back onto the object world, which in this case the safest target in the group was me. The hope was that ultimately such a redirection allowed the group member to reconnect with the feelings of repressed rage toward the hated loved objects in his life and put those feelings into words. Peter to the session in question, I received a terribl phone call from Karen, a member of that group. She said, “I’m okay. But I was hit by a car!” Obviously, she was traumatized by this event. She agreed to allow me to tell the group about what happened. I began the group with, “I have good news and bad news about Karen. She’s alive but she was hit by a car!”

Everyone let out a collective gasp; everyone except Peter. He said, “I don’t feel anything for Karen. I’m numb.” While other members expressed their concern for her and asked me questions about her well-being, Peter sat stock still, staring off into space until he blurted out, “I need to speak. I can’t contain it any longer.” With that, he launched into an agitated, emotionally disconnected and paranoid monologue about how he felt unsafe in the room. In a near hysterical voice, he screamed, “I can’t talk here because the room may be bugged!” Some group members were incredulous that he redirected the attention away from Karen and back to himself; I felt angry with his diversion. Having seen Peter for individual therapy the night before, however, I had a hunch about what was going on for him but waited to see how this scene would play out.

Looking around the room, I noticed Colleen was scowling at Peter. Using my feelings of irritation with Peter to hypothesize that Colleen felt similarly, I bridged to her, “Are you angry with Peter for leaving the group’s discussion about Karen?” Colleen said, “How did you know? It’s so rude of him.” I said to her, “You’re having the right feeling. Peter is angry, and you’re having his feeling.” She asked me to explain what I meant.

Before I could, the other members tried to reassure Peter that he was safe in the group and the room wasn’t bugged; but this only increased his agitation. Suzy noticed that he was safe in the group and the room wasn’t bugged; I felt touched by my words and said he was moved by the group, I told him that his change in attitude and behavior didn’t excuse his self-destructive drug binge, but it made his behavior all too understandably human. At the end of the session, I told him that his change in attitude and behavior was nothing short of remarkable. The other agreed. Peter felt touched by my words and said he was moved by the group’s warm response to him. He was noticeably more stable as he left group that night and headed to his weekly NA meeting.

Did progressive emotional communication take place during this session? I would say so. The interaction was progressive in that it began in a negative place, but ended in a positive, yet constructive way. My emotional intelligence was such that I was able to use the moment to the power of my emotional intelligence in that powerful, spontaneous feelings were put into words by Peter and the others, and there was communication between members. Peter presented new material in an emotionally charged way, and the group was supportive, protective, and understanding when he did. The group evidenced emotional intelligence when members empathized with the emotional pain and hurt that underlie Peter’s rage.

Putting feelings into words, as they occur in the moment, and toward other members (and the leader) in the group is critical toward honing greater emotional intelligence and maturation in a therapy group.

References


“Group psychotherapy can be thought of as a healing of the soul—an education or even re-education of one’s own emotions and the emotions of others. This is my idea of emotional intelligence.”
Grenada
Grenada, an island nation in the Eastern Caribbean, has had its share of trauma, including hurricanes and a revolution that provoked a United States military invasion ordered by President Ronald Reagan more than 30 years ago. Working with the local liaison, Doris Kenis Douglas, MD, staff of the Mt. Gay Hospital in Saint George have welcomed group training that makes psychosocial treatment more accessible. In addition, thanks to the Icahn Mt. Sinai Global Mental Health Program, a rotation of wonderful fourth year psychiatric residents adds to their capability and capacity for meeting these challenges. Each of these three nations have elements in common, including: local liaisons who understood the need for change and who were very receptive to group approaches; a potential pool of group leaders who were enthusiastic about leading groups; countries that have been traumatized and seek a method for addressing and resolving trauma and chronic conditions; and a commitment to working with non-governmental, non-profit organizations to promote quality and cost-efficiency.

As a trainer, I have some general observations to offer based on these three and other international training experiences. I hope these are useful for anyone considering doing this work.

When I am invited to teach, I generally have a sense of how experienced the students will be, but I also prepare for the unforeseen. I have lessons in my toolbox aimed at all levels of training. My preparatory consultations with the local liaison (host) plus my introductory exchanges with the students determine the topics of interest. Some were interested in organizational consultation; others were interested in trauma; still others were interested in couples counseling. I know most will be interested in Power Point slides, demonstration groups, role-playing, and supervision. It’s quite clear that everyone entitled wants a chance to interact with the teacher. The photo opportunities serve to memorialize the experience.

Training should be as experiential as possible, but only after the basic groundwork about theory and technique is done. After the basic groundwork about theory and technique is done, the trainers need to make participation as safe as possible. Personal disclosure should not be required.

Instead, exercises where participants are assigned fictitious characters to role play can be a transition to greater personal disclosure, should members want to do so.

Colleagues in the US often ask about possible controversies that arise over political differences and humanitarian concerns. I am very sensitive to the risks of wading into the political waters. If I did in that direction by a trainer, I am inclined to stay with the preplanned agenda. On the other hand, when patient rights need to be discussed around issues of confidentiality, reporting abuse, etc., I frequently turn to my hosts to explain the ways to deal with such cases. I am aware that I am not there to change the system but to teach and advocate for quality treatment. Visiting trainers must think through how to manage the tension surrounding this issue without violating their sense of values and ethics.

Be prepared to spend some evenings socializing with the people who invited you. This getting-to-know-you experience combines developing trust with planning for the future. In informal settings (homes, restaurants, parks, or tourist spots), you learn about the culture, what drives different stakeholders, and receive feedback from workshop participants. You should expect long days; it is crucial to take care of yourself, building in time for rest, connecting with people back home, and visiting museums and local places of interest. If you are co-teaching, you and your partner can debrief and share concerns each evening. Look for evidence of splitting and countertransference. Repairing breaches between the two of you is extremely important to the program’s success.

From a public health perspective, I have learned:
- There is no easy transition from working in a clinic to working in another culture, which involves translating skills and knowledge in one context to an entirely different one: Understanding the cross-cultural differences in the definition of mental illness, the experience of stigma, and local theories on what helps those afflicted by severe emotional distress is critical.
- Building a solid infrastructure and foundation, such as having local group therapy practitioners who can serve as liaisons, organizational and government support for group therapy training, a skilled volunteer pool, translators when needed, and developing cultural sensitivity and awareness on the part of the trainers and care-givers, improves the chances that you will succeed.
- Countries developing more sophisticated mental health services for dealing with trauma and disaster need more than a helicopter-in, helicopter-out approach. To institutionalize group-oriented trauma and disaster relief programs, they require sustainable efforts in the form of ongoing consultation, training, and supervision. When planning missions abroad, one must secure buy-in from the host country and from local mental health organizations and practitioners. Preparing for the trip through online video conferencing, such as Skype, as well as discussions with citizens of the nation you’re visiting who reside in the US, can be helpful.
- It is helpful to have a translator as a cultural navigator. Using translators enhances services and chances for success so long as they can communicate language and cultural nuances.
- Networking with other visiting trainers also keeps one current on shifting political trends in the country receiving training.
- Finally, conducting a post-visit discussion with the local liaison about next steps, including funding prospects, will always be welcomed. The visiting trainer will probably wind up spending some of his or her own money for travel expenses to supplement whatever external funding is available.

To prepare for my evolving role as a trainer and public health consultant, I returned to school to obtain a Master of Public Health degree, and learn about health systems models, political capital, stigma about the mentally ill and treatments, patient rights, victims of violence, displaced persons, and the need to build protective factors for mental well-being, among others. All of this input, as well as the opportunity to discuss health concerns that are different from our own, was invaluable as I began to travel and teach, and learn from the host countries.

The global stage has been set to promote group approaches as an important strategy in the toolbox of mental health treatment. Evidence now exists in a number of countries that training is affordable and well received, that group therapy is compatible with local cultures, and that it can complement other forms of treatment. Let’s see if this hopeful trend continues.

GLOBAL STAGE

Richard Beck, LCSW, BCD, CGP, FAGPA, has been elected President of the International Association of Group Psychotherapy and Group Processes.

Nina Brown, EdD, LPC, NCC, FAGPA, AGPA Past Secretary, was a guest on the podcast Nina Brown, EdD, LPC, NCC, FAGPA, Richard Beck, LCSW , BCD, CGP , FAGPA, Shoshana Ben-Noam, PsyD, CGP , as possible. Personal disclosure should not be required. groups. The trainers need to make participation as safe training should be as experiential as possible, but only after the basic groundwork about theory and technique is done. After the basic groundwork about theory and technique is done, the trainers need to make participation as safe as possible. Personal disclosure should not be required. instead, exercises where participants are assigned fictitious characters to role play can be a transition to greater personal disclosure, should members want to do so. colleagues in the us often ask about possible controversies that arise over political differences and humanitarian concerns. i am very sensitive to the risks of wading into the political waters. if i did in that direction by a trainer, i am inclined to stay with the preplanned agenda. on the other hand, when patient rights need to be discussed around issues of confidentiality, reporting abuse, etc., i frequently turn to my hosts to explain the ways to deal with such cases. i am aware that i am not there to change the system but to teach and advocate for quality treatment. visiting trainers must think through how to manage the tension surrounding this issue without violating their sense of values and ethics. be prepared to spend some evenings socializing with the people who invited you. this getting-to-know-you experience combines developing trust with planning for the future. in informal settings (homes, restaurants, parks, or tourist spots), you learn about the culture, what drives different stakeholders, and receive feedback from workshop participants. you should expect long days; it is crucial to take care of yourself, building in time for rest, connecting with people back home, and visiting museums and local places of interest. if you are co-teaching, you and your partner can debrief and share concerns each evening. look for evidence of splitting and countertransference. repairing breaches between the two of you is extremely important to the program’s success. from a public health perspective, i have learned:

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the global stage has been set to promote group approaches as an important strategy in the toolbox of mental health treatment. evidence now exists in a number of countries that training is affordable and well received, that group therapy is compatible with local cultures, and that it can complement other forms of treatment. let’s see if this hopeful trend continues.
Dear Consultant:

I have an ongoing therapy group that’s been meeting for two years. A few people have come and left, but there is a core group of six consistent members. They are very open and engaged and are willing and able to talk about what goes on in the room as well as their outside lives. One of the men is missing half a finger. He makes no effort to hide it, and talks with his hands whenever he speaks. He seems completely unconscious about it. No one in the group has ever mentioned it. No one has ever asked him how he lost it. I haven’t mentioned it either. I’m deeply conflicted about whether to bring it up. On the one hand, he seems to have no discomfort about it, and maybe the group shares his comfort level. In some ways, it’s a non-issue, irrelevant to all the important topics the group deals with so readily. Maybe it’s just my own countertransference, and none of the group members care about it at all. On the other hand, it could be an elephant in the room that everyone sees but avoids talking about. Sometimes it makes me wonder what else they might be avoiding. I don’t want to shame him, but I don’t want to embarrass myself either. Should I say something? How can I address it without causing more of a problem than actually exists?

Dear Stymied:

I’d really like to have more information about the makeup of the group, particularly the core group of six members who remain steadfast. Men, women, ages, and generational status information would be helpful. Is each also in individual therapy, and if so, with you or with another therapist? What were the criteria for accepting members into the group? How has the issue of the intermittent loss of group members been handled? Have these losses been addressed, in fact? If so, has the group spoken generally of loss, as well as having processed loss of members of the group and their feelings before, during, and after the changes in the group’s membership? Without knowing these details, I find it difficult to imagine why loss hasn’t been a key topic within the group over the two years it has been experienced. If loss was a readily discussed item for the group, loss of things other than group members certainly has had room to emerge. I’m wondering why it has not been spoken about.

Your first line of inquiry does, indeed, need to be focused on your countertransference, as you noted. Delve into that before you explore, or decide not to explore, the feelings of the members of your group about losses of all kinds—group members, body parts, etc.

Further, while I suspect that countertransference would be my first interest under any circumstances, after reading your request for consultation it is glaringly so. Let me explain why. In your brief description, you use the expression, “On the one hand,” followed by “On the other hand,” and my response to those phrases is that it’s unlikely you used them to be funny, making a pun. Explore your feelings about this group member’s hand with its missing half-finger and whatever else that means—to you. Additionally, explore your personal feelings regarding the occasional losses of group members. Are you aware of reasons for your deep conflict regarding speaking yourself, as if for the group-as-a-whole, about this one group member’s lost portion of a finger? It may be a complex, possibly deeply-rooted issue for you.

Once that exploration of your own feelings accomplished, you will be better able to answer your own questions regarding saying anything or not as the group leader without the burden of embarrassing yourself.

Anne Ziff, MS, MA, LMFT, CGP
New York, New York

Dear Stymied:

Trust your intuition. How can a core group of six members, who have been together for two years, and are very open with each other, never talk about something so obvious? Nobody ever said, “Dude, how did you lose your finger?” What is stopping people from talking freely about this? There is an old adage in group therapy that says, “Anything that cannot be talked about becomes dangerous.” In the midst of this sturdy group process, there is some fragility. Is the one member too fragile to ask the question? Or is the rest of the group too fragile to ask the question? What other questions or feelings might they be pushing down?

Usually the answer will be clearest in the countertransference. What are your feelings? The two feelings that jump out are shame and embarrassment—shame that you might say the wrong thing, and embarrassment that you might expose yourself to what? Ridicule! Criticism! Contempt! Your unconscious is onto something.

There is the appearance of full openness, but it is not true. People are holding things back. Things are being avoided. This is a group resistance, perhaps a status quo (Rosenthal, 1987) resistance. Everyone likes where they are and doesn’t want to go deeper or push harder. They would have to reveal other sides of themselves about which they are ambivalent. The caring person would have to admit having angry or critical feelings. The confident person would have to admit his or her self-contempt.

But this could be fun to work with. What if during the next group you kept asking, “What didn’t you say” after each person speaks, or better yet asking another group member, “What is he or she holding back?” Group members will become very irritated with you for even thinking they were not being fully honest. But if you persist, you will find out the truth.

David Dumais, LCSW, CGP
Brooklyn, New York


Members are invited to contact Lee Kassan, MA, CGP, LFAGPA, the Editor of the Consultation, Please columns, 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. Email Lee at lee@leekekassan.com.
The Atlanta Group Psychotherapy Society (AGPS) is going through a difficult transitional period and is attempting to tap the energy of members in helping AGPS grow into the future. AGPS has been a stalwart in the group psychotherapy community in Atlanta since the mid-80s, offering training, workshops, and conferences. It is optimistic that AGPS will continue to provide these services to the Atlanta psychotherapy community.

The Carolinas Group Psychotherapy Society (CGPS) is hosting its Asheville Social in May at the beautiful Circle on Main. This social event will feature local and national presenters, all in addition to CGPS members. Interested newcomers from South Carolina and the Asheville, NC area were in attendance. Picture, left to right, are: Erin Smith, CGP, Sandy Bush, CGP, D. Thomas Stone, PhD, CGP, and, Leilah Moore, LCSW.

The Four Corners Group Psychotherapy Society (FCGPS) is hosting a one-day conference, Expanding the Circle, in New Mexico. This conference will feature local and national presenters, all in addition to FCGPS members. Interested newcomers from the Four Corners region and the Albuquerque area were in attendance. Picture, left to right, are: Dr. Susan Ewing, PhD, BC-DMT, CGP, and, Dr. Alan Schneider, LCSW, CGP.

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The Houston Group Psychotherapy Society (HGPS) is hosting the Houston General Conference and Fall Trainings in Houston, Texas. The keynote speaker is Sandra López, LCSW, ACSW. Three ethics CEUs are offered. HGPS has held a free Brown Bag Training program, The Unsayable and the Unknowable: Non-ordinary Moments in Psychotherapy, with Nanine Ewing, PhD, BC-DMT, CGP, FAGPA, and Alan Schneider, LCSW, CGP. This conference is going through a difficult transitional period and is attempting to tap the energy of members in helping AGPS grow into the future. AGPS has been a stalwart in the group psychotherapy community in Atlanta since the mid-80s, offering training, workshops, and conferences. It is optimistic that AGPS will continue to provide these services to the Atlanta psychotherapy community.

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