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groupcircle

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

Aziza Belcher Platt, PhD

EDITOR'S NOTE: *Aziza Belcher Platt, PhD, is a licensed psychologist providing culturally responsive individual, group, and family psychotherapy. She works with clients of diverse backgrounds, specializing in racial-cultural issues, trauma, and grief. She was inspired to get into mental health to make therapy more acceptable, accessible, and affordable, particularly for marginalized communities. Social justice and liberation are an indelible part of her work. For patients, she aims to eliminate barriers, structural and otherwise, to seeking and receiving quality and culturally competent mental health care, especially for underrepresented and under-served communities. As a practitioner, she strives to help the field and practitioners become increasingly more culturally aware and responsive.*

Cultural diversity within therapy groups has greater potential for interpersonal exploration and development (Chen, Kakkad, & Balzano, 2008). 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, Thombs, & Costa, 2003). 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. Disarming 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 hostile, derogatory, or negative racial slights and insults toward people of color" (Sue et al., 2007, p. 273). Racial microaggressions occur in a myriad of settings including individual and group therapy (Belcher Platt, 2017; Constantine, 2007; Owen et al., 2011). The prefix, micro, is a reference only to their subtlety and underlying commentary, not their impact. Racial microaggressions are harmful; their impact lingers; and they have a cumulative impact for those frequently targeted (Sue et al., 2007; Sue et al., 2008). In individual therapy, microaggressions, if not addressed appropriately, diminish the client-therapist alliance and outcome (Constantine, 2007; Owen et al., 2011). This holds true exponentially in group therapy; member-therapist alliances, member-member alliances, and multiple members' outcomes are at risk of being diminished if microaggressions are not appropriately addressed. Sue et al. (2007) developed a taxonomy of 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 subservient roles? What in your environment, despite your personal beliefs, will compound 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 stressors in her microsystem and accommodated these structural barriers as much as possible. I often switched my late 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 profiling 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.

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from the president

Molyn Leszcz, MD, FRCPC, CGP, DFAGPA

As we enter Fall, I am confronted with how challenging these times are. Evidence of racial and social injustice abound, and I prepare this column in the aftermath of the passing of Ruth Bader Ginsburg, an icon of social justice. COVID-19 continues to impact us across the United States and globally; devastating wildfires and hurricanes, too many to be named, have been very prominent for many of our members and their clients. Our trauma resources continue to be drawn upon regularly. I frequently remind myself of Judith Herman's axiom: the solidarity of the group is the best response to trauma. That is at the heart of what we aim to do in AGPA in every action and every step we take.

I know people will read this issue of the *Group Circle* with great interest and will be deeply touched by the contributors' profound reach into issues of discrimination and the impacts of anti-Black racism. This is an important focus for AGPA, and we are very grateful for the leadership of the Diversity, Equity and Inclusion (DEI) Task Force. We took an important step in our work on this front with a Town Hall meeting in July, which was attended by several hundred AGPA members. It was challenging and instructive. We are now on the cusp of launching a series of focus groups and consultation groups to learn more about the experience of our BIPOC members and the steps to AGPA's evolution into an anti-racist organization. Much hard work lies ahead.

To foster communication on our listserv, the AGPA Board and DEI Task Force have issued revised listserv guidelines, with a 30-day window for comment. This will be an iterative process that we want to get right so that we construct a listserv that allows our members to speak openly and passionately about matters that are important to them; that allows us to protect our not-for-profit status regarding commercial notices; and that continues to be an effective forum for professional exchanges, consultation, referrals, and sharing of resources.

COVID continues to impact our members and their communities. Recovery has been slow for many affected by this virus, and the myriad ways in which it can impact

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what's inside

from the editor

Leo Leiderman, PsyD, ABPP, CGP, FAGPA

In this critical edition of the *Group Circle,* we address the epidemic of racism. Racism, especially against Black Americans, has been a cancer in the U.S. inarguably since the crimes of slavery. Racism has led to gross legal violations, violence, hate crimes, discrimination, and the lack of equality and social justice in our systems of criminal justice, housing, social services, health care, employment, government, education, and professional organizations. For those who do not identify as being Black, Indigenous, and People of Color (BIPOC), acknowledging systemic and structural racism begins with meaningful admission of privilege, how we deny racism and a ceaseless examination, understanding, education, and trainings of how racism, prejudice and stereotyping is present in our personal and professional interactions. We can then strive to make systems antiracist by becoming activists who advocate for needed reforms and BIPOC leadership.

In her feature article, *Black Lives Matter in Therapy Groups Too: How do Therapists Defang Racial Microaggressions?* Aziza Belcher Platt, PhD, addresses how to disarm racial microaggressions in group. Latoyia Griffin Piper's, LCSW, CGP, article, *Dismantling Institutional Racism and Implementing Organizational Change in AGPA* in our new *Widening the Circle: Racial & Social Justice* column, conveys how she has been impacted by institutional racism within AGPA. Francis Kaklauskas', PsyD, CGP, FAGPA, *Microaggressions and Group Psychotherapy* article in *Research Matters* provides a comprehensive overview of the literature, relevance, and need to understand the impact of microaggressions in groups. AGPA Connect 2021 Institute Co-Chair Anne Slocum McEneaney, PhD, ABPP, CGP, FAGPA provides: *Treating Insecure Attachment in Group Psychotherapy* an interview with Aaron Black, PhD, CGP, FAGPA, elaborating about his Special Institute at AGPA Connect 2021. *Mindfulness-based Cognitive Therapy and Emotion Regulation: An Interview with Zindel Segal, PhD* by AGPA Connect 2021 Institute Co-Chair Joe Shay, PhD, CGP, LFAGPA, overviews Dr. Segal's Special Institute at AGPA Connect 2021.

In companion articles in *Group Assets,* AGPA Connect 2021 Conference Co-Chair D. Thomas Stone, Jr., PhD, ABPP, CGP, FAGPA, provides: *Treating Racial Trauma: Science, Art and Spirituality* with the Anne and Ramon Alonso Plenary Address speaker Thema Bryant Davis, PhD, which captures her insights and multifaceted approaches on racial trauma; and the Mitchell Hochberg Memorial Public Education Event speaker Elizabeth Ford's, MD, *An Unexpected Education in Hope, Truth and Humanity in the Midst of Systemic Racism and Social Injustice,* which overviews systemic racism and social injustice in the criminal justice and mental health systems. These two sessions are sponsored by the Group Foundation for Advancing Mental Health and supported by endowment funds in the Foundation.

In his *From the President* column, Molyn Leszcz, MD, FRCPC, CGP, DFAGPA, provides an overview of the multifaceted measures AGPA is taking to evolve into an antiracist organization. *The Consultation, Please* column features AGPA's Racial and Ethnic Diversity (RED) SIG members Karin Bustamante, PsyD, LPC, CGP, ACS, and Marcia Nickow, PsyD, CADC, CGP. *A View from the Affiliates* features a piece by Jonah Schwartz, LCSW, highlighting the *GROUP* journal's social justice issues that create barriers for BIPOC authors.

I welcome your comments and feedback about this column or anything else about the *Group Circle.* I look forward to your providing us with your article on a contemporary, scholarly group psychotherapy topic at lleiderman@westchester-nps.com.

FROM THE PRESIDENT

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people has become painfully clear. We wish all well and a full recovery to good health. Another COVID effect has been our continued use of online platforms for our groups. We have a unique opportunity to learn about online group therapy from our members. You have been invited to complete a brief survey about your online group work. The survey is a collaborative project of AGPA and APA Division 49.

Plans are moving apace for our virtual AGPA Connect 2021 meeting. I had the recent experience of being guest faculty for the Group Psychotherapy Association of Los Angeles (GPALA). The meeting, which was intended to be in person, shifted to online; it was heartening to see how effectively the format worked. It requires a lot of technological attention, but that one-and-a-half-day meeting allayed my apprehension about a virtual conference. In fact, some elements, such as the demonstration groups, were even easier online.

AGPA is gaining more experience daily with virtual meetings, and I am confident we will have an outstanding conference. Guided by your feedback, the program will be spread out over several weeks. We hope this makes AGPA Connect more accessible and that without the costs of personal travel and accommodations, our scholarships will enable many more people to attend in full. Much thanks to Co-Chairs Katie Steele, PhD, CGP, FAGPA, and D. Thomas Stone, PhD, CGP, FAGPA, Professional Development Senior Director Angela Stephens, CAE, and their colleagues. They are putting an enormous amount of work into ensuring the success of our meeting. Please register for AGPA Connect 2021 if you have not yet done so.

The AGPA office continues to be enormously busy. We are very grateful for the dedication and hard work of the administrative team. I am very pleased to announce that we have recognized three key members of our team with new staff titles: Desiree Ferenczi is now Membership and Credentials Assistant Director; Jenna Tripsas is now Professional Development Assistant Director; and Angie Jaramillo is now Communications and Executive Associate.

As always, please contact me directly with any feedback, input or suggestions, at m.leszcz@utoronto.ca. I wish you all health, wellness, and peace of mind.

BLACK LIVES MATTER IN THERAPY GROUPS TOO

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Introspection and Group Composition

Another important preventative consideration is racial identity development, ours and our potential members. Sometimes microaggressions are a result of premature racial identity status and lack of cultural knowledge or interaction. One way we can preemptively address microaggressions is to begin with ourselves. What is our racial identity, and where are we in our racial identity development? What are our implicit biases, and where are our blind spots? What is our comfort level in addressing issues of race and culture? What is our cultural competence and humility? One consideration, where feasible, is to partner with a co-facilitator, who complements your racial-cultural knowledge and supplements your areas for growth. Similarly, when conducting pre-group screening, consider informally or formally assessing potential group members' racial identity statuses, as well as their racial-cultural experiences, comfort, and concerns.

Understanding the varying stages of racial identity development with the group-as-a-whole and group members is recommended. Creating a group with white members in the Contact or Disintegration stages of White Identity Development as described by Helms (1995) and Black members in the Internalization stage of Black Identity Development as described by Cross (1995) cultivates an environment ripe for microaggressions. For example, a white group member in the Contact stage is likely to express statements consistent with the Myth of Meritocracy subtype of microaggression, which denies the impact of systemic racism and admonishes a Black, Indigenous, or Person of Color (BIPOC) with a pull-yourself-up-by-your-bootstraps attitude. A white individual in the Pseudoindependence stage (Helms, 1995) would be more likely to exhibit the Denial of Individual Racism subtype; that is acknowledging systemic racism but seeking to distance themselves from it by adopting a color-blind stance. This does not imply that microaggressions between white members in the Pseudoindependence stage and Black members in the Black Nationalist Identity stage will not occur. It suggests that with the pretext of their identity development and racial consciousness, they are more likely to avoid such actions and be amenable to repair when they occur. The latter's awareness, acknowledgement, and attrition regarding systemic racism creates an openness to hearing about others' oppression and to critique that is absent in the former. Yalom & Leszcz's (2005) therapeutic factors, such as interpersonal learning and universality, can bridge some gaps. Such disparity is a chasm that likely can be traversed, but at what costs to Black members already greatly burdened in their daily lives by virtue of living in a racially biased society?

Remediation

Prevention, introspection, and composition considered, our focus shifts to remediation. To do that, it is important to gain a palpable sense of the experience of racial microaggressions from the perspective of a BIPOC. Microaggressions can be conceptualized like a snake's bite—often unforeseen, shocking, painful, immobilizing, potentially venomous, and with enduring effect. With that understanding, the importance of and need for immediate and therapeutic care is clear. Therapeutic responding involves immediately acknowledging the incident, identifying the underlying communication, and helping members counteract any toxicity. Think: being moved away from the snake and immediately receiving an antidote. Nontherapeutic responding is well-intentioned but ill-conceived. Think: comforting someone but not signaling for help or administering the wrong antivenom. Antitherapeutic responding ranges from ill-mannered to ill-natured. Ironically, antitherapeutic responses can often redouble the harmful effects, compounding the initial microaggression with another of the same or a different subtype. Think: two snake bites or being thrown into a snake pit.

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Widening the Circle: RACIAL & SOCIAL JUSTICE

Dismantling Institutional Racism and Implementing Organizational Change in AGPA

Latoyia Griffin Piper, LCSW, CGP

EDITOR'S NOTE: *Latoyia Griffin Piper, LCSW, CGP (she, her, hers) is in private practice, providing individual, family, and group therapy attentive to holistic care and with a systemic approach. She has a history of faculty appointments, clinical program development, and supervision of social work interns. She also develops educational materials for distribution, systems analysis, and policy and procedure development, as well as corporate, professional and organizational training for local, state, national, and international audiences. Diversity and cultural inclusivity are critical to her professional and personal life. She is Secretary of the Northern California Group Psychotherapy Society and is on the AGPA Diversity, Equity and Inclusion Task Force.*

I was reluctant to write this article due to the personal toll that racism has taken, 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 amid African American/Black young 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 clinical training programs. My heart sank as I thought: "This is still happening." Despite personal experiences and those of colleagues, bearing witness to the impact of racism on another generation took a different toll. Their stories reminded me of the traumatic impact of institutionalized racism, compounded by repeated incidents of individual racism that put in place, support and reinforce systems that allow for the repetition of incidents for generations. I chose to remain very present with the range of feelings that emerged, including anguish, sadness, and guilt. The experiences being shared and noticed eventually transitioned those initial feelings to conviction and determination and my subsequent thoughts: "This is why we fight;" "This is why I will not back down, not turn away;" "This is why I will continue this work with vigor, passion, conviction, and urgency;" "The stakes are too high." Thus, I write this with those thoughts in mind, dedicated to the dismantling of institutional racism and structural racism (Keleher and Lawrence, 2004), as well as implementing organizational change.

When we look to numerous long-standing international organizations, including the library of the United Nations and the International Federation for Human Rights, as well as US organizations, such as the Human Rights Campaign, we find volumes about institutionalized racism around the world and its impact. This includes published material by a range of individuals within the disciplines of psychology, psychiatry, social work, group psychotherapy, and additional disciplines around racism in the clinical arena (at the macro and micro level) and its clinical impact.

Institutional and Structural Racism and Marginalization within AGPA

For years, Black, Indigenous, and People of Color (BIPOC) and those holding additional marginalized identities have shared information about incidents of harm 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 unchanged. 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 perpetual cycles of harm, with little attempt at repair. Lack of attention to inclusivity of BIPOC and those holding marginalized identities is apparent in educational material and training, policies written, awards bestowed, who sits at the decision-making table and in other leadership roles across the organization, as well as by the structures in place that sets the stage for limited attention to diversity for years to come. Attention to such matters is often placed as a side note, marginalized instead of addressed in an inclusive manner. Some BIPOC and those holding marginalized identities have stepped away for self-preservation (Tatum, 2017), while others have attempted to remain engaged and address these issues, even while facing personal biases, privilege, personal and institutional racism, and marginalization, leading to disparity in these individuals' abilities to effectively implement organizational change.

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 on the listserv incidents of racist, sexist, 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 not other posts that fell outside of the requested refocus 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 is often a common institutional response where racism is present and named by BIPOC. It served to relieve non-BIPOC of the emotional reckoning of the trauma being caused, while not completely addressing the issues for those being harmed. In addition, by not prohibiting racist, sexist, homophobic, transphobic, and other such posts that BIPOC and those holding marginalized identities specifically and continuously reported was the cause of harm, it reinforced 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 excluded. It is also reinforced by those who push back or devalue BIPOC, those holding marginalized identities, and allies who point out the problems 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 disenfranchising others.

Where Does AGPA Go from Here?

Many at AGPA are trying to take steps toward addressing institutional racism and attending to inclusivity. Those steps are valuable, yet the systemic racism in AGPA cannot be mitigated or eradicated without depth—intensive work that requires self-reflection—and breadth—ongoing and varied work over time—of personal work by those in leadership positions and the membership. The personal work is a necessity to more readily recognize and address the issues and rely less on having to be told about them. It allows individuals to take greater ownership for attention to these concerns, to feel a greater sense of commitment to a path of preventing and reducing harm instead of relying on a cycle of repeated injury and attempts at repair. The personal work decreases the tendency of asking BIPOCs and those holding marginalized identities to repeatedly point out blind spots in the wake of negative experiences or to do the bulk of the work to resolve the problems; relying too heavily on them inflicts additional harm. The work is necessary by both those who strive to work in allyship (Kendi, 2019), as well as those who identify as BIPOC and who hold marginalized identities (Cultural Bridges to Justice, 2020).

An indicator of whether additional personal work is needed is to consider whether you were able to independently recognize the issues raised in this article, to what depth and level of impact, and if your reactions were defensive, e.g., anger, frustration, irritability, guilt, fear, withdrawal (Diangelo & Dyson 2019). Also consider when you encounter these issues in general, whether you feel 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. My 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 that 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.

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Microaggressions and Group Psychotherapy

Francis Kaklauskas, PsyD, CGP, FAGPA

EDITOR'S NOTE: *Francis Kaklauskas, PsyD, CGP, FAGPA, serves on AGPA's Science to Service Task Force and Institute Committee, is a member of the Racial and Ethnic Diversity Special Interest Group, and received the 2020 Anne Alonso Award for Excellence in Psychodynamic Group Theory for the book Core Principles of Group Psychotherapy.*

Each generation must, out of relative obscurity, discover its mission, fulfill it, or betray it in relative opacity. —Franz Fanon (1961).

Intercultural aggression and oppression have existed between groups throughout history. While some are atrocious, overt actions, such as slavery, genocide, the withholding of needed resources, and the separation of families, other actions are more subtle, 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. Peirce stated 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, Mclaughlin, Goates-Jones, & Mejia (2020) indicated that "Microaggressions are subtle forms of discrimination, often unintentional and unconscious, that send negative and denigrating 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 media war waged against addressing microaggressions and exploring our differences. Others have described the reluctance to embrace microaggression conversations as gaslighting 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, 2018; Haidt & Lukianoff, 2018). Others use minimization, sarcasm, labeling, distorted stories, and even violence to minimize these conversations.

Academically, Lilienfeld (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, interpersonal, 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 dwarfs 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 & Drinane, 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. Zaharopoulos and Chen (2018) 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 unfinished 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 warzone, demilitarized zone, and cultural sanctuary. Therapeutic 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), Fattoracci, Revels-Macalinao, and Huynh's (2020) research found increases in validity with the piloted Interactional Microaggression Scale (IMS). The significance of this research for group leaders lies in holding complex ideographic 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 cognizant 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) perpetuate 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 fallibility. 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, Pomerantz, Segrist, and Ro (2020) examined response options when a therapist perpetrates a microaggression. Three vignettes (therapist microaggression with apology, therapist microaggression without apologies, and therapist avoided microaggressions) 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 suggestion 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

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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, PhD, is 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 sadness or unhappiness by observing and without judgment. He is Distinguished Professor of Psychology in mood disorders in the Department of Psychology at the University of Toronto Scarborough. He is also the Director of Clinical Training in the Graduate Department of Clinical Psychological Science. Dr. Segal will be delivering a Special Institute at AGPA Connect 2021 on* Mindfulness Based Cognitive Therapy: Distinct and Overlapping Elements of Group Delivery and Mindfulness Meditation.

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 my colleagues and I developed, Mindfulness Based Cognitive Therapy (MBCT), to illustrate this in concrete ways, including the theoretical rationale, efficacy data, and neuroscience behind this work. The *sine 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 processes may feature in one approach but be 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 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 continued 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 it 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 experience 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 inquire 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? Which papers or books would you 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 work, including:

Williams, M., Teasdale, J., Segal, Z., & Kabat-Zinn, J. (2007). *The mindful way through depression.* New York: The Guilford Press.

Farb, N.A., Anderson, A.K., Mayberg, H., Bean, J., McKeon, D., & Segal, Z.V. (2010). Minding one's emotions: Mindfulness training alters the neural expression of sadness. *Emotion,* 10(1), 25-33. doi:10.1037/a0017151.

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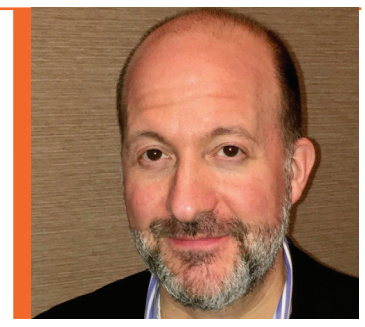
JS: We are definitely looking forward to seeing you at AGPA Connect in February!

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 Institute title is *Treating Insecure Attachment in Group Psychotherapy.* I'm hoping to create a wide-ranging exploration of attachment theory as applied to psychodynamic group treatment. Participants will learn how developmental concepts of attachment theory can be used to provide interventions that enhance emotional maturation within the group. A didactic presentation will be coupled with demonstration groups and a large-group discussion.

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

AB: I'll be addressing such topics as attachment as emotional regulation, the basics of mentalization theory (how one engages intentional mental states in self and other), the ways insecure attachment manifests in group, the differences between general attachment styles and insecure mental states, and how knowledge of 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.'

AM: How did you get interested in this topic, and why does it continue to hold your interest?

AB: It started in graduate school. The first paper I published was an empirical study on the effects of attachment quality among middle school students experiencing their parents' marital disruption. At the time, divorce was thought to be always damaging to children. I compared adolescent children who were experiencing varying degrees of interparental conflict. We found that secure attachment served a profound protective function, shielding the child from the potentially toxic emotional effects of their parent's marital conflict. Children in high-conflict, divorce situations, who reported a secure attachment to at least one parent, fared nearly as well emotionally over time as children in intact families. Remarkably, children in high conflict situations who reported secure attachments to both parents were psychologically indistinguishable from children in intact families. At the time, I thought that any theory with that kind of predictive power was worth knowing more about. As a psychologist working with patients from a psychoanalytic perspective in therapy, I also found that attachment theory often provided a more grounded way to work with some of the key elements of self-psychology and object relations theory, so it was useful in my work as a therapist as well.

AM: Could you give a group example of when you chose an intervention in response to an unmentalized (primitive) mental state? How would it differ from a response based on your view of the patient's attachment style?

AB: I don't spend much time thinking about individual attachment styles in group therapy, which might seem confusing based on everything I just mentioned, so let me explain. There's a danger when applying attachment theory in being pulled into literal, concrete ways of thinking. Categorizing attachment style is useful for research purposes, but clinically, it can lead to a glossing over of the enormous variability in relational functioning, so I try not to categorize group members. Group therapists want to be working towards greater emotional and relational complexity, and worrying too much about a general attachment style can interfere with that process. Instead, anyone can manifest an insecurely attached mental state. The group benefits when the

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MICROAGGRESSIONS AND GROUP PSYCHOTHERAPY

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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 developed in structural oppressive cultures. Leaders can learn new interventions framed in curiosity and humility, and bravely promote diversity and identity conversations. Group psychotherapy leadership is a continuous process of learning and unlearning. As Audre Lorde (1986) reminds us, "It is not our differences that divide us. It is our inability to recognize, accept, and celebrate those differences."

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BLACK LIVES MATTER IN THERAPY GROUPS TOO

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Case Example: Xavin, a trans group member of color, recounted that they were initially the lone person of color in their support group for people who hear voices. During introductions, their chosen name which had cultural and gender identity significance was dismissed by a white member who declared "Well, I'll never be able to pronounce that." Xavin offered to help the member and was rebuffed. The dismissive response to their name was a pathologization of their cultural values and communication styles, another subtype of microaggression. Characteristic of an antitherapeutic response, no one, including the group therapist, noticed or addressed the occurrence. Had they noticed, they could have engaged in therapeutic responding. In so doing, they would have addressed Xavin's sense of rejection. They also would have clarified if the white member's statement miscommunicated his willingness to engage with Xavin or confirmed his lack of consideration for Xavin's racial-cultural aspects. Even if the latter were true, there still was an opportunity for interpersonal learning. However, given that the microaggression went unaddressed, the member-therapist alliance and member-member alliances were diminished, as was Xavin's therapy outcome. Going forward, they reported a need to "be more careful about the way that I talk about race in that group…and the way race impacts me." In keeping with the snake analogy—once bitten, twice shy. An example of a nontherapeutic response is "I'd love to hear more about your chosen name but what can we call you that's easier for us to pronounce?" While curiosity is expressed, the culturally significant aspect of the individual is dismissed and the onus for patience and adaptation is on the person with the marginalized identity. An example of a therapeutic response is "I don't know how to pronounce your name yet but the issue is my tongue not your name so I will keep trying until I get it" or "It's important to me to pronounce your name the way it's meant to be said. Do you mind helping me now and correcting me if I pronounce it wrong in the future?" These types of responses do not other the BIPOC or their racial-cultural aspects and invites immediate and future interpersonal learning.

As group therapists, we are trained to observe many people and dynamics simultaneously and to facilitate engagement even through conflict. Microaggressions are an additional dynamic to add to our awareness and intervention. In so doing, we reduce and remediate these occurrences through therapeutic responding. Consequently, we strengthen alliances, increase group cohesion, and bolster therapy outcomes. Being accountable for our own microaggressions and emphatically addressing microaggressions committed by others has an impact beyond our groups. Synergizing the therapeutic factors (such as imparting information, interpersonal learning, socializing techniques, and imitative behavior) with therapeutic responding (Belcher Platt, 2017; Yalom & Leszcz, 2005), we facilitate a corrective experience for BIPOC and non-BIPOC members who are then able to extrapolate that to their individual microcosms. Given the backdrop of the twin pandemics, COVID-19 and racism, this is an opportunity for group therapists to inject antivenin in a festering wound.

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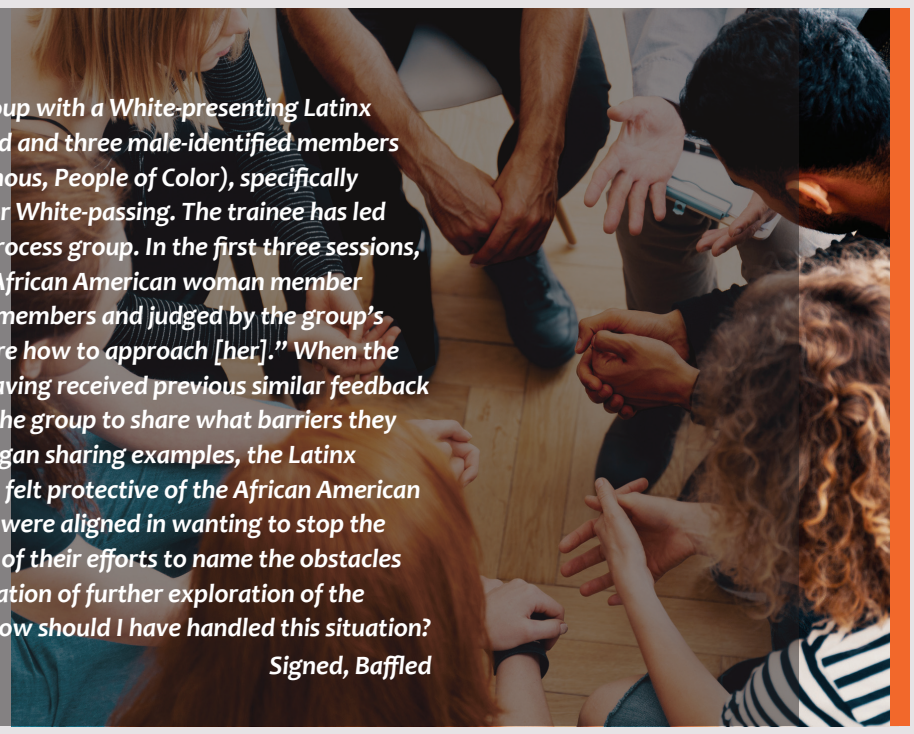
consultation, please!

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 Shemika Brooks, PsyD, CGP (drshemikabrooks@gmail.com), Latasha Smith, PhD, LCSW, CGP (smithlatasha@gmail.com), and Marceé 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.



Dear Consultants:
I'm an African American woman (mid-30s) co-facilitating a mixed-gender process group with a White-presenting Latinx male trainee (early 30s), using a shared-leading model. There are six female-identified and three male-identified members of varying socioeconomic backgrounds. Two of the women are BIPOC (Black, Indigenous, People of Color), specifically one African-American and one Latinx; the remaining members are White-identified or White-passing. The trainee has led support and psychoeducational groups, but this is his first experience facilitating a process group. In the first three sessions, he made several gender and race microaggressions. Recently (seventh session), the African American woman member shared that she feels vulnerable in therapy groups where there are not many BIPOC members and judged by the group's White members. The trainee's feedback was that "maybe other members are not sure how to approach [her]." When the African-American woman member asked what would give that impression, due to having received previous similar feedback without contextualized statements, the trainee/co-facilitator responded by inviting the group to share what barriers they have experienced in efforts to reach out to her. As the White-presenting members began sharing examples, the Latinx woman interrupted, sharing a desire to stop what was occurring and saying that she felt protective of the African American woman. This situation created a split in the group, wherein the two BIPOC members were aligned in wanting to stop the exploration of the barriers and the remaining members shared that the interception of their efforts to name the obstacles were precluding their ability to connect. I felt torn between interrupting the continuation of further exploration of the barriers and re-directing group members to utilize their current in vivo experience. How should I have handled this situation?
Signed, Baffled

Dear Baffled:

This group dilemma brings up a number of considerations that run the gamut from co-leadership dynamics, to the interpersonal, to the 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 feat. 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 give voice to their predicament. Groups benefit when social justice and equity issues arise by establishing norms that include guidance on how to name microagressions and by creating a brave space versus a safe space. While at first glance it appears important to explore interpersonal factors that make connection difficult for individual members, in this instance talking about barriers redirects the focus away from the discomfort White members may be experiencing. While gender may be in play during facets of group dynamics, potentially between co-leaders, race seems to be at the forefront in this example.

I would encourage you, the African American female co-facilitator, to press the pause button on the barriers conversation and allow self-reflection. You might ask the group-as-a-whole what feelings or thoughts surfaced when the African American member named feeling judged, normalizing possible feelings of guilt or shame. Highlighting the process at play, namely the tendency as a society forged in the US to caretake White bodies by colluding or turning away from discomfort, can help group members understand underlying forces at play within the group field. In learning how to work with discomfort, the group may recognize its innate resilience and possibly find new ways of relating to each other, thus resolving the impasse that the focus on barriers had established.

Karin Bustamante, PsyD, LPC, CGP, ACS
Littleton, Colorado

Dear Baffled:

This scenario mirrors the dynamics of a White supremacist culture. The co-leaders—a Black female and a White-presenting Latinx male trainee—easily hand over power to a bloc of seven White-presenting group members.

Metaphorically, you and your co-leader abandon the Black and Latinx female members. If the two women wish to avert a reenactment of race-based, gender-based oppression, they are left to shift the power dynamic on their own. They do it subtly and indirectly; issues of race, marginalization, and subjugation haven't yet been established as welcome content.

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 member'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.

Marcia Nickow, PsyD, CADC, CGP
Chicago, Illinois

NEWSLETTER OF THE
AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION
INTERNATIONAL BOARD FOR CERTIFICATION OF GROUP PSYCHOTHERAPISTS

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See *Group Assets* insert

a view from the affiliates

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

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

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 that 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 understanding and tolerance of difference. The issue also included reviews of three books that critiqued the standard clinical approaches of CBT, psychoanalysis and addiction treatment, and how traditional Western treatment modalities diminish the experiences of the oppressed rather than focus on the unjust societal structures that keep the oppressed in their places.

The experience of co-editing the social justice issue helped me see more clearly the barriers that people of color and the economically disadvantaged face when they try to enter the field of mental health or write about their experiences for a scholarly journal. Drs. Isaac and Shepard catalogue the multiple challenges their Black, Indigenous and People of Color (BIPOC) students face in both graduate and undergraduate programs, including: lack of funds or even stable housing; burdensome family obligations; having to work part- or full-time while attending school; a dearth of relatable mentors; and all manner of hostility and discouragement, both overt and covert, based on their racial and ethnic backgrounds.

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 academy, 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 finding new voices amongst the people who are doing the hard work of assisting those who have been wounded by a deeply unjust social contract. Mentoring authors who are new to scholarly 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.

TREATING INSECURE ATTACHMENT IN GROUP THERAPY

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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 Alonso, PhD, CGP, DFAGPA, and Lou Ormont, PhD, DFAGPA. I'm so glad that I got to experience their work in person 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!

AM: Can you say something about the way in which your work with primitive mental states is applied to subgroups and group-as-a-whole?

AB: While attachment dynamics are by their nature dyadic, meaning based upon a two-person configuration (like caregiver-child), mentalization is not. Not only do group members have individual variation in the capacity to mentalize, but each of my groups have different mentalizing capacities. As leaders, we want to support the development of mentalization in the group-as-a-whole. When it comes to putting feelings into words, this means using our curiosity to address the questions of what members want emotionally, what they feel, where in the body they have those feelings, why they are feeling them, and how other members of the group (and leader) are contributing to those feeling states. Groups that collectively learn to address those questions are especially effective in doing the work over time and increasingly need less of the leader's mentalizing capacity.

AM: What advice can you offer participants for getting the most out of this experience with you? Which papers or books would you recommend for participants to read to become familiar with your work?

AB: A basic understanding of attachment theory would be a plus. Any of John Bowlby's books would be useful. Philip Flores, PhD, ABPP, CGP, LFAGPA, has published some excellent articles in the *International Journal of Group Psychotherapy (IJGP)* about how attachment and polyvagyl theories can be applied to group therapy. My recent article in the IJGP would also be meaningful background reading. *Treating insecure attachment in group psychotherapy: Attachment theory meets modern psychoanalytic technique* (Volume 69, 2019, Issue 3) makes a case for how modern analytic techniques can identify and resolve barriers to secure attachment and mentalization.