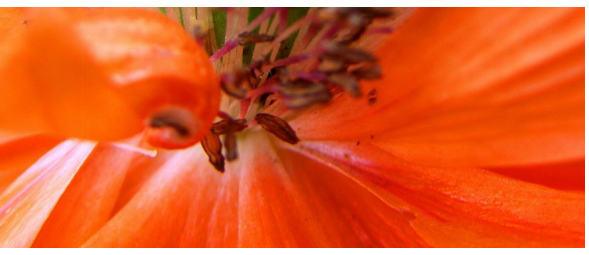

NEWSLETTER OF THE
AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION
INTERNATIONAL BOARD FOR CERTIFICATION OF GROUP PSYCHOTHERAPISTS

Summer 2018

groupcircle

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 browsed 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 outreach 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 widening between mental illness and services available (less than 10% of the mentally ill in low resource countries receive the treatment they need). In addition, stigma against being mentally ill, or even treating the mentally ill, has not diminished, and the number of displaced persons from wars, genocide, famine, floods, and earthquakes rises every year.

In the family-oriented cultures of the countries in which I worked, groups fit well with their recapitulation of family supports. After all, family is the first group we experience and for some, group membership feels familiar and even less daunting than individual psychotherapy.

Health ministers and administrators liked the idea of group interventions in that they were thought to be a way of stretching their inadequate mental health dollars. Government leaders constantly reported that bias against the mentally ill, as well as economic shortfalls, would not soon be alleviated, so group as first aid offered hope for reaching the most people as quickly as possible.

In the following sections, I offer three portraits of countries that received trauma and disaster recovery group training, which will illustrate how we have expanded training opportunities beyond our American borders.

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, residue from 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 Korinteli, 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 to 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 six five-day 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 outpatient clinics and hospitals have been made a priority as a result of the adoption of the nation's Mental Health Law that was 26 years in the making.

Continued on page 6

from the president

Barry Helfmann, PsyD, ABPP, CGP, DFAGPA

As I write my second column, I find that there are so many activities AGPA conducts it is difficult to choose which one to highlight here. A most exciting, yet formidable issue facing AGPA is member recruitment and retention—a challenge with which other organizations similar to ours are also grappling.

AGPA has done a fantastic job attracting younger professionals through the Group Foundation Scholarship Program to attend AGPA Connect and increasing our cultural diversity and relevance. Our new Safe Environment Conduct Policy is another important step in providing our membership with a friendly, safe, respectful, and welcoming environment, regardless of gender, sexual orientation, ethnicity, religion, political affiliation, disability, age, appearance or other personal characteristics and socioeconomic status.

As we look ahead, however, it is clear that changes need to be considered and implemented; specifically, Board Composition, Membership Voting Rights, and Membership Categories are being examined. Any changes to these areas will need a bylaws vote by the entire membership. The Executive Committee and Board are in the very early stages of examining our membership issues and are nowhere near making any recommendations to our membership. In fact, I am asking you, our members, for input now so that we take the broadest views into consideration for whatever changes will be recommended.

The leadership has started these initial conversations to get the ball rolling. So far, we have come up with two possible scenarios. Please view the chart on page 2, which outlines our current thoughts. These are by no means meant to be the entire list of possibilities, so please weigh in with a letter to the *Group Circle* Editor Steve Van Wagoner, PhD, CGP, FAGPA (slwagoner@verizon.net), by contacting our CEO Marsha Block, CAE, CFRE (mblock@agpa.org), or me (drblh@aol.com) with your

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what's inside

from the editor

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 in store for AGPA Connect 2019 attendees more than six months from now. The interview with Cheri Marmarosh, PhD, and Martyn Whittingham, PhD, CGP, FAGPA, gives a preview of good things to come at our upcoming meeting, to be held February 25-March 2 at the Westin Bonaventure Hotel, Los Angeles, California. Get your registration in early.

Jeffrey Kleinberg, PhD, CGP, MPH, DFAGPA, writes about the challenges and rewards of consulting, teaching, and training mental health professionals in other countries and cultures as he takes lessons learned after 9/11 and converts them into programming around trauma recovery and disaster relief efforts around the globe. I am also pleased to publish Robert Pepper's, CSW, CGP, PhD, article on helping group members develop and hone emotional intelligence and communication.

This month, Molyn Leszcz, MD, FRCPC, CGP, DFAGPA, combines and integrates the *Practice Matters* and *Research Matters* columns, demonstrating that they are not categorical opposites, but rather in dynamic interplay and mutual influence. Check out another interesting dilemma in *Consultation, Please,* and all the *Affiliate Society* and *Member News*.

Given the emphasis on social justice and diversity at the AGPA Connect 2018, I again invite articles on these important topics, especially since they would easily flow from some of the terrific workshops offered this year. I hope you enjoy the remainder of your summer.

FROM THE PRESIDENT

Continued from page 1

STRATEGIC PLANNING MEMBERSHIP DISCUSSION

	CURRENT	SCENARIO 1	SCENARIO 2
BOARD COMPOSITION	**Officers:** 4 **Retiring Officer:** 1 (even years) **Board Members:** 12 **ASA Officers:** 3 **GF Chair:** 1 **IBCGP Chair:** 1 **Total:** 21-22 **Election Eligibility:** Fellows, Clinical Members, Academic Members, Research Members	**Officers:** 4 **Retiring Officer:** 1 (even years) **Board Members:** 6 **Student/New Professional Board Members:** 2 **ASA Officer:** 1 **GF Chair:** 1 **IBCGP Chair:** 1 **Total:** 15-16 **Election Eligibility:** Fellows, Clinical Members, Academic Members, Research Members; New Professional/Student Members for two designated positions	**Officers:** 4 **Retiring Officer:** 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
VOTING RIGHTS	Fellows Clinical Members Academic Members Research Members	Fellows Clinical Members Academic Members Research Members Associate Clinical Members Adjunct Members New Professional/Student Members	Fellows Clinical Members and/or CGPs Academic Members Research Members Associate Clinical Members Adjunct Members New Professionals/Students vote NP/STU Board positions
MEMBERSHIP CATEGORIE	Fellows Clinical Members Academic Members Research Members Associate Clinical Members Adjunct Members New Professionals Students	Fellows CGPs Academic Members Research Members Members New Professionals Students	Fellows CGPs Members Students

feedback. Your participation and our transparency are most crucial.

Why is there a need for change? A smaller Board can be nimbler 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 that determines 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 challenge 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.

groupcircle

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RENEW YOUR MEMBERSHIP

Help AGPA remain the vibrant organization that it is. If you haven't yet sent in your dues renewal for the current year, you can do it online at: https://member.agpa.org/signon.

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

Editor's Note: ***Cheri Marmarosh, PhD,*** *and* ***Martyn Whittingham, PhD, CGP, FAGPA****, will present* Clincial Applications of Attachment and Interpersonal Theories to Group Psychotherapy: Two Sides of the Same Coin *as a Special Institute at AGPA Connect 2019, to be held February 25–March 2, at the Westin Bonaventure Hotel, Los Angeles, California. Dr. Marmarosh, a fellow of Division 29 (Psychotherapy) and Division 49 (Group Psychotherapy), is an Associate Professor in the Professional Psychology Program at the George Washington University and a licensed psychologist practicing in Washington, DC. She has published more than 40 empirical and theoretical articles on group and individual psychotherapy. Dr. Marmarosh is the lead author of* Attachment in Group Psychotherapy and Groups: Fostering a Culture of Change, *and Editor of* Attachment in Group Psychotherapy, *a monograph of manuscripts from the special edition of the* International Journal of Group Psychotherapy *dedicated to attachment theory. She is an Associate Editor of* Psychotherapy, *has served as an associate editor of* Group Dynamics: Theory, Research, and Practice, *and is on the editorial boards of the* International Journal of Group Psychotherapy *and the* Journal of Counseling Psychology. *Dr. Marmarosh is a member of the Science to Service Task Force for AGPA, a Co-Chair of the Research Special Interest Group for AGPA, and was recently elected President-Elect of APA Division 49, a position she will assume in January 2019.*

Dr. Whittingham is 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, he founded Focused Brief Group Therapy (FBGT)*, now featured in the* Sage Encyclopedia of Theory in Counseling and Psychotherapy. *He has 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. He has authored numerous book chapters and articles, including the chapter on "Group Therapy in University Counseling Centers" for the* Handbook of Group Counseling and Psychotherapy. *In 2010, 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 2013. 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.*

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

CM: When I was in graduate school, I observed Jack (John G.) Corazzini's, 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, experience. 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, Fonagy's mentalization, and the neuroscience of Shore 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.

MW: In my early clinical work, I was looking for a road map that could really guide me through my clinical decision-making process. Finding the interpersonal circumplex 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 always doing their best with what they know is a key part of unconditional positive regard that underlies interventions, and these theories really help with that understanding.

It continues to hold my interest because as I give workshops in places like China and Singapore, I get strong feedback from attendees that tells me this not only applies to American clients but also people around the world. Loneliness as a construct is now becoming an issue linked to major health outcomes. Recent research has shown that loneliness is heavily implicated not only in mental health but also in physical health, with Mushtaq, et al. (2014) reporting its impact on risk for heart disease, Type 2 diabetes, and even dementia. By focusing on improving interpersonal skills and connection, we can impact not only mental health but potentially impact physical health outcomes as well. This really expands the importance and relevance of group as a modality, and the theories and techniques we are discussing are ones that put group processes at the center of healing in a very contemporary way.

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

CM: Martyn and I agree that bridging the theory, research, and practice is critical. In the first part of the workshop, I will focus on attachment theory, starting with a review of theory and the application to group work. After reviewing the research findings that demonstrate the relationships among member attachment, cohesion, and outcome, I will shift gears and focus on a videotape demonstration group that reveals interacting attachments and a rupture within the group. The demo video leads perfectly into Martyn's FBGT and his notion of inoculating members for group therapy. Those who attend our Special Institute will definitely see how the theory guides our clinical interventions.

MW: We will be really focusing on how the theories can be used to actively inform clinical work. My work in developing FBGT emphasized blending research and practice in very usable ways. We will be integrating findings from the literature, our research, and actual clinical examples to show how using science can really enhance the art and practice of therapy. We will be asking the audience to get involved, with case examples, role plays, and applications of the theory to some of the most challenging cases we work with. We are going to be focusing on the most challenging client behaviors, looking at those through the lens of these theories, and discussing proven techniques for promoting good outcomes.

AM: ***Will you be using demonstration groups, and how are they different from therapy groups?***

MW: The important thing to remember with these groups is that they are for the purposes of training. I initially did not use demonstration groups in my workshops since FBGT emphasizes pre-group preparation and inoculating members against self-sabotage in an individualized session before group starts. However, for the purposes of trainings, I now sometimes use demonstration groups, depending on available time. It is important to remind participants that this is not a time for personal therapy. They are free to participate at any level they choose, but must be able to act as a participant-observer, where they are noticing the impact of interventions rather than simply being immersed in the experience as a client. It is a difficult task to take on, and requires a lot of the demonstration group member.

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 motivations, the cohesion are all the same. There is a lot we can learn from observing them.

To me, the difference is in the safety. These groups have no confidentiality, no screening, and no preparation. For that reason, there are risks that some group experiences will not be therapeutic. In some small cases, the group experience could be destructive. There is a reason why we screen, prepare, and select members for therapy groups. That being said, demonstration groups can still teach us a lot about intrapsychic processes, interpersonal dynamics, group dynamics, and how to address these in therapy groups we lead.

AM: ***How do you feel that the learning will be relevant for 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. Bring 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.

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research & practice BOTH MATTER

Editor's Note: This column typically alternates between a focus on practice and research. For this issue, members of the Science to Service Task Force and the Public Affairs Committee integrated ideas to focus on an area of important convergence between practice and research—quality in care.

Molyn Leszcz, MD, FRCPC, CGP, DFAGPA

As the leading organization for advancing the practice of group psychotherapy, AGPA supports quality care through its advocacy for standards in the field, provision of publications, practice resources, and educational programs both at AGPA Connect and throughout the year through its E-Learning Programs.

What do we know about quality in our field?

The good news is that there is compelling evidence that group psychotherapy is a potent and effective treatment. Studies, literature reviews, and meta-analyses underscore that group psychotherapy is equivalent to individual psychotherapy: Both produce substantial benefits across a range of disorders (Burlingame et al., 2016). Group psychotherapy adds the benefit of maximizing the use of psychotherapy resources. We also know that group psychotherapy is complex. Identifying and managing group process and group dynamics make it a more challenging treatment to deliver than individual treatment. We know what we do matters. How we do it may matter even more.

Not only are the psychotherapies effective, but there is no single gold standard of psychotherapy model or approach. Good work is equivalent to good work. That is very good news.

The less good news is that, although the therapeutic modalities are equivalent, there is no similar equivalence with regard to therapists. In fact, studies show there is a significant variation amongst therapists in clinical outcome; this is the quality gap (Jorm et al., 2017). A practice research network study examined 85 therapists who used varying models treating 10,000 patients with mood and anxiety disorders. Of patients who completed the assigned treatment, 72% improved, 7% deteriorated, but 34% dropped out. Comparing the top 20% of therapists measured by client outcome to the lowest 20% of therapists, we see that those clients who saw the more effective therapists had excellent outcomes with large, positive effects sizes of 1.0-1.5. Of concern, however, is that therapists in the bottom 20% produced negative effect sizes of a similar proportion (Saxon et al., 2017).

We have every reason to believe the same findings are relevant to group psychotherapy. Group therapists are more likely to be effective if they build strong relationships with their clients marked by: 1) empathy, warmth, and respect; 2) attunement to diversity; 3) developing and sustaining group cohesion; and 4) utilizing countertransference effectively. We can ensure that we implement these evidence-supported group therapist practices by maintaining a rigorous, reflective approach to our work and engaging in deliberate practice. It is the commitment to deliberate practice that harvests the full benefit of our clinical experience. Like Atul Gawande, the Harvard surgeon who described in *The New Yorker* how he invites other surgeons into his operating room seeking feedback about his technique, our openness to feedback about our work is a significant contributor to improving our effectiveness (Leszcz, 2018).

The value of evidence-based practice

Deliberate practice includes the thoughtful review of challenging groups and sessions, planning for future sessions, and opening oneself up to feedback and consultation. Training workshops at AGPA Connect, through AGPA's E-Learning Programs, or an Affiliate Society meeting play an important role in deliberate practice because these open us to feedback and offer the opportunity to develop additional techniques or refine existing skills. Experiential training increases awareness of how we use ourselves as therapists and what we bring to our work from our own nature and life experience. Supervision and consultation also enhance the group therapists' reflective capacity.

What we also learn from the literature is the value of practice-based evidence. In the way that our family physician checks our blood work, practice-based evidence provides similar feedback to the group psychotherapist. We tend to underestimate negative outcomes in group psychotherapy, and human nature being what it is, we tend to overestimate our effectiveness. Routine outcome monitoring, using one of the growing number of systems that are available in the field can provide group therapists with real time feedback about how well our clients are doing clinically, the quality of the therapeutic relationship and group cohesion, and point to areas of concern. A number of outcome monitoring systems are available, including the widely used Outcome Questionnaire (OQ45), Partners for Change Outcome Monitoring System (PCOMS), and the Treatment Outcome Package (TOPS). Modern technology and the use of electronic platforms make it easy to complete these questionnaires on a smartphone or secure website, and the reports can also contribute to clinical records and progress notes (Wampold, 2015).

Although tracking outcomes may add little to treatments that are going well, outcome monitoring adds greatly to the 20-30% of treatments in which group members are struggling. Adding feedback can significantly improve outcomes for these clients, enhance fuller collaboration between clients and therapist, maximize alignment of goals and tasks within the therapeutic alliance, and enhance group cohesion. The client's direct voice addresses power differentials and supports mutual respect and care.

Introducing this within organizations and clinical settings requires a culture and climate that aims to improve both client outcome and therapist satisfaction, professional development, and effectiveness.

AGPA is committed to being the central resource for members so they can provide high-quality, effective group psychotherapy. This is the spirit that runs through all of our education, publications, training programs, and practice resources. It is also evident in the new edition of the soon-to-be-published *Core Principles of Group Psychotherapy: A Theory, Practice and Research-Based Training Manual.* Under the outstanding editorial leadership of Francis Kaklauskas, PsyD, CGP, FAGPA, and Les Greene, PhD, CGP, LFAGPA, the expanded manual and teaching guide will be a rich resource to the field and a teaching platform for Certified Group Psychotherapists.

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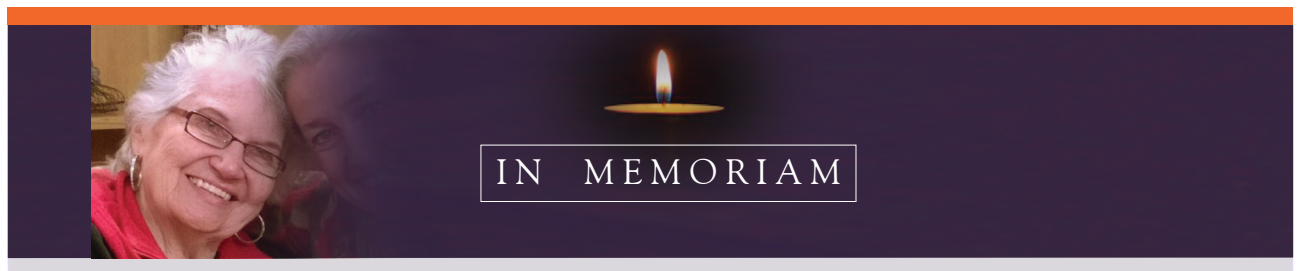

AGPA extends its condolences to the family and friends of **Etta Martin, MSW, CGP, FAGPA**, a long-time and active member of AGPA, who passed away in May. Etta was featured in the Fall 2017 issue of the *Group Circle* in the article "Generational Mentoring: Weaving Mentees and Mentors Together," written by her mentee Karen Travis, LCSW, BCD, CGP, FAGPA. Visit www.agpa.org/home/practice-resources/the-group-circle/mentor-tribute-article to learn about how Etta affected the lives of those she touched.

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 point in their lives? Many of us do not know how we come across in relationships. As a consequence, we develop maladaptive ways of communicating that are ultimately destructive. That is why I believe, at one time or another, we are all good candidates for group psychotherapy, which can help us become more emotionally aware of ourselves in relationship to others and allow for maturation to occur.

Central to the nature of all emotions is the existence of a duality in which we can feel conflicted about nearly everything. We hate and love the significant others in our lives. We seek stability in our relationships but also want excitement and adventure. We want change in our lives but cling to our bad habits. It is the group leader's task to help members resolve their ambivalence about change. This can be accomplished through the development of progressive emotional communication between group members (Ormont, 1999). Progressive means that the dialogue adds new dimensions to their relationships; emotional means that the interaction is infused with spontaneous feeling; and communication refers to the interpersonal nature of the interaction. This is a challenge because a member's emotional investment in the status quo is a strong one, even if it isn't working.

Group psychotherapy can be thought of as a healing of the soul—an education or even a re-education of one's own emotions and the emotions of others. This is my idea of 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 Spotnitz (Spotnitz, 1985). Spotnitz took issue with Freud's notion that pre-oedipal patients—schizophrenics, psychotics, borderlines, and those with character disorders—were suffering from a re-direction of libido away from the outside world and back onto themselves. In Spotnitz'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 follows 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. Prior to the session in question, I received a terrible 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!"

> *"Group psychotherapy can be thought of as a healing of the soul—an education or even a re-education of one's own emotions and the emotions of others. This is my idea of emotional intelligence."*

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 as Peter spoke. 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 his face appeared bloated, and she quickly made the connection when she said to him, "You have coke bloat!" Peter admitted to having come to group high on coke, "So what of it?" he said. Peter then resumed his rant about the bugged room. I joined him and said, ""Shh! Whisper; there may be people listening in." He was furious with me when he said, "You're mocking me. Your computer has a microphone, and someone is listening in." Then he said, "I know you hate me." I asked him, "Why would I hate you?" Peter said, "'Because I 'don't walk with God.'" The group was alarmed by his statement, but I thought I knew what he meant. Although he appeared to be delusional, Peter had told me the same thing the night before in his individual session. Hoping Peter would reveal the context on his own, I asked him, "Why would I think that?" Peter expressed his rage screaming, "I'm in a rage. I hate you. I hate my parents. You are just like my parents. You hate me because I'm gay, just like they do." I saw this as an opening into a discussion of what had sent him into this downward spiral and said to him, "Tell the group what you're talking about."

He said, "This weekend is the christening of my newborn nephew, and I'm not going." Linda asked," Why aren't you going?" Peter said, "Because I don't have a suit to wear." I knew it was more than that and I said, "You're leaving out the most important part of the story." Then the anger and hurt came pouring out. Peter said, "I wasn't invited to be his godfather because my parents told me, 'You don't walk with God.'" Now it all made sense, and group members responded in kind. There was a shift in the mood of the group, and the others attitude toward him greatly softened. Members could now understand the pain and hurt that underlined the rage.

I turned to James, the oldest group member, a devout Catholic and father to a teenage daughter, and asked: "Would you ever say such a thing to your daughter?" James' face turned red and said, "No way. I would never say such a hateful thing to her. I am furious with Peter's parents. Such hypocrites! I love my daughter, and her happiness is the most important thing to me. I would never judge her sexual orientation." Anita said, "I feel so protective of Peter. What despicable people his parents are. Their love for him is so conditional. They have ex-communicated him from the family. No wonder he's so furious." I asked her, "What was his parents' unspoken message to him?" Peter answered for himself, "They hate me." I said to him, "You understood their message but you turned it back onto yourself." Peter calmed down and started to cry. He said, "I feel so loved and cared for here." He cried because an unconscious need had been met. Then he made a joke, "I don't really care if the room is bugged." His 180-degree turnaround didn't excuse his self-destructive drug binge, but it made his behavior all too understandably human. At the end of group, I told him that his change in attitude and behavior was nothing short of remarkable. The others 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 painful, yet constructive place. It was emotional 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.

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Continued from page 1

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 Keens 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 teaching 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 enrolled 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 taught through lectures and questions and answers. Some trainees have never experienced role-playing or process groups. 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 led in that direction by a trainee, 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 host 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 proponents 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 disasters 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 are able to 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 and 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, were 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.

member NEWS

Richard Beck | Nina Brown | Bonnie Buchele | Shira Marin | Jill Paquin | Ginger Sullivan | Tony Sheppard

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 *Conversation with Alanis Morissette*, where she spoke about the four kinds of destructive narcissistic patterns and how to navigate relationships with them. Listen at alanis.com/news/podcast-episode-18-nina-w-brown.

Bonnie Buchele, PhD, ABPP, CGP, DLFAGPA, edited a special issue (Volume 38, Issue 4, 2018) of the *Psychoanalytic Inquiry Journal* on "Today's Bridge Between Psychoanalysis and the Group World." Most of the authors in this issue are also AGPA members, including:

- **Shoshana Ben-Noam, PsyD, CGP, LFAGPA—**"Cracking the Intrapsychic Glass Ceiling for Women in Leadership: Therapeutic Interventions;"
- **Susan Gantt, PhD, ABPP, CGP, LFAGPA—**"Developing Groups that Change Our Minds and Transform Our Brains: System-Centered's Functional Subgrouping, Its Impact on Our Neurobiology and Its Role in Each Phase of Group Development;"
- **Robert Grossmark, PhD—**"The Unobtrusive Relational Group Analyst and the Work of the Narrative;"
- **Molyn Leszcz, MD, FRCPC, CGP, DFAGPA—**"The Evidence-Based Group Psychotherapist;" and
- **Andrew Smolar, MD—**"Enhancing the Dyad: The Benefits of Combining Group Therapy with Psychoanalytic Treatment."

Shira Marin, PhD, LMFT, presented on *Fostering Personal Intimacy through Mixed-Media Visual Journaling and Group Process* at the 2018 International Association for Group Psychotherapists Congress, Malmo, Sweden. In private practice in San Rafael, California, she is also the author of *Shards of a Broken Mystery: The Restoration of Hekate.*

Jill Paquin, PhD, spoke on using the science of group dynamics to enhance teaching effectiveness in social justice and multiculturally-focused coursework at the Society for the Psychological Study of Social Issues' Summer Conference. Dr. Paquin is an Assistant Professor in the graduate program of counseling psychology at Chatham University and the new Editor-in-Chief of AGPA's *International Journal of Group Psychotherapy.*

Ginger Sullivan, MA, LPC, CGP, FAGPA, published *The Road Out: Musings from a Southern Wanderlust*, chronicling her journey out of the South and into herself as she leaves home and attempts to find her place in the world.

Tony Sheppard, PsyD, CGP, FAGPA, received the Alumni of the Year Award from the School of Professional Psychology at Spalding University, Louisville, Kentucky. Dr. Sheppard received his MA from Spalding in 1999 and his PsyD from the school in 2002. In addition to teaching group psychotherapy, he trains doctoral students in psychological assessment, and individual, family and group psychotherapy. His practice, Groupworks, offers Spalding School of Professional Psychology students in-depth training in group psychotherapy. The award was presented by Brenda Nash, PhD, Director of Clinical Training for the School of Professional Psychology.

consultation, please!

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 unselfconscious 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?

Signed,
Stymied

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 general 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 hear 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

Rosenthal, L. (1987). Resolving resistance in group psychotherapy. Northvale, NJ: Jason Aronson, Inc.

Members are invited to contact Lee Kassan, MA, CGP, LFAGPA, the Editor of the *Consultation, Please* column, about issues and/or questions that arise in your group psychotherapy practices. They will be presented anonymously, as in the question here, and two members of AGPA will be asked to respond to your dilemma. In this way, we all benefit from members' consultation from an objective point of view. SIG members are also encouraged to send cases that pertain to your particular field of interest. Email Lee at lee@leekassan.com.

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

groupcircle

25 East 21st Street, 6th floor
New York, NY 10010

See *Group Assets* insert

affiliatesociety NEWS

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-90s, 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 going to the beach! Jeff Georgi, MDiv, MAH, LCAS, LPC, CGP, will present *Connection: Unlocking the Vise of Addiction* at Trinity Center, Pine Knoll Shores, North Carolina, September 14-16. Mr. Georgi is a Consulting Associate in the Department of Psychiatry, Addiction Division, Duke University Medical Center, Durham. This workshop will focus on the treatment of moderate to severe substance use disorders and recommended modifications clinicians can make in their group and individual practices to more effectively treat individuals struggling with addiction. Visit carolinasgps.org.

CGPS held its Asheville Social in May at the beautiful home of two members, Pamela Millis, LPC, CGP, and Peter Millis, MSW. In addition to CGPS members, interested newcomers from South Carolina and the Asheville, NC area were in attendance. Pictured, left to right, are: Esther Swim-Wright, LCSW; Katie Cushman, LPC; Duncan Tam; Frances Stockdale, MFT; Sunya Kjolhede; Vicky Acton, LPC; Pamela Millis, LPC, CGP; Peter Millis, LCSW; Tom Thorsheim, PhD, CGP; and, Carl Losacco, LCSW.

THE FOUR CORNERS GROUP PSYCHOTHERAPY SOCIETY (FCGPS) will host Marcée Turner, PhD, at its Annual Conference *Group Cohesion and Unity: Expanding the Circle,* November 10-11. Institute and Workshop leaders will come from all four states and have a wide variety of racial, ethnic, gender, and educational backgrounds. The Institute leaders will be supervised again this year by Gil Spielberg, PhD, ABPP, CGP, FAGPA; his expertise ensures that the groups are held to the highest standard. FCGPS is offering a 30% discount on ticket sales to members of other AGPA Affiliates to help counter balance travel costs; just enter the code: AGPAALLIES on its Eventbrite Page. For more information about its upcoming conference, visit FCGPS's new and improved website at www.fcgps.org or email info@fcgps.org.

THE HOUSTON GROUP PSYCHOTHERAPY SOCIETY (HGPS) is hosting a one-day conference, *Diversity Within Diversity: The Intersection of Identities Within Groups*, on October 19 from 8:30 am to 5:30 pm at The Council on Recovery, 313 Jackson Hill, Houston, Texas. The keynote speaker is Sandra López, LCSW, ACSW. Three ethics CEUs are offered. HGPS 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, LPC, LMFT, CGP, on July 13. The training focused on the unusual and non-ordinary events and experiences that happen in the inter-subjective space between the therapist and the client. The presenters shared extraordinary moments in their private practices to open up a discussion with HGPS members about the mystical or unconscious collective experiences. How therapists make use of this associational and indirect material allows them to see it as reverie to catch the drift of the unconscious. This discussion helped therapists understand their work as a mystical and spiritual practice.

THE ILLINOIS GROUP PSYCHOTHERAPY SOCIETY (IGPS) will hold its Fall Conference in Chicago, October 19-20. *Power, Privilege, and Social Location: The Challenge of Exploring Difference in Groups*, to be presented by Paul Gitterman, LICSW, MSC, CGP, will provide both theoretical and experiential opportunities to examine the role of different aspects of identity and discuss the implications for group work. The conference will explore the essential behavioral differences leading to group cohesion and relationships in general. Through exploring difference, the group establishes protective norms and can therefore effectively negotiate misattunements and microaggressions. Gitterman is an Adjunct Associate Professor for the Smith College School for Social Work and a psychotherapist at Williams College Integrative Wellbeing Services; he also has a psychotherapy practice in Williamstown, Massachusetts.

THE NORTHERN CALIFORNIA GROUP PSYCHOTHERAPY SOCIETY (NCGPS) will present its Fall Event, featuring Jeffrey Hudson, MEd, LCP, CGP, FAGPA, on October 6 in San Francisco. His workshop, Emotional Availability in Group: Fostering Intimacy in Challenging Times, will examine both group members' and leaders' resistance to emotional involvement. It will include discussions of sources of resistance and the influence of the current political environment on groups. Additionally, he will explore Modern Psychoanalytic approaches, such as joining, emotional communication, and contact functioning. NCGPS implemented a series of small events called Open Group Studios a few years ago. These events, styled after Artists' Open Studios, showcase local group therapists, hosting two-hour intimate gatherings of no more than 10 people at their own offices. Presenters focus on their current project or expertise, offering a taste of their work, usually with an experiential component to local group and individual therapists who are just dipping their toes into group work and have not yet committed to larger group therapy events. NCGPS's membership has found these events friendly and a welcoming opportunity to learn more about the local Affiliate. A small fee is charged. Visit ncgps.org.

Friends and colleagues gathered at NCGPS's June Annual Training Conference at Asilomar in Pacific Grove. From left to right: Erica Anderson, PhD, NCGPS President; Judye Hess, PhD, CGP-R; Shira Marin, PhD, LMFT; and Ron Rohlfes, MA, MFT.

THE SAN ANTONIO GROUP PSYCHOTHERAPY SOCIETY (SAGPS) hosted a 12-hour *Core Principles of Group Psychotherapy** course this spring, taught by senior members Cheryl Kalter, PhD, LPC, CGP, Robert Kalter, MD, CGP, Bettise Specia, LCSW, CGP, and D. Thomas Stone, PhD, CGP, FAGPA, with nine practitioners in attendance. Attendees engaged in the didactic and experiential material over four weeks, and many noted the space between sessions gave them time to process content and experience which added to the richness of their learning. A rewarding all-day workshop on leadership, *Desires to Lead: Perils and Passions*, with Karen Travis, LCSW, BCD, CGP, FAGPA, had over 40 participants and was enhanced by the attendance of a group of nurse leaders in the community. The annual free-for-members ethics workshop led by Past President Susan Mengden, PhD, focused on *Gray Matters in Group Psychotherapy*.

THE WESTCHESTER GROUP PSYCHOTHERAPY SOCIETY (WGPS) is hosting *Infants and Children as Change Agents with Group Work with Parents Impacted by Trauma* on October 12 from 12:00-4:30 pm. The speaker is Wendy Bunston, BSW, PhD, of WB Training & Consultancy (Australia); she has worked in the child and family welfare sector for 30 years. Her 2016 PhD won the prestigious Nancy Millis Award. Dr. Bunston is the author of multiple international articles and chapters. Her book, *Helping Babies and Children to Heal after Family Violence* was published in 2017, and she has another book due out next year. On November 9, Neal Spivack, PhD, CGP, FAGPA, will present *Utilizing a Systems Centered Approach to Group Therapy as a Means to Help Veterans Struggling with Readjustment to Civilian Life.* He is a clinical psychologist at Veterans Health Administration, New York and a Past President of the Eastern Group Psychotherapy Society. He has extensive experience presenting both locally and nationally on various topics related to group psychotherapy interventions. On December 14, from 12:00-4:30 pm, Roberta Omin, LCSW, will present *When the Therapist Becomes the Medical Patient, Courageously Engaging with Illness and Mortality*. She is a Certified Gestalt Therapist and Certified in Internal Family Systems. These models have been integrated into her practice. Contact, Gloria Kahn, EdD, ABPP, CGP, FAGPA, at (914) 428-0957 or globatkahn@gmail.com.

**This event meets requirements for the Certified Group Psychotherapist (CGP) credential from the International Board for Certification of Group Psychotherapists.*

PLEASE NOTE:

Please note: Affiliate Societies may submit news and updates on their activities to Susan Orovitz,PhD, CGP, Editor of the Affiliate Society News column, by e-mail to: sussiego@me.com.

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