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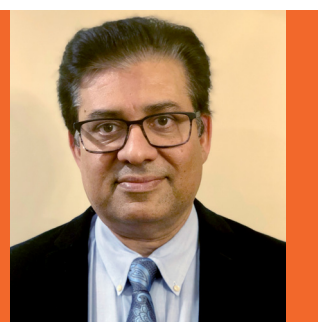
AMERICAN GROUP PSYCHOTHERAPY ASSOCIATION
INTERNATIONAL BOARD FOR CERTIFICATION OF GROUP PSYCHOTHERAPISTS

SPRING 2021

groupcircle

Existential Factors in Group Psychotherapy During Pandemics: Losses Galore*

By Maryetta Andrews-Sachs, LICSW, CGP, FAGPA, and Farooq Mohyuddin, MD, CGP, FAGPA



The sculptures by Bruno Catalano entitled *Voyageurs* (The Travelers) capture some of the feel of this past year. What have we lost? What holes have been blown open— in our sense of self? in our families? for those who identify as BIPOC or White? for those up-ended by climate disasters? for immigrants?

Existential factors always weave throughout our work but rarely as clearly as over the past year. At AGPA Connect 2020, the Mid-Atlantic Group Psychotherapy Society had its annual dinner. Half of our table got COVID-19. Fortunately, no one died. Our country continues to pass terrible milestones in terms of deaths from COVID-19—more than a half a million at this writing. If we think about each of these deaths and the impact each death has had on the people around them, the losses are staggering.

But COVID-19 has not been the only pandemic. We were always intrigued by a Biblical passage in Acts 9:18: "Let the scales fall from our eyes." The brutal death of George Floyd ripped scales from many eyes. (We wish we could say from everyone's eyes.) I (Maryetta) teach a group therapy course at Howard University's School of Social Work. Many of my Black students live a different reality from mine in terms of policing, health care, etc. One of my White colleagues said recently: "I feel like I've been blind!" Toni Morrison said: "Americans are White; everyone else is hyphenated." We would like to help build a world where everyone gets to shine. Otherwise, we are all diminished. We can choose to be blind or to look closely at the truth of things. This is a choice.

This connects to the third pandemic reflecting existential concerns, that of the polarization in this country. A recent *Washington Post* article stated, "some psychologists likened the spread of QAnon and the increase in conspiratorial thinking to a global pandemic." Family members and friends are ripped apart by ideology. This political chasm evokes further feelings of isolation, of existential angst.

How might an existential lens help in our therapy groups during these difficult times when leaders and members struggle with the same existential dilemmas. Our ability to live in the usual space of denial has been stripped away. First, what is "existential psychotherapy"? Yalom (1980) defines this as "a dynamic approach to therapy which focuses on concerns that are rooted in the individual's existence." He identifies core existential concerns: isolation, freedom, responsibility, choice, meaning, meaninglessness, loss, and death.

As noted, losses and death or the fear of death have loomed large this past year. Helping our group members grieve amid continued loss is an important task. Plus, all of us are feeling varying degrees of isolation. For some group members, the group session can be the great source of connection they feel in a week. Since we need human connection from the first sentient moment of life to the last, focusing on how group members are managing this distress and

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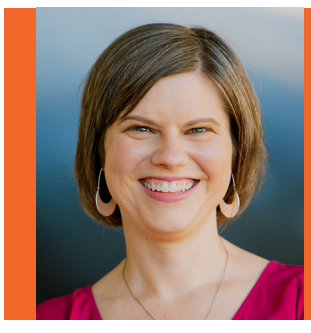
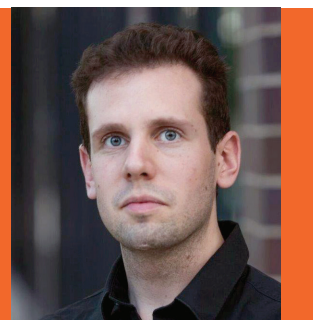
**This article is based on an Institute at AGPA Connect 2021 facilitated by the authors.*

The Group Therapist's Social Dilemma

Christina Dixon, LCSW, and Marc Azoulay, LPC, LAC, CGP, ACS





Last summer Netflix released *The Social Dilemma*, a documentary detailing the long-term negative psychological impact of social media. The movie portrayed disturbing evidence about rising anxiety, depression, and addiction related to social media overuse. This is ironic as these platforms were originally created to foster community and connection.

Social Media's Impact on Depression and Anxiety

According to numerous research studies, large amounts of time spent on social media negatively impact depression and anxiety (Karim et al., 2020). Excessive use of social media platforms results in contract comparison with your peers. This skewed perspective is intensified by the engagement metrics (likes, shares, follows) that quantify validation and social clout. Not only do you see other people's curated lives, but you also see how popular they are. For younger generations, they are getting an unrealistic view of life, and their self-worth can plummet when they compare themselves to their friends and influencers (Chen, 2013).

Case Study

Jessica is a 16-year-old who attends public school in a Colorado suburb. She identifies as a white, heterosexual cisgender female. She entered therapy because of feelings of depression linked to negative body image. Over the course of her treatment, she would show her therapist social media posts of her peers in which teenage girls were provocatively posed and sexually charged captions were added. Additionally, many of the girls were using photo filters to edit their pictures before posting. Jessica would lament to her therapist that she did not look as pretty as these girls and that she was not getting as many likes.

She said she was uncomfortable taking provocative photos but felt that if she did not, she would never have a boyfriend. Once she was able to work through negative influences of social media, she was able to find a different group of friends that were more aligned with her values. By finding a healthier community, Jessica rose out of her depression and is on track to go to college and pursue her dreams. Her time in

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from the president

Molyn Leszcz, MD, FRCPC, CGP, DFAGPA

In writing this column just after the successful conclusion of our AGPA Connect 2021 meeting, I naturally thought back to last year at this time. In the immediate aftermath of our New York meeting, the COVID-19 pandemic exploded around us and has dominated much of our lives for the past 12 months. This year's AGPA Connect followed closely the brutal winter storms that knocked Texas and many of our members there off the grid for days. We are grateful that people were able to get reconnected and recovered quickly from the impact of that devastating weather. Today, buoyed by the broad reach of vaccinations, the success of AGPA Connect 2021, and the approach of spring, I feel heartened with eager anticipation for the year ahead.

The feedback that we received about AGPA Connect 2021, echoes my own experience—the virtual meeting exceeded our expectations. Nearly 60 attendees, a record in my recollection, attended the evaluation meeting at the end of the conference. Nearly 1,000 individuals attended various parts of the meeting, including 250 first-time and 90 scholarship attendees. When we went live, there was a breath of deep relief that the technology was going to work as we had hoped. It is a tribute to Katie Steele, PhD, CGP, FAGPA, and D. Thomas Stone, PhD, CGP, FAGPA, AGPA Connect Co-Chairs, and their remarkable Committee that the meeting was so successful. We are enormously grateful and indebted to Marsha Block, CAE, CFRE, our CEO, Angela Stephens, CAE, Katarina Cooke, MA, Angie Jaramillo, Diane Feirman, CAE, Desiree Ferenczi, MA, and Tamzen Naegele for being ever present, effective, and gracious in supporting our members in accessing the meeting. The faculty meeting Wednesday night ahead of

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what's inside

from the editor

Leo Leiderman, PsyD, ABPP, CGP, FAGPA

Spring 2021 represents a period of transition, marked by optimism and gratitude after a very successful virtual AGPA Connect 2021 and an effective national vaccine rollout providing hope and opportunity for a post-pandemic future. During this time, we are also confronted by the multiple losses and mass trauma occurring concurrent with the pandemic, including: the ongoing political divides; the secondary trauma of watching via media outlets the insurrection against the US Capitol; mass shootings; skyrocketing hate crimes against BIPOC, Asian Americans, and Pacific Islanders (AAPI) communities; new and ominous voter suppression laws targeting disadvantaged populations of color; and the secondary trauma watching the trial of the brutal killing of George Floyd.

These factors challenge us both personally and professionally and impact our group members. Being aware of the culminate effects of mass trauma and co-morbidities of depression, anxiety, etc. will better prepare us for when these factors emerge in our groups and from our group members. Since we are also simultaneously experiencing the same mass trauma caused by the pandemic, and we anticipate that the negative emotional impact will be long term, we must be aware of and apply methods of self-care on a frequent basis to prevent burnout and fatigue.

This edition of the *Group Circle* includes a feature article that brings meaning and understanding to the collective multifaceted losses caused by the pandemic: *Existential Factors in Group Psychotherapy During Pandemics: Losses Galore* by Maryetta Andrews-Sachs, LICSW, CGP, FAGPA, and Farooq Mohyuddin, MD, CGP, FAGPA. The article by Christina Dixon, LCSW, and Marc Azoulay, LPC, LAC, CGP, ACS, *The Group Therapist's Social Dilemma,* denotes the impact and dilemma caused by social media. Leslie Lothstein, PhD, ABPP, CGP, author of *GROUP: Seasons One and Two*, provides insight and highlights this YouTube video series.

In his *From the President* column, Molyn Leszcz, MD, FRCPC, CGP, DFAGPA, provides an overview of the AGPA Connect 2021 and shares his compassionate vision for the future. Martyn Whittingham's, PhD, CGP, FAGPA, and Gary Burlingame's, PhD, CGP, DFAGPA, *Practice Matters* column article on *Reimbursement Rates Improve Access and Lead to Social Justice* summarizes the advocacy and social justice activism needed by AGPA and its members to address unfair reimbursement rates for group psychotherapy. Sabrina Sarro's, LMSW, *Widening the Circle: Racial & Social Justice* column article, *Blackness and Trans-ness Inside Me: What it means for me to hold these identities as a therapist,* conveys important guidance and understanding about the treatment of transgender or gender non-conforming people. *The Consultation, Please* column features AGPA's Mental Health Agency & Institutional Settings Special Interest Group SIG members Ingrid Söchting, PhD, RPsych, CGP, and Richard Beck, LCSW, BCD, CGP, FAGPA.

As we hope and pray that the race toward herd immunity will be globally won in the near future, I wish all of you and your loved ones safety and wellness. 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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the Thursday start to the conference was shaped by Angela's calm, reassuring, and effective guidance.

Although we all missed the in-person contact and connection, the experiential nature of our learning together was well preserved through Zoom. The very positive feedback strongly endorsed the format, and we are now looking ahead to AGPA Connect 2022 planned for Denver. Your feedback will be incorporated into our planning for next year and beyond. We will build atop what we are doing well, and we will learn from those things that we must modify to do better.

Our members have asked the AGPA Connect Committee to look at ways of creating a hybrid that makes the best use of in-person meetings and increases access through the virtual platforms. We now know with certainty we will present an outstanding meeting next year. Program submissions are being received, and there is optimism that members will respond positively to invitations to be faculty whether in person or online.

Our various Board meetings all took place before and after AGPA Connect. We also held our first virtual Membership Community Meeting, and for the first time in our history, we had people pushing to get into the meeting, until we addressed a glitch that limited the number of attendees. There was much to acknowledge and celebrate in the Community Meeting. You will see over the next few weeks notices of awards and appointment of new Fellows, as well as the appointment of new leaders of Committees and Special Interest Groups. The Membership Community Meeting was recorded, and it's available at https://youtu.be/Dt3I2lvjXhc.

We also learned that we could host virtual social and music events, mindfulness, singalongs, a Zoom dance evening, and even a remarkable Family Feud game, which many people want to see as a mainstay going forward. David Songco, MA, PsyD, CGP, Co-Chair of the Internet, Technology and Social Media SIG, and Co-Chair of the e-Learning Task Force, looks like he is preparing for a new career as a game show host. Our Special Interest Groups (SIGs) found effective ways to meet together. I was impressed by the energy and enthusiasm for the work of the SIGs and for the organization as a whole.

The Plenaries were all outstanding, and although recorded in advance, the opportunity to have Q&A later in the day with our Plenary speakers was welcomed and utilized to good effect. We learned more about: the importance of understanding the impact of early life adversity on our neurobiology and even neurosociology as noted by Bruce Perry, MD, PhD; the importance of addressing people's humanity in a hopeful fashion regardless of the settings in which they are being treated, as noted by Elizabeth Ford, MD; and the need to revise our models of treatment to comprehensively incorporate the impact of racial trauma and discrimination; and honor our patients as addressed by Thema Bryant Davis, PhD. Our own Alexis Abernethy, PhD, CGP, FAGPA, kicked off the Institutes with a powerful and personal Plenary about the importance of finding home, belonging, and inclusion in all domains of our life.

These themes continue to be very prominent as we move into the spring and roll out the second round of our DEI consultation and focus groups. By the time you read this issue of the *Group Circle*, we will have held focus groups on restorative justice, white allyship, listening to BIPOC members, clinical implications of racism for treatment of BIPOC individuals and international anti-racism, as well as consultation groups on our publications and training. This work is essential to who we are, and I feel encouraged that we are advancing in ways we have not done so in the past. I'm also reminded, painfully, of how much work still lies ahead. We are committed to that as an organization in a deep and profound way.

As we begin planning for the next year, I carry with me two important feelings. One is a sense of humility at the scope of what lies ahead for us organizationally and as practitioners as we truly realign the way in which we approach our work to ensure that it is inclusive and welcoming across issues of race, gender, gender identity, sexual orientation, culture, age, and health. But I hold a dialectic. Alongside that feeling of humility is a deep feeling of appreciation for the opportunity to work closely with the members of this outstanding organization, our leadership teams, our administrative supports, and of course our remarkable CEO Marsha Block.

I welcome comments and suggestions and can be reached at m.leszcz@utoronto.ca.

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EDITOR'S NOTE: *In 2020, the Human Rights Campaign reported at least 44 transgender or gender non-conforming people were murdered, the majority of whom were Black and Latinx transgender women. Three Black women, two of whom identify as queer, conceptualized Black Lives Matter to center the lives most endangered. Sabrina Sarro is a Black/Haitian/mixed-race, queer, trans* therapist, writer, and spirit exfoliator. They work primarily with Black and Brown folx, many of whom identify as queer or on the LGBTQIA*+ spectrum. They are an LMSW from Columbia University and are currently pursuing an MFA in memoir from the College of the City of New York. They are currently a LightHouse Book Project Participant, working on a memoir about their experience as a food rape survivor. They live in Queens with their deeply feeling golden retriever, Mooshu.*

Blackness and Trans-ness Inside Me: What it means for me to hold these identities as a therapist

Sabrina Sarro, LMSW

How is 2021 travelling inside me? I sigh, asking myself, as I stare into the calendar, now this strange symbol of grief. I think back to 2020, its teeth still feel sharp inside my head and wonder about the ways in which my relationship to time has bended, broken. I think of my Blackness as the toaster chimes. I think of white supremacy as I relocate my fear back towards my own hunger, the butter making me sick. My gut clenching into itself the way nausea climbs up a throat and lingers. This continual grieving making me sick. There are no words to capture the heaviness I contend with daily, the heaviness of being in a body that is constantly policed, erased, negated. *When will my people get rest? When will our communities be centered? How can I center and hold space for joy and thriving for my clients?*

This is most mornings for me. As someone who identifies as a queer, Black mixed-race trans* therapist, I'm always thinking of how white supremacy has robbed me of so much time, has made me constantly interrogate the ways in which I am participating in my days, filling the hours. The ways in which my body feels consistently depleted, withered down. The ways in which it's laborious to find safe people and experiences, to connect and participate in community. My anecdote inquires: *How is 2021 travelling inside the bodies of Black trans folx as we continue to move through spaces and experiences that are consistently showcasing and communicating how little we are valued?* How much we are erased. How we are cast as invisible, forgotten. How our deaths do not matter. How we need to be centering disabled, fat, dark-skinned Black folx.

Translations

Lesbian, gay, bisexual, transgender, queer/questioning (one's sexual or gender identity), intersex, and asexual/aromantic/agender (LGBTQIA)

Transgender/gender-nonconforming (TGNC)

***Note from the author:** I put an asterisk to connote that these words are always subject to definitions outside of any context we may associate with them and that there is no one way to be trans, TGNC, etc.*

As a therapist who works mostly with community members who share my own identities, I think of ways to celebrate my clients. I think of ways to discuss my privilege as a light-skinned/mixed-race Black person, participating in a medical-industrial complex that centers me over my mono-racial, unambiguously Black counterparts. I think of how that power dynamic undoubtedly presents in sessions. I think of what I can do to acknowledge it, how I can give up power and de-center and de-platform myself in the field, a field which desperately needs continued interrogation and decolonization. I think of how I co-create and co-collaborate with my clients, how I can help re-activate or re-ignite dormant energies, how we can illuminate things we might not have seen, processed, or synthesized before.

I am inspired by my clients and the in-session magic we create. I am inspired by my community's tenacity; despite the world's attempts to exterminate us, we persist in thriving. We grab at our joy; we claim spaces taken from us. I want to further celebrate my Black trans* clients, advocating harder for LGBTQIA*/TGNC sensitivity and understanding. Part of furthering this care, tenderness, and attention to community members is asserting what it means to deliver accessible Black/Trans* mental health care. Because most Black trans* therapists are treated as invisible, it is critical to thrust these practitioners to the front. It is crucial for clients to know we exist and are looking for them as they might be looking for us. We are not new or a novelty. We have always existed and will continue to exist globally. It is imperative for clinicians to show up, believe TGNC*+ clients' needs and wants, and hold themselves accountable with clients in the LGBTQIA*+ community.

Black trans* clients and community members deserve access to mental health professionals who look like them and share their identities; to explore themselves and their dreams while accessing safety and experiencing visibility in session; to work with and co-collaborate with therapists that they do not need to educate; a safe forum to focus on our thriving, on our ancestral resilience; on growth, healing, and joy without industries sensationalizing our traumas. Often, TGNC* clients are subjected to unintentional heteronormative underbellies and violent rhetoric. Many clinicians are not trained appropriately in decolonizing gender, and consequently harm clients. It is on us to educate ourselves and remember that TGNC*+ clients are the experts of their lives, experiences, and narratives—and deserve to be centered, seen, and heard.

Being a Black trans* therapist will always be deeply sacred to me. Having the privilege to hold space and participate in meaning making with other community members feels revolutionary and deeply connecting to the magic of this narrative work, of this healing through resistance and play. As 2021 continues to usher into my body, I want to remain connected and in reverence of my community and the members with whom I work. I want to celebrate the sanctity of our bodies. I want to continue to give up power and decolonize the medical-industrial complex, amplify ways in which practitioners need to hold themselves accountable, push dark-skinned, Black trans* therapists to the front, and continue showing up, abolishing anti-Blackness, and providing clients with spaces to heal and thrive.

Resources

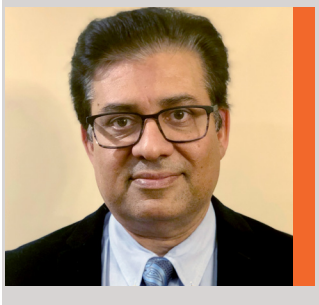
AGPA's Special Interest Group on Gay, Lesbian, Bisexual, Transgender and Queer Identities is a safe and welcoming place for LGBTQ therapists and anyone interested in better understanding the LGBTQ population. The SIG provides programming, networking, and social events.

AGPA's Special Interest Group on Racial and Ethnic Diversity 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.

Reference

The Human Rights Campaign. (n.d.). *Fatal violence against the transgender and gender non-conforming community in 2020.* www.hrc.org/resources/violence-against-the-trans-and-gender-non-conforming-community-in-2020.

Harold S. Bernard Group Psychotherapy Training Award Presented to Farooq Mohyuddin, MD, CCP, FAPA, FAGPA



The International Board for Certification of Group Psychotherapists (IBCGP) presented its 2021 Harold S. Bernard Group Psychotherapy Training Award to Farooq Mohyuddin, MD, CGP, FAPA, FAGPA, during AGPA Connect 2021's Membership Community Meeting.

This award was established in 2001 and is given annually to an individual or organization whose work in group training and/or education contributes to excellence in the practice of group psychotherapy. It was renamed through a legacy gift provided to the Group Foundation for Advancing Mental Health by Dr. Bernard for the purpose of endowing the award. Throughout his lifetime, training in group psychotherapy was near and dear to Dr. Bernard's heart. His legacy bequest and this award ensure that individuals and programs meeting a high standard of training quality be identified and honored for their contributions to the field in developing the next generation of clinicians who use group psychotherapy to help people.

Dr. Mohyuddin was recognized for his significant contributions in training and leadership in the field of group psychotherapy on a local and national scale. Dr. Mohyuddin has been Chair of Psychiatry Training and Education at Saint Elizabeth's Hospital in Washington, DC since 2013; prior to that, he was the Program Director for the Psychiatry Residency Training Program. His residents receive extensive group therapy training for the duration of three years. Since 2008, Dr. Mohyuddin has been teaching AGPA's Core Principles of Group Psychotherapy course at the Washington School of Psychiatry. From 2018 to 2020, Dr. Mohyuddin served as Chair of the Faculty at the National Group Psychotherapy Institute.

EXISTENTIAL FACTORS IN GROUP PSYCHOTHERAPY DURING PANDEMICS

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anxiety is essential. The existential therapist stresses the concept of being fully present with others in relationships at home or in groups. The only way to be fully present is to be in touch with your own existential concerns.

Discovering and strengthening this capacity in group members also links to the exploration of meaninglessness. The philosopher Martin Buber once said, "All real living is meeting." To discover that you really matter to other group members is a transformative experience. The group therapist becomes the midwife, completely being there but with the specific purpose of helping the others bring to birth something within themselves. But therapists need to learn to be fully present to themselves before they can be fully present for others.

Paul Tillich was probably the greatest Christian theologian of the twentieth century and beloved by many mental health professionals. He escaped Nazi Germany and taught at the University of Chicago. With a group of college students, I (Maryetta) spent a weekend where we sat around having conversations with this brilliant man. I was too blocked, too anxious to remember a thing, but his seminal work, *The Courage to Be*, stays with me. He believed all humans are anxious. He taught that we must ask a higher power—or perhaps our therapy group—for the courage to be fully alive despite our anxiety. He broke anxiety into two parts: the courage to be all alone, to take a stand and the courage to be a part of a couple, a group, a community. Autonomy and Intimacy: in therapy groups, isn't this what we work on in a nutshell? To live courageously, authentically at any point in human history has been a challenge, and we all do this better when connected with others. If only every human had a good therapy group to attend weekly.

Another existential concern is about freedom, responsibility, and choice. Think of how many people have difficulty with agency in their lives. One example is a group member who dreamed the night before a group that she was at a party where Jeffery Dahmer was hitting on her. Her friends warned her not to leave with him, telling her he was a serial killer, but she wanted to have sex, so off she went! She was seeking therapy because she picked terrible people to befriend. What a wonderful dream to present to the group for the reason you are joining. How many of us have needed help with our picker—the agency we have in making choices? In our groups, we are hopefully helping people chip their true selves out of the block of ice they developed to protect themselves, or the wall of rage they arrive with or whatever defensive armor they have developed to get them through the day and the night. We help people find their voices, their truths, to make better decisions. This is what sets us free. We do not have true freedom until we have our true selves.

There are added dimensions to this for BIPOC friends and patients. Tamir Rice, the 12-year-old Black boy playing with a toy gun in a park, was shot and killed within two seconds of the policeman arriving at the park. Two seconds. Implicit bias is real, powerful, and mostly unconscious. BIPOC individuals have a different calculus to make upon leaving their homes. One friend described how carefully he positions his license, his registration, or anything else he has to access if stopped by a policeman so it will be within reach and within the policeman's view. Black children are taught not to pick up items in a store to look at or open a package until they have left the store. Black parents must have a different talk with their children than White parents. The issue of freedom, choice, and agency can be quite different depending on the color of your skin. Tamir Rice had no opportunity to have agency.

A Man Doesn't Have Time in His Life

By Yehuda Amaichi

A man doesn't have time in his life
to have time for everything.
He doesn't have seasons enough to have
a season for every purpose. Ecclesiastes
Was wrong about that.

A man needs to love and to hate at the same moment,
to laugh and cry with the same eyes,
with the same hands to throw stones and to gather them,
to make love in war and war in love.
And to hate and forgive and remember and forget,
to arrange and confuse, to eat and to digest
what history
takes years and years to do.

A man doesn't have time.
When he loses he seeks, when he finds
he forgets, when he forgets he loves, when he loves
he begins to forget.

And his soul is seasoned, his soul
is very professional.
Only his body remains forever
an amateur. It tries and it misses,
gets muddled, doesn't learn a thing,
drunk and blind in its pleasures
and its pains.

He will die as figs die in autumn,
Shriveled and full of himself and sweet,
the leaves growing dry on the ground,
the bare branches pointing to the place
where there's time for everything.

A patient with almost no close relationships over five decades had the following dream: She is swimming in the ocean and can see two people way out; one is her sister. She wants to go out there but is too anxious about what may be under the water. What is lurking beneath the water? What terrors keep us from the connections we need to thrive? Just think of the Still Face Experiments by Dr. Edward Tronick on YouTube (2016). It is clear we need good connections with at least a few others from the first sentient moment of life to the last. We know that good eyes neurologically ground us. Few do well in isolation.

Can we tolerate the anxiety of these pandemics? How do we hold onto our best selves? COVID-19 has compounded the issue of isolation tremendously. I (Maryetta) think of the people dying without the comfort of loved ones being present. So many are missing the good eyes we all need to get through. Our Zoom meetings must make do, but they are not the same as being truly present with each other. If only AGPA Connect had been in person! But like Victor Frankl, in his classic book *Man's Search for Meaning*, we must make meaning and connection as best we can with whatever circumstances we find ourselves in.

Recently, in a mixed therapy group, a woman adopted in Ireland and raised in a family with a very narcissistic, cruel mother and a passive, loving father who nevertheless never protected her, presented this dream. She had joined this group just prior to it going online for sessions. She bonded with another adoptee and sexual assault survivor, Ralph, whose addiction to meth and lack of meaningful relationships has been an ongoing focus for him in the group. In her dream, she returns to Ireland where her birth family still lives. She is in a car driving down her childhood street. She parks outside her childhood home only to see her father exiting their house and getting into his car. Instinctively, she knows he is headed out to sea for a swim, his favorite pastime. She parks her car and suddenly realizes that her entire group, including the therapist, are in the car. This is impossible as the car is tiny—a clown car—but somehow everyone in the group fits in. She exits the car, and the group comically follows suit, tumbling out of various doors that she did not know existed. The group turns toward her father who has stopped his car in surprise, delighted to see her. She rushes to him, and they embrace. The group follows suit. She introduces each member to her Dad, crying tears of joy. There are hugs and kisses all around, a strange occurrence as her father is not a physically demonstrative man. Soon, her father says he must head off for his swim. The group waves goodbye. She turns toward her childhood home, only to see her mother standing in the garden. Ralph turns to her and makes a gesture fixing an imaginary tie. "Right," Ralph says, winking at her and turning toward her home. "Let's do this."

The transformation in the group for members—even on Zoom—to grieve together, to develop authentic, meaningful connections during our clown car crazy times is the antidote every group member and leader needs. May we all support each other to do the important work we do and make our way to better times.

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Zero to Three (2016, March 25). Still Face Experiment with Dr. Edward Tronick [Video] YouTube. https://www.youtube.com/watch?v=YTTSXc6sARg.

Yalom, I. (1980). *Existential psychotherapy*. New York, NY: Basic Books.

THE GROUP THERAPIST'S SOCIAL DILEMMA

Continued from page 1

therapy helped her to access self-love, learn how to set effective boundaries, and have cathartic experiences around her internalized shame and oppression that were exacerbated by social media. If Jessica was in a process group, the therapist could have focused on validating her experience, bridging her with other peers who have similar anxieties and facilitating emotional connection that's not skin deep.

Jessica had many privileges that allowed her access to mental health services. For those who are not able to attend therapy or are struggling with stigma or resistance, seeing a licensed mental health provider post content on social media not only normalizes one's feelings, but also provides concrete tools one could use to address life's challenges.

Call to Action

Mental health professionals are essential to challenge the norms within social media communities. Social media use extends the therapist's ability to provide education, model healthy behaviors, and support positivity in a medium that fosters negative coping mechanisms (O'Riley, 2020).

Becoming competent in social media is a way to create a diverse platform and to reach individuals who may not be aware of psychological services. Some social media users in marginalized communities cannot afford the time or money required to enroll in therapy but can benefit from engaging with mental health topics on social media.

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In the summer, AGPA will be offering an online course—New Media Strategies: Becoming a Group Therapy Ambassador led by Christina Dixon, LCSW. The multi-week course, originally developed by Marc Azoulay, LPC, LAC, CGP, ACS, will offer lectures to discuss the essentials of social media marketing and a process portion to discuss fears, resistances, and other emotional challenges. The course will take place on Tuesdays, 12:00 – 1:30 PM EST, beginning on June 15 and running for 8 sessions through August 3rd.

You Can Register Here: https://member.agpa.org/itemdetail?iproductcode=-COACHING2021itemdetail?iproductcode=COACHING2021itemdetail?iproductcode=COACHING2021

GROUP: Seasons One and Two

Leslie Lothstein, PhD, ABPP, CGP

EDITOR'S NOTE: *Leslie Lothstein, PhD, ABPP, CGP, is a clinical and forensic psychologist and researcher-author. He is an Associate Professor in Psychiatry at Case Western Reserve University and is a lecturer in law and psychiatry at Yale University. He was Director of Psychology at the Institute of Living at Hartford Hospital Department of Psychiatry for 26 years and in private practice in Connecticut and Massachusetts. He also serves on the Boards of the International Association of Forensic Psychotherapy and Whiting Forensic Hospital. This review may encourage consumers and providers to watch this series to expand their understanding of group process and the efficacy of group therapy. You can view the video series at https://youtube.com/c/GROUPtheseries.*

The video series *Group* (seasons one and two) on YouTube is a wonderful series, professionally done by director and filmmaker Alexis Lloyd, and run by a group therapist Elliot Zeisel, PhD, LCSW, CGP, DFAGPA. It has the potential of providing group therapy training programs with a platform of group therapy videos to stimulate reflection and learning. It is also a disturbing reminder of how our clinical practices have changed in such a short period of time, from the office to the home office practice during COVID-19.

Dr. Zeisel, who identifies as a Modern Group Analyst (and was trained by Louis Ormont, PhD, DFAGPA, Dolores Welber, PhD, and Hyman Spotnitz, MD), portrays Dr. Ezra on the series, an engaging, energetic, and sincere group psychoanalyst allowing us all to observe his therapeutic style with no holds barred. The series was influenced by Yalom (2009) in his novel, *The Shopenhauer Cure,* which was also turned into an earlier video with Yalom & Leszcz (2011) and reviewed by Lothstein (2013).

Each video session is given a name that summarizes the major theme of the program, usually focusing on the dangers involved in rule breaking and seeking relationships within the group. Each episode runs between 11-20 minutes.

The Cast

The group members were all professional actors who were given scripts describing the nature of the role they were playing and then told to improvise. Almost all the episodes were filmed within a brief period, with many takes. Lloyd edited the series by first listening only to the audio recording, hearing the rhythm of group dialogue. He added the visual experience later. The process was well done, very artistic, and real. Both the video and sound are clear.

The actors included four men and four women. The male characters names were Frank, Stuart, Henry, and Mann, and the female characters names were Pam, Tilda, Karina, and Rebecca.

Season One: Group Before COVID-19

In season one, episode three, Dr. Ezra says that when we meet new people, "in the unconscious mind people either want to make love with you or kill you." What he is saying is that core unconscious fantasy is present here in the group, and the group leader must set up boundaries to prevent an enactment that would kill the group.

The episode titles allow us to see the group's progression. For example, right from the beginning Rebecca tells us she is a danger to herself and might be a danger to the group as she plays with fire in her sexual enactments and needs to slow down. Some group members wonder if this kind of enactment is allowed in group and whether they can break the rules. Although Dr. Ezra says that group members need to give themselves permission to make five mistakes a day and bring all the temptation into the group so they can learn about their self-destructive tendencies, he makes the group aware that he will provide the limits within which they can bring their desires to the group to be worked on.

As themes of enactments occur, Dr. Ezra does not admonish people for their resistance to therapeutic interventions and breaking the rules. Pam and Manny, for example, met outside the group and were not going to talk about it. When it does come up in group, Dr. Ezra tried to understand what purpose their resistance served to sustain their safety and emotional health. He believes the troubled part of the self wants to be bad. When Karina interprets Pam's relationship to Manny as similar to Pam's acting out her earlier relationship with Henry, Manny erupts in rage and becomes paranoid, thinking the group has no right to interfere in the Pam/Manny dyad. As jealousies and shame arise, they are focal points of discussion in the group, to everyone's benefit.

A central force in human relationships that Dr. Ezra points out to the group is the need to be seen, recognized, loved, and admired. He says: "Each of us needs every day the attention we don't get." When pairing takes place in the group, some people are left out. When enactments take place outside the group, we are all left out. The fact that Tilda does not receive any sexual attention in group is not discussed, though at one point she tells Stuart that she fantasizes having wild sex with him, and he is flattered. Ultimately, she is alone and not desired in the way Rebecca, Pam, and Karina are desired. This is a dynamic that would need to be illuminated in a real group, and it would be very painful for everyone.

The Group During COVID-19 and Zoom

When season two begins, the United States is on lockdown, and the actors and Dr. Zeisel are in quarantine all over the country and meeting on Zoom. During this time, the entire mental health field went online, using up to 25 different virtual platforms to continue providing care online. While telehealth was always available, it suddenly became a necessity.

When season two begins, we learn that one of the patients, Henry, dropped out of the group because he did not want to be on Zoom.

In the first session, Karina asks Dr. Ezra "Are you okay?" Dr. Ezra talks to them in detail about what happened and that he is very much alive, though debilitated. Dr. Ezra (who reflects Dr. Zeisel's own experiences of contracting COVID and spending eight days in the hospital) goes into detail about his move from the hospital to his summer home. One member brings up knowing that Dr. Ezra's mother died while he was in the hospital. Dr. Ezra (Zeisel) has tears in his eyes. He says it was very painful to bury his mother from his hospital bed. He has been crying. It is important for the group to hear this and hear his feelings in the here-and-now. He says "I find myself crying at times in ways that are surprising. It leaves and then comes back." He gives them the opportunity to help him through his mourning. If he were to deny his feelings, it would violate his method and be dangerous for some of them who think of him as already dead. Karina asks him if he can run this type of group—to allow members to be angry when he is not yet healed and in mourning. He tries to reassure them that he is fit for duty. We also learn that at least two other group members were diagnosed with COVID-19 and that there is illness, death, and sadness in the group.

While similar themes from season one also come up during season two, there is one major difference: The format has changed dramatically. While it is not COVID alone that traps us, we are using necessary technology that both alienates us from the embodied self but also provides group therapists with connections we need during the pandemic. Zoom is a tradeoff.

While the director used the pandemic as an opportunity to change the visual array of the group, I was disappointed and perplexed. Rather than staying with the gallery view, the filmmaker alternated shots: wide screen with one person or two people or three and then back to the rectangles. While it was cinematically interesting and suggested isolation, this is not the format Zoom provides to clinicians as the gallery view is the preferred one (except for those using their phones), and the images are either stacked on top of each other and tiny or you have to swipe back and forth to change views.

Problem Areas to be Worked On

The pandemic has made teletherapy and health technologies available to all mental health professionals (Yellowlees & Shore, 2018) and has made online therapy the new norm (Weinberg & Rolnick, 2020). One can say that there has been a seismic shift in the way we practice group therapy.

What might be different if the series continues? There is a need to have a group of less pretty people, who are less verbal while also being appealing and entertaining. Tilda, whom I found to be the most appealing person, has HIV and is suffering, being isolated and worried she will never fall in love or have someone love her. COVID is making her more depressed. While Dr. Ezra notes that as a group they were also "trapped before COVID-19," the series does not do justice to the way things have really changed for all of us.

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Congratulations New Fellow

Fellowship indicates outstanding professional competence in leadership, and AGPA Fellows visibly represent the highest quality of the Association. The Fellowship and Awards Committee takes five areas of activity into consideration and expects candidates to have shown excellence in leadership in at least two; one of which must be leadership in the AGPA and/or its Affiliates, as well as leadership in the field of group psychotherapy, clinical practice and/or administration, teaching and training, and research and publications. AGPA welcomes its newest Fellow: Deborah Sharp, LCSW-S, CGP, FAGPA.

Deborah Sharp, LCSW-S, CGP, FAGPA, (Austin, Texas) has been an AGPA Member and a Certified Group Psychotherapist since 2015. Ms. Sharp has served in several leadership positions, including serving as a Board member of the Austin Group Psychotherapy Society (AGPS) and as its President, as the Affiliate Society Representative for AGPS, and as Co-Chair of AGPA's Affiliate Societies Assembly Scholarship Review Committee. She presented at AGPA Connect 2020 on maintaining co-leadership relationships and at AGPA Connect 2021 on restorative justice circles. Twice honored with the Cornerstone Award for Exceptional Service and Leadership by the University of Texas, Ms. Sharp was also awarded the President's Outstanding Staff Award by the University.

Ms. Sharp is the Director of the Conflict Mediation and Dispute Resolution Office at the University of Texas at Austin, where she regularly facilitates training circles and community-building circles as part of her commitment to teaching restorative justice practices. She has taught social work courses in human behavior, group methods, and policy as adjunct faculty for the University of Texas and Texas State University. She holds certificates in management of non-profit organizations, as well as in clinical hypnosis therapy, and is pursuing training in modern analytic group work at the Center for Group Studies in New York City.

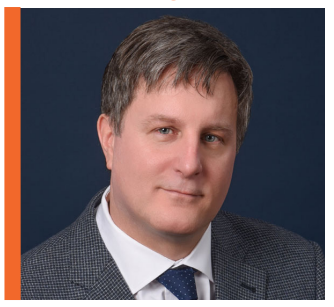
Ms. Sharp has led two Modern Analytic process groups in her private practice for five years, as well as co-led two weekly process groups. During her tenure as a Project Manager and Program Developer at Candlelighters Childhood Cancer Foundation, she implemented numerous groups for children in treatment, parents and siblings, as well as bereavement and off-treatment groups.

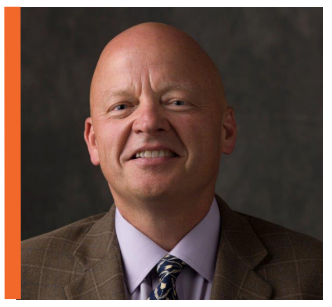
She received her master's in social work and her bachelor's degree from the University of Texas at Austin.

Reimbursement Rates Improve Access and Lead to Social Justice

Martyn Whittingham, PhD, CGP, FAPA, FAGPA
Gary Burlingame, CGP, DFAGPA

Martyn Whittingham





Gary Burlingame

EDITOR'S NOTE: *Martyn Whittingham, PhD, CGP, FAGPA, FAPA, is the Founder of Focused Brief Group Therapy, an integrative interpersonal process group approach. He is currently on the American Psychological Association's Health Care Financing Advisory Group, and AGPA's Public Affairs Committee and Science to Service Task Force. Gary Burlingame, PhD, CGP, DFAGPA , President-Elect of AGPA, is Professor and Chair of Psychology at Brigham Young University and affiliated PhD program in clinical psychology. His writing and research focuses on group treatments and mechanisms of change that explain member improvement.*

Those without money, the sick, the elderly, and minority groups in underserved areas are more likely to need services and are least likely to be able to access them (APA, 2017). The absence or reduction of group psychotherapy means reduced access to mental health services for those most in need. Group therapy offers efficiency, effectiveness, and equivalence (Yalom & Leszcz, 2020). By offering more groups, wait lists and bottlenecks can become easier to manage and services can be delivered more rapidly at the point of care. However, setting rates that therapists can make a living from and that agencies can at least break even are a prerequisite for access. Paradoxically, group rates that are too low can reduce access, since without providers, there is no one to offer these services.

How payment rates are set, why they go up or down, and how payment from one source impacts payment from another are all questions that require a very deep dive into processes that are seldom transparent. In this article, some of the key processes, committees, and agencies are briefly introduced to illuminate how payment processes work at a high-level.

In order to understand payment, it is first important to understand who sets the rates. The process begins with a committee that is an offshoot of the American Medical Association, which is called the AMA/Specialty Society RVS Update Committee (RUC). The RUC is a multi-disciplined council that is populated by representatives from more than 30 physician specialties. Representatives of the non-physician specialties, including psychology, sit on a subcommittee, known as the Health Care Professionals Advisory Committee (RUC HCPAC). APA's RUC HCPAC advisor represents all types of psychological services provided by psychologists including psychotherapy, health behavior services and testing services.

The RUC cannot set payment rates for healthcare services, but it does make recommendations that are often adopted, with or without modifications, by public and private third-party payers. The RUC develops its recommendations based largely on surveys of clinicians who provide the service in question. Each service is represented by a unique billing code, known as a CPT code. Codes are subject to being surveyed through the RUC when they are first created and subsequently reviewed. Attempting to increase the payment rate of an existing code requires some change in the service, the service providers, or other new information to justify re-examining the code's value.

The Centers for Medicare and Medicaid Services (CMS) reviews the recommendations made by RUC when it determines the payment rates for services covered by Medicare under the following year's physician fee schedule (PFS). Because of a requirement set by Congress, known as budget neutrality, Medicare's costs under the PFS cannot increase by more than $20 million each year. As a result, when new services are added to the PFS or existing services have their payment rates increased, the additional costs must be offset by reducing the costs of other services. This is achieved through a variety of means, ranging from adjusting values of other codes to changing conversion factors—the number or formula needed to convert a measurement in one set of units to the same measurement in another set of units. The final Medicare reimbursement amount allotted to the therapist is calculated using this formula:

(Work Relative Value Units (RVU) x Geographic Practice Cost Index (GPCI)) + (Practice Expense RVU x GPCI) + (Malpractice Expense RVU x GPCI) x Conversion Factor (CF).

The RVUs are based on the provider's work relative to other services, overhead costs, and malpractice insurance. The CF assigns monetary value to the RVUs and is the result of another complex formula involving a range of issues including, but not limited to, performance of the economy, budget neutrality and legislation. The GPCIs adjust payment based on regional differences in income for the work RVU and costs for the practice expense (e.g., New York City rent being higher than Idaho), and malpractice expense RVUs.

Advocacy to CMS by individuals and organizations can sometimes impact the agency's payment decisions.

To further complicate matters, Medicare is federally run, and Medicaid is run by the states. To illustrate, when the code for group health and behavior services was implemented several years ago, it was reimbursed under Medicare across the country. However, states may choose to turn on or turn off the code or set the rate at a different level. If a code is not turned on, it will appear to be billable but actually will result in no payment. A code activated by Medicaid is subject to the local political and/or fiscal climate. That is why Medicare group therapy rates are largely the same, although subject to geographical adjustments, across all states but Medicaid reimbursement varies between states.

The final recourse for Medicare rate changes is Congress. If CMS is willing to change rates but has its hands tied by the legal need to maintain budget neutrality, Congress must get involved. Congress has a variety of processes and procedures it can enact to impact payment rates, but this requires intense lobbying from interested parties.

Third-party payers, such as Humana or Blue Cross/Blue Shield, typically use the CMS rates to guide their rate setting. That is why *when Medicare rates change, the whole of third-party payment typically follows that lead.* Therefore, paying close attention to how Medicare rates fluctuate and lobbying against reductions has a major knock-on effect to all other rates.

Third-party payers also rely on their own internal calculations. Therefore, although rate increases or decreases from CMS typically guide third-party payer payment, that is not always the case. Each insurer will also have its own agenda and internal information that may cause it to reimburse more or less than federal or state rates. National organizations, such as APA can lobby private payers with fact sheets and information, but they require research and figures demonstrating effectiveness and cost savings.

Third-party payer rates can also be impacted by private practitioners or agencies communicating directly with insurers, particularly if cost-savings can be shown. For example, showing group therapy keeps clients out of the emergency room (a very costly service) or reduces overall cost of care, would be a compelling case for a payer. However, private practices seldom know they can negotiate rates and, in some cases, may have trouble establishing communication with a person who has decision-making power at the company.

The upshot of this complexity is that payment can seem to arbitrarily change and that practitioners feel very out of control of the process. However, change is possible.

Examples of Changes Impacting Group

Recent changes in telehealth have involved intense lobbying targeting multiple different processes. APA, in partnership with its state associations and other interested parties, intensely lobbied CMS and the net result was the emergency authorization of group telehealth as a code. With repeated lobbying, this code has now become a permanent one and so group telehealth will continue once the COVID-19 emergency period has ended.

One of the highest utilized rates in all of healthcare, the outpatient Evaluation and Management (E/M) code that pays for primary care physician and patient visits, was revised leading to a rate increase. This resulted in the need to reduce rates for all codes in the PFS (including all psychology service codes) by an equivalent amount to ensure budget neutrality. CMS proposed raising rates on individual psychotherapy to offset the decrease since it was judged to be an equivalent service to an E/M code. APA supported this increase but advocated that it be extended to all psychological services. CMS adopted its original proposal to increase only individual psychotherapy services, thus slating other psychological services, including group therapy, to dramatically reduce in 2021 in order to achieve budget neutrality.

The fight then went to Congress. After more lobbying, Congress reduced the decrease in rates from 10% to a much lower decrease, with variations depending on the type of service (see https://www.apaservices.org/practice/clinic/medicare-changes-2021). Group therapy rates then went from reducing by 10% to reducing by just over 2%. However, this rate change is for 2021 only, and further lobbying is needed to ensure the changes continue for 2022 and beyond.

Advocacy and A Call to Action

The fight to impact the RUC, CMS, Congress, and third-party payers continues. The authors of this article are currently working on several strands of research and influence to present to the RUC, CMS, third-party payers, and those lobbying for change. APA is looking to partner more closely with AGPA on lobbying efforts and is seeking to improve reimbursement rates due to issues of access and meeting the needs of the underserved.

AGPA needs members to respond to requests for comments or to write letters to Congress when asked. A sea of comments and letters at the right time can influence those making decisions, sometimes with great success. Equally, involvement in and support of state committees under which you are licensed, such as state psychological associations, can make a significant difference. National and state organizations also need your membership fees to be effective in lobbying. They are often fighting against special interests with multi-million dollar budgets, so your membership is essential. Equally, if you are ever solicited to be a part of a RUC Survey, please make sure to fill it out. This is an essential means by which opinions are sought before codes are modified or added and your contribution is critical.

This Is A Social Justice Fight

For social justice to take place, group needs to be accessible to those who most need it. If a psychiatric hospital in a rural area or underserved part of a city closes because its rates went down too far, then those most in need of care and least able to afford it are the ones who suffer. Involvement in reimbursement is an issue of social justice and advocacy that speaks to the heart of our profession.

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Members are invited to contact Lee Kassan, MA, CGP, LFAGPA, Editor of the Consultation, Please column, about your issues and/or questions that arise in your group psychotherapy practices. Special Interest Group members are highly encouraged to send cases that pertain to your field of interest. They will be presented anonymously. Email Lee at lee@leekassan.com.

consultation, please!

This month's dilemma and responses are supplied by the Mental Health Agency & Institutional Settings Special Interest Group (SIG). The SIG offers an interactive, supportive, and creative space for those interested in or connected to agencies and other institutional settings that render group services. The SIG addresses the central role of group treatment and other uses of knowledge of group work and dynamics in a variety of settings, including inpatient, outpatient, rehabilitation programs, structured and other independent settings and systems. The SIG also addresses the need to promote and develop appropriate group modalities, training, and supervision. Contact Co-Chairs Claudia Arlo, LCSW-R, ICADC, CGP, FAGPA, at claudia.arlo@gmail.com or Greg Crosby, MA, LPC, CGP, FAGPA at gregc1112@aol.com, with questions about the SIG. To join the SIG, email agpamemberservices@agpa.org.

Dear Consultants:
Mental health agencies and institutions have been challenged by the demands and adjustments needed to respond to the COVID-19 pandemic. Many mental health agencies and institutions had an initial period of very limited services until they could figure out how to formulate a response. The pandemic has disrupted the normal therapy service delivery model more than any time in professional mental health agency and institutional history. There have been so many losses and changes. There is also personal and organizational learning we are acquiring from this chaotic period and from implementation of new practices personally and organizationally. We are in the middle of a transition period coming to a close, with the pandemic beginning to be managed, and then moving to the reconstruction phase could take approximately a year and a half or more. Agencies and institutions are all attempting to respond, and it has been hard to find the North Star to guide us to a new normal. What advice can you give about how agencies or institutions have adjusted to online group therapy, types of groups, group rules, challenges of doing group therapy in homes, and with diversity issues?

Signed, Adjusting

Dear Adjusting:

The pandemic has profoundly disrupted our personal and professional lives to the point where the question may not be about when we return to normal, but more about what the new normal will look like. Patients and therapists alike are challenged to accept and to roll with uncertainty about our personal and global lives. As a psychologist, I have found myself having expanded empathy for patients who have difficulty tolerating uncertainty. Intolerance of Uncertainty (IU) is a treatment target for people receiving CBT for generalized anxiety disorder and some presentations of OCD. I have a new appreciation for the perceived need to know what will happen and the attempt to cope by using various mature defenses, such as intellectualization (getting as much information about COVID-19 as possible) and excessive planning for various scenarios (illusions of controlling the future), to name a few.

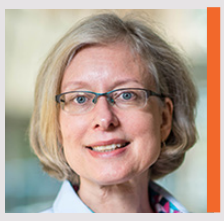
In our training clinic, we swiftly moved our groups online, and I had the opportunity to supervise a virtual, integrated CBT group for OCD, which was daunting.

I will share a few up- and downsides of such a group, which overall went better than expected. We encountered new ethical challenges of group work. The consent form had to be revised to include lines about the importance of group members securing privacy at their end and being technologically prepared (in addition to psychological readiness) with strong internet connections. We struggled with unstable connections, group members' screens freezing, or losing the connection altogether. As we plan to offer more virtual groups for anxiety and are excited about the possibility of reaching new populations in rural and remote areas, we will need to take the technological requirements for successful group participation more seriously. We developed a new appreciation for the socio-economic privilege of having strong WiFi and private rooms. Perhaps we need to help clients explore grants in their local communities for improved home technology.

Some unexpected new ground rules also emerged. The virtual environment is less psychologically intense, which is both a plus and a minus. For people with anxiety, especially social anxiety, it may be a more attractive first-group experience, given that one is not required to show one's full self (the biggest downside for more psychodynamically oriented groups). This comes with the important ground rule of asking people to at least turn their video on and not hide behind their name, a nickname, or worse, another family member's name. Also, payment before sessions is harder to enforce. While our clinic has moved to electronic charts, our payment system is still the outdated cash or checks. A silver lining is a promise from our institution to move to online payment.

An incredible upside was the new opportunities for group members to support each other with coping in their home environments. Given the emphasis on skills training in CBT groups, the virtual environment continues to surprise me with its possibilities. Group members would literally follow someone with contamination obsessions into the kitchen, see them handle raw meat, wash their hands only once, and then return to the group for their exposure debriefing. Because of this, some group members improved more than they likely would have in an in-person group. Who could have predicted that?

Ingrid Söchting, PhD, RPsych, CGP
British Columbia, Canada



Dear Adjusting:

There is a principle in chemistry known as Le Chatelier's principle, which says when a system is at equilibrium and a stressor is introduced that system will reach a new equilibrium. The coronavirus pandemic is a profound stressor introduced into the equilibrium of the world and all of our professional lives. Unlike a stressor that enters and leaves, this pandemic is ongoing. We are living in peri-traumatic times, uncertain when this pandemic will end. The new equilibrium is constantly changing as people, organizations, and systems react and respond to the pandemic.

My teaching at Columbia University went overnight from in-person classes to classes online, with many graduate students returning to their home of origin, often sitting in lectures with pets on their laps to soothe them. At New York Presbyterian Hospital, where I conduct a process group for psychiatry residents, we transitioned to having their experiential group conducted online, as the spread of the virus in New York City skyrocketed. For both the graduate students and psychiatry residents, the challenge of learning their craft increased exponentially with the additional anxiety and uncertainty that the pandemic created.

My clinical practice shifted overnight in March, after I learned that a colleague, who attended along with me and many others a group therapy conference in New York, tested positive for the coronavirus and posted that fact on Facebook. I immediately cancelled all in-person sessions in my office and began to work online with my entire private practice. One female group member, who was angry at me for holding groups online, saying that she could not trust the group, the internet, or me if I worked online, never returned to treatment. Group members reacted to that group member, whose premature termination stirred up abandonment issues in them, as well as deep concern for her.

Trauma theory informs us that loneliness is a major sequela of any traumatic event, and a pandemic is certainly a traumatic event. The internet, which can both isolate and connect people, became a way to help reduce people's sense of loneliness, enhance connection and information sharing about resilient ways members are coping and increase a sense of community in the group therapy world.

Richard Beck, LCSW, BCD, CGP, FAGPA
New York, New York

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

a view from the affiliates

Affiliate Societies Assembly Presents Awards

The Affiliate Societies Assembly (ASA) recently recognized several members who have contributed significantly to their Affiliate Society. ASA Awards were presented to Joshua Gross, PhD, ABPP, CGP, FAGPA and Miguel Lewis, PsyD, CGP, both from the Florida Group Psychotherapy Society (FGPS); Jessica Bucholtz, PsyD, of the Atlanta Group Psychotherapy Society (AGPS); and Karen Eberwein, PsyD, CGP, of the Mid-Atlantic Group Psychotherapy Society (MAGPS).

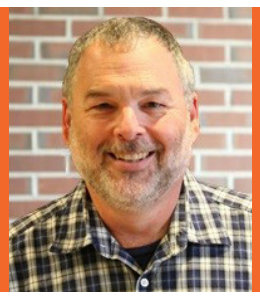
JOSHUA GROSS, PhD, ABPP, CGP, FAGPA, was recognized for being instrumental in creating the FGPS. His energy provided inspiration for many of the FGPS' founders to become involved, and particularly for Miguel Lewis, PsyD, CGP, to become the Affiliate's President. He hosted early Board meetings and developed programming for FGPS trainings.

MIGUEL LEWIS, PsyD, CGP, received the award in honor of his tireless and successful efforts to establish FGPS as a viable, growing AGPA Affiliate Society and to acknowledge his role in inspiring the reformation of the ASA Nuts and Bolts Committee. Thanks to his passion and perseverance, FGPS was transformed from a Steering Committee of five people to a fully functioning AGPA Affiliate with around 50 members, five board members, and a Facebook page. FGPS is building a listserv and website, expanding its membership, hosting a series of online training workshops, and planning its second Annual Conference in the fall.

JESSICA BUCHOLTZ, PsyD, was recognized for maintaining a dedicated commitment to AGPS through its difficult transitions and growing pains. As AGPS was on the verge of folding, Bucholtz remained the one AGPS member and Board member to stand on the bridge of transition. She has been able to give voice to the past, while staying positive about the growth into the present and the future.

KAREN EBERWEIN, PsyD, CGP, was noted for her various roles on the MAGPS Board, where she currently serves as President, along with working on Board projects, including establishing listserv practices; conducting an organizational needs assessment; assisting in revising MAGPS's Conference Process Group Task descriptions; and developing the Affiliate's Outreach Proposal process and guidelines. She was also instrumental in developing, writing, and implementing the MAGPS Operations Manual with then-President Lorraine Wodiska, PhD, ABPP, CGP, FAGPA. The manual is an important document for MAGPS and was shared with the AGPA to help other Affiliates when writing their own manual.

JOSHUA GROSS



MIGUEL LEWIS

JESSICA BUCHOLTZ

KAREN EBERWEIN

FRAN WEISS

Member News

Fran Weiss, LCSW-R, BCD, DCSW, CGP, coordinated and edited a recent special issue of the *American Journal of Psychotherapy*, which featured articles on group therapy. Other AGPA members who contributed to the publication include **Joseph Shay, PhD, CGP, LFAGPA**, who wrote "Terrified of Group Therapy: Investigating Obstacles to Entering or Leading Groups;" **Haim Weinberg, PhD, CGP,** who wrote "Obstacles, Challenges, and Benefits of Online Group Psychotherapy;" **Sophia Chang-Caffaro, PsyD,** and **John Caffaro, PhD, CGP, FAGPA,** who wrote "When Co-leaders Differ: Rupture and Repair in Group Psychotherapy;" **Martyn Whittingham, PhD, CGP, FAGPA, Noelle Lefforge, PhD, MHA, CGP, ABPP,** and **Cheri Marmarosh, PhD, FAGPA,** who wrote "Group as a Specialty: An Inconvenient Truth;" **J. Scott Rutan, PhD, CGP-R, DFAGPA,** who wrote "Reasons for Suggesting Group Psychotherapy to Patients;" and **Michele Ribeiro, EdD, ABPP, CGP, FAGPA,** who wrote "Intentional Call to Action: Mindfully Discussing Race-Ethnicity in Group Psychotherapy." **Noelle Lefforge, PhD, MHA, CGP, ABPP,** wrote a book review of "Core Principles of Group Psychotherapy: An Integrated Theory, Research, and Practice Training Manual," edited by **Francis Kaklauskas, PsyD, CGP, FAGPA,** and **Les Greene, PhD, CGP, DLFAGPA;** and **Leslie Lothstein, PhD, ABPP, CGP,** wrote a book review of "The Theory and Practice of Group Psychotherapy" (6th edition), by **Irvin Yalom, MD, CGP-R, DLFAGPA,** and **Molyn Leszcz, MD, FRCPC, CGP, DFAGPA.**