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

SUMMER 2020

groupcircle

The Perfect Storm

Leo Leiderman, PsyD, ABPP, CGP, FAGPA*, Group Circle *Editor

This article is about continuing the AGPA community's messaging of hope, unity, shared learning, and resilience while confronting mass trauma. It is dedicated to a small pool of brave and generous AGPA members I was fortunate to interview, who share their unique experiences with COVID-19. As the circumstances around the pandemic test our foundations for safety, we can learn from each other's experiences and skills as group therapists to deal with the unknown.

The combination of the COVID-19 pandemic with a chaotic response by our government has led to catastrophic results and mass trauma—a perfect storm. The pandemic has changed our worldview by the death and sickness of countless people, crippling the world economy, skyrocketing hunger and unemployment rates, and altering our lives with social distancing, and the loss of freedoms we all took for granted. In the United States (US), the virus has exposed the underbelly of racial and socioeconomic inequality and neglect for communities of color, which have disproportionate levels of illness and mortality.

During a mass trauma and global health crisis, citizens yearn for leaders who are calm, able, consistent, promote unity, and relay scientific facts, policies, and data that can provide them with assurances for their safety and the safety of others. These factors tend to reduce mass trauma symptoms.

Messages of hate, fear, and who is American or un-American (Leiderman, 2020, p. 179), xenophobia, and racism (Klein, 2020) makes many feel unsafe, activating additional trauma. Terms like "Chinese virus" and the "kung-flu," for example, have led to a spike in hate crimes against Asian Americans (Anti-Defamation League [ADL], 2020).

Group therapists are prone to vicarious trauma in small groups (Herman, 1992) and large group levels when thousands or even millions experience the same monumental mass trauma under unsafe conditions (Volkan, 2001). With this pandemic, millions are simultaneously enduring the same traumatic situations—vulnerability to an infectious contagion, isolation, fear, lack of financial security, death of loved ones, and social unrest.

Interventions to Address Mass Trauma

We have been inspired by the unwavering courage of our frontline medical workers and ancillary essential workers across the country. We are moved by countless acts of kindness, charity, and volunteerism within impacted communities.

AGPA members have spontaneously facilitated large and small, national and international virtual meetings for overwhelmed colleagues and healthcare workers. They have volunteered to facilitate Care for Caregivers initiatives for their affected communities. The AGPA Connect email listserv has conveyed countless messages of compassion, concern, encouragement, and empathy for those who have been ill or lost loved ones. The email listservs have expressed the much-needed support, group cohesion, comfort, and belonging during times of high anxiety and interpersonal distancing.

Hobfoll and colleagues identified essential empirically supported interventions needed to recover and enhance resilience following mass trauma (Hobfoll et al., 2007; Tuma, 2007; Norris & Stevens, 2007). These include:

- *Promoting a sense of safety* by disseminating factual, accurate information and true strategies to maintain or re-establish a sense of safety with community-based interventions and psychoeducation.
- *Enhancing calming* by teaching effective skills to self-regulate following prolonged periods of stress and problem solving and normalizing stress reactions.
- *Increasing self-efficacy and collective-efficacy* by enhancing self and collective sense of control over positive outcomes. This can be established individually by self-regulating one's thoughts, feelings, and behaviors or collectively by belonging to a group in which one experiences positive outcomes.
- *Establishing connectedness* via interpersonal support and attachments with loved ones and/or social networks.
- *Inspiring hope* in others and maintaining optimism which promotes more favorable emotional outcomes.

Psychoeducational responses to mass trauma also need to be tailored according to the specific disaster (Reifels, et al., 2013). This is especially true today as we deal with what is for many a once-in-a-lifetime/once-in-a-century pandemic and face circumstances that we have never experienced before, such as social isolation. Group therapists can address these unique challenges by encouraging members to: a) conduct personal inventories each day and asking themselves: What am I feeling? What do I need? What do I want? How do I set limits with others or things that makes me feel worse? b) carry out an inventory of resources (people, things, or even places that are positive) and sharing these resources with friends, family, and colleagues; c) balance work and isolation with some form of connection and fun. Our psyches need laughter, humor (Irving, 2019), play, and intimacy, if possible, each day to recharge our emotional batteries. Other strategies include exercising daily and adopting good eating and sleeping habits. Online stress reducers, including those to regulate breathing, are helpful.

Family strategies can also be suggested during the pandemic to enhance resilience for those who are socially isolated with their nuclear families, especially when the children are adolescents or young adults returning to live with parents. These include: a) communicating with children about the rules of the house, including how chores will be divided; b) asking all members to address conflicts by talking directly to the parties involved as soon as the conflict arises. Conflict resolution involves mutual listening, communication of feelings related to what one is upset about, understanding of the other's point of view, reciprocal respect, taking turns between the roles of communicator and listener, calm and forgiveness since moving on is vital; c) speaking with children frequently about their thoughts, feelings, and reactions to the pandemic; d) having meals together; and e) enhancing the quality of communications and fun. These skills will enhance the adjustment process for all family members.

I only interviewed a small, random sample of AGPA members who contracted COVID-19 after attending AGPA Connect 2020. Their depth in sharing their reactions, experiences, and perspectives is enriching. They share how they dealt with their own personal traumas, as well as those of their clients.

Continued on page 3

from the president

Molyn Leszcz, MD, FRCPC, CGP, DFAGPA

I am writing this column as summer is beginning. This year, however, summer will be different: We are in the midst of two very serious public health pandemics. COVID-19 has had dramatic impact on us both psychologically and economically and will continue to be challenging over a long period of time, as we learn more about the enduring psychological impacts of the coronavirus and the social and economic lockdown it has necessitated. We've also become painfully attuned to the pandemic of racism. For some, this is not new; but for many, we have become acutely aware of anti-Black and anti-Asian racism in ways that demand our response.

In both these difficult and traumatic situations, our expectations of AGPA are that we will work hard together and contribute to make things better. Our members are skilled and committed. In every step AGPA takes, our aim is to be an organization in which membership makes people feel proud and effective. Our aim is to learn and grow through adversity. Let me highlight some of AGPA's key responses.

In response to COVID-19, AGPA has been providing training and assistance for members who have been directly impacted, as well as by supporting the transition to delivery of group therapy online. Shortly, you will be asked to complete a survey about this practice transition, emerging from a collaboration between AGPA's Research SIG, led by Joseph Miles, PhD, Rainer Weber, PhD, and Zipora Schechtman, PhD, DFAGPA, and APA Division 49, led by Cheri Marmarosh, PhD, Giorgio Tasca, PhD, Gianluca Lo Coco, PhD, and Salvatore Gullo, PhD.

Our e-Learning programs, coordinated by Jan Morris, PhD, ABPP, CGP, FAGPA, and Haim Weinberg, PhD, CGP, FAGPA, have addressed the psychological impacts of COVID-19 and provided ongoing training for those who are offering group support to healthcare workers.

Continued on page 2

what's inside

from the editor

Leo Leiderman, PsyD, ABPP, CGP, FAGPA

We are in the midst of multiple national crises, including a pandemic, economic recession, plus violence, racial oppression, and systemic racism especially against Black Americans, people of color, and marginalized groups. This has led to anguish, outrage, disbelief, and grief culminating in mass trauma. On the other hand, the denial of systemic racism against Blacks, especially by those in power has ignited activism and what many argue as the greatest civil rights movement in 50 years. As a child of two social political activists in the 1960s, I remember many marches my family participated in during that time and am so inspired by today's movement.

The focus of this edition of the *Group Circle* is COVID-19 and racism. We hope to dedicate our Fall 2020 edition to topics centering around systemic racism, marginalized groups, diversity, and multiculturalism and group therapy.

I hope this edition of the *Group Circle* provides you with meaningful connection to AGPA. My article, The *Perfect Storm*, includes heartening interviews with 11 AGPA members who survived COVID-19 while addressing mass trauma, encapsulating our shared experiences at this time. Our second feature article, *Moving from the Circle to the Square: Group Therapy in the Time of COVID* by Clare Gerada, MBBS, highlights the personal and professional struggles, as well as the changes forced upon us by the pandemic. AGPA Connect 2021 Institute Co-Chair Anne McEneaney, PhD, ABPP, CGP, FAGPA provides *Finding Home in an Unprecedented and Digital World* with AGPA Connect 2021 Institute Plenary keynote speaker Alexis Abernethy, PhD, CGP, FAGPA, which exceptionally captures her insights about the pandemic and systemic racism.

In his *From the President* column, Molyn Leszcz, MD, FRCPC, CGP, DFAGPA, provides hope and a commitment by AGPA leadership to address the COVID-19 and racist pandemics we are simultaneously dealing with as a community. The *Consultation, Please* column features a clinical dilemma and responses from AGPA's iSIG Co-Chair's Lindsey Randol, PsyD and David Songco, PsyD, CGP. A *View from the Affiliates* features articles by Stacy Nakell, LCSW, CGP, Secretary, Austin Group Psychotherapy Society's Diversity, Equity and Inclusion Committee; Rudy Lucas, LCSW, CASAC, SAP, CGP, and Christine Schmidt, LCSW, CGP, Co-Chairs, Eastern Group Psychotherapy Society's Work Group for Racial Equity; and Peter Millis, LCSW, President, Carolinas Group Psychotherapy Society.

I wish all of you and your loved ones health and safety. 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.

STAY CONNECTED

Keep up with AGPA and what we are doing on our website at www.agpa.org and on social media.

Follow us on Twitter at
https://twitter.com/agpa01

Watch us on our YouTube channel at
youtube.com/user/agpa212

Like us on Facebook at
www.facebook.com/American-Group-Psychotherapy-Association-136414920537

FROM THE PRESIDENT

Continued from page 1

Groups for healthcare workers have launched across the country. We know that even as we help support members as they plan how to return to in-person treatments, when allowed by public health, this work will not end soon.

Working very hard behind the scenes, Marsha Block, CAE, CFRE, CEO, has been instrumental in securing federal government financial support that will help protect us economically through these turbulent times. It has been a Herculean effort. We know some of our members have been adversely impacted financially, and AGPA will coordinate with you to enable you to continue your membership through this time.

One of the largest COVID-19 impacts has been the determination to move AGPA Connect 2021 to a virtual platform. The Board of Directors, in collaboration with the AGPA Connect Co-Chairs Katie Steele, PhD, CGP, FAGPA, and D. Thomas Stone, Jr., PhD, CGP, FAGPA, and their Committee have made this painful decision. It is a necessary loss and our listserv has been filled with people's sense of disappointment at not meeting in person. AGPA's leadership feels that loss as well. Why did we make this decision? It was clear that the uncertainty and ambivalence of having an in-person meeting, which would necessitate travel and gathering in person as a large group, was blocking people from making a commitment to the meeting. The safety risks to our members were too high. Committing now to a virtual conference enables us to put all our resources into having the best meeting possible, and we can benefit from the experience of other organizations whose conferences precede ours. We are hopeful that our AGPA Connect 2021 will be even more inclusive and accessible to those for whom costs have been limiting in the past. Scholarships will be as important now as ever in facilitating attendance, but now a scholarship can cover the entire cost of the conference.

AGPA has gathered tremendous experience in working online through our e-Learning programs, even as we gain additional expertise to use these online platforms more effectively. Please do not be deterred from submitting proposals and attending. We have mounting experience on the technology front. One example was a recent virtual fundraising event — our first — where I was very pleased to join Irv Yalom, MD, CGP-R, DLFAGPA, who shared with nearly 500 participants his experience of writing a *Matter of Death and Life* about his beloved wife Marilyn. Irv detailed poignantly his love, grief, and loss.

The second public health pandemic we are confronting is racism. Black lives do matter! It is shameful to acknowledge that such a statement needs to be made. The brutal murder of George Floyd, embedded in a series of other Black lives being taken as a result of systemic racism, has become a tipping point around the world. It has galvanized us all to look closely inward and determine what elements of systemic racism, bias, or discrimination we carry as individuals and as an organization. AGPA members have responded to these tragedies with incredible compassion, transparency, and courage. We have both challenged and supported one another in what is an early stage of a long and important journey.

AGPA issued an important declaration of our strong commitment to confront bias, racism, and discrimination. Our Community Outreach Task Force, led by Suzanne Phillips, PsyD, ABPP, CGP, FAGPA, and Craig Haen, PhD, LCAT, CGP, FAGPA, worked with the Diversity, Equity & Inclusion Task Force (DEI), led by Sophie Aguirre, PhD, CGP, and Wendy Friedman, PhD, CGP, and our Racial and Ethnic Diversity SIG, led by Latasha Smith, LCSW, and Marcee Turner, PhD, CGP to write that statement. The DEI Task Force has mobilized its members to provide and curate resources that address racism, the impact of white privilege on group psychotherapy, and models for dealing with bias and the effects of discrimination in our practices. Both as an organization and as individuals, we have much to learn, and we each must assume responsibility for our own learning in this regard. I am reminded of a comment made by Canada's Prime Minister Justin Trudeau, who recently joined a Black Lives Matter protest march: Our leaders, and each of us, must "put our money where our march is!" Words without action or virtue signalling without implementation are meaningless. One key area of change in AGPA is the commitment to governance that is more diverse and inclusive. The recent Zoom orientation for new Board members underscored that we are making progress in this regard.

All of our committees continue to move apace. Space does not permit fuller detail, but I do want to congratulate Noelle Lefforge, PhD, MHA, CGP, for assuming the position of Vice President of the Group Specialty Council, ensuring continued effective leadership and building on the work of Nina Brown, EdD, LPC, NCC, DFAGPA.

Thank you for supporting us in this important work. As always, I welcome feedback, comments, and questions. Wishing us all wellness, peace, and justice.

groupcircle

is published four times a year by the American Group Psychotherapy Association, Inc. and the International Board for Certification of Group Psychotherapists.

AGPA
25 East 21st Street, 6th floor
New York, NY 10010
phone: 212-477-2677
toll-free: 877-668-AGPA
fax: 212-979-6627
e-mail: info@agpa.org
www.agpa.org

EDITOR
Leo Leiderman, PsyD, ABPP, CGP, FAGPA

EDITORIAL STAFF
Erica Gardner-Schuster, PhD

Lee Kassan, MA, CGP, LFAGPA

MANAGING EDITOR
Marsha Block, CAE, CFRE

EDITORIAL/PRODUCTION MANAGERS
Diane Feirman, CAE
Nicole Millman-Falk

Continued from page 1

Shari Baron, MSN, CNS, CGP, FAGPA (Lane Media, PA)

My husband and I were fortunate to both have relatively mild cases of COVID-19. After quarantining together in our home for a month, we renewed our commitment to each other after 50 years of marriage.

We have lost five friends in the past few months, a crushing reminder of how fragile life is. The experience of attending memorial services on Zoom has been difficult. While our inability to see some of our children has been painful, we have been moved by their support from a distance, as well as the support of our religious community and friends who brought us groceries, dinners, and chocolate. Groups—our family group, our friends' group, our religious community, and our neighbors—have all been part of our recovery and our ability to move on despite our illness, our sadness, and the financial impact this all has had on us. The virus has shut down my husband's business, and he is being forced to suddenly retire. Friends walked him through applying for unemployment, a humbling experience. Simultaneously, we are thankful for our recovery and current health, our family, our friends, our communities (including AGPA), and our position of privilege.

We shudder to think about those so much less fortunate than we are for whom this experience has been forcing choices of health, rent, or food for their families. We have much to be grateful for. Now that we have both recovered, we have been finding ways to give back: participating in studies (lots of tubes of blood!), donating plasma, and helping others in our community who are ill by cooking for them. I have led a support group for our congregation and am now co-leading a peer support group for health care providers. It's the least we can do to show our gratitude.

Paul Berkelhammer, MA, LMHC, CP, CGP (Seattle, Washington)

I was one of the first to be tested at the University of Washington. I felt the ethical responsibility to let everyone at AGPA know. When I got the diagnosis, I was angry at the level of denial but felt responsible for people to take it seriously. It was scary for me when I first got sick. I am approaching 60 and have had a history of pneumonia and asthma. I was afraid I was going to die. The disease itself was hard, especially the fatigue and headaches. I was afraid my body would betray me.

My relationships on every level helped—my wife, family of origin, friends, AGPA colleagues, and the AGPA Connect listserv. What also helped me was my self-care discipline—eating, exercising, being active, and using my lungs. This was not a time for me to isolate but instead to find ways to creatively stay connected with people. Being proactive, on top of things, helped me with moments of depression. As a group therapist, I remember a psychodrama book Who Shall Survive: A New Approach to the Problem of Human Interrelations *(J.L. Moreno, 2013) in which we all find ways to connect.*

I am also a member of a Zoom training group. I like the Zoom technology and have great appreciation for Zoom groups both as a participant and a leader. There is a disinhibition in people being in their own houses.

I am also facilitating a Care for Caregivers support group for therapists. I lead a group and consult. I have also donated plasma. During these days of COVID-19, my favorite way of connecting is by jamming in my front yard with a band.

Helen Chong, LCSW, CGP, FAGPA (Houston, Texas)

The AGPA listserv helped me the most because it was my go-to source for updates regarding news, how to cope, understand, and process my feelings about COVID-19; it was emotionally cathartic. It was painful but so loving. I trusted the realness of what people were sharing, their firsthand accounts. It was hard for me to trust the media and government.

In terms of resilience, I've had a benign brain tumor for 10 years. Coming close to death, then and now, has led to growth. I existentially ask myself "why am I here?" It helps us reevaluate, people look at themselves, their existence, are they in the place they want to be. We can now also discuss death more freely, which is a part of life.

Life is so much bigger than each of us and our individual perspectives. On the other hand, collectively, we all may be stuck in a situation, but individually we can make small strides; this crisis is time-limited.

When ill, I also reflected on my heritage. I grew up in a small village in South Korea. We had to use a common outhouse. There is a simplicity to how the world evolves. Being close to nature and the simplicity of things grounds me. Life has cycles and cycles are not complex.

The insights I gained for myself were wonderful. It's like I needed this right now to help me understand that it's okay to be inconvenienced, I will survive; there are options; and I will feel frustrated, challenged, sad, AND have fun messing up.

Jennifer DeSouza, LICSW, CGP (Cambridge, Massachusetts)

What helped me the most during my illness and recovery was the support and care of my husband. He was a gem. I was very appreciative of my PCP practice. At times, I was scared about my lung function. My elderly father called me every day, and that meant a lot to me. Snuggles with my little black pug helped too (she did not get sick).

I only got tested because I'm a hospital employee; otherwise, I wouldn't have had that available to me. Difficulty breathing and fatigue were my most challenging symptoms. It was a struggle to get back to work and took me close to a month.

The biggest trauma for me was that no one was in charge; we do not have a national leader. There is no one looking out for you.

My group therapy community was a critical support. People texted and emailed, and several of us compared notes.

The experience really humbled me. I am so very grateful. It's clarified for me the important things in life and has allowed me to be more present. It's also made me keenly aware of the disparities in our nation. Some people have no abilities to social distance and must work at the supermarket, etc. These people are sacrificing so much for us. I am so privileged to not have to worry about shelter, food, and decisions about making a living. Because of this, my gratitude is bittersweet.

Einar Gudmundsson, MD, (Gardabaer, Iceland)

I was one of the first individuals diagnosed with the virus in both Iceland and the US. The national tracking and containment systems in Iceland are highly effective. They currently tested 50,000 with 1,800 positive cases and 10 deaths (compared to almost 100,000 in the US) Iceland's CDC and surgeon general gave briefings each day, sharing how the country was responding to the medical crisis. Today we are opening the country for gatherings up to 200 people with social distancing, unlike other similar Scandinavian countries, like Sweden, where they did things differently and have incurred thousands of deaths.

This is a reminder that a nation is more than a concept. In Europe, people are returning to their countries of origin by the hundreds of thousands to sit out the virus. People feel safer and more comfortable with the nations of origin where their families and support systems can be found.

One thing which affected my COVID-19 experience deeply is that I have Chronic Lymphocytic Leukemia (CLL). I was due for my cancer treatment, but it was postponed because of the virus. I already had to delay treatment to attend AGPA Connect, and I still haven't started treatment, which worries me. It is not easy to have this hanging over me. CLL puts me in a special risk group for the virus, since it affects the immune system. I was in isolation and with fever for 14 days. I reframed the isolation as a much-needed time out, a mental rest from an overwhelming schedule. I rested, read, and watched TV. I meditated and reflected on my life.

Alison McGrath Howard, PsyD, MEd, CGP (Washington, DC)

The very long duration of the illness and the lack of information about the virus impacted me greatly. I was sick with a chronic fever, cough, and tested positive a couple of times. I was alone and away from my children for two months.

When I ask myself how I got through two months of isolation from any other human being, the answer is two-fold but interrelated. One is by working. It kept me grounded and gave me a sense of purpose and intent, as well as meaning. The second is derived from a quote that a yoga teacher shared with a class, which spoke to me so deeply because I had been saying something to its effect to my patients: "We have never stayed home long enough to experience the truth about ourselves." Erich Schiffmann.

My patients also had a hard time with me being ill. They were upset with me. What I decided to do was to be honest with them about how I was feeling. They saw my vulnerability. Prior to COVID-19, I would not self-disclose with patients. Being ill has changed me to share my feelings more, be more open and genuine. Initially, patients were worried that I would not be able to care for them. I invited them to share all their feelings towards me and potentially how this related to their own histories and trauma backgrounds. That is the beauty of transference and transference analysis. There initially were issues of shame related to my own trauma history. I handled isolation for two months with an incredible support system and playing online chess. This has been an experience of self-regeneration. Sometimes I was afraid, but I am not afraid anymore. It's good to ask people for their love. I really reached out to others, which is not easy and unusual for me.

Robert Hsiung, MD (Chicago, Illinois)

Physically, I could barely get out of bed. I had a fever of 102 and symptoms for 16 days. It panicked me to think that by breathing on my wife, I might kill her (she's a member of a high-risk subgroup). I spent 34 days away from her in hotels.

I wanted to test negative before I went home, but I tested positive two times. I was disheartened, verging on despairing. Getting two tests already felt greedy when so many people, including AGPA members, couldn't even get one test. I emailed a colleague in infectious diseases, and she said it would be "probably just fine" for me to go home after 14 days of no symptoms.

I felt like a prisoner getting parole. But would my wife survive? The following days were most fraught with worry. Not only did she survive, she didn't even get symptoms.

Being a group therapist helped me see parallel processes and feel more empathy for others. I felt the helplessness and rage I imagine have-nots feel: those who have limited access to health care and those who are undocumented/discriminated against.

It helped me even more to have a subgroup, as Yvonne Agazarian, EdD, DLFAGPA, used to say. In this case, the 24/7 AGPA lists in which I stayed connected with and my fellow veterans from the frontlines in New York City. I hear a lot, "Take a risk." Well, we took a special risk this year.

Barbara Keezell, LICSW, CGP, FAGPA (Brookline, Massachusetts)

The slow healing has been frustrating and depressing. It has been physically overbearing while affecting me cognitively, like I've been in a chronic brain fog. My energy level has been zapped, so I've had chronic fatigue. During earlier stages of the virus, I also overcame the more serious symptoms of fevers, nausea, headaches, loss of sense of smell, and cough. There were two bad nights where I was constantly in touch with my physician because of labored breathing.

What helped me during the worst of times, was the AGPA Connect emails I received from the community. I also have found virtual music and dance inspiriting.

The one main lesson I have learned is to take one day at a time. I've been through a lot in life. I've managed and have strength and courage. When I was at my low points of this illness, I kept on telling myself I will get through this as well. I kept on giving myself pep talks. I've told my patients we are in this together and that there are many lessons to be learned. They need to not push themselves and find a balance. I am more open to self-disclosure. Being more forthcoming about my wellbeing. I've also used humor a lot to help me get through this. I think we need to laugh and find humor where we can.

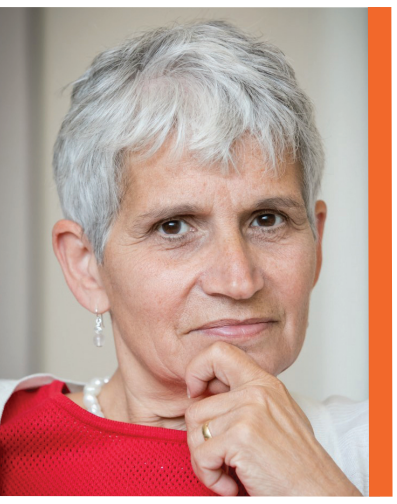
Jan Morris, PhD, ABPP, CGP, FAGPA (Austin, Texas)

Telling my patients after I was diagnosed was the hardest part. I am supposed to heal not inflict illness onto others. There was a stigma like I've done something bad. I invited

Continued on page 8

Moving from the Circle to the Square: Group Therapy in the Time of COVID

Clare Gerada, MBBS



Clare Gerada, MBBS, is a general practitioner and psychiatrist in the United Kingdom. She heads up the only nationally funded mental health service for doctors in England. She has held many leadership roles, including head of her professional body (Royal College of General Practitioners). She trained as a group therapist and has written about and runs groups for physicians.

So much has happened over the last few weeks that even the word, "unprecedented" seems understated. As therapists, alongside containing our patients' anxieties over COVID-19, we have had to deal with our own fears, death of friends, relatives, and colleagues, and for some, our own encounter with the virus. In the process, there has been little time to mourn what we have lost. A weariness is engulfing many of us, borne not just from late nights and tight schedules but from struggling to absorb the enormous changes forced upon us over the last three months. This article, drawn from a personal perspective, looks at how we have transformed the way therapy is delivered and what this might mean for our discipline and for our patients.

In March 2020, I attended AGPA Connect. I had a wonderful time and felt enlivened by the whole experience. The last day of the Conference coincided with New York declaring a state of emergency due to COVID-19. I didn't know what this meant, but instinctively wanted to be home, away from any disruption I imagined would follow. The day after returning to London, I became unwell, developed the most violent headache, high temperature, cough, and muscle pains. For four days, I stayed in bed, rising only to go to the bathroom. Even trying to lift my head to drink was a great effort. The fever was followed by excruciating pains in my calves followed by fatigue making the simplest journey, such as climbing one short flight of stairs, leaving me exhausted. I was able to get tested, and by the time I received my results (COVID-19 positive), my illness was subsiding. Walking to work after almost a month's absence reminded me of the opening scene in *The Day of The Triffids,* the 1951 post-apocalyptic novel by John Wyndam. The book's protagonist wakes up in the hospital, his eyes bandaged having been blinded by watching a meteor shower, to discover London had completely changed, with streets devoid of people and those who were around wandering confusedly. That morning, my journey to work was eerily unfamiliar. The streets—normally packed with pedestrians, children on their way to school, street sweepers, traffic wardens, and even the homeless who occupied the underpass—were now largely empty. Vauxhall cross, a massive transport hub often gridlocked with traffic, had barely any cars. This was before any official lockdown. Workers were already staying at home, shops and restaurants were closed (or closing), and people were in a state of panic-buying food and toilet paper. As they say, the rest is history. Over the next few days, governments across the world issued new guidance around social distancing, home confinement, closure of public spaces, shops, sporting events, and much more. For most health professionals, the coronavirus pandemic was about to change the way we worked, possibly forever.

I work in the UK National Health Service (NHS) and am both a general practitioner (family physician) and psychiatrist. In the later role, I lead a treatment service for doctors with mental illness and addiction (NHS Practitioner Health www.practitionerhealth.nhs.uk). The service was established in 2008 following the suicide of a psychiatrist, who, suffering from severe postnatal psychosis, killed herself and her three-month-old baby. Over the years, my team has seen and treated more than 11,000 doctors across England; around 75 new cases present per week. Group therapy is an important aspect of treatment (Gerada, 2016). The COVID-19 crisis meant that we urgently moved all care online and in so doing, rapidly learned to use the various digital platforms, created the operational and governance arrangements, and bought necessary licences. Like many, we packed several years of transformation into a few short days.

Providing medical and even psychological care online is not new. My GP practice has offered patients online consultations (e-consult) for nearly a decade (Cowie et al., 2018). Cognitive behaviour therapy has been delivered remotely for many years and is an effective way of delivering healthcare to a diverse population, and with evidence of efficacy (Greenhalgh et al., 2016). It has been shown to be efficient in conditions such as post-traumatic stress disorder (Acierno et al., 2017). Psychotherapists have been providing virtual individual and group psychotherapy (Ragusea & VandeCreek, 2003), including via text messaging (Golkaramnay et al., 2007) and feedback suggests participants feel more confident talking about personal issues virtually rather than face-to-face (Yuen et al., 2013). Most of the studies on remote therapy relate to those delivered on a one-to-one rather than group basis.

There is literature on internet groups we can draw on. For example, Haim Weinberg, PhD, CGP, FAGPA, has written on and led virtual groups for many years. His book, *The Paradox of Internet Groups, Alone in the Presence of Virtual Others,* published in 2014 was one of the first analysis of internet groups. While there are only a few passing references to video, as opposed to internet (chat) groups, his research can be extrapolated to virtual video groups (VVGs). For example, he suggests that virtual groups, even where one can see the face of others, lead to less committed relationships to the group and always involve more projections and problems with boundaries, which in internet groups seem non-existent (Weinberg, 2014). Since this book, Weinberg has gone on to edit another, this time specifically how to conduct individual, family, and group therapy online using video conferencing tools (Weinberg & Rolnick, 2019).

COVID-19 meant that all my groups are now run online, previously established ones and new ones set up to support health professionals during the pandemic. As with many who have done this, I had anxieties. I worried whether the same intimacy could be created in the virtual world compared to a small room; whether I would be able to read the mood of silent members; pick up on cues (even how and where they sit in a real group tells me something); or miss the silent tears running down faces. I need not have worried. It is harder to track emotions across a screen or feel the distress, but it is possible, and group members appear to project a more authentic view of themselves from the comfort of their own homes. Attendance has improved, as members do not need to factor in travel time or costs into their consideration to come to the group.

But of course, there are problems, not the least being the occasional child or dog walking into the scene, technology glitches created by unstable internet connections, frozen screens, accidently forgetting to unmute or being unmuted at the wrong time. There are problems with confidentiality as not all group members (including myself) have soundproof rooms where we can have intimate conversations with others.

What we are learning, and what Weinberg's work tells us, is that leading (also referred to facilitating, managing, conducting) groups in the virtual world is not the same as in the real world. The group, its members, shape (from circle to square), regulatory requirements, boundaries, and group content brought forth through the social unconscious are all different and need attention. We have had to understand how transference, countertransference, and projections occur in the virtual space, especially given the disembodiment of participants in virtual video groups. The ability to hold another's gaze has disappeared, and we cannot tell, without naming, who is engaging with whom. We have had to understand how authority, which normally resides with the group leader, shifts between frames and different people, as those who speak most become more visible on screen and are able to literally take center stage.

We are also experiencing changes in the interactions between group members, including between the leader and group members, to which we have to adjust. Boundaries are more fluid. It might be impossible to create a truly confidential consulting room as practical implications (where the router is situated, which room can be closed off to other household members) will need to be met and we have to accept imperfections. We also naturally disclose more of ourselves when we conduct therapy from our home, especially if personal effects, such as photos, pictures on the wall, or even our furnishings, cannot always be hidden. For support rather than therapy groups, gone are the moments before and after each session when the talking stops and new connections are formed.

Because we have had to learn these new skills in a short time, finding our way through trial and error, it is hardly surprising that so many of us are exhausted, a phenomena I referred to in an article as COVID-fatigue (Gerada & Walker, 2020). This experience is not just related to the extra work we may be doing because of seemingly back-to-back virtual video meetings or groups, or the weariness of constant change; though these situations are contributary. Rather, it is the physical and psychological manifestation of our grieving for our recent past while at the same time rapidly adjusting to the future. This feeling of grief is expressed in almost all my group sessions, where as the leader, I have to contain on behalf of the group. As someone in the same boat, it becomes difficult to hold the therapeutic line and be a distant bystander. As with my patients, I, too, am anxious, fearful, bereaved, and at times engulfed by overwhelming feelings of helplessness. This new way of working also reinforces our isolation, the paradox being that as more of us feel connected through the virtual matrix, we are even more distant to each other. The process of working through this is wearisome.

Nevertheless, as I and others have adapted and grown through the process, I am reminded of one of Yalom's therapeutic factors—hope. In our transformation from the circle to the square, we have demonstrated hope. We have created, through our hard work, determination, and love, the ability for our patients to continue to receive care from us and from fellow group members. Yael Danieli, a clinical psychologist who works with victims of trauma, talked of hope being the ability to have options, and that the greatest source of hope is belonging (Danieli, 1994). Group therapists have provided hope to their patients and to themselves and their profession, through their tremendous demonstration of resilience. The future is uncertain, but what is certain is that groups, and the connections they create between people, are more vital now than ever before.

References

Acierno, R., Knapp, R., Tuerk, P., Gilmore, A. K., Lejuez, C., Ruggiero, K., Muzzy, W., Egede, L., Hernandez-Tejada, M.A., & Foa, E. B. (2017). A non-inferiority trial of prolonged exposure for posttraumatic stress disorder: In person versus home-based telehealth. *Behaviour Research and Therapy,* 89, 57–65. https://doi.org/10.1016/j.brat.2016.11.009.

Cowie, J., Calveley, E., Bowers, G., & Bowers, J. (2018). Evaluation of a digital consultation and self-care advice tool in primary care: A multi-methods study. *International Journal of Environmental Research and Public Health, 15* (5). https://doi.org/10.3390/ijerph15050896.

Danieli, Y. (1994). Countertransference, trauma, and training. In J.P. Wilson and J.D. Lindy (Eds.) *Countertransference in the treatment of PTSD* (pp. 368–388). New York: Guilford Press.

Gerada, C. (2016). Healing doctors through groups: Creating time to reflect together. *British Journal of General Practice,* 66 (651), e776–e778. https://doi.org/10.3399/bjgp16X687469.

Gerada, C., & Walker, C. (2020). *Covid fatigue is taking an enormous toll on healthcare workers—The BMJ.* https://blogs.bmj.com/bmj/2020/05/04/covid-fatigue-is-taking-an-enormous-toll-on-healthcare-workers/

Golkaramnay, V., Bauer, S., Haug, S., Wolf, M., & Kordy, H. (2007). The exploration of the effectiveness of group therapy through an internet chat as aftercare: A controlled naturalistic study. *Psychotherapy and Psychosomatics, 76* (4), 219–225. https://doi.org/10.1159/000101500.

Greenhalgh, T., Vijayaraghavan, S., Wherton, J., Shaw, S., Byrne, E., Campbell-Richards, D., Bhattacharya, S., Hanson, P., Ramoutar, S., Gutteridge, C., Hodkinson, I., Collard, A., & Morris, J. (2016). Virtual online consultations: Advantages and limitations (VOCAL) study. *BMJ Open,* 6 (1), e009388. https://doi.org/10.1136/bmjopen-2015-009388.

Ragusea, A.S., & VandeCreek, L. (2003). Suggestions for the ethical practice of online psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 40* (1–2), 94–102. https://doi.org/10.1037/0033-3204.40.1-2.94.

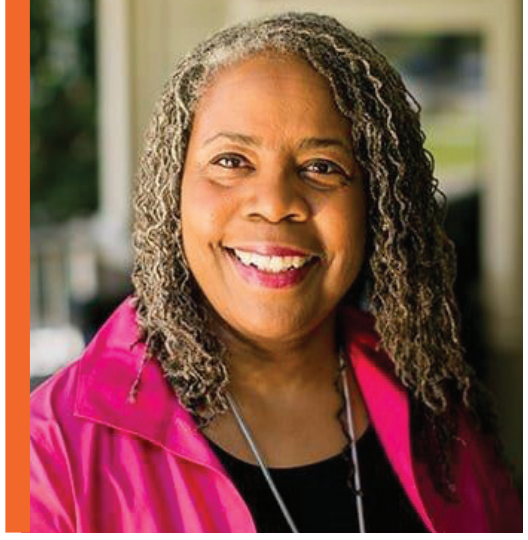
Weinberg, H. (2014). *The paradox of internet groups: Alone in the presence of virtual others by Haim Weinberg.* https://www.karnacbooks.com/product/the-paradox-of-internet-groups-alone-in-the-presence-of-virtual-others/29425/

Weinberg, H. & Rolnick, A. (2019). *Theory and practice of online therapy: Internet-delivered interventions for individuals, groups, families, and organizations.* New York: Routledge.

Yuen, E.K., Herbert, J.D., Forman, E.M., Goetter, E.M., Juarascio, A.S., Rabin, S., Goodwin, C., & Bouchard, S. (2013). Acceptance based behavior therapy for social anxiety disorder through videoconferencing. *Journal of Anxiety Disorders, 27* (4), 389–397. https://doi.org/10.1016/j.janxdis.2013.03.002.

Finding Home in an Unprecedented and Digital World

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



EDITOR'S NOTE: *Alexis Abernethy, PhD, CGP, FAGPA, is a Clinical Psychologist and Professor in the Graduate School of Psychology and Associate Provost for Faculty Inclusion and Equity at Fuller Theological Seminary, Pasadena, California. In addition to having conducted numerous institutes and workshops nationally on cultural competence and spirituality in group therapy, she has published widely on the same subjects, including co-authoring with Lee Stevens, PhD,* Neuroscience and Racism: The Power of Groups for Overcoming Implicit Bias *and with David Allen, MD, MPH, and Marie Carroll, PhD,* Adapting Group Therapy to Address Real World Problems: Insights from Groups Offered in the Bahamas. *A current AGPA Board member, Dr. Abernethy was Institute Co-Chair and AGPA Connect Committee Co-Chair. She will present the Institute Plenary at AGPA Connect 2021.*

AM: What is the title of your Institute Plenary?

AA: Finding Home in an Unprecedented and Digital World.

AM: How have your earlier experiences with AGPA Connect Institutes, as a participant, leader, committee member and Institute Committee Co-Chair and AGPA Connect Committee Co-Chair, impacted and influenced you as a person, an educator, and a group therapist?

AA: When I attended my first AGPA meeting in 1988, I soon found a home. My Institute experiences contributed profoundly to this feeling. I felt that I was seen and heard in these groups. I felt that the leaders worked with me out of the fullness of my identity, not simply my racial identity. I did not feel othered. I received help in addressing some of my interpersonal issues related to intimacy and conflict. The example of many of my Institute leaders helped me become a more effective group therapist and demonstrated to me the power of group therapy.

I have not missed an AGPA meeting for the past 32 years because it has continued to be my group home and a source of growth for me personally and professionally. Things have, at times, been difficult at home. I have had my own concerns related to diversity, inclusion, and equity, and I am mindful of the voices of my Black sisters and brothers as they have cried out for AGPA to be a home for them. They want to feel at home in AGPA, but there are times when it not only doesn't feel like home, but rather a source of hurt, pain, and even trauma. I have seen, known, and experienced this pain as well, but not to the extent of others. Because I know this pain is real, in my varied roles at AGPA, from Membership Chair, Institute Co-Chair, and AGPA Connect Co-Chair, I have worked to increase diversity in membership, instructors, and leadership. AGPA has also worked to increase the cultural competence of instructors and taken strategic steps toward inclusion and equity. We are making progress, but we have a long way to go.

AM: What do you expect to cover in your Plenary?

AA: Following an invitation to speak and after suggesting that I should not offer the Plenary given my recent role as AGPA Connect Co-Chair, I reluctantly accepted this honor. The extrovert in me was looking forward to the opportunity to speak to a room full of people, to feel the energy of the room, and to connect with others in an embodied way. My talk is emerging and will be informed by the many ways our world will continue to change over the next few months. My talk will include some elements of my immediate experience following AGPA, my struggle to find a home, and the journey toward a virtual home at AGPA Connect 2021.

In early 2020, COVID-19 came. Following AGPA Connect 2020, we made our way back to our homes and then we heard about people getting sick. I left AGPA Connect 2020 and went to visit my 91-year-old mother for a planned visit of 18 days. I was able to see her only four days before a 14-day self-quarantine. I was two miles away from the home where I grew up that was sold 10 years ago, and one floor below my mother's room in assisted living, but I was very far from home. My childhood home and my mother's new home in assisted living were no longer available to me, and I had to face the reality that I might never see my mother again. So close and yet so very far. (I am thankful that my mother has been symptom-free for the past three months.)

It was at the moment of feeling a sense of homelessness as I was looking at a beautiful view of the Chesapeake Bay that I remembered the voices of my Black sisters and brothers as they have cried out for AGPA to be a home for them. It is painful to not have a home where you have always had one, or where you hope to find a new one. I had expected to connect with my mother during this period, but this did not happen. I felt unmoored, disappointed, frustrated, and sad.

The decision to not see my mother was based on a clear understanding that that was safest for everyone. Although, not seeing my mother for the remaining 14 days was excruciating, on the other side my brothers and I have connected with my mother in a way that we never have before. My brothers and I do not keep in regular contact with each other but following the suggestion of my older brother to talk to my mother on Zoom for Mother's Day, we have connected by Zoom every Sunday. I call it Sundays with Mommy. Although my mother enjoys my nearly daily phone calls, her heart is overjoyed when all three of her children visit her together at her new assisted living home. Being together on Zoom is the next best thing. The amazing reality is that our weekly Zoom calls would not have happened if it were not for COVID-19. This pandemic has provided a new way of connecting with my mother and my brothers. Although we had pursued other video options, the necessity and urgency of the pandemic helped us realize an option that we had overlooked.

AM: How has this period of deepened awareness to inhumanity toward Black bodies influenced you?

AA: At this moment, with the coexistence of COVID-19 and undeniable recognition of our racial pandemic, I am encouraged not only by the solidarity evidenced in the protests, but also the commitment to change as evidenced in the implementation of new policies. One of the ways that I have described this moment is an opportunity to move beyond incremental change (this is important and often increases sustainability) and transformational change (this is often required in the face of tragedy or dire circumstances). Dire circumstances associated with COVID-19 have required certain actions that are less than ideal. We will not be in person for AGPA Connect 2021. We mourn that loss, and I hope that you will have space during your Institute to mourn this loss. On the other hand, an online Institute experience provides an opportunity for those who have not connected before to participate. The decision to have a virtual AGPA Connect is based on wisdom and concerns for our safety. Despite the sense of loss in not experiencing the countless hugs and benefits of being in person, I do have faith that some new opportunities and ways of connecting more deeply may be possible.

Out of the tragedy of COVID-19 and 'COVID-1619' (term coined by Pastor Raphael Warnock referring to the racial inequality the persists from chattel enslavement and continued oppression of Black bodies) emerges a new opportunity. We have the chance to consider what does the realization that BLACK LIVES MATTER have for how I lead and participate in my Institute. Following the three murders of Ahmaud Arbery, Breonna Taylor, and George Floyd, I vacillated between activism and immobilization in the first week. It meant all the world to me when one of my white students in an online group therapy class took the lead in acknowledging the tragedy and stood in solidarity. I was too emotionally exhausted that day to actively process it. That solidarity and support lessened the weight and made it feel like this was something that we were going to do together rather than something that I had to help people, even my students, see. The tragedy of the George Floyd murder was not only that he was murdered by police in broad daylight, but that it was done so casually with the police officer's hand in his pocket. This dehumanization is frightening. This officer is so out of touch with his own humanity. The stark reality of this tragedy has awakened many to see what they have been ignoring or not seeing. This forces us to consider in what ways are we living that dehumanize others. In what ways do we lead groups that are destructive to Black bodies and Black people?

Just like this new connection that I have with my mother and brothers, there is also the opportunity for us to connect in a more intentional way than we have ever done before. We are undergoing a fundamental re-examination globally, nationally, locally, organizationally, and personally. What would it mean if our Institutes reflected this transformation? What would it mean if in this new virtual space, we could find a way of creating a home for everyone? This shift in the physical space of the Institute provides an opportunity to shift our mindset. We need to begin by questioning our foundations, clinical practice, and theoretical, to build on what has been best, but to weigh carefully any way that our actions, beliefs, and behavior, as well as our theories and clinical practices, may be contributing to the oppression of others, particularly Black bodies.

AM: What advice can you offer participants for getting the most out of the Institute experience? Are there any papers or books you would recommend for participants to read?

AA: The Institutes will offer an example of skilled leadership. First, I encourage you to participate and work with what comes up for you. Be open to learning some new and unexpected things about yourself. If you feel comfortable enough, take a risk. Although the groups will have varied foci, I cannot imagine that themes and work related to the viral and racial pandemics will not emerge. Ibram Kendi (*How to Be an Antiracist,* Random House, 2019) describes racism as a metastatic cancer. He outlines how to be an antiracist in helpful steps: "I stop using the 'I'm not a racist' defense or denial (p. 226)." He encourages us to confess the racist policies and ideas that we support and acknowledge their origins. He defines an antiracist as someone who supports antiracist policies and ideas. He encourages us to consider how racism intersects with other bigotries. If I were participating in an Institute, I would want to be able to engage my experience of this unprecedented time in relation to all aspects of my cultural identity.

What might our Institute experience be like if we took these months to read Kendi's book, Michelle Alexander's book, *The New Jim Crow* (The New Press, 2012) and Dominique Gillard's work, *Rethinking Incarceration* (IVP Books, 2018), which includes an examination of the role of incarceration and the Christian church's involvement as well as creative solutions, Austin Channing Brown's book, *I'm Still Here: Black Dignity in a World Made for Whiteness* (Convergent Books, 2018), and Robin DiAngelo's contribution, *White Fragility: Why It's So Hard for White People to Talk About Racism* (Beacon Press, 2018). My articles on addressing racial (*Working with Racial Themes in Group Psychotherapy* https://link.springer.com/article/10.1023/A:1023025500831) and cultural differences (*The Power of Metaphors for Exploring Cultural Differences in Groups* https://www.researchgate.net/publication/226692514_The_Power_of_Metaphors_for_Exploring_Cultural_Differences_in_Groups) may also be helpful.

AM: Given your many years of experience with the Institute, how do you expect members to be impacted by being virtual for AGPA Connect 2021?

AA: The experience will be different, and my first assumption is that it will be less intimate, but my experience in teaching online, conducting demonstration and consultation groups online, and doing clinical work online highlights another dimension. What has been critical is to process what it feels like being online with one another and to acknowledge the sense of loss, frustration, unpredictability, as well as potential opportunity. The therapist's transparency in this process, in terms of authentic disclosure about the challenge, as well as encouraging the members' communication has been key. While it is a different space—a different address—there is a way of making it feel like home. The most unexpected experience of being online has been that connecting with people from their homes has allowed me to connect more with their context. Sometimes, this means beloved pets and background images are seen. Conversations emerge about who they are and what makes them feel at home that might not otherwise emerge. There is a way that my home is connecting with their home, setting to setting, context to context. I have a deeper sense of them as a person embedded in a family or community. Similar to my new virtual connection with my mother and brothers, at the online Institutes at AGPA Connect 2021, we may discover something new and find a new way of connecting. I think that we have the opportunity to find a digital home together.

a view from the affiliates

EDITOR'S NOTE: A View from the Affiliates *highlights the Affiliate Societies of AGPA. This column shares with the larger AGPA community Affiliate Society perspectives, initiatives, and ongoing activity and conversations to promote group therapy, advance the training and professional development of group therapists, use group therapy expertise to meet community needs, and engage with important issues pertaining to the field of group therapy and organizational and societal group dynamics. This section also provides a space to explore the relationship and opportunities for partnership on the local, regional, and national levels among the Affiliate Societies, the Affiliate Societies Assembly (ASA), and AGPA.*

The Austin Group Psychotherapy Society Tackles Issues of Diversity, Equity, and Inclusion

By Stacy Nakell, LCSW, CGP, Secretary, Austin Group Psychotherapy Society's Diversity, Equity and Inclusion Committee

Throughout a decade of membership in Austin Group Psychotherapy Society (AGPS), I have observed ruptures around issues of diversity can arise in demo groups and social events, sometimes leading to repairs and understanding and sometimes left unresolved. In 2016, I was relieved when AGPS began to explore the complicated issues of diversity, equity, and inclusion directly. These steps included developing a diversity statement, working with visiting presenters about how to set up demo groups with non-binary approaches to gender, and inviting Rudy Lucas, LCSW, CASAC, SAP, CGP, and Christine Schmidt, LCSW, CGP, to present their workshop, *The Relational Dilemma Of Race, Visible to One and Invisible to the Other: Ethical and Practical Implications*.

In 2017, building on momentum from the open communication fostered at this workshop, AGPS formed a Diversity, Equity and Inclusion Committee. The Committee has met monthly, with a focus on providing input to the Board on event planning and quarterly Diversity Dialogues on topics such as how to work with diversity of age, gender, sexual orientation, and immigration status in groups. Recent presentations, including Neathery Thurmond LCSW, CGP, who spoke on the gender spectrum in groups, have been well-attended. Stacy Spencer, MSW, is spearheading a dialogue with AGPS's Board to integrate the Committee's work.

In April, Committee member Aaron Bandy, NBCT, LMSW, led an online dialogue on *Class, Money, and Privilege: Counter Transference and Barriers to Care*. Although we were nervous about tackling such a sensitive topic online, AGPS realized that the topic was more relevant than ever, as class differences were laid bare in the varied access to health care, childcare, internet service, and the ability to work from home.

Aaron opened the dialogue by modeling vulnerability. He noted that he is more comfortable talking about the areas in which he is disenfranchised rather than those in which he occupies a position of privilege; he disclosed his personal experience on both sides of that dynamic. His disclosure led to honest conversations about the struggles participants face when making decisions about fees within the context of the pandemic, as well as how to overcome our own avoidance to effect open dialogue about class differences within our groups.

Lavanya Shankar, PhD, Committee Chair, and I also questioned whether to hold our fall workshop, *Exploring the Hidden Costs of Micro-Aggressions in Group Therapy,* online. We found ourselves facing new fears around how to contain the intensity of feelings the topic can engender without physical closeness and with inevitable technological challenges. Aaron's courage and our community's ability to meet the challenge encouraged us to proceed, and we are even planning to include a demo group in our Zoom workshop. One benefit of the online format is that our workshop will be accessible to those beyond the Austin area. To learn more, email pamgreenstone@me.com.

Eastern Group Psychotherapy Society's Forum: The Case for Reparations in the Time of COVID

By Rudy Lucas, LCSW, CASAC, SAP, CGP, and Christine Schmidt, LCSW, CGP, Co-Chairs, Eastern Group Psychotherapy Society's Work Group for Racial Equity

When the COVID-19 pandemic erupted in the United States in early March, the absence of national and local preparation was disproportionately lethal to Black Americans. The mortality statistics—who lived and who died—told the story of racial injustice embodied by racially disparate healthcare, poverty, insecure housing, and criminalization. The coronavirus pandemic is haunted by the legacy of slavery.

In February 2020, the Eastern Group Psychotherapy Society (EGPS) unanimously endorsed the Statement to Support Reparations for Slavery. The endorsement was the culmination of many hours of discussion and reflection by the Board of Directors since the initial proposal in September 2019 by the Work Group for Racial Equity. Within the Board, the group process over the course of many months opened a space for expressions of urgency, doubt, fear, and hope. As a result, the statement was revised several times before being adopted in final form. The process was integrally woven into the product. The statement declares, "As we advance our work to create a diverse, equitable, and inclusive organizational culture, EGPS seeks to affirm our values as group practitioners, particularly as they relate to healing the moral, spiritual, and material harm caused by the atrocities of the transatlantic slave trade."

On October 18, the Work Group for Racial Equity of the Eastern Group Psychotherapy Society will host an online forum, *The Case for Reparations in the Time of COVID*. The forum aims to engage members of our group and mental health community to confront the pandemic of racism that lies within the coronavirus pandemic. Co-sponsors include five other psychotherapy, psychoanalytic, and group organizations that share the urgency to make a case for reparations for slavery. Keynote speakers are Medria Connolly, PhD, and Bryan Nichols, PhD, authors of *Transforming Ghosts into Ancestors: Unsilencing the Psychological Case for Reparations to Descendants of American Slavery*. Participants will have an opportunity to engage in dialogues with each other and with the keynote speakers. Visit: www.egps.org.

Reimagining an Affiliate: The Carolinas Group Psychotherapy Society's New Initiatives

By Peter Millis, LCSW, President, Carolinas Group Psychotherapy Society

It became apparent to me after returning from AGPA Connect that volunteering to be the Carolinas Group Psychotherapy Society (CGPS) President was an illusion—putting on a few workshops and grousing about the time commitment, which had been my plan, just weren't going to cut it.

Since then, CGPS decided to take on new initiatives. We've put together and completed a series of eight, free, online open support/process groups for therapists, led by four volunteer CGPs from our membership—Seamus Bhatt-Mackin, MD, CGP, Larry Liebgold, MA, LPC, CGP, Robert Dick, PhD, and Pamela Millis, LCMHCS, CGP—who deserve much more for their generosity and skill than just to be named here. We've initiated an ongoing online evening support group for members, which I'm facilitating, and we've reimagined our fall workshop, an institute focused just on group psychotherapy, as an online event.

Since CGPS began this, our membership has doubled. Eliminating fees for 2020—another recent initiative—has helped. In the upcoming months, CGPS hopes to demonstrate enough value in membership that many of these new members will pay to re-up for next year.

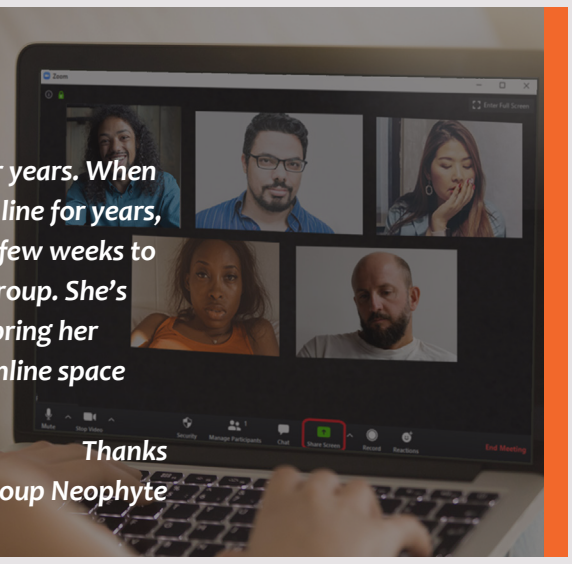
Finally, Chaplain Angel Lee, MDiv, MBA and I are working to create an interracial online group focused on building relationships between individuals and communities. As co-facilitators, we hope to establish a framework that helps participants focus on and be supported in their own experiences, without pressure to take care of or educate others. Talk-based responses to our culture's implicit and explicit violence against people of color might feel superficial right now, but CGPS wants to do what it can with the people and the training we have, while scrambling to get more. Sliding-scale fees will be donated to a regional social justice organization. Visit: https://carolinasgps.org.

consultation, please!

This month's dilemma and answers are supplied by AGPA's Internet, Social Media and Technology Special Interest Group (SIG). The SIG is for those who are interested in how the internet and technology are changing how we connect with each other and affecting the groups we lead and belong to. Co-Chairs are Robert Hsiung, MD, bob@dr-bob.org, Lindsey Randol, PsychD, lindseyrandol@gmail.com, and David Songco, MA, PsyD, CGP, dsongco@newinsightsllc.com. To join the Internet, Social Media and Technology SIG email: agpamemberservices@agpa.org. For questions about the SIG contact the Co-Chairs at their emails above.

Dear Consultants:
I have a mixed-gender therapy group (three men, two women), which has been meeting in my office for four years. When the coronavirus hit and everything shut down, we moved online. Although I have seen individual patients online for years, I have never run an online group. So, while I was comfortable with the change, the group has been taking a few weeks to adjust to the virtual environment. I have another female patient who has expressed interest in joining the group. She's a lovely young person with great energy, enthusiasm and would be a great addition to the group. How do I bring her in? What kind of preparation does the group need? How long should I let the group feel around in the new online space before adding a new member? Is there anything I should be on the alert for?

Thanks
Cybergroup Neophyte



Dear Cybergroup Neophyte:

We have moved a long way from the primarily auditory experience in Freud's consultation room to a highly visual online environment. Becoming neophytes again has naturally left us feeling de-skilled. Is anxiety about our changed world landing on our changed groups? Feeling less experienced technologically can also cross over into feeling less confident about our group therapy skills. How do you feel about your capacity to create a virtual holding environment for your group?

How would you typically bring a new member into your group? The dynamics of introducing a new member into your online group will be similar to bringing a new person into an in-person group. There will likely be feelings of competition and uncertainty. Perhaps, there will be pandemic themes of fearing that the new person could infect the group or relief to see a new face after all the isolation and distancing.

How do you feel about navigating another significant change in your group? In this new virtual space, there are new virtual disclosures: Members and leaders now have access to different kinds of information about each other. Video groups can be likened to group house calls. How has it been for you and your group to have a view into (or to have a virtual background hide) each other's homes? What is now visible that was previously not talked about? Is the group able to discuss what they see and the meaning they are making? Are there differences in power, privilege, and status that have become more visible since moving online?

While many things are similar about running groups online, there are some unique differences and opportunities presented. In the online setting, some patients (and therapists) find that their attention is irresistibly drawn to their own image, and their energy becomes focused on visual self-monitoring, almost as if there were mirrors in the therapy office or they were actors in a TV drama. Some online platforms allow members to hide their image from themselves. However, there may be opportunities for group members to develop new perspectives on themselves, and we also have a unique chance to literally see ourselves at work.

There is a paradox that group members can feel both visually exposed and also unseen. One of the benefits of this highly visual environment is that we can better track facial expressions within the entire group; however, we (and they) lose the capacity for direct and personal eye contact. When you bring in this new member, I would encourage you to listen for themes of feeling seen and unseen.

As you may have surmised, I have an agenda that you add this new member as soon as you feel ready and resourced. This agenda comes from my belief that the work we do is essential and that this person will surely benefit from the power of your group.

Lindsey Randol, PsyD
Co-Chair, iSIG
Boulder, Colorado

Dear Cybergroup Neophyte:

Running and facilitating groups online is no easy feat, and I imagine that many group therapists are becoming disillusioned with the notion that "it's the same, just online." There are so many things lost in the online space—full body language, direct intentional eye contact, and a sense of physical containment within a room or space.

Yet, with all that is lost, there are so many new things to be found. There is the additional space. What is mediated therapy through the screen, which some posit may act as a protective barrier, a way to keep distance, decreases some defenses while increasing others. I've noticed a more casual, friendly disposition among my own group members. These members have been sharing more about themselves and their experiences outside of group. While on one level this may appear to be functional group movement, i.e., self-disclosure, revelation, we must also attune to what may not be happening, i.e., interaction and relating between group members. We must strike the delicate balance of knowing about versus experiencing with. Group therapy is about forming and developing connection and understanding the process in the here-and-now, within the individual group member, between group members, and in the group-as-a-whole.

We must continue to try to attune to the unfolding process and attempt to bridge members together. In person, members could pick up and sense nonverbal cues that other members were talking to them or wanted to hear from them. Online, we must more actively direct and draw connections between members, often calling them by name. For example, in person we could simply say, "What's happening for you right now?" with a physical gesture toward Sarah, as opposed to, "What's happening for you, Sarah, as you hear James share his experience just now?"

The introduction of a new member online presents unique opportunities and challenges. Preparation is key for both the group and the new member. It is important to give the group enough notice that a new member will be joining the group, so they can process thoughts, feelings, and reactions about a new member joining. It is also essential to do a thorough orientation with the new member about group rules and expectations, as well as the therapeutic frame and boundaries within the online space.

The introduction of the new member to the group, whether in person or online, invites a new object to project upon. It will be important to address feelings surrounding safety with the addition of a stranger to the group and attune to the pacing of the demands of the group, i.e., group members bombarding your new member about informational and background questions (knowing about versus experiencing with, as mentioned above). It is also important to ensure the new member feels safe and welcome. Attend to the process of the desire to know the other and you will inevitably be setting up a beautiful experience for both the new group member and the group-as-a-whole.

David Songco, PsyD, CGP
Co-Chair, iSIG, IBCGP Director
Milwaukee, Wisconsin

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

PERFECT STORM

Continued from page 3

people to tell me how they felt. The disclosures on the AGPA listserv helped me to not feel alone. I am grateful being part of the AGPA community, where people were concerned and joined me in talking about their symptoms; it meant so much. Outside of the shock, anxiety, and despair, it was hard for me to feel so powerless, frightened, and vicariously to see all the trauma.

What helped was the balance of diet, walks, being appreciative and grateful, but also grieving.

Now that I am running online groups, I'm learning how to be more active as group leader, as well as to share what I feel. I tell them now not to take the virus lightly. It's very serious.

I was able to donate plasma 28 days after the last days of my symptoms. This is one way to make something good. Being in a community that can talk, share their care, compassion, laugh, and talk about what scares us, provides optimism. I do not experience dread or depression; I am always looking for hopeful things, finding a way for hope.

Helene Satz, PsyD, ABPP, CGP, FAGPA (Kailua, Hawaii)

I tested positive for both Influenza A and COVID-19. I was overwhelmed by unfamiliar illness—coughing, throat pain, vomiting, and fever. I could not drink or hydrate. When my health took a significant nosedive, I was hospitalized. I was terrified and believed I was on my way out. I prayed a lot. I am a non-religious Jew, but I prayed more than I ever did before. I cared about recovery so that I would survive for my loved ones. My focus became narrow; I was going to do what I had to do to survive. I did not want to die. The hospital saved my life since my body was shutting down. My husband was the greatest gift on earth. He nursed me to health for weeks. Without him, I would not have survived.

It was an existential crisis. At 73 years old, I learned from this experience that I need much less than I ever needed before.

I feel blessed to be a part of AGPA. The AGPA Connect listserv after the conference helped me feel validated, surrounded by a community of support and hope. It was my oxygen. I am so grateful for AGPA.

Lorraine Wodiska, PhD, ABPP, CGP, FAGPA (Arlington, Virginia)

I felt alone and frightened. I was the only one in the family and circle of friends with the virus. I felt unwanted and someone to be feared.

There were no markers for days and nights; they blended one into the other. As I had symptoms so early in the outbreak period, there was little knowledge and no known treatments. Physicians suggestions for rest and fluids were accurate but were pathetically ineffective given the severity of the virus. I had little hope about chances of recovery.

What helped me most was the care of my husband, who was by my side for three weeks. When I had any energy, I read the AGPA listserv posts and deeply appreciated the responses.

Spiritually, when I felt the most ill and was without information or hope, I asked my parents (who have been dead for over 30 years) for their assistance—to die or to recover. I felt their energy and was comforted by the contact. I also knew others cared about my health and some were praying for me to recover. That mattered.

We are a global family living in a challenging period of virtual (that is, not complete) connection during a time of seemingly bottomless grief. However, grief is only part of our current experience. Many of us have found ways to be positively engaged with rich relationships, and many are considering our blessings anew. As someone in her 70s, I remember other times, 50 years ago, when there were long years of societal upheaval, political chaos, and no obvious positive outcome for the future. Yet, many of us found our values renewed and retooled. As individuals and groups, we were able to create ripples of goodness that have impacted us and our larger communities and prepared us for this time. I feel optimistic.

References

Anti-Defamation League. (2020, May 19). *Reports of Anti-Asian Assaults, Harassment and Hate Crimes Rise as Coronavirus Spreads*. [Press release]. Retrieved from https://www.adl.org/blog/reports-of-anti-asian-assaults-harassment-and-hate-crimes-rise-as-coronavirus-spreads.

Herman, J.L. (1992). *Trauma and recovery: The aftermath of violence—from domestic abuse to political power*. New York, NY: Basic Books.

Hobfoll, S.E., Watson, P., Bell, C.C., Bryant, R.A., Brymer, M.J., Friedman, M.J., Friedman, M., Gersons, B.P.R, Jong, J.T.V.M., Layne, C.M., Maguen, S., Neria, Y., Norwood, A.E., Pynoos, R.S., Reissman, D., Ruzek, J.I., Shalev, A.Y., Solomon, Z., Steinberg, A.M., & Ursano, R.J. (2007). Five essential elements of immediate and mid–term mass trauma intervention: Empirical evidence. *Psychiatry, 70*(4), 283-315. doi: 10.1521/psyc.2007.70.4.283.

Irving, K. (2019). The role of humor in priming intersubjectivity. *Psychoanalytic Psychology, 36*(3), 207–215. https://doi.org/10.1037/pap0000221.

Klein, R.H. (2020). Introduction to the special issue on migration problems in the US and their implications for group work. *International Journal of Group Psychotherapy, 70,* (2), 141–161. doi: 10.1080/00207284.2020.1718503.

Leiderman, L.M. (2020). Psychodynamic group therapy with Hispanic migrants: Interpersonal, relational constructs in treating complex trauma, dissociation, and enactments. *International Journal of Group Psychotherapy, 70,* (2), 168–182. doi: 10.1080/00207284.2019.1686704.

Norris, F.H., & Stevens, S.P. (2007). Community resilience and the principles of mass trauma intervention. *Psychiatry, 70*(4), 320-328. doi: 10.1521/psyc.2007.70.4.320.

Reifels, L., Pietrantoni, L., Prati, G., Kim, Y., Kilpatrick, D.G., Dyb, G., Halpern, J., Olff, M., Brewin, C.R., & O'Donnell, M. (2013). Lessons learned about psychosocial responses to disaster and mass trauma: An international perspective. *European Journal of Psychotraumatology, 4,* 1-9. doi: 10.3402/ejpt.v4i0.22897.

Tuma, F. (2007). Mass trauma intervention: A case for integrating principles of behavioral health with intervention to restore physical safety, order, and infrastructure. *Psychiatry, 70*(4), 358-360. doi: 10.1521/psyc.2007.70.4.358.

Volkan, V.D. (2001). Transgenerational transmissions and chosen traumas: An aspect of large- group identity. *Group Analysis, 34*(79), 79–97. doi:10.1177/05333160122077730