

The Group Circle

Summer 2014

The Newsletter of the
American Group Psychotherapy Association
and the International Board for Certification of
Group Psychotherapists

Leading A Therapy Group in China Without Speaking Mandarin

Elaine Cooper, LCSW, CGP, FAGPA

As a member of AGPA's Community Outreach Task Force, I taught the *Principles of Group Psychotherapy* core course to a staff of 10 mental health workers at a psychiatric hospital in central China using Skype. Groups in the hospital were held daily, but the professional staff had no group therapy training. The groups were topic oriented, and according to staff members, bored them and their patients. The patients wanted a quick fix, and the therapists felt guilty that they could not deliver.

The core course was conducted in English. The students' facility with English varied, so I was never sure if everyone understood the language or the concepts. We finally arrived at a formula: I spoke for 10 minutes, followed by a discussion among themselves until everyone seemed to understand. In this way, they were teaching each other, contributing to greater group cohesiveness, and checking out the accuracy of theory by asking me questions. My here-and-now assignments brought many giggles, making the experience quite enjoyable for us all.

I combined a trip to visit my granddaughter in Beijing with a trip to central China for five days. Staff members pleaded with me to lead groups with their patients, so they could actually see what I do; they were having trouble visualizing the process. I was prepared to lead process groups with staff; the request to lead inpatient groups scared me. I finally said, "I will try, but keep in mind that it is an experiment and I am not sure I can do it." (I also led daily process groups for the staff.)

In preparation to lead the inpatient groups, I called upon the experience I documented in *Group Intervention* (Lonergan, 1980) where I used a self-psychology approach to treat wounded self-esteem. In a chapter in *Group Therapy – 1978* (Cooper, 1978), I describe the characteristics of this stage (e.g., parallel talk, idealizing the leader) and techniques to help such a group develop. My approach was to respect narcissistic defenses (grandiosity and idealization), gratifying them but then expecting members to work by taking steps to recognize others.

I led three 1½ hour groups on a locked floor and three on an unlocked floor. Discussion with the staff followed. Staff members took turns sitting in the group and translating. Following is a description of the groups with my thought process in parentheses.

The Locked Floor: First Session

This floor had 30 patients, all of whom attended the group with the staff. I walked into the room, and 30 pairs of eyes met mine, which was my first surprise (this eye contact is the first sign of relatedness). They stood up and applauded with great vigor, which was my second surprise (another sign of relatedness). A few were practically jumping out of their seats, wanting to ask me questions. Patients tried to talk to me in English, but I soon realized that they had to speak in their native tongue (Mandarin) or the group would not gel. Because I could not demonstrate treatment with the large group, I decided to lead two fishbowl groups in succession, each with different members, giving most of the patients a chance to be in a small group. I concluded with the large group. Some of the highlights follow.

The first question to me was: "How much does it cost to go to the U.S. to see a doctor who can cure us? Is it hundreds? Millions?" (We start with the pre-group, parallel talk and idealization of the leader.) I can't help smiling, which gratifies their narcissism in that they are amusing me.

I replied, "You must not feel great about your doctors, if you are asking me this." (Their anger is apparent very early.)

I encourage an attractive, young woman who hasn't said anything to speak. She shares a paranoid fantasy that I might be invading them. (I am relieved that she has spoken.) I thank her for being honest. I highlight the anger and disappointment that they are feeling in and outside of the hospital.

"Do you have different medicines in the U.S.? Are the doctors better?"

I say, "no" and explain that they want me to have a magic wand and neither I, nor a doctor has one. I tell them that I know this is hard to hear, but the answer is in them; all a doctor can do is help them explore what's inside of them. (Here I educate them about group therapy, enlisting the ego.)

"Okay. Tell us how to solve our problems. Here's my problem and tell me what I should do." Two women describe their problems with their husbands.

"Okay, I will tell you. You have to help each other and listen to each other in group and then you will get better," I reply. I add that change and growth takes

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From the President Science and Psychotherapy

Les Greene, PhD, CGP, L FAGPA

As a kid, my favorite television show was "Watch Mr. Wizard." I loved Mr. Wizard. Every Saturday morning, he patiently and authoritatively



explained to some neighborhood child how scientific phenomena, such as static electricity or optical illusions, worked. I still like science, or rather, the scientific method. There is something comforting and reassuring about its logic, precision, clarity, and integrity: Develop a strong hypothesis about how something works; establish incontrovertible methods to test the causal relationship; incorporate conditions that will test competing hypotheses; and draw conclusions based on the findings.

Given this abiding interest, it's no wonder that I've taken to the empirical study of group psychotherapy. I actually enjoy reviewing the group therapy research literature, seeing what's new and trendy. At the same time, however, I admit that I've become somewhat jaded about what our scientific efforts have amassed to date. I won't bore you with the conceptual, methodological, and statistical critiques I've previously described that plague psychotherapy research (Greene, 2012, 2014a, in press). By far, the prototypical scientific product to date is an outcome study that pits the researcher's prized brand of therapy with either a wait-list control condition, a treatment-as-usual condition, or, in rarer cases, some competitor's brand of therapy.

The good news is that over the years we have, indeed, accumulated an empirical database that attests to the effectiveness of our work for a great many clinical conditions and using a number of different technical orientations (cf. Burlingame, Strauss, & Joyce, 2013); one of AGPA's webpages lists some of the research and is currently being updated to show the most recent findings. The bad news is that this monolithic approach to scientific study—adopting the design of the randomized control trial from

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Member News

The 2014 Smith College School of Social Work's Day-Garret Award was presented to **Josephine Tervalon, MSW, LCSW, CGP, LFAGPA**. The award recognized Tervalon's many years of service and invaluable contributions to the School and to the profession of social work.

From the Editor

Steven Van Wagoner, PhD, CGP, FAGPA

Often the lead up to the summer issue is slower, requires some cajoling for contributions and articles, and necessitates a little worry on my part that we won't have enough to fill the pages. While this was in part true, something happened that I didn't expect, and that I haven't experienced in my nearly five years as Editor. Four readers, with strong reactions to two of the articles from the last issue, sent me letters that I am thrilled to publish. When an article generates some controversy, and there is opportunity for further dialogue, I feel like life has entered these pages, and it is further reward for me as Editor. While I do not wish to turn these pages into a venue for political discourse, as that is not the purpose of *The Group Circle*, there are issues and challenges that we face as an organization that sometimes need some air and subsequent discussion, and the letters by Ray Naar, PhD, ABPP, CGP, TEP, LFAGPA, George Saiger, MD, CGP, FAGPA, Joseph Shay, PhD, CGP, FAGPA, and Earl Hopper, PhD, CGP, DFAGPA, set the stage for further exploration of these complex issues, which may more appropriately continue in the Large Group, the SIGs, Community Meeting, and other venues too many to mention. What these letters, and the articles that stimulated

their writing, have shown us is that it takes great courage to speak to the more difficult issues that we as group psychotherapists and AGPA members often face.

This recent experience had me reflect on my tenure thus far as Editor, and caused me to reflect upon whether I have accomplished what I set out to do, and largely the answer is "yes." As other *Circle* Editors probably know, we walk a line between reporting relevant news about AGPA, our members, elections, the Annual Meeting, important committee work, and new organizational initiatives, and offering some pieces that stimulate thinking, discussion, dialogue, and the occasional controversy. I would like to believe that I have largely accomplished that balance. From time to time you have offered your praises, wishes, and the occasional critique. I would like our newsletter to be widely read, and fantasize that readership has tripled since I took on this task, but whether or not that fantasy approaches reality, I have greatly appreciated the opportunity and challenge to collect an array of articles, reports, and interviews, and present them to you quarterly in a fashion that keeps you not only informed, but perhaps stimulated intellectually, as well as emotionally. Not all issues will generate controversy; not all will present some unique endeavor or program upon which one of our members has embarked; but if the group-as-a-whole (each issue being a member) intrigues, challenges, informs and occasionally seems fresh and progressive, then I will feel quite

satisfied.

Also in this issue, we have two members of the Science to Services Task Force responding to a group therapy dilemma in the *Consultation, Please* column from an evidenced-based perspective. I mentioned last year that we would be doing this. I am pleased to see this become realized and that Michael Hegener, MA, LPC, CGP, FAGPA, the column's Editor, was open to this new perspective. I would like to remind readers of my conversation with Gary Burlingame, PhD, CGP, FAGPA, Molyn Leszcz, MD, FRCPC, CGP, DFAGPA, and J. Scott Rutan, PhD, CGP, DFAGPA, reported in *The Group Circle (Closing the Research to Practice Gap: An Open Dialogue for AGPA, Summer 2013)*, when we agreed that many practitioners are already engaging in evidenced-based practice, but in this issue's responses, this perspective will be specifically illuminated. I encourage members to think of dilemmas in other realms, such as co-leadership, couples groups, and consultation and organizational development. Submit your questions to Michael along with people you believe might have the requisite expertise to offer a response.

We also have a funny, poignant, and thoughtful article from Elaine Cooper, LCSW, CGP, FAGPA, about her experience leading actual inpatient groups in China as part of a group therapy training she facilitated with non-group therapist mental health practitioners in a psychiatric hospital.

I hope everyone is enjoying his or her summer and trust that this issue will be great beach reading. ●

AGPA Releases New Training Video On The Power of Couples Group Psychotherapy

The American Group Psychotherapy Association has a new and innovative training DVD with Judith Coché, PhD, ABPP, CGP, LFAGPA: *The Power of Couples Group Psychotherapy*. This DVD teaches mental health professionals how to use couples group psychotherapy in clinical settings. Working with colleagues acting the parts of group members, this entertaining and fascinating DVD draws you into the story of four couples and the first hour of their treatment with Dr. Coché. Watching this DVD gives clinicians needed tools to successfully lead small groups of clients who want to rebuild troubled intimate partnerships and create life-long couples satisfaction. This DVD is also useful in training work with couples and groups in academic and professional settings.

The Power of Couples Group Psychotherapy will increase the mental health professional's understanding and skill in:

- Incorporating group and couples psychotherapy into leading clinically effective couples psychotherapy groups;
- Structuring dynamic interventions for members, couples and groups; and
- Helping clients see connections between their behavior, their thoughts, and their feelings.

Featured presenter and developer of the DVD, Dr. Coché is the Founder and Director of The Coché Center,

LLC, where she has dedicated her career to improving the lives of individuals, couples, and families with children, adolescents, and adults. She is a Clinical Supervisor with the American Association of Marriage and Family Therapy, as well as a Clinical Professor at the Medical School at the University of Pennsylvania. She has written extensively on couples group therapy and appeared on numerous national and local radio and television shows, including *The Today Show*, *Good Morning America*, and *The Oprah Winfrey Show*. Interviews about her work have appeared in newspapers and magazines, such as *The New York Times*, *The Wall Street Journal*, *Time Magazine*, *Philadelphia Magazine*, and *Harper's Bazaar*, as well as featured in the book *The Husbands & Wives Club: A Year in the Life of A Couples Psychotherapy Group* by Laurie Abraham.

"This training DVD is a valuable addition to AGPA's inventory of group psychotherapy training tools," said Les Greene, PhD, CGP, FAGPA, AGPA President. "Working with couples in groups to help them develop healthy, fulfilling relationships is a specialized skill; this DVD teaches that skill thoroughly and masterfully."

To purchase this DVD, visit the AGPA Online Store at www.agpa.org.

Our New IBCGP: An Interview with Tony Sheppard, PsyD, CGP, FAGPA

Steven Van Wagoner, PhD, CGP, FAGPA, Editor, *The Group Circle*

Tony Sheppard, PsyD, CGP, FAGPA, was recently named Chair of the International Board for Certification of Group Psychotherapists (IBCGP), which certifies group psychotherapists according to nationally and internationally accepted criteria and promotes these practitioners and criteria to other mental health professionals, employers, insurers, educators and clients as maintaining the highest standards for group psychotherapy practice and quality care.

SVW: Could you tell us about your trajectory toward this position?

TS: I wrote AGPA's *Group Psychotherapy with Children* curriculum, and apparently some people were impressed with that. So Greg Crosby, MA, LPC, CGP, FAGPA, approached me about whether I might be interested in leadership, specifically serving on the IBCGP Board. During the 2009 Annual Meeting in Chicago, he told me that the Board voted me in and invited me to dinner. I met the other Board members and immediately felt at home with them. In 2010, I chaired the Practice Development Committee. It was a few years later that I was approached by Jeanne Pasternak, LCSW, CGP, FAGPA, to follow Sherrie Smith, LCSW-R, CGP, FAGPA, when she decided to step down after four terms as Chair of IBCGP. While I really liked what I was doing on the Practice Development Committee, I thought I would like the challenge.

SVW: So you rose on the leadership ladder very quickly.

TS: Yes. I brought that up, but Jeanne and Marsha Block, CAE, CFRE, CEO, thought I was ready for this and had confidence in me, and the Board members have been gracious and supportive.

SVW: Now that you have been in the post for several months, have you developed a sense of the direction you would like to see the Board go?

TS: The Board has clear goals that I would like to continue meeting. We are an aspirational International Board; I would like to see the number of applicants from outside the United States increase because it has value to group psychotherapists worldwide. We have seen a trend that suggests an increase in international CGP applications, especially in European countries. We believe in the CGP as a credential and want to make more people aware of it. Equally important is further enhancing the value of the CGP in general so that we interest more therapists in the credential.

SVW: As the international community becomes more involved, do you see that having any impact on the process of certification?

TS: There are many differences in the ways that different countries credential group therapists. That being said, finding common ground with standards benefits everyone. We have a subcommittee that is working toward that goal.

SVW: When IBCGP's rebranding took place a couple of years ago, there was some disgruntlement about the use of the term "international" in the organization's name. What steps are being made to address the concerns of that constituency?

TS: We acknowledge that there could have been more outreach about our desire to change the name of the organization, as we aspired to include more people from different countries in the certification process. I think that the intention when we had discussed the name change came out of a desire to acknowledge and include all of the people in the international community who had been involved with our organization and had become interested in the CGP (Certified Group Psychotherapist) designation. I was involved in those discussions, and recall the sentiment being one focused on inclusion and collaboration.

One good thing that came from the controversy is that dialogue has been created, and we are talking. The IBCGP Board stands by our goal of inclusion and synergy and sincerely seeks to promote group therapy as a healing source in our world.

SVW: Are there any efforts to expand the range of groups that can earn certification?

TS: Our Standards Committee continues to review credentialing criteria in different fields to determine where we can expand. For example, we recently expanded to allow occupational therapists (OTs) to apply for the CGP because many OTs are highly qualified. There has been some expansion with regard to physicians in Canada. We have a desire to do that with other specialties, but we are managing an ongoing tension between our identity as group psychotherapists and how we define ourselves and opening the door to others who meet our criteria. It is an ongoing, but important discussion. We not only want to offer the CGP credential to more eligible professionals, but we also hope it will bring more people to AGPA.

SVW: How do you address the concern that expanding eligibility might dilute the credential? How do we uphold the core standards required to be eligible for the CGP because not all psychologists, social workers, psychiatrists, LPCs, etc., are well trained in group psychotherapy?

TS: The Standards Committee was strategically composed of members with differing views on this, with some members wanting to push expansion and other members very dedicated to maintaining the integrity of the credential. I trust that the committee and the Board-as-a-whole will be able to accomplish both goals and find the right balance.

We have also been reaching out to training programs to help them understand what the minimum standards are for training, and urging them to maintain a quality group therapy training curricula.

Our first step is working with the disciplines' credentialing bodies like APA and NASW, and try to educate them about the importance of including and/or maintaining group therapy as a core curriculum. We plan to present them with outcome and utilization data to encourage them to maintain group therapy as a part of their training programs.

SVW: Isn't the onus on the graduate to get the requisite training?

TS: It is up to the graduate of these programs to make sure they have the required training to meet the CGP eligibility standards, but it depends on how in-depth the group therapy training is in any graduate program as to whether additional postgraduate training is necessary. But it is possible for a graduate to have met the criteria in his or her graduate program. All of this must be demonstrated when a person submits the CGP application.

SVW: How did the Centers of Excellence designation come about?

TS: The Centers of Excellence is the brainchild of former Board Chair Sherrie Smith and former Board Member Travis Courville; Sherrie is now chairing that committee; and Travis serves as a consultant to the committee. It is a way to recognize programs and organizations as Centers of Excellence in group therapy. So just as the individual can apply for the CGP designation, so can an organization apply to receive the Centers of Excellence designation.

SVW: What kinds of centers can we expect to see apply for the designation?

TS: Service delivery systems that specialize in group therapy, which could include hospitals, counseling centers, community mental health providers, and even large private practices. The committee is following up with those programs that have expressed interest to encourage them to apply. The program will need to acknowledge group therapy as a specialty treatment, value continuing education in the field of group therapy, employ qualified clinicians to facilitate therapy groups, and provide high quality group treatment supported by evidence.

SVW: Are there standards that must be met for the designation?

TS: What I just mentioned are the core standards that must be met. There would be a site visit to the program, and it would be rated on these core criteria

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Therapy Group in China

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courage. (Here I educate them about group process.)

“Thank you very much.” A few minutes later, a woman asks me the same question. “I told you what to do and I see you weren’t listening to what others were saying,” to which she politely responded, “Thank you very much.”

Now, it is time for them to work. I ask the fishbowl group: “Can any of you tell me if there is someone in this room who has helped you?” Several people point to a quiet, mature woman. She smiles broadly. I ask her how she is feeling, and she says, “happy.” We continue with this exercise, and many people get recognition for their support of others. Even the most withdrawn patients contribute if I turn to them for comment. (Now, I am demonstrating group interaction and facilitating the altruistic defense, which is healing. They are giving each other narcissistic gratification.)

Second and Third Sessions

The theme of wanting a magic cure continued. I kept coming back to the process of change, the need to tolerate discomfort, discover inner courage, and find the answer in themselves (repetitive psycho-education, appealing to the ego). Everyone is attentive.

To the shock of her therapist, one formerly silent woman tearfully revealed to the group why she was in the hospital. Her child was walking with her mother, and her mother was hit by a car and killed. The child is still traumatized. The woman’s pain was too much to bear, and she became depressed. I talked about human resilience and the mourning process (more psycho-education).

Near the end of the meeting, a patient asked: “How do you tell your children that there is no Santa Claus?” (I am taken aback and then realize that I am telling them that there is no Santa Claus/idealized parent. I associate to the Wizard of Oz story.) I smile and relate the story, telling them that the magic of group therapy is in how they relate to each other, and that like the Wizard in the story, all I have to do is point out the positive ways that they interact, and have them see the value of who they already are to each other. (I truly believe this as I witness the affection that the patients and staff have for each other.)

Time is up. Everyone stands up and applauds heartily. I applaud back.

The Unlocked Floor

Thirteen patients are on this floor, and I meet with the whole group. We sit in a circle. One young woman says in English, “You are very beautiful.” Another woman says, “You are very nice.” Another says, “You are very calm.” Another asks, “How old are you?” I am taken aback. Later, I learned that they were so excited about my coming, that they were practicing English for three days. (Just the fact of my coming is a boon for their narcissism. Again, they see me amused and smiling, gratifying their narcissism.) Some patients walk in late, check cell phones, and bring food. I set strict limits on all three of these actions (providing a container and focusing their complete attention to themselves and others). The patients and staff are surprised and are not sure I am serious. The patients test me, and I stand firm. They make an effort to comply.

Although the talk was more fluid, the themes were the same as those on the locked floor. I had the impression that the staff provided a reparative nurturing environment for the patients. After the group meeting, I expressed concern to the staff that the transition to the outer world might be hard because real life is not so kind and accepting. The group is a place where patients can get help coping with their family and work problems, which might include more challenging interactions. I hope to demonstrate this.

A male patient speaks excellent English and tries to be my co-therapist. He is dominating the group. I need to stop him but don’t want to wound him. I talk to the whole group about how listening is as important as talking and how helping each other is curative. He comes back the following session describing an incident outside the group. A young woman was alone in her room crying. He remembered what I said and went in and asked what was the matter. She said that she couldn’t tell him and asked him to leave. He finally left but brought it up in the group. She said that she couldn’t accept help from him because she had nothing to offer him in return. The group was stunned because

she is clearly an educated, attractive, and thoughtful woman. He said, “letting me help you is giving something to me.” The group then mirrored her strengths.

Lively discussions ensued about several members’ work problems. One woman described trouble with her boss. A businessman said that even though she dislikes him, she should give him a present. She yelled, “I’m not going to do that! I hate him! What should matter is that I am the best worker there.” “But this is what people do to get along,” the man replied. Several members began to examine changes they will have to make in their lives and got feedback from others about this. One young girl was wounded by me and cried when I set a limit in the group. The girls sitting next to her comforted her; she left the room. Another followed her out and then came back. Sensitive to my puzzlement (and distress), one of the women told me not to worry, that the girl is only 15 years old, very sensitive, and they will take care of her. Together we were demonstrating in the moment how real life interactions can be challenging, and by experiencing it in the group creates opportunities for learning coping skills necessary to make the transition back to their lives.

One beautiful, young yoga teacher said that she cannot look men in the eye. I asked her to try in the group. She blushed, covered her face, laughed, and then did it successfully. Again, the group offers opportunities to practice new ways of relating to others that might increase their interpersonal effectiveness.

At the end of the last session, one member asked if they could hug me. I said, “yes.” Every person in the room waited patiently for his or her hug. One student came in halfway through the group to observe. Afterward, the staff behind the one-way mirror said that his feelings were hurt because I didn’t hug him. Another woman told her therapist that she loved the groups. She hadn’t said a word in the group, but smiled at me throughout the sessions.

Upon Reflection

Unlike in the U.S., patients can stay in the hospital for up to three months in China. In addition, even on the locked floor, patients seemed less ill than what I have seen in the U.S. A number of patients on the unlocked floor could be considered partial hospital patients or even outpatients in the U.S. I wanted them to continue in outpatient groups, but this is not yet part of the treatment culture. I am continuing to supervise the staff through Skype and hope they will form outpatient groups. They are starting to have interactive inpatient groups.

A difference with the staff and the patients on the unlocked floor was that the staff and healthier patients were very light-hearted. They rarely went more than 10 minutes without laughing. They truly seemed to enjoy each other’s company, reflecting their pleasure with connection. This does not mean that they didn’t confront each other; they could be blunt and direct, like the woman yelling at the group that she disagreed with them about giving a present to her boss. She held fast to her decision not to follow their advice, but ended up laughing about the fight, suggesting that she might have been learning how to manage conflict more directly. The group accepted the conflict and she chose what to take from her peers.

We all have preconceived ideas (Popper, 1959) when we approach a new group, especially one in a foreign country. When we are open to surprise and new learning, leading a group in a foreign culture is a refreshing and enlightening experience. Ultimately, we see that we are more similar than we are different. For these reasons, I encourage our members to join AGPA’s outreach efforts and teach the core course on Skype to those who have no other means of being trained in group therapy. ●

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Letters to the Editor

Dear Editor:

As do many others, I appreciate the article by Karen Travis (*The Group Circle*, Summer 2014) about her experience of the process of being nominated and then standing for election for President of AGPA. She shows that although Eleanor Counselman won the election and is our new President-Elect, Karen Travis is not a loser. She has also reminded us how important it is that we develop and maintain ways of holding close those who have been nominated for office but who have not been successful in their respective elections. Such candidates have much to offer us, which is, of course, why they were nominated in the first place. However, this assumes that they are willing to continue giving of themselves, and that they have not been injured by their experience of comparative loss and rejection by the electorate.

I have learned from my own experience that elections can be traumatizing, not only for those candidates who lose, but also for the organization-as-a-whole. This is especially so when nominations have unwisely been made along the various fault lines of the organization, such as between those who identify with “analysis” as opposed to “action,” or even between object-relations oriented psychoanalysts and self-psychologists. Colleagues who have won elections, whether directly or indirectly through their favored candidates, can become triumphant, and those who have lost, dejected and bitter. The latter can also become passive, un-cooperative, and marginal, and they are actually lost to the organization. This can take hold very quickly, and last for a long time. Such matters require open discussion, working through, and sensitive management, even at the level of ‘Governance.’ Certainly, such processes should be aired in the context of large groups in which the community life of the organization can be discussed, both consciously and unconsciously.

In my view, elections can also traumatize whole societies. Traumatogenic processes in societies are especially difficult when elections are won with very small majorities. This is not only schismatic, but also a challenge to the legitimacy of the electoral process, creating a background of diffuse political apathy among the citizenry. Perhaps people turn away from primal scenes. Of course, I have in mind the aftermath of the Kennedy-Nixon election, not to mention the Bush-Gore election. Is it a coincidence that the first was followed by assassinations and the second by an extreme military response to what was taken to be a threat to national security?

In many societies the organization of professional sport is more thoughtful and sophisticated than the organization of political elections. There is much to be learned from the work of the late Norbert Elias and his students who have written about the nature of excitement and apathy in sport

and games. His theories have influenced group analysts in their conceptualization of the sociality of human nature and the social unconscious. This may be relevant to our management of electoral processes and patterns of commitment. Societies and organizations are not the same as teams, and sports teams are not “real life,” but it is often difficult to make these distinctions.

*Earl Hopper, PhD, CGP, DFAGPA
London, England*

Dear Editor:

I have just finished reading the *The Group Circle* (Summer 2014) piece by Karen Travis entitled “On Not Winning the Election,” and I wanted to communicate my deep appreciation to her for sharing it with us. It’s a remarkably honest and movingly courageous expression of her experience running for AGPA President. I don’t know when I have last read something by a colleague that made me gasp in awe. Bravo, Karen. You are an inspiration to all of us in the organization.

*Joseph Shay, PhD, CGP, FAGPA
Cambridge, Massachusetts*

Dear Editor:

I enjoyed and was touched by much of Dr. Avula’s article in the Summer 2014 of *The Group Circle*; however, I take exception to her comments on Israel and the Palestinians. No, I do not believe that her comments are anti-Semitic, and I commend her for speaking her mind. I believe, however, that the facts she presented are one-sided and taken out of context.

Since the United Nations Partition Plan for Palestine went into effect, and the day after the last British soldier left Palestine in 1948, the combined armies of Egypt, Syria, Jordan, Lebanon, the PLO army, and units of the Iraqi army invaded the fledgling state of Israel. Since the end of the Arab-Israeli 1948 war until 1967, not one single, solitary Jew was allowed to pray at the Wailing Wall. Imagine the international outcry, legitimately so, if Arabs had been prevented from worshipping at Al Aqsa Mosque. When Israelis were barred from their most holy site, I do not remember hearing well-meaning voices such as Bishop Tutu’s of these days condemning the Jordanians. Why were they also silent when the nascent State of Israel was being strangled by decades of economic boycott led by Saudi Arabia?

I believe it is true that Palestinians in Israel are treated like second-class citizens as Dr. Avula describes it. It is also profoundly sad. I am not writing this letter to the Editor to justify it. It may sound trivial, but I do not believe that two wrongs make a right. But I am writing this letter to put the discussion into a wider context, something Dr. Avula did not attempt to do. Jews in Israel have lived in constant threat of invasion, attacks from outside and within her borders, and so understandably have adopted measures to assure survival. Many attempts to reconcile differences and find a path to coexistence have been attempted, but there are many who continue to support Israel’s destruction. This is the context in which to

understand these events.

I believe that the greatest damage inflicted upon the Jews by the Nazis was forcing us to change some core values. We were good, hardworking, gentle people. From our midst came Moses, Jesus, Maimonides, Spinoza, Einstein, Freud, Moreno, innumerable artists, scientists, and Nobel Laureates. Our greatest values were for healing and betterment, not killing. I believe this left us open to pogroms, crusades, inquisitions and holocausts. And then one day, when there were few of us left, we decided enough was enough. We decided to survive by fighting back. We decided to fight to defend the State of Israel. But through decades of fighting, we also lost something very precious in the process. When I was in my twenties, a few years after being liberated from Bergen-Belsen, I wrote this poem. I could have written it today, 64 years later. I believe that Dr. Avula and others will understand.

To the Six Million Who Died

Arise, and let the unspeakable horrors
Bow the heads of those who do not comprehend
Arise, let the tears of the children and the screams
of the mothers
Flood all hearts with anguish
And the world with shame

Arise and like the wind on the steppes, like a
devouring flame
Like, an erupting mountain or gigantic wave
Let your anger put guns in the hands of your
children
And let them say, “Never again.”

But if some day they understand, then

Be a drop of rain
The flight of a bird
A smile of compassion
A helping hand
The laughter of a child and
The love of a mother
Be the tear of pride in a father’s eye
The hope of dawn
The fulfillment of night
A burst of sunshine and
The whispering wind

And let the world know

That the death of one is the death of us all.

*Ray Naar, PhD, ABPP, CGP, TEP, L FAGPA
Pittsburgh, Pennsylvania*

Dear Editor:

The Summer 2014 issue of *The Group Circle* was outstanding. There were so many intriguing and thought-provoking pieces: Les Greene on the idea of “home;” Bob Schulte on the intersection of theater and group process; Karen Travis on losing an election; and the keystone piece by Kavita Avula on the subtleties of racial identity and identification.

This last piece is especially important to AGPA, to students of the social unconscious, to all of us who care about groups—indeed, to all citizens. As Dr. Avula kept reminding us in the article,
continued on page 8

Consultation, Please

Dear Consultant:

Jack has been in my group for 12 years. For the first three years, his attendance was erratic. Since he stopped drinking seven years ago, he has been more regular in coming to the group or calling when he cannot be there. In the last several months, he has been having some serious health problems and has been missing about one group per month. Since I see him individually, he has talked with me about his health issues, although I encourage him to talk with the group as well. Group members are becoming angry when he misses group, remembering his earlier patterns when he was drinking. When group members voice their suspicions, Jack feels hurt that they see him as he used to be, but because he does not share his health issues with the group, they have no way of knowing why he is absent. I am afraid he will become a scapegoat and am unsure how to help him and the group. Can you advise?

Signed,
Stuck

Dear Stuck:

Evidence-based practice is often mistakenly conceptualized as encompassing only manualized treatments that have been subject to randomized clinical trials. However, as laid out in *AGPA's Clinical Practice Guidelines* (Bernard et al., 2008), the best available evidence should be utilized in combination with clinical judgment and an understanding of clients' contexts, cultural variables, and preferences. Moreover, under the umbrella of evidence-based practice comes the idea of practice-based evidence—utilizing assessment data in real time to better respond to clients individually and as a group. Tools such as those described in the *CORE-R Battery* (Burlingame, et al., 2006) can aid in group screenings, process, and outcomes, as they are designed to augment, but not replace, the judgment of the therapist. They are particularly useful in covering therapist blind spots, with research showing that group leaders frequently fail to predict group dropouts or treatment failures. Finally, when empirical evidence is incomplete, expert consensus may serve as a guide. For this situation, as with most cases, a combination of different types of evidence may be used to augment clinical judgment.

A complicating factor in your situation is that Jack is also engaging in combined psychotherapy, a clinical situation that requires considerable thought from the therapist regarding the ethics of boundaries, confidentiality, informed consent, and management of information between settings. Thus, there is considerable risk of his prematurely exiting both group and individual therapy unless the situation is handled effectively at its earliest stages. Utilization of expert consensus, such as the *Clinical Practice Guidelines* in combination with articles on the ethics of concurrent therapy, such as Brabender and Fallon (2009) can provide helpful guidance. For example, you cannot bring material from individual sessions into the group, but you may choose to explore in individual therapy Jack's reluctance to disclose health concerns to the group. The *Clinical Practice Guidelines* caution that the client should not be pressured in

individual therapy to disclose faster in the group than he is ready to. However, the group must also be monitored for potential dropouts, as other group members who become frustrated may choose to confront directly or avoid their own expressions of anger by leaving themselves. Practice-based evidence measures can augment your judgment of the relationship variables to prevent Jack or other group members from dropping out.

The Group Questionnaire (GQ; Krogel, et al., 2009) measures multiple relationship variables within the group by assessing the working alliance with the group leader, as well as group climate. Measuring the working alliance aids in measuring the degree to which Jack agrees with the problem definition. For example, one hypothesis comes from health psychology literature—another form of empirical evidence. It states that there is a change in identity that comes with chronic illness. For example, if a client had liver disease and needed a catheter, then he may be struggling with considerable feelings of shame and embarrassment. Gender, age, and ethnicity variables can amplify these concerns, leading to feelings of loss of a healthy identity and a consequent inability to then function socially. Due to Jack's inability to advocate for himself as a person with a newly acquired disability status, he is unable to explain to the group that their attempts to rescue him from a return to alcoholism are currently unnecessary.

Administering the GQ to Jack can show whether he agrees with this definition, thereby strengthening the working alliance—an evidence-based factor predictive of outcomes. Task agreement is another aspect of the working alliance, and in this case, it will involve agreeing to disclose his health condition to the group and explore how this impacts his sense of self within that group.

By administering the GQ to the whole group, cohesion can also be measured and changes that result from client disclosures monitored. As the *Clinical Practice Guidelines* suggest, this early detection of issues allows the group leader to intervene to prevent role lock as members' projections risk turning Jack into a scapegoat. However, while much of the therapist's attention may be focused on the immediate conflicts and scapegoating, this tool may also detect the quieter group member who is at risk of dropping out in response to the tension.

The risks of acting out, resistance, and premature dropout from this scenario are considerable. However, careful reference to and thoughtful integration of a variety of evidence-based practice strategies can significantly increase your ability to manage the complex, interwoven forces at play. Clinical judgment can, therefore, be augmented considerably by the integration of different forms of evidence allowing you to be proactive rather than reactive.

Martyn Whittingham, PhD, CGP
Cincinnati, Ohio

Brabender, V., & Fallon, A. (2009). Ethical hot spots of combined individual and group therapy: Applying four ethical systems. *International Journal of Group Psychotherapy*, 59(1), p.127-147.

President

continued from page 1

drug studies—leaves many questions unanswered. Most of all, we really don't know how therapy works. The RCT methodology that pits one form of therapy against another condition is ill equipped to explore the specific mechanisms of change for specific individuals in specific situations. It is a methodology that is divorced not only from clinical practice, as I have argued in my talk at our Annual Meeting in Boston, but also from theoretical models of therapeutic change.

By the time you read this column, I will have presented a more expanded talk on science and psychotherapy at the Annual Meeting of the American Psychological Association (Greene, 2014b). In this

presentation, I call for a paradigm shift in our investigations of psychotherapy, away from the obsession with which brand works to a more complex, theoretically guided study of how group psychotherapy works, that is, to the formal study of therapeutic group process, an orientation that I believe is of greater inherent interest to both clinicians and theorists. I will have offered my wish list of studies I'd like to see more of—studies that explore underlying mechanisms of change via mediator analysis, studies that examine the effects of various group processes over time on outcome, studies of factors that contribute to differential outcome across patients within the same group, intensive case studies—all designed to identify the active ingredients in what we do clinically. I'm excited about preparing this talk, as well

as having the opportunity to spread the word to group, social, and organizational psychologists within APA about AGPA with the hope of deepening ties between the two organizations for mutual enrichment. And I encourage each of you, as you present at or attend various professional conferences, to similarly reach out to those sponsoring organizations and their memberships with information about, and invitations to link with AGPA. In fact, let AGPA know where you are presenting; there is potential opportunity to have the program co-sponsored by AGPA. Just as I hope that researchers and practitioners working collaboratively will be mutually beneficial to both domains, strengthening our bonds with fellow mental health organizations can be reciprocally rewarding. ●

Burlingame, G., Strauss, B., Joyce, A., MacNair-Semands, R., MacKenzie, R., Ogradniczuk, J., & Taylor, S. (2006). *American Group Psychotherapy Association's CORE Battery—Revised*. New York: American Group Psychotherapy Association.

Kroegel, J., Burlingame, G., Chapman, C., Renshaw, T., Gleave, R., Beecher, M., & Macnair-Semands, R. (2013). The Group Questionnaire: a clinical and empirically derived measure of group relationship. *Psychotherapy Research*, 23(3), p. 344-54.

Leszcz, M., Kobos, J.C. (2008). Evidence-based group psychotherapy: Using AGPA's practice guidelines to enhance clinical effectiveness. *Journal of Clinical Psychology*, 64 (11), p. 1238-1260.

Dear Stuck:

This is a rich and challenging group situation. Jack has made positive gains in his life while in treatment with you. Likely, the group dynamics have created a curative culture for him and others. Our suggestions in this situation will draw on the empirical literature, as well as clinical experience. Primarily, we work as clinicians using the group psychotherapy research literature to inform our clinical approaches. Process research explores how group dynamics are most useful and beneficial. Many of the process variables are well known from the therapeutic factors discussed by Yalom and Leszcz. Although process research is sometimes considered less rigorous than evidence-based outcome research, the conclusions from process research often echo the training and instincts of clinicians working in the field.

An emerging trend to consider in this situation is the use of practice-based evidence. Using practice-based evidence, clinicians employ assessment tools to capture the type and amount of symptom change, as well as the interpersonal and group-as-a-whole dynamics that they may be missing as they manage the moment to moment culture of the group. Many well-validated tools exist that capture the dynamics of therapeutic alliance, cohesion, and other processes that could clarify what the members are experiencing and inform interventions. Sometimes members are more willing to report their experience on assessment instruments than risk speaking about these topics aloud in the group.

The following process factors are known to influence the successful outcome of group treatment: therapeutic alliance (the bond and trust between client and therapist); safety; cohesion; individual goal clarification; and the processes to achieve these goals (i.e., self-disclosure and regular attendance). Continuing to help Jack talk about these topics in his individual sessions may provide an opportunity to work through Jack's hesitancy to be more forthcoming in group. Alliance, safety, and disclosure are highly relational variables and discussing them with Jack will likely bring forth information that could be understood from a psychodynamic perspective.

Repetitions, transferences, internal conflicts, and potential family of origin dynamics may be involved in Jack's behavior both in and out of the group.

While the suggestion here is to continue talking with Jack in his individual sessions, this may also be an opportunity for the entire group to discuss their current goals and the best methods towards reaching these goals. Regularly revisiting group members' feelings regarding therapeutic alliance, safety, and cohesion helps everyone adjust the climate towards better meeting each group member's needs. Impasses are inevitable in group dynamics, yet sometimes these frustrating tensions can lead to breakthroughs, increased disclosures, insight and beneficial changes.

Jack may be inducing the group to organize against him by unconsciously communicating his experience through the action of missing group without talking. He may unconsciously wish to have the group organize against him to recreate old feelings of being left out and to recreate past situations when he was targeted with other's anger. He may have already organized the group to scapegoat him. Jack may require protection from the group leader, as well as subtle ego-dystonic joining. Since it is clear that you have a long-standing, strong alliance with him (given the time that he has committed to group and your individual therapeutic relationship with him), you may be able to offer well-timed, maturational disruptions to his current reenactment. It sounds as though the group has attempted to be direct with him by addressing his absences head on, yet this seems to be giving him the exact old feelings that match his past experiences of himself. His illness may be creating a regression into previous, less functional coping mechanisms and defensive patterns.

Interventions that may be less directed at Jack's ego and more directed at the procedural patterns could lift him out of this regression. Interventions directed at the group's unconscious organization that is unknowingly contributing to this regression may be useful as well. It would benefit Jack and the other group members to discontinue engaging in this pattern. Causing this disruption will likely build group cohesion by organizing the emotional focus onto the leader. If we consider that Jack's regression is composed of feeling disappointed, frustrated, hopeless, and helpless, it would be helpful to give him new feelings by using progressive communications that might surprise him and engage him to feel more competent, hopeful, and confident again. This may mean that he and the other group members direct their anger, frustration and annoyance more consciously at you.

One way to work with the group is to ask what they would be talking about if they were not focusing so much on Jack, to suggest that there must be dynamics in the group that are not being explored with the focus settling so much on him. Individually, it may be helpful to join with Jack around not talking by suggesting that, perhaps,

he is not ready yet; that perhaps he prefers to stay stuck in an old way of being. He may indicate that he does not prefer that, but you could point out that while he says he does not, his actions suggest otherwise. Employing an object-oriented approach, you could ask him what he thinks you mean by these comments and why you might see it this way. You may feel induced to work hard to help Jack, but it may be useful to engage his capacity to help himself.

Additionally, you could ask the group what is occurring in the process that might be contributing to a group member's irregular attendance. You might ask, "What may make it difficult for people to share their challenges in here?" In this way, we are using the group as a supervisor to understand Jack's hesitancy without outing him. Ask the group what you could be doing differently to shift this group pattern. Exploring with the group what unconscious dynamics could be contributing to the reenactment might help them think more cognitively about the situation; this discussion might slow the procedural patterns and lead to more willingness to express the underlying feelings. The group members may already sense that Jack is sick, frightened, and overwhelmed, but they don't have the information to match their feelings. This is likely confusing and disturbing for them. Continuing to talk these issues through, without necessarily pushing Jack to tell the details, may prompt Jack to speak more openly.

These interventions may provide insight and move all the group members towards more disclosure. By taking the time to explore and discuss the above dynamics with the group, the culture may continue to strengthen allowing Jack and all the other members to come forth with more honesty and vulnerability. Jack is facing a major challenge in his life, and it sounds like working with you has been very helpful and will continue to be as he works these patterns through both in group and in individual treatment.

Francis Kaklauskas, PsyD, CGP, FAGPA
Elizabeth Olson, PsyD, CGP
Boulder, Colorado

Members are invited to contact Michael Hegener, MA, LCP, CGP, FAGPA, the Editor of the Consultation, Please column, about issues and/or questions that arise in your group psychotherapy practices. They will be presented anonymously, as in the question here, and two members of AGPA will be asked to respond to your dilemma. In this way, we all benefit from members' consultation from an objective point of view. SIG members are also encouraged to send cases that pertain to your particular field of interest. Michael can be reached by fax at 512-524-1852 or e-mail at hegener.michael@gmail.com.

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- Greene, L.R. (2014b) *My top 10 (or so) list of group psychotherapy studies I'd like to see and a few that I hope not to see*. Invited paper, The 2014 Arthur Teicher Group Psychologist of the Year address to be presented at the American Psychological Association meetings, August, Washington, DC.
- Greene, L.R. (in press). Dissemination or dialogue? *American Psychologist*.

Interview with Tony Sheppard *continued from page 3*

ria. A navigator would be assigned to help the organization through the application and evaluation process. The navigator would assess whether the program meets the core criteria, and if they do not, recommendations would be made to address deficiencies.

SVW: Tony, your enthusiasm is infectious. You really seem excited about being in this role, but Sherrie is a tough act to follow.

TS: Yes she is, but fortunately she has remained involved on the Board, and has been a terrific mentor and role model. The Board members are like a really good family, and are so supportive and capable. Marsha Block and the AGPA staff have also been extremely supportive and helpful as well.

SVW: We are all looking for good things from you, and I wish you well in the coming years. ●



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See *Group Assets* insert

Affiliate Society News

The Atlanta Group Psychotherapy Society will host D. Thomas Stone, PhD, CGP, FAGPA, on September 13 for a workshop on *Ethics and Group Psychotherapy*.

Yvonne Agazarian, EdD, DLFGPA, will be the plenary speaker at the Eastern Group Psychotherapy Society's Annual Conference, to be held November 21–22. The theme is *Hide and Seek in Groups: Losing and Finding Ourselves and Others*. Hilary Levine, PhD, CGP and Libby O'Connor, LCSW, are Co-Chairs. Visit egps.org for additional information.

The Group Psychotherapy Association of Los Angeles (GPALA) offered a workshop on *Using Patient Photographs in Group Therapy*, led by Nancy Fawcett, MFT, CGP. In July, GPALA held its Annual Summer Party, featuring a silent auction to benefit the scholarship fund. GPALA has set for itself the goal of serving all group therapists working in all modalities. To that end it has launched both a Guide Program for new members, as well as an Outreach Program whereby GPALA members offer talks on group psychotherapy at training sites, clinics, and academic programs in the Los Angeles area. Through these programs and an expanded scholarship program, GPALA hopes to increase both the diversity of its membership as well as offering educational opportunities on treating a broader range of clients.

At the Mid-Atlantic Group Psychotherapy Society's (MAGPS) Spring 2014 Conference, attendees experienced a session on Psychodrama, where Certified Group Psychotherapists and certified psychodramatists unknown to one another co-lead the small groups working to integrate the two methods. MAGPS's Fall Conference will be held October 24–26 at the Hyatt Regency Chesapeake Bay. Justin Hecht, PhD, CGP, a psychologist and certified Jungian Analyst in private practice and on the clinical faculty of University of California, San Francisco, will present on *Becoming Who*

We Are In Groups: Jung's Ideas on Individuation, Fulfillment, and Personal Authenticity. The conference will include a didactic presentation, a demonstration group, small groups, and a large group experience, in addition to time for questions and answers, and supportive collegial interaction. MAGPS members Karen Eberwein, PsyD, Mathew Fleming, PsyD, Eleanor Hoskins, LCSW, CGP, Victoria Lee, PhD, Rose McIntyre, MSW, LCSW, CGP, and Bridgett Nemo, PsyD, were six of nine graduates of the National Group Psychotherapy Institute's (NGPI) Fellowship in Leadership program at the Washington School of Psychiatry (WSP) program. The Fellowship, which was co-constructed by Michael Stiers, Jr., PhD, CGP and Ayanna Watkins-Northern, PhD, CGP, provided opportunities for participants to experience, examine, and understand the exercise of authority and leadership in group and organizational life during a four-year period. The cultures of dominant and non-dominant groups and concepts related to ethnic, religious, class, age, ability/disability, gender, and sexual orientation based dynamics in society were recognized and explored.

The North Carolina Group Psychotherapy Society's (NCGPS) is working on its 46th Fall Event to be held November 8. Ronnie Levine, PhD, ABPP, CGP, FAGPA, will present *Exploring Barriers to Intimacy in Group Psychotherapy*. NCGPS's new President Randy Dunagan, MS, MFT, began his term on June 1.

Selena Gray, MA, moved from Membership Co-Chair into the role of Program Chair for the Puget Sound Group Psychotherapy Network. The Board has decided to expand the Secretary position to include someone who will oversee its technology and internet communications.

Please note: Affiliate Societies may submit news and updates on their activities to Kathy Reedy, MSW, MFT, BCD, CADC, CGP, Editor of the Affiliate Society News column, by e-mail to: Kreedy57@gmail.com.

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

Letters *continued from page 5*

quoting Janice Gump, PhD, we need to keep our eye on reality, and the undeniable impact of culture on perceptions, especially the reality and perception of race, diversity, and divisiveness.

Therefore, I was startled when, while she cited the Israeli treatment of Palestinians as an important case in point. Dr. Avula noted that her objections to the Israeli occupation (my objections, too, and those of many) are being brushed aside as an expression of anti-Semitism. She treats the idea

that anti-Semitism figures into this discussion as defensive (at best) and an obfuscation designed to suppress dissent (at worst). This feels much too casual to me. Is criticism of Israeli policy truly free of anti-Semitism? Following Dr. Gump, I would remind Dr. Avula that the reality with which we live is that anti-Semitism is thriving in today's world. Ukrainian nationalists unabashedly adopt a Nazi salute as a sign of solidarity; one third of French citizens openly espouse (not harbor, but express) anti-Semitic views; The Protocols of the

Elders of Zion, a libelous 19th century anti-Semitic text, enjoys brisk sales in Cairo bookstores; a Palestinian professor feels forced to resign when his university will not support a field trip for students to Auschwitz. Do I need to go on? Dr. Avula should apply the same standard she uses in recognizing denied racism, what she calls "the undeniable impact of culture," to recognizing denied anti-Semitism.

George Saiger, MD, CGP, FAGPA
Rockville, Maryland