

Fall 2018

groupcircle

The Group and Parkinson's Revisited: When Therapist and Members Share the Diagnosis

Leon Paparella, MSW, CGP

EDITOR'S NOTE: Leon Paparella, MSW, CGP, is a Faculty Member of the National Group Psychotherapy Institute of the Washington School of Psychiatry, a Support Group Specialist for the Parkinson Foundation of the National Capital Area, and in private practice in Washington, DC. This article represents the creation, development, and maintenance of a unique group resource for people with Parkinson's disease, under the auspices of the Parkinson Foundation of the National Capital Area. It is a tribute to the group experience and those who have been a part of it. The author thanks Robert Schulte, MSW, CGP, FAGPA, for his editorial assistance.

I have led more than 850 sessions of a psychosocial therapy group for people with Parkinson's disease (PD) since 1999. This account represents the creation, development, and maintenance of a unique group resource for people with Parkinson's disease, under the auspices of the Parkinson Foundation of the National Capital Area, and the many issues and group dynamics that have been identified, illuminated, and repeatedly worked through since I wrote my first article on this subject (Paparella, 2004). It is a tribute to the group experience and those who have been a part of it.

The group composition has changed, as well as the range of symptoms that develop over time in a diverse group of members suffering with a lifelong disease such as Parkinson's. In my 2004 article, I explored the question, "What is the therapeutic effect on the group when the therapist suffers and displays the same illness as members of the group?" Now 15 years later, I find myself facing a variation on this query: "What is the therapeutic effect on the group when the therapist continues in his role as leader, despite the progression of his own illness and the increasing uncertainty of his future availability?" Since the group began, more than 75 members ranging from 60 to 85 years old have participated. The average age is 73; there are currently nine active members. Over time, members have entered the group, moved away, or have died. For some, attendance became too difficult to continue. I have been the one constant. "But for how long?" I ask myself.

Parkinson's Disease and Parkinsonism

Those who develop Parkinson's disease face a myriad of physical, psychological, and social changes. It is a complex, slowly progressive illness diagnosed by observable symptoms, such as tremor, stiffness, slowness, and loss of balance; however, the type of symptoms and rate of change in them experienced by Parkinson's sufferers differs greatly. While the average age of onset is 60 years old, 15 percent may be diagnosed prior to age 50. Although it is medically treatable, there is no cure for Parkinson's disease.

Because there are no definitive diagnostic tests for Parkinson's, the diagnosis can sometimes be unclear. The term Parkinsonism refers to a broad category of neurological diseases that cause slowness. It includes a classic form of Parkinson's, many atypical variants called Parkinson's Plus Syndromes, and any other brain disease that resembles Parkinson's. In all cases, there

is a disturbance in the dopamine systems of the basal ganglia—a part of the brain that controls movement.

Classic (idiopathic) Parkinson's is the most common and most treatable, representing 85 percent of cases. Atypical variants are more serious and less treatable, representing the remaining 15 percent. They include MSA (multiple systems atrophy), PSP (progressive supranuclear palsy), CBD (corticobasal degeneration), and Lewy body dementia. Because there is no cure for Parkinson's, once the diagnosis has been established, it is an enduring life experience. The chronic nature of Parkinson's makes it reasonable to determine there is need for an ongoing, well-functioning support system.

The Value of an Ongoing Group

When initially diagnosed with Parkinson's, most people feel overwhelmed by the possible implications, making it too stressful to make long-range decisions and commitments. A short-term group designed to address specific needs and questions of being newly diagnosed is more appropriate in the beginning; however, for those who have lived with the diagnosis longer, there are many benefits of an ongoing, open-ended therapeutic group. Among the benefits are reduced isolation and shame, the opportunity for emotional expression, being able to reclaim one's identity apart from that of a Parkinson's patient, and an instilled sense of hope. Group cohesion is most important. The knowledge that others share the experience of this illness is unifying.

Uncertainty and Psychosocial Challenges

The very nature of our human existence is forever in flux. Despite our efforts to find constancy, consistency, and lasting security, we are part of a dynamic and ever-changing process. Our daily challenge is to live fully in the face of uncertainty, unpredictability, and impermanence, knowing that one day we are going to die. This challenge is powerfully palpable when diagnosed with a chronic condition, such as Parkinson's. Confronted more sharply with the awareness that life is finite, the prospect of facing real and imagined limitations is daunting.

Although the shock of their initial diagnosis is past, most members of my group still contend daily with the uncertainties and vagaries of Parkinson's. The most prominent psychosocial concern described in groups is everyday functioning and the potential loss of personal effectiveness. The complexity of daily tasks, unexpected events, emergencies, transitions, and travel all can cause increased anxiety and overwhelming stress. This anxiety encompasses the ability to manage and maintain responsibilities with family, friends, employers, and the public. Congruent with these concerns are an increased sense of vulnerability, a loss of confidence, and a diminishing sense of personal vibrancy.

A therapeutic group has the potential to alleviate or reduce the psychosocial suffering of its members. It can protect, insulate, and absorb individual feelings of anxiety, confusion, and chaos. In the group, I try to keep my mind open to new possibilities of discovery and coping as I listen to members describe stressful events. I

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from the
president

Eleanor Counselman, EdD, CGP, L FAGPA

I did not expect to write another President's column, but here I am writing this in the wake of the recent resignation of Barry Helfmann, PsyD, ABPP, DFAGPA, as AGPA President. I am so sad that this has happened. The decision of the New Jersey Board of Psychological Examiners to hold him accountable for his lawyer's failure to redact private health information before sending bills to a collection agency is an unbelievable miscarriage of justice. The suspension of Barry's license deprives him of his livelihood, his patients of their trusted therapist, and our organization of our esteemed President. It is an outrageous and upsetting outcome and one that we hope will be reversed quickly on appeal. Barry has handled this incredible blow with grace and dignity, and he deserves our greatest admiration.

What happened to Barry could happen to any one of us who rely on a lawyer to handle an issue such as bill collection. Part of AGPA's mission is to advocate for our field, and we are advocating in this situation by filing an *Amicus Curiae* Brief. An *Amicus Curiae* Brief, literally "friend of the court," is a document that introduces new information filed by someone who is not party to the case, but which points out broader implications of a decision. AGPA will focus on the fact that the disciplinary action against Barry sets a concerning precedent that any practitioner entrusting a lawyer to handle a practice situation, such as collection of accounts, could be held liable for the lawyer's actions. The AGPA Board unanimously supported the decision to file this brief.

While it is understandably upsetting to lose a leader, the process of the presidential transition has been managed carefully and effectively. AGPA is a strong, effective, and resilient organization. I am glad to help, and, of course, I know the job. I just hate the reason for the need. My stepping in as President maintains the strong leadership team of President and President-Elect that has served AGPA well over the years. President-Elect Molyn Leszcz,

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Steve Van Wagoner, PhD, CGP, FAGPA

In this issue, there are subtle and not so subtle references to existential challenges facing many of us as we navigate everything from aging, disorders, and illness, to how we approach the threat of polarization to ourselves, our relationships, and our communities and society.

I feel honored that my colleague Leon Paparella, MSW, CGP, approached me about publishing his moving and informative account of an 18 year-long therapy group for adults diagnosed with Parkinson's. This article allows the reader to understand the challenges in leading such a group and working with people who cope with a progressive and debilitating condition, but also presents a poignant personal account of his work while also coping with the disease himself.

Now that fall has arrived, we are ramping up to AGPA Connect 2019 in full force with the interviews of William Doherty, PhD, and Joyce Slochower, PhD, ABPP. Attendees wishing to participate in one of the Monday Special Institutes will find Dr. Doherty's topic of working with polarization timely. While his focus will be on the work in couples and group therapy, he will also address how to deal with polarization that can divide us in workshops, conferences, and other venues where differences are an inevitable part of the our interpersonal landscape.

Dr. Slochower will be speaking on how our own aging affects the way our patients perceive us, as well as the way we feel about ourselves, how we approach our work, and how we approach the theories that we employ. In her interview, she speaks of her clinical and theoretical development throughout her training in psychoanalysis, her movement away from a classical Freudian model to object relations and, ultimately to relational psychoanalysis. How she integrates a relational perspective with the experience of an aging therapist will be explicated in her Anne and Ramon Alonso Plenary Address at AGPA Connect.

I hope that *Consultation, Please* continues to provide useful clinical insights in addressing group dilemmas; *Research Matters* offers a way to translate research to clinical practice; and *Affiliate Society* and *Member News* keeps you up to date on some exciting things our local societies and colleagues are doing to promote group psychotherapy. 🍷

FROM THE PRESIDENT

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MD, FRCPC, CGP, DFAGPA, and I have already begun our collaboration. Marsha Block, CAE, CFRE, our CEO, has guided the transition process with a steady hand, and we are very grateful to her. We all know each other well and care deeply about AGPA.

I do have some good news to share. In August, the American Psychological Association officially approved Group Psychology and Psychotherapy as a specialty! As many of you know, this has been a huge, multi-year effort, requiring the filing of several very long and detailed petitions. This recognition is a very significant step because as a specialty, the practice of group psychotherapy now merits specialty training. We are developing plans to work with both pre-doctoral and postdoctoral programs, along with agencies, to help develop increased group therapy training. Specialty status will also underscore the importance of our CGP credential. We are now embarking on efforts to develop similar group specialty recognition in other mental health professional organizations. We would love to hear from any member with direct access to leadership in other professional societies.

The Group Specialty petition was a group effort, and the many people who contributed are too numerous to name here. AGPA enjoyed a successful collaboration with the American Board of Group Psychology (ABGP), the APA Division of Group Psychology and Psychotherapy (Division 49), and the International Board for Certification of Group Psychotherapists. But special appreciation goes to Nina Brown, EdD, LPC,

NCC, FAGPA, for her perseverance over three years of petition work. Thank you, Nina!

Before we know it, AGPA Connect 2019 will be here, and we will be gathering at the Westin Bonaventure Hotel in Los Angeles, California, for a week (February 25 through March 2) of being together for learning and fun. The online program should be available by the time you are reading this. We have our usual amazing lineup of institutes, workshops, open sessions, and the always popular Friday night dance. (I'm told the post-dance party is always fun, too.) This year our Special Institute presenters are William Doherty, PhD, who will present on polarization in our intimate and civic lives, and Cheri Marmarosh, PhD, and Martyn Whittingham, PhD, CGP, FAGPA, who will present on attachment. This year's Plenary speakers are: Institute Plenary: Susan Gantt, PhD, ABPP, CGP, DFAGPA, FAPA; Mitchell Hochberg Memorial Public Education Lecture: Marco Iacoboni, MD, PhD; Conference Opening Plenary: Allan Schore, PhD; Anne and Ramon Alonso Plenary: Joyce Slochower, PhD, ABPP; and Louis R. Ormont Lecture: Karen Maroda, PhD, ABPP. For our Saturday Group Foundation luncheon entertainment, we will be treated to an interview conducted by Moly Leszcz with Irvin Yalom, MD, DFLAGPA, our 2017 Lifetime Achievement Award recipient. I look forward to seeing you there!

As always, I welcome questions or comments about this column or anything else. Contact me at EleanorF@Counselman.com. 🍷

letter to the editor

Dear Editor:

Jeffrey Kleinberg, PhD, CGP, MPH, DFAGPA's article, "Group Psychotherapy on the Global Stage," in the summer 2019 issue of the *Group Circle*, touched on many key issues when working internationally. AGPA members continue to learn how to respond to disasters, nationally and internationally, needing to respect the culture that the events occurred in. As Winnicott wrote, there is no such thing as a baby; there is only a baby and another. The same can be said with respect to disasters, in that they always exist within the context of the culture in which the disaster, natural or manmade, occurred.

After Beth Knight, MSW, CGP, DFAGPA, appointed Tom Stone, PhD, CGP, FAGPA, and myself Chairs of our AGPA Community Outreach Task Force, CEO Marsha Block, CAE, CFRE wisely counseled us that times of disasters are no time to make new best friends, in that the best outreach takes place when invited by trusted and known colleagues.

Jeff points out in his very well-written article the overlap between many AGPA and IAGP members who are experts in trauma and who are members of both organizations. In my IAGP Presidential address, I referenced a quote by Abraham Lincoln, as told in Steven Spielberg's film. Lincoln quoted the mathematician Euclid, a theorem several thousand years old. Euclid stated, "things which are equal to the same thing are equal to each other."

AGPA and IAGP are both organizations that deeply believe in the efficacy of group to help people. The collaboration and cooperation between our organizations benefit members in both organizations and the world at large. Thank you, Jeff Kleinberg, for writing such an eloquent and poignant article about group therapy on the global stage. We all need to respect each other's cultures.

Richard Beck, LCSW, BCD, CGP, FAGPA
President

International Association of Group Psychotherapy

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The Impact of Relational Psychoanalysis on Exploring the Patient's Subjective View of the Analyst's Aging

An Interview with Joyce Slochower, PhD, ABPP

Alexis Abernethy, PhD, CGP, FAGPA, Co-Chair, AGPA Connect

Editor's Note: Joyce Slochower, PhD, ABPP, will deliver the Anne and Ramon Alonso Plenary Address on Getting Better All the Time at AGPA Connect 2019, to be held February 25-March 2 in Los Angeles, California. Dr. Slochower is widely published in psychoanalytic journals and is the author of *Holding and Psychoanalysis: A Relational Perspective and Psychoanalytic Collisions*. She is a professor of psychology at Hunter College and Graduate Center, and a faculty member of the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis, The Stephen Mitchell Center, The Psychoanalytic Institute of Northern California, and the Philadelphia Center for Relational Psychoanalysis. Dr. Slochower has served on the editorial boards of *Psychoanalytic Dialogues*, the *International Journal of Psychoanalysis*, and *Psychoanalytic Perspectives*. She has a private practice in New York City.



AA: Share a little about your presentation, *Getting Better All the Time*.

JS: Psychodynamically informed therapists think a great deal about the impact of early loss, trauma, and conflict as they inform and shape the patient's and analyst's experience in the present. Whatever our particular psychoanalytic theory, we're accustomed to making these links and working to help people unpack and move beyond their personal ghosts. But there's a future ghost that most of us evade, no matter whom we're working with—whether in individual, couples, or group therapy. It's the ghost of who we will become—of our own aging and the changes it portends. Therapists have enormous difficulty dealing with the inevitability of growing old, much less our death. We rarely examine, much less theorize, its impact on us as therapists and on our patients. How will we manage the impending diminishment of capacity that comes with aging? How will we help our patients confront it in us and in themselves?

After considering the impact—personal and theoretical—of aging on us as therapists, I will explore how aging may inform our relationship to the work we do. Aging can affect—and change—both the theory we use and how we use it. These shifts are subtle, often procedural, and easily go unnoticed. I'll describe the way my own, and several colleagues' use of theory has changed over time.

AA: How did you become interested in psychoanalysis? What theorists and experiences influenced you?

JS: Full disclosure: I grew up in the world of Freudian psychoanalysis; my mother and my stepfather were both psychoanalysts. My father began his career as a psychoanalytically informed professor of literature but lost his teaching job during the McCarthy era. At that point, he trained as a psychoanalyst. I grew up adjacent to this mysterious and intriguing world, and by the time I went to college I knew I wanted to become a psychologist.

Virtually no clinical courses were taught in college; the best were in social psychology, which I found intellectually challenging and counter-intuitive. After a year in a social psychology program, however, my enthusiasm waned; the field was too concrete and data-based for me. So I approached the Chair of my department at Teachers College, Columbia University, Morton Deutsch, PhD, and told him that I wanted to go into clinical psychology. He had been trained as a psychoanalyst but then became a social psychologist, and a famous one at that. Mort's response was extremely generous. He suggested that I do a joint clinical-social program and offered to set it up for me. This was an extraordinary opportunity to get the best of two worlds. I ended up with a PhD in clinical and social psych. I can teach research methods with the best of them! But I didn't really want to.

After I received my PhD, I became an Assistant Professor at Hunter College and the Graduate Center, City University of New York, and shortly afterward went on to train at the New York University Postdoctoral Program. There, I began to move away from the Freudian thinking that had dominated my graduate school training and became fascinated by object relations theories, especially those of Donald Winnicott. My interest was intensified when I received a gift from a family friend (herself a Freudian analyst) of Winnicott's *The Child, the Family & the Outside World*. The volume is a collection of BBC lectures directed to parents, not professionals. Most of the lectures speak about early development, what the baby needs (and doesn't) from parents, and about the baby's own capacities. It's an evocative, indeed, idealized vision of the mother-infant relationship, and I fell in love with it and with Winnicott. Here was a new vision of an improved mother/father that seemed to offer an antidote to much that had plagued me.

My interest in Winnicott grew over time. I was particularly taken with the notion of analytic holding. I began working on an expansion of that model that accounted for other kinds of affect states, addressed the role of the analyst's subjectivity when she tries to hold, and reconciled the holding model with relational thinking. This project was the focus of nearly 30 years of writing, beginning in the early '90s.

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Polarization in Intimate Life and Civic Life

An Interview with William Doherty, PhD

Lisa Mahon, PhD, CGP, FAGPA, Co-Chair, AGPA Connect Institute

Editor's Note: William Doherty, PhD, will present a Special Institute on Group and Couples Approaches to Addressing Polarization in our Intimate and Civic Lives at AGPA Connect 2019, to be held February 25-March 2 at the Westin Bonaventure Hotel, Los Angeles, California. Dr. Doherty is Professor and Director of the Marriage and Family Therapy Program in the Department of Family Social Science, College of Education and Human Development, at the University of Minnesota, where he is also an Adjunct Professor in the Department of Family Medicine and Community Health. He is Past President of the National Council on Family Relations and the author or editor of nine books and numerous articles.



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

BD: During my Institute I will be:

- Addressing polarization in couple relationships, particularly when one partner is leaning out of the relationship and the other is leaning in;
- Covering how to help a group therapy client who is the leaning-in partner or the leaning-out partner;
- Dealing with polarization in civic life between liberals and conservatives, focusing on learning tools I've developed to do group work to help depolarize society; and
- Demonstrating how to address polarization on issues that divide workshop participants.

LM: How did you get interested in these topics and why does it continue to hold your interest?

BD: I've been interested in couple dynamics my whole career. This work arose out of my frustration with how to deal with highly polarized couples, where divorce was on the table. These situations usually involved one partner considering divorce and the other opposing it. There are many unnecessary divorces because we haven't been effective in helping couples in this kind of crisis, as well as many overly conflictual divorces because couples have

not come to grips with what happened to their marriage.

After several years of working with collaborative divorce lawyers, who were seeing a lot of divorce ambivalence in their work, I developed an informal approach to helping these mixed-agenda couples and then codified it into discernment counseling. The divorce versus working-on-the-marriage decision is a crucible for adult life. It's always intense.

I've had a long-standing interest in what I call "citizen therapist" work—our role, as therapists in the community. My specific interest in civic polarization started in earnest after the 2016 election, when I was asked to facilitate a workshop for Trump and Clinton voters. After the workshop, I helped found a nonprofit called "Better Angels," based on a phrase attributed to Abraham Lincoln*, which has the modest goal of depolarizing America. It's been like starting a new career.

LM: I understand that in your work with couples you focus on polarization and couples on the brink of divorce. Can you describe this process of polarization?

BD: At some point in the relationship, one spouse and/or partner begins to think about divorce but often

doesn't share this with the other. After a period of time, the leaning-out partner brings up divorce, and the other responds by saying "don't go, we can work it out," thus becoming the leaning-in partner. When they present for therapy, they often find therapists who are not equipped to help them, since the models of couples therapy generally assumes that both partners are motivated to work on the problems. When they go as individuals to therapy, it's the same thing: Therapists have trouble conceptualizing the leaning-in versus the leaning-out dynamic and tend to the side of their individual client.

My approach, called "discernment counseling," helps them decide whether to try serious couples therapy or proceed towards divorce. This approach accepts the reality of their polarization around whether to continue or end the marriage, and does not try to force premature closure

**"We are not enemies, but friends. We must not be enemies. Though passion may have strained, it must not break our bonds of affection. The mystic chords of memory will swell when again touched, as surely they will be, by the better angels of our nature."*

President Abraham Lincoln, First Inaugural Address, March 4, 1861

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AA: *What key concepts in relational theory may be of greatest interest to group therapists?*

JS: The most interesting and clinically useful relational ideas for group therapists organize around the concepts of co-construction and reenactment in the clinical moment.

Relational theories emphasize the ubiquity of the therapist's subjectivity and the potential clinical power of work around the co-constructed clinical element. Relational thinking views our countertransference as something other than a veridical expression of our experience. It assumes that our patients know quite a bit about us and what we feel, and that exploring this area will be clinically fruitful. We consider the patient's experience of our subjectivity as potentially accurate rather than a transference distortion.

The relational perspective, unlike the classical one, rejects the value (and the possibility) of analytic neutrality. Yes, relational analysts interpret, but interpretation is just one clinical element—and usually not our most important therapeutic tool. It's the use of ourselves that really gets the work going; we focus on the reenacted element, addressing our patient's experience while simultaneously considering how we've participated in a given moment of impasse. By unpacking its place in the clinical encounter, we open therapeutic space, invite our patient to look at what's happening between us in a way that locates things squarely in the dyad.

I'm not talking about being confessional. I know that relational analysts are often stereotyped as engaging in ongoing self-disclosure, but this is a stereotype. It's our openness to considering our own participation in reenactments that helps us move out of transference-countertransference locks. By thinking about impasse in a way that's more systemic than reflective of two one-way

sources of influence, we move out of an authoritarian ("I know best") position and invite patients to think with us about what's going on between us. This point of entrée makes room for our patient to see us and communicate what they see because we're willing to acknowledge it.

Work around co-constructed reenactments can take place in group work as well. The group therapist, like the individual one, is vulnerable to getting pulled into a repetitive dynamic interaction, perhaps with a single group member, with a few members, or even with the group-as-a-whole. The therapist's ability to look at how members experience him/her and to consider how he/she participated in creating the group dynamic could potentially open up more space within the group therapy context.

AA: *In your work as an analyst, what insights have surprised you or what insights were unexpected?*

JS: I'm surprised every day. Sometimes I'm surprised by what comes out of my mouth. At times, I find myself uttering a real clunker—something incredibly banal, off base, or insensitive. Sometimes I'm surprised because I articulated what felt to my patient like a stunning insight that really moved things in ways I hadn't anticipated. Most often, though, I'm surprised by what my patient says, what she knows, and, of course, by what she sees about me.

AA: *What do you see as important current contributions of psychoanalysis?*

JS: We have vastly deepened and expanded the ways we can help people know themselves and change. I never cease to be amazed by what people can overcome with help. Individual change has a ripple effect so while we may see only a relatively small number of

people over our lifetime, I find hope in the idea that if they then treat others differently they also affect a larger group. And of course, psychoanalytic thinking has seeped into our culture—notably, into the arts, literature, the law, and into theories of child rearing and education. It informs how we parent, educate, and sometimes adjudicate. On the other hand, I feel quite pessimistic about psychoanalysis' potential to effect any kind of large scale socio-political change. I feel something close to despair about the current political situation in the US and elsewhere. I wish I thought we had the capacity to, if nothing else, get people to think about the dynamics driving this—e.g., what function racism or xenophobia serves individuals and groups and how we can intervene to shift this? But I see no evidence that what we understand—even if we're correct—has had any significant impact on the world.

AA: *Do you have any advice for therapists who are considering psychoanalytic training?*

JS: Yes. Do it! It will deepen your clinical skill even if you find yourself doing DBT much of the time. Do it because you find the field intriguing, intellectually stimulating, clinically and personally useful. Pick a program that fits your intellectual and personal sensibility and talk to lots of people—candidates and faculty—about their experience with the program you're considering before you go ahead.

My advice would be to look for a program that is non-polemic. Don't become narrow; take courses across the theoretical spectrum. Be flexible, learn psychoanalytic concepts and techniques and be prepared to apply them in a range of settings. Don't plan to get rich unless you already are—you'll be sorely disappointed! 🙄

member NEWS



| Scott Fehr



| Martha Gilmore



| Ann Steiner



| Barney Straus



| Robert Tyminski

Scott Fehr, PsyD, CGP, FAGPA's new book, *Introduction to Group Psychotherapy: A Practical Guide* (3rd ed.) was just released. Dr. Fehr is an Adjunct Professor of Clinical Psychology at Nova Southeastern University and in full-time private practice in Hollywood, Florida. This edition combines group theory with relevant clinical material geared toward student, novice, and experienced group therapists.

Martha Gilmore, MA, PhD, CGP, FAGPA is the recipient of the Clinical Faculty Distinguished Teaching and Service Award from the University of California Davis Department of Psychiatry for 25 years of leading the psychiatry residents process group. She is a Clinical Professor of Psychiatry at UC Davis Medical Center as well as in private practice.

Ann Steiner, PhD, MFT, CGP, FAGPA's new book, *Help Your Group Thrive: A Workbook and Planning Guide*, includes an overview of different kinds of groups, leadership strategies, tips for dealing with common group challenges, and more. The book provides group leaders with a roadmap for clarifying their group's objectives, as well as ways to help their group thrive.

Barney Straus, LCSW, CGP, FAGPA authored a new book—*Healing in Action: Adventure-Based Counseling with Therapy Groups*—for therapists wanting to integrate interactive games and challenges into their work. The book includes current research supporting using Adventure-Based Counseling with trauma survivors and those recovering from addictions, as well as its efficacy with a broader population. Twelve activity-based chapters take the reader through various one-hour sessions of activities based on a particular theme or material used.

Robert Tyminski, DMH, Past President of the C.G. Jung Institute of San Francisco, and Clinical Professor in the Department of Psychiatry at the University of California, San Francisco, authored a new book, *Male Alienation at the Crossroads of Identity and Cyberspace*. The book looks at the male psyche from boyhood through adolescence and into adulthood, and provides examples from clinical practice, current events, art, and literature that show what happens when alienation is severe and leads boys and men to discharge their emotional problems in the outside world. 🙄

Purchasing a member's book through Amazon benefits AGPA. Connect through the Member's Only section of our website, or go to: <https://tinyurl.com/y9jqgy8c>.

Asking Group Members for Feedback: Facilitating Treatment and Preventing Dropout

Cheri Marmarosh, PhD

I thought my new member was adjusting well to the therapy group. She appeared engaged, took risks, and other group members seemed to embrace her. Four weeks later during the session, I was shocked when she revealed a significant amount of hurt and disappointment in the group. I had been unaware of the intensity of the negative feelings she was managing and assumed she was doing well. I was wrong. Given her history of pleasing others, avoiding her needs, and splitting off her angry feelings, it would have been impossible for her to disclose her experience of the group directly or for anyone around her to know how she was truly thinking and feeling. When there are eight interacting members sitting in the circle, it is not an easy task to imagine how each one of them is doing in the group. Despite how challenging a task this is, we often ask ourselves to do it without any assistance.

The research shows that our intuition may not be enough. Although many of us assume we know how our patients are doing in treatment, our clinical intuition is often biased, and we make incorrect assumptions. Researchers have shown that therapists are unable to predict client deterioration any better than chance in both individual and group therapy (Hannan et al., 2005; Chapman et al., 2012). What is most important is that when clinicians receive feedback, patient outcomes improve. The truth is that we need to rely on feedback from our group members.

One way to gather additional information about how our group members are doing is to ask them after the sessions. I edited a special edition of *Psychotherapy*, the journal for Division 29 of the American Psychological Association, that was dedicated to examining feedback monitoring in group psychotherapy. The special edition included articles that address what type of feedback group leaders can collect, how feedback monitoring can facilitate the repair of ruptures, and how leaders can use member feedback to decrease dropout and enhance treatment outcome.

Studying the Impact of Feedback Monitoring in Group Therapy

Burlingame et al. (2018) have done the most to understand the impact of group member feedback and have developed a sophisticated tracking system that allows group leaders to monitor each member simultaneously after each session and identify at-risk members. After a session ends, the group leader asks members to complete a measure (e.g., measure of symptoms) selected by the group leader from which the group leader receives a visual display of how each group

member rated their symptoms compared to the rest of the group and compared to how each member rated himself in the prior sessions. This information can be extremely useful when observing sudden shifts in well-being and examining members who may be at risk of self-harm.

Janis, Burlingame, and Olsen (2018) focus on the development of a therapy relationship monitoring system for group treatment. Instead of asking group members about their symptoms after each session, the researchers ask members about the quality of the relationships in the group and their engagement in the group using an empirically valid measure linked to treatment outcome, the Group Questionnaire (GQ) (Burlingame, Gleave, Beecher, et al., 2016).

The GQ is unique in that it is the only group process measure that generates alerts for group members who are starting to struggle in the group, thus giving the leader time early on to intervene. The group leader receives a notice indicating that there has been reliable deterioration in the quality of the relationship in the group since the previous GQ administration. The leader can see how well all the members are doing week to week and identify at-risk members. This is one important way to detect ruptures in the group and to track the repair of those ruptures over time.

Feedback Monitoring and Outcome

Burlingame et al. (2018) used the GQ in a randomized clinical trial that examined the effectiveness of monitoring group member feedback. They added group member status alerts so that leaders can actually see when members are declining. Their findings are impressive and indicate that group leaders can actually alter group member deterioration within two sessions of receiving an alert compared to similar no-feedback groups led by the same leader. In essence, when group leaders know a member is declining or struggling, the leaders can choose to intervene in ways that help these patients. When leaders are not aware of the decline, they do not intervene the same way.

Complexity of Feedback Monitoring

Gold and Kivlighan (2018) describe the complexity of group factors that influence the impact of feedback monitoring in group work. They focus on the overwhelming amount of information that can get in the way of leaders knowing how to help specific members and the group after feedback is received. Instead of concentrating on one individual in the group based on the feedback monitoring, they suggest that sometimes the leaders will need to address how one member's feedback compares to others in the group, and the

leaders will need to make group-as-a-whole interventions rather than focusing on the one member. They also describe situations where leaders would not want to focus on the one member during the next session, but instead may want to engage a sub-group of members who share a similar perspective about the group. Their approach, based on empirical findings, addresses the many ways group leaders can intervene when they know that members are struggling in the group.

Summary

All of the papers in the special edition of *Psychotherapy* shed light on how critical it is for group leaders to be more aware of our limits to read minds and know how each of our members is doing in our groups. The research shows us that although we think we are aware of who is doing well and who may be struggling, we are not always correct. Asking our patients and group members to give us feedback may be necessary for reducing dropout and from preventing patients from falling through the cracks. 🧠

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POLARIZATION IN INTIMATE LIFE AND CIVIC LIFE

Continued from page 3

on the question. The choice is framed by whether to make a serious effort at couples therapy, with both partners in for the process, or to move towards divorce. Most of the intense work goes on with each partner separately because each one comes with a different agenda.

LM: *How does this concept of polarization apply to group process and our society-at-large?*

BD: Humans are tribal creatures, which means that groups tend to compete with one another and polarize unless they find ways to connect across differences. In earlier eras of U.S. history, members of our two main political parties, even when they polarized around issues, had many more cross-group relationships than they do today. Today we have a high level of social polarization, with liberals and conservatives occupying different social worlds and otherizing each. The other side is to be avoided, disparaged, and even demonized.

My Better Angels work starts with the reality of polarization: We are a divided nation. We bring together small groups of "reds" and "blues" in structured workshops with the goal of better understanding each other beyond stereotypes and finding common ground. We then help form red/blue alliances to work on common issues. One

reason Better Angels is getting traction is that people are building relationships to resist toxic polarization. We are now finding interest among political leaders in our approach, which does not try to change people's minds about issues but does help people change their minds about each other.

LM: *How do you conceptualize the repair process as it has evolved in your work with couples, groups, and society?*

BD: Three key processes cut across levels: understanding the other on their terms (not my own terms); looking for common values and goals; and accepting humility about the limitations of one's own side. The key to intervention is to create a structure for these processes to occur.

LM: *What would you anticipate would be one of the most important insights that participants will derive from your Institute?*

BD: Attendees will learn about the common processes of polarization and healing across levels of connection, from intimate relationships to communities and society. Participants will learn how group psychotherapists can be part of this healing.

LM: *How do you feel that the learning and principles of your work will be relevant for participants who are primarily interested in group work?*

BD: Many group therapy clients have polarization going on in their intimate relationships (they are leaning-in or leaning-out partners in a relationship), and many clients are suffering from political stress related to polarization. This shows up in conflict with family and friends, and in demoralization about the state of the nation and world. This workshop can help group therapists better serve their clients with these concerns.

This Special Institute will be useful for people at all levels of experience. These are issues that therapists encounter whether we are new to the profession or have many years of clinical experience.

LM: *What advice can you offer participants for getting the most out of this experience with you?*

BD: Come open to thinking about polarization processes that are more micro than groups (that is, in couple relationships) and more macro (that is, in society). Have fun pushing your professional purview! 🧠



encourage members to identify and share with each other to broaden their awareness of personal, interpersonal, and universal struggles. Ultimately, my effort as facilitator is to strengthen the supportive capacity of the group and increase each group member's ability to accept and tolerate the reality of not knowing what fate will bring.

Therapist–Member Relationships

My credibility and effectiveness as a group psychotherapist is enhanced by the group members' identification with me as a fellow sufferer. Viewing me as an active working person also provides hope, as it models a sense of success in coping with the persistence of the illness. In Paparella (2004), I reported on a clinical decision I made to acknowledge my experience of serious Parkinson's tremors and anxiety that interfered with my ability to lead the group in the usual manner. To cope, I needed to stand against the wall, and my decision to immediately disclose the difficulty and make an adjustment brought me needed relief. It allowed me enough physical comfort to regain my sense of balance so I could respond to the group's needs. Group members seemed able to address their concerns, support each other, and adapt positively to the situation.

After reading my article, a group member wrote her own account of the group experience and shared it with me. Her poignant description of the powerful thoughts and emotions involved in the therapeutic process and leader-member relationship illuminates the complex nature of the role of therapist in addressing the underlying issues of Parkinson's disease in the group. Here is a brief excerpt (Paparella, 2010):

Leon, our therapist, who also has Parkinson's, in summing up our struggles, lets fly the word-arrow that punctures my tremulous silence. "Fear," he says, is what we are fighting.

A week ago, Leon challenged my absence. "Where have you been?" he asked. "Cooking for company," I replied, "so I don't have to come here." Truthful but not the whole story, as I sensed he guessed. I was glad to have an excuse not to come to the support group. For while I wanted to pretend that I was still part of the healthy living, I wanted to forget our group

struggles with fear and body failings, my own rapidly increasing tremors, spasms of dyskinesia, and cloudy double vision.

Then in the end was a word, "fear," and I couldn't hold back. Leon said nothing, offered no comfort. Was his response that of the detached therapist? Was his role just to listen and wait for the patient to make self-discovery? I passed him in the hall and he averted his eyes, still the therapist, or had I expressed his fear too, since he suffers as much as I?

Her words amplify the complexity of the therapist-member relationship when both share the diagnosis of Parkinson's. How do I fulfill my role as therapist and still attend to my own health needs? Truthfully, I wish to minimize the effect of Parkinson's on me during these sessions. Yet I realize sharing my own fears within the group may help members give voice to their concerns. On the other hand, exposure of my human core may be experienced by some as a betrayal of an unconscious contract implying I don't have to deal with the same issues as everyone else.

Therapist Transparency

I was absent one session due to my mother's passing. In the subsequent session, my humanity was directly exposed when much attention was given to the loss of my mother. A card given to me by a member read, "Through your kind work, I have experienced the kindness of your mother. I thank you both." I was very moved as I tried to express my heartfelt thanks to the members of the group. This seemed to mark a change in therapist transparency as I became freer to disclose personal information going forward.

The trauma of my mother's passing and the group's empathic response led me to disclose additional feelings of vulnerability and loss. Doing so was in contrast to my usual practice of cautioned consideration of the effect on the group. In this instance, my sharing was not judiciously decided but rather a spontaneous response of genuine need, similar to an unwitting exposure. Also, my sharing prompted group members to recall and speak to their loss of parents and family members. The benefit that members and I received from this mutual transparency was in part the result of the longstanding positive therapeutic relationship that already existed between therapist and members.

It has been 30 years since I was diagnosed with PD, and the fluctuations in medication effectiveness are observable by anxiety, slowness, and extreme caution in movement on one end of the spectrum, and involuntary body movements (dyskinesia) on the other. Often, the themes and content of our group discourse focus on worrisome changes that are visible and invisible impacting our ability to function that may lead to life-changing decisions. Although there is great diversity of Parkinson's symptoms in the group, the fear of progression is common to all.

A concrete example of my ongoing concern with the progression of my symptoms occurred in session 826. While moving my chair forward as I sat, I fell. Embarrassed, I quickly got up. In response, one member said, "Are you trying to teach us how to get up from

falling?" I did not respond immediately, sensing the question reflected the member's unconscious denial of my vulnerability. But later I raised the topic of my own progression of Parkinson's disease. The initial consensus in the group was that my fall was of no consequence since I had gotten up so fast. I pressed the issue of how group members viewed me in terms of how I physically functioned. Characteristically, members voiced positive perceptions of me and the work in the group. Nevertheless, I acknowledged my fear and vulnerability and expressed my concern about an uncertain future. Through this modeling, members joined me by recalling difficult situations in which they needed to withdraw due to social anxiety and expectations that were greater than they could meet.

I typically emphasize to members that they not make premature life-altering decisions due to anticipated disease progression, as PD symptoms routinely fluctuate. Instead, I have recommended increasing one's tolerance for anxiety and the uncertainty of not knowing what the future will bring. Yet I sense the boundary between maintaining my facilitative function as leader and withdrawal due to personal self-care is beginning to thin. Containing the various losses that occur in the group has become more difficult for me now. Still, I am committed to the responsible function of my facilitative role despite the increased momentum toward spontaneous leader self-disclosure.

Summary

Sharing the diagnosis of Parkinson's with members of the group for more than 18 years as group therapist has been a contributing force to member's trust, commitment, and group success. Maintaining task focus and containing members' distressing experiences as they face the progression of PD, while internally managing my own health concerns, has been a countertransference challenge for me throughout the life of this group.

Because people with Parkinson's suffer from societal devaluation and stigma, the group is an effective healing force. Initially, I was uncertain the participants would accept and trust a therapeutic group led by a professional psychotherapist. However, group candidates welcomed the opportunity to participate and praised the quality of their experience and the group's beneficial effect. To this day, members continue to state the benefits derived from each session in which others' distressing challenges are courageously confronted and elaborated.

Coach Wes Unseld of the Washington Bullets (now the Washington Wizards) once said about playing the game of basketball, "It's not how fast you run but how long you run fast." So it is with this group: It's not the short distance sprint that matters, but rather being able to stay the full course of life, despite uncertainties, adapt to limitations, and stay in the game. I have been privileged to experience this unique group endeavor in my role as the group facilitator, recognizing and articulating members' invaluable contributions to one another within the context of the larger community of sufferers. In the here-and-now of my work and life, despite the continual stress of PD, I choose to accept and embrace uncertainty as a guiding principle. 🍷

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Additional Resources

AGPA offers practice resources on groups and medical illnesses in its website section on Evidence-Based Practice in Group Psychotherapy at <https://tinyurl.com/yc6rvels>. There is also a Special Interest Group on Health and Medical Issues. This SIG supports group therapists who address health concerns in medical and non-medical settings, provide psychological treatment to the medically ill, and incorporate wellness techniques into their group work such as meditation, and mindfulness.

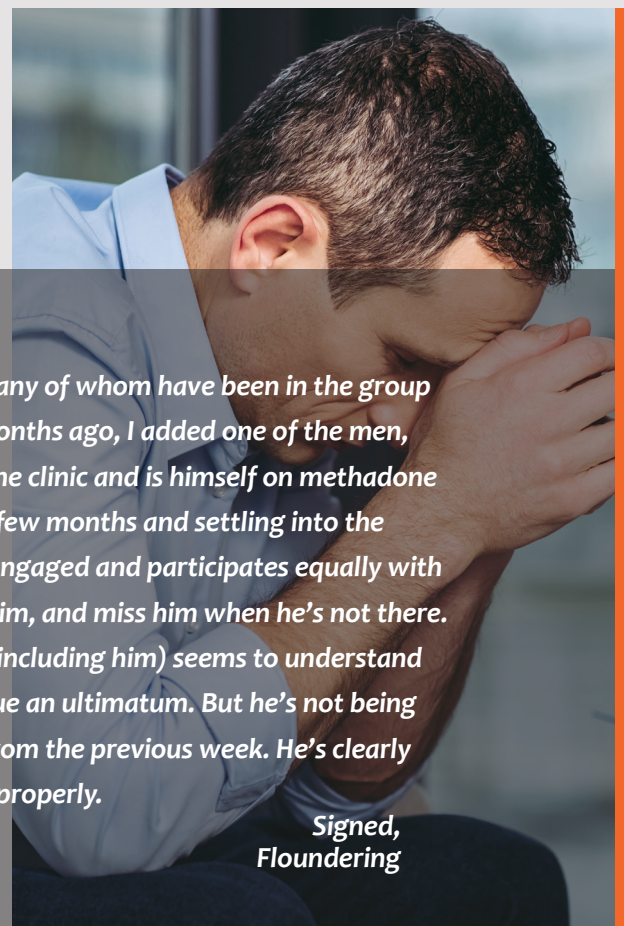


consultation, please!

Dear Consultant:

I have a weekly group that's been meeting for several years. There are currently four men and four women, many of whom have been in the group for a long time. It's a very engaged and active group, and they work hard without prodding from me. A few months ago, I added one of the men, Bill, whom I had been seeing individually for a year. He is an ex-addict who works as a counselor at a methadone clinic and is himself on methadone maintenance. He sometimes drinks to excess (but has never come to group drunk or high). After coming for a few months and settling into the group, he seems to have found a rhythm by which he comes every other week. When he is present, he is fully engaged and participates equally with the other members. He never questions the bill and always pays for missed sessions. The other members like him, and miss him when he's not there. Sometimes they gently confront him, and he acknowledges his pattern. He doesn't quite say it, but everyone (including him) seems to understand that it's as much as he can tolerate. What do I do about this? I don't want to paint myself into a corner and issue an ultimatum. But he's not being a full member, and when he's there he doesn't always know what the group is working on if it's carried over from the previous week. He's clearly getting something important out of being in the group, but I'm worried that I'm somehow not managing this properly.

Signed,
Floundering



Dear Floundering:

You and the group have apparently reached an assumption about why Bill misses groups (that is, that he can't tolerate coming more regularly) and seem to have accepted the situation based on that assumption. It would be quite useful to clarify this. When someone comes inconsistently to group, it's typical to inquire (preferably, the group members would initiate this inquiry) about the reason for a member's absences, pointing out that the issue is important because the group cares for and misses him when he isn't there. Inquiring in this way would convey that Bill is wanted and is a valuable member of the group and would not leave him feeling scapegoated. Sometimes, people don't realize that it matters to the others if they come to group. They may even feel the group is better off without them and stay away for that reason.

Depending on the actual reason Bill is missing groups, some of your options might be: 1. re-assess whether you feel he's actually able to participate fully in the group, and whether he's sufficiently motivated to do so; 2. remind him of the informed consent he signed, and ask him if he thinks he is capable of coming every time, and if not, why not?; 3. have the group assist him with remedying what might be keeping him from coming every week; 4. encourage him to make more frequent use of his sponsor and other outside supports, to help him attend group consistently.

If you're right in believing that Bill has been missing groups because coming every other week is all he can tolerate emotionally, there are still several options to pursue. Perhaps during his individual therapy sessions, you could provide more support for the emotions that get stirred up in the group. Might there be another group nearby that could more clearly meet his current needs? Or perhaps, if the group is cohesive enough and willing to do so, he could continue to come every other week for the time being, and assess over time how that was impacting both him and the group.

While the tendency is to consider all possible options to keep Bill in the group, given that he is apparently well liked by the group members, sometimes it is not possible to retain a member whose behavior is significantly disruptive to the group, if the group is unable to address and resolve this behavior with the member. If this is the case, it may make more sense to have Bill take a break from the group and reapply at a later date.

Bottom line: Although it's not commonly recommended to run outpatient groups when all members can't come consistently, sometimes groups survive quite well even though there is a disruptive variable they have to grapple with. Careful advance screening can help group psychotherapists prevent these disruptive situations.

Barbara Finn, PhD, ABPP, CGP, FAGPA
Menlo Park, California

Dear Floundering:

What a great group you have! To be able to tolerate a member who misses every other week and to keep working and holding the frame is a hard thing to do. You have done a good job of building this group.

One thing that doesn't work is issuing an ultimatum. That just turns into a power struggle, and whoever wins has a very hollow victory, as the relationship is often compromised.

If you are no longer working with Bill in individual therapy, you might meet with him one to one and talk about his experience in group. You might be able to help him build more tolerance so that he can attend more regularly.

Consulting with your group is another way to address this issue. Ask the group, when Bill is in attendance, what you are doing or not doing that prevents him from attending every session. This does several things: First, it takes the pressure off Bill. If he has a low tolerance for the group

anyway, it might protect him more. Second, it draws the frustrated and angry feelings toward you rather than Bill, which would help the group talk more openly about their feelings about his missing every other week. Your job is to tolerate the frustration and anger of the group, as well as take responsibility for not helping Bill enough to be in group weekly. It gives Bill a chance to see he is valued and cared for, and that he has impact on the group. It also allows the group members to express their feelings, and helps you express your desire for the group to be consistent and healthy so everyone can get as much as they need out of group.

You could be having this conversation about Bill in the group for several months. Eventually, Bill will gain more capacity and will be able to attend more regularly.

DeLinda Spain, LCSW, CGP, CEDS
Austin, Texas

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



NEWSLETTER OF THE

AMERICAN GROUP
PSYCHOTHERAPY ASSOCIATION

INTERNATIONAL BOARD FOR
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groupcircle

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See *Group Assets* insert

affiliatesociety NEWS

THE AFFILIATE SOCIETIES ASSEMBLY (ASA)

Chair Maryetta Andrews-Sachs, MA, LICSW CGP, FAGPA, reports that one of the benefits of being a leader of an Affiliate Society is the opportunity to join other local Presidents (or their representatives) at the yearly ASA Retreat in Chicago. People fly in from all over the country to work on concerns they have about having assumed leadership roles and the perils and privileges involved, and to discuss best practices for the societies. The meeting began on Friday evening with drinks and dinner, which was a great way to get the ball rolling. On Saturday morning, there was a process group, where introductions took place, along with discussions about the challenges each representative is facing personally and in his or her society. Jenna Noah, MA, from Boulder, Colorado, led a workshop in which small groups developed elevator speeches to better market group therapy and belonging to an Affiliate as well as to AGPA. The focus was on what to say to each of these four groups: inexperienced therapists, experienced individual therapists, current patients, and to the community-at-large. Following a business meeting, there was a wonderful tour with the Chicago Architectural Foundation prior to dining together. A Sunday morning brainstorming session focused on society issues, such as succession planning, developing diversity, wounded feelings among members, programs that have worked well, among others. Andrew-Sachs said, "I always fly home filled with enthusiasm, excitement, and new ideas, as well as new or strengthened connections to group colleagues. Every Affiliate member should consider when and how they can serve their society in some fashion."

THE AUSTIN GROUP PSYCHOTHERAPY SOCIETY (AGPS)

will host its Annual Fall Conference: *Cultivating the Internal Secure Base in Group Psychotherapy* with Aaron Black, PhD, CGP. Dr. Black will present on the *Intersect between Attachment Theory and Modern Analytic Work* on November 9-10. He will explore how attachment develops in childhood and manifests within the therapy group.

THE CAROLINAS GROUP PSYCHOTHERAPY SOCIETY (CGPS)

co-hosted a social with the International Association for Social Work with Group. (IASWG). Since both organizations focus on groups, they discussed co-sponsoring a workshop and learning about each other's

organization. This idea began when Susan Orovitz, PhD, CGP, CGPS, President, led a demonstration group at an IASWG workshop and met the IASWG Board. Dr. Orovitz's topic was: *Mindfulness: What Just Happened?*

THE EASTERN GROUP PSYCHOTHERAPY SOCIETY (EGPS)

is highlighting one of its members, Rudy Lucas LCSW, CASAC, SAP, who serves on its Board of Directors. He is



Rudy Lucas, LCSW, CASAC, SAP

a psychotherapist in private practice in Greenwich Village and has offered extensive training to professional organizations about racial dynamics in psychotherapy with a particular focus on colorism. He was instrumental in starting the EGPS Work Group for Racial Equity, which he co-chairs with Christine Schmidt, LCSW, CGP. The Work Group for Racial Equity continues to host monthly discussions via Zoom about racial dynamics from selected articles, books, films and podcasts. Mr. Lucas has also helped organize the Witness to History Expedition to Alabama, which will take place in January 2019. The purpose is for mental health professionals to learn and reflect on the impact of racial violence. The EGPS Training Program in Group Psychotherapy has a good-sized class already enrolled for 2018-19. Christine Schmidt, LCSW, CGP, and Lucas will offer two classes for trainees and a half-day workshop for faculty on *Racial Dynamics in Group*. The Training Program thanks Ellen Rubin, PsyD, and Arlene Neuman, LCSW, CGP, and welcomes Leah Slivko, LICSW, PsychA, and Carolyn Ehrlich, MSW, LCSW, CGP, who will be stepping in as Co-Director and Co-Dean of Admissions, respectively. The EGPS journal, *GROUP*, is looking for articles on any aspect of group therapy and

group functioning. Contact Lee Kassan, MA, CGP, LFAGPA, Editor, at lee@leekassan.com for more information.

THE FLORIDA GROUP PSYCHOTHERAPY SOCIETY (FGPS)

is in the process of finalizing its bylaws to submit by the end of the year to AGPA to petition for official Affiliate Society status. FGPS has been consulting regularly with the President from the Four Corners Group Psychotherapy Society, Marc Azoulay, LPC, LAC, CGP. A big note of appreciation to Marc for his continual guidance and assistance in this process towards Affiliate status. FGPS has been active since 2016, when a team of mental health professionals, spanning the 500-mile length of Florida, joined together to develop the Florida Group Psychotherapy Society. Since then, FGPS has been active in: creating an executive board; developing a listserv; publishing a monthly electronic newsletter, which includes a member spotlight and book review; providing two consultation groups; and offering a newly formed book club. For more information or to join FGPS's listserv, contact Miguel Lewis, PsyD, CGP, ABPP, at Miguel.lewis@va.gov or join FGPS on Facebook at www.facebook.com/FloridaGPS.

THE HAWAIIAN ISLANDS GROUP PSYCHOTHERAPY SOCIETY (HIGPS)

began a monthly online book discussion group in March based on the book *From the Couch to the Circle: Group-Analytic Psychotherapy in Practice*, by John Schlapobersky, BA, MSC, CGP. The author joined the meeting from London for the August session. The meetings cover each of the book's 18 chapters and are a free member benefit. Jan Morris, PhD, ABPP, CGP, FAGPA, facilitated HIGPS' two 2018 Institutes, one held on Oahu and the other on Maui.

THE HOUSTON GROUP PSYCHOTHERAPY SOCIETY (HGPS)

hosted educator Sandra Lopez, LCSW, ACSW, who spoke on culturally competent ethical practice at the 2018 HGPS Institute, held in October at the Council on Recovery. Three ethics CEUs were given. This year's theme was *Diversity within Diversity: The Intersection of Identities Within Groups*.

THE NORTHEASTERN SOCIETY FOR GROUP PSYCHOTHERAPY (NSGP)

Foundation presented its first Lifetime Achievement Awards to members of

the NSGP community. Those receiving these awards were selected for their outstanding contributions to the work of group psychotherapy by a confidential balloting by members of the Board of the NSGP Foundation at its Annual Meeting. Awards presented at the Foundation's spring Gala went to: Suzanne Cohen, EdD, CGP, FAGPA; Jerome Gans, MD, CGP, DLFAGPA, DLFAPA; and J. Scott Rutan, PhD, CGP, DLFAGPA. NSGP's training program is offering a year-long *Experiential Group, an Observation Group*, and a *Principles of Group Psychotherapy* course.* This six-module course will meet monthly on Saturdays from 9:30 AM to 1 PM from January through May. The Annual Conference, scheduled for June 7-9, is titled *Diving In: From the Shallows to the Deep* and will highlight the broad scope of group treatment modalities. Requests for Proposals (and other information about NSGP activities) are on the NSGP website at nsgp.wildapricot.org.

THE WESTCHESTER GROUP PSYCHOTHERAPY SOCIETY

is co-sponsoring with The Group Foundation for Advancing Mental Health, a day-long conference entitled *Migration Crisis: How to Effectively Use Community Resources*. The event, hosted by New York Presbyterian Hospital, Westchester Division Cornell Psychiatry, will take place on December 1. The Migration Crisis, which is characterized by a chaotic process of reuniting thousands of migrant children and parents separated by the zero-tolerance policy, poses great psychological risks, both short- and long-term. AGPA trauma experts join forces with immigration community activists and attorneys to produce a multifaceted approach to address the crisis. Register at: <http://wgps.org/conferenceregistration.html>.

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

PLEASE NOTE:

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

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