REVISED EDITION

101 INTERVENTIONS IN GROUP THERAPY

SCOTT SIMON FEHR
EDITOR

FOREWORD BY
J. SCOTT RUTAN

Scott Simon Fehr, PsyD
Editor

101 Interventions in Group Therapy

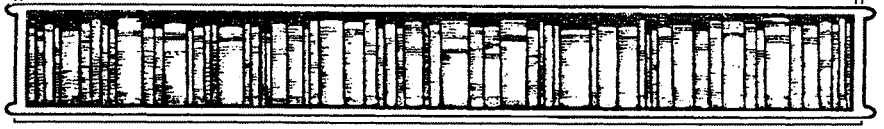
Pre-publication
REVIEWS,
COMMENTARIES,
EVALUATIONS . . .

"Dr. Fehr's ecumenical all-embracing spirit of inclusion allows him to understand that there are 'many roads to Rome.' This quality has enabled him to attract contributing therapists who employ many diverse and distinctive interventions. The group interventions are kaleidoscopic in range and present many, many views on how different therapists approach their work, thereby providing a fascinating treasure trove of clinical experiences. Once again Dr. Fehr is to be commended for creating an engaging volume that conveys the clinical 'nuts and bolts' of group psychotherapy."

Michael Brook, PhD, CGP
Founding Faculty and Training Analyst
at the Center for Group Studies, New York

"Another excellent and relevant informative text by a prominent group therapist. The book is comprehensive in scope and provides a thorough review of multiple therapeutic techniques that lead to emotional growth and recovery. I highly recommend this book to any therapists looking for ideas and insights, through the group process, to help their clients make the changes they want and need to live happier, more productive, and satisfying lives. I particularly like the pervasive theme of optimism in many of the articles."

Herbert L. Rothman, MD
Geriatric Psychiatrist
at Mt. Sinai Medical Center,
Miami Beach, Florida



More pre-publication
REVIEWS; COMMENTARIES, EVALUATIONS . . .

"This book is concise and highly enjoyable. In his goal of attempting to enhance the self-knowledge of his readers, Dr. Fehr has been truly successful. If the role of a group therapist is like the director of a play, the knowledge and wisdom gained from absorbing the subject matter in this classic will enable those therapists to do their work better, thus benefiting clients who place their trust and hopes in those of us who serve to influence their lives in a positive direction. Thank you, Dr. Fehr, for a most enlightening and meaningful journey."

William A. Weitz, PhD
Licensed Psychologist,
Independent Practice, LTC,
U.S. Army (Retired)

101 Interventions in Group Therapy

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Revised Edition

Scott Simon Fehr, PsyD
Editor

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This book is dedicated to my esteemed colleagues, who gave
of their time, expertise and willingness to share their wealth
of knowledge and experience toward creating
this wonderful read and para Elizabeth
con todo mi agradecimiento.

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ABOUT THE EDITOR

Scott Simon Fehr, PsyD, CGP, has had a private psychology practice with his wife, Ellen, since 1979. He was accepted as a student in the first PsyD class in the state of Florida. Since 1993, Dr. Fehr has been a faculty member with the Master's Mental Health Counselor Program, the School Counselors Program, and APA Doctorate Clinical Psychology Program in the Center for Psychological Studies at Nova Southeastern University in Fort Lauderdale, Florida, where he teaches group theory and processes and advanced group theory and processes, and supervises both doctoral directed research studies and doctoral practicums. He also has supervised licensed eligible post-masters and post-doctorate interns for the past twenty-five years. Dr. Fehr is a member of the American Group Psychotherapy Association (of which he is the Past President of the Florida Affiliate), he is a certified group psychotherapist (CGP), and also is a member of the International Association of Group Psychotherapy.

His first book, *Introduction to Group Therapy: A Practical Guide,* his second book, *Group Therapy in Independent Practice,* and his third book, *Introduction to Group Therapy: A Practical Guide* (Second Edition) are published by The Haworth Press. He has been a reviewer for numerous psychology books and journals, has been published in the *Journal of Independent Private Practice,* and was the guest editor of the Special Edition of Group Psychotherapy in the *Journal of Psychotherapy in Independent Practice* (both from The Haworth Press). Dr. Fehr's formal education was in behavioral psychology but his personal twelve-year analysis, both in individual and group, was psychoanalytic. Dr. Fehr is an international lecturer in group psychotherapy and has led over 6,000 psychotherapy groups. He is an avid collector of eighteenth-and nineteenth-century antiques and a student of the Spanish language and the Jungian Tarot.

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Foreword

The Spanish have a delightful tradition of serving "tapas," small portions of food that allow diners to sample a wide variety of tasty treats without being overfilled. Scott Simon Fehr's newest book can be considered the tapas of group therapy. Fehr has assembled an international cast of well-known authors who address important issues in group therapy in concise, brief chapters.

As with tapas, sometimes these chapters whet our appetites for more, and at other times the brief "taste" is sufficient to answer the questions that are addressed. This approach allows Fehr's authors to range far and wide, examining instances that occur regularly in groups but are sometimes not addressed.

At times the chapters focus on technique, for example, how a leader might modify a dysfunctional group norm that has been established, or tell stories, or the use of humor and animals in group therapy. Other chapters focus on working with varied clinical populations, such as pregnant women, war veterans, trauma survivors, and individuals in the military. There are chapters devoted to tiny but very significant issues—if a member is absent or a group is not filled, should an empty chair be in the circle or should there only be as many chairs as there are expected members?

This is an entertaining as well as filling book. The reader can pick and choose topics of interest, or the reader can enjoy reading from cover to cover, knowing that the book can always be put down within a page or two and picked up at a later time.

Enjoy!

J. Scott Rutan
Senior Faculty, Boston Institute for Psychotherapy

Preface

Dear Colleagues and Future Colleagues,

The book you are about to read is unusual in the specialty of group therapy. It has been written by group therapists, of which I am one, but that is not unusual as most group therapy books are written by group therapists. It is unusual because the format of the book, which is quite simple in design and yet profound, not only tells us about the creative work of our colleagues but also tells us about our colleagues themselves.

We group therapists are an unusual lot, to say the least. We are, I truly believe by nature, a group of professionals who seek and perhaps need to work with groups of other individuals. We are the "aggregators." We bring people together and this intrinsic motivation appears to be an inherent part of the totality of our being.

We have overcome whatever obstacles that may have inhibited us in the past, if any. Those who have not developed group therapy practices may not have the motivation to join or come together as a whole in a similar manner as we do.

We, too, are a funny lot in our general psychological and personality makeup. We have moments in our work of brilliance, passion, ignorance, excitement, humor, sadness, anxiety, pride, success, failure, etc. etc. etc., but do not seem to have too much difficulty expressing these emotions about our work to other group therapists. We can be a forthright group of individuals and I would also like to add that the majority of us dance with abandonment when we come together at our conventions.

I guess, it definitely sounds like we are human and because we are human we have the hope of changing the world in a positive direc-

tion–a few people at a time while sitting face to face in a circle in an arena of emotional expression.

These extraordinary people have written the book you are about to read. Ultimately, through their work, their motivation is to bring harmony and balance into a person's life and thus ultimately bring harmony and balance into the world.

You are going to be taken on a very interesting trip. A trip written by individuals who have subjectively observed their work and themselves in order to bring to you interventions that have been successful with their clients, in group therapy, and which you may replicate in the hope that they will be successful for you if faced with similar group or client issues.

You may agree with the intervention or you may not agree with the intervention but whichever you may feel, allow yourself to take the trip along with them. In our agreements and disagreements, we have the greatest opportunities to learn about our work and about ourselves. It is this self-knowledge that ultimately is the core of our work and determines whether we will be attuned to both the internal and external processes in our clients and in ourselves.

No matter how much one may believe that he or she can separate the essence of his or her being from his or her work, the chances are highly unlikely that will be the case. This is why we as group therapists encourage future group therapists and practicing group therapists to have the experience of being a group therapy member for the purpose of understanding others and self-knowledge. There is an old Orthodox psychoanalytic statement which says, "We can only take a patient as far as we ourselves have gone."

It is my hope that you, dear reader, will go quite far and that you enjoy and learn a lot from these forthcoming authors and their chapters. I know I did.

Chapter 1

Who Owes You an Apology?

Ellen J. Fehr
Gary L. Sandelier

UNFORGOTTEN HURT

It is quite realistic to believe that most sentient beings have had experiences in their lives where they have been either judged, abused, misunderstood, or in fact rejected for either real or imagined perceptions on the part of another person or persons. These types of experiences often have a profound effect on the recipient and can, if repeated, cause dramatic changes in the individual's personality and interpersonal relationships in the present and in the future. It was suggested (Fehr, 2003) that a simple intervention/technique could be used to generate, perhaps, information that might not necessarily come to light in a group therapy session that ultimately will have a profound effect on the client ultimately helping to restructure an individual's personality and current interpersonal relationships. This generated information can then offer avenues and roads for further exploration with possible conscious decision-making behaviors toward what one may choose to leave behind and thus no longer be burdened in his or her present nor the future.

THE APPROPRIATE POPULATION

For this intervention to be effective, the group population must have a certain degree of ego strength, the ability to be somewhat introspective, open to disclosure with a minimum of defensiveness, and

be willing to reexperience previous emotional pain on the continuum of mild to perhaps intense.

AN INTERVENTION OF DIALOGUE

This intervention could not be any easier for the group therapist. It is only two direct questions: one presented before the other with concomitant discussion and then subsequently the other with its concomitant discussion. It is not uncommon for this intervention to take two group sessions, if not longer, if the information disclosed brings forth multiple associations within the group members' lives. It is suggested that the two questions be kept separated and solely presented in a group session for which it has been designated.

The Two Questions

- Who owes you an apology?
- To whom do you owe an apology?

SURPRISING CLIENT RESPONSES

It is not uncommon, at all, to find that group members truly get into this intervention. For some initially, there may be trepidation but once the group members begin to disclose their previous experiences of hurt, a prolific dialogue ensues. Clients often identify not only with the events or experiences in another group member's life, and if not the experience, at least the feeling or the residual feeling which the client has been carrying around, in many cases, for many years.

CONCLUSION

This very simple intervention/technique will elicit a wealth of personal information on the part of the group members. They will often have the opportunity of experiencing the corrective emotional experience, because the group members are often very supportive and sympathetic to the disclosure, and they offer multiple identifications to the group member disclosing his or her feelings. This experience of

multiple identifications with support and empathy helps the client to not feel alone or what Corsini and Rosenberg (1955) referred to as "universalization," which (Yalom, 1970) later referred to as "universality." Interestingly, when the question is posed, "To whom do you owe an apology?" a number of group members will say, No one! Thus we can introduce at this time how often many people are very sensitive to what has been done to them but are insensitive to what they have done to others. This often helps elicit, for some members, recollections of what, where, and when they have been less than sensitive in their relationships.

CONTRAINDICATION

Although we have not found this intervention to have had any contraindications if explored with the appropriate population, it was suggested (Chew, 2006) that posing such questions without knowing the vulnerabilities of the group members and not having clinical tact and timing may place the clients in danger of unnecessary negative experiences. We do not disagree with that statement but feel the ethical and experienced group therapist is well aware of the ego strength of his or her group members.

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Chapter 2

The Group Therapist As Storyteller

Marvin Kaphan

> Storytelling reveals meaning without committing the error of defining it.
>
> (Arendt, 1968)

MAKING UNCONSCIOUS AMBIVALENCE CONSCIOUS

In my view, one important function of the group is the education and acculturation of its members, in order to achieve a level of psychological sophistication where they can identify the psychodynamics of their fellow members and themselves. My own orientation is eclectic and psychodynamic. Like most of us, when I began training, I received a psychoanalytic background, which has been modified by my experiences with interpersonal theory, humanistic and existential psychology (Sullivan 1968; Jones, 1953-1957; Maslow, 1968). One major goal of my work is making unconscious ambivalence conscious, so that patients are free to make conscious choices. This process makes use of interpretation. I believe, whenever possible, that there are significant advantages to making these interpretations through stories serving as parables (Crawford, 2004). One advantage of this approach is that the interpretation is not experienced as an ex cathedra authoritative pronouncement, but as an account of a discovery made by an "equal," from which the patient can draw the interpretation himself or herself.

DESCRIPTION OF THE GROUPS

All six of my groups were open-ended, having continued for over forty years, with patients entering and leaving based on their needs and growth. The groups are all heterogeneous psychodynamic groups, with, wherever possible, a family-like configuration of younger men, older men, younger women, and older women. Since these are all private patients, the groups all tend to be more or less high functioning, but each group seems to develop a personality of its own, which persists through the years.

THE INTERVENTIONS

One of my goals in psychotherapy is to lead the patients' focus away from the "slings and arrows" the world seems to throw at them, and from patients' beliefs that they must be passive victims of the vicissitudes of life. Through making the unconscious conscious, patients have the opportunity to become aware of their own part or responsibility, however small that part might be, in creating those "slings and arrows." This consciousness can empower patients to become aware of and change those patterns, freeing them to make conscious choices. These interventions, as well as others, encourage the patients to examine subjective experience from a different viewpoint. In this exploration, it is essential that the patients be encouraged to avoid self-blame for unconscious forces of which they have been unaware.

As discussed, one of the interventions I have used with success is "storytelling." These poignant and often wise stories come from the self-disclosures of other patients over many years. Obviously, personal names are never used when relating the story nor are details given that could be used to identify another patient.

I have found the following story very useful when a group is dealing with patterns of disappointments: A woman in one of my groups came up with a very interesting observation. She said, "If the same thing happens to me in several situations, I have recognized that the only common factor is me."

- This can open a discussion of the many ways we can unconsciously determine the outcome of a situation, such as: tone of voice, body language, choice of a person to interact with, etc.

A similar device useful in a discussion of feelings of helplessness is as follows: A man in one of my groups said he feels like someone who carries around two steel bars that he holds in front of him wherever he looks, while shouting, "Let me out of this jail."

- This usually provokes laughter and recognition of similar dynamics in the group members themselves.

A longer story that I found useful in a discussion of truth as a panacea was: A man in one of my groups was a salesman. He had devoted his life to trying to tell people what they wanted to hear. His group frequently told him that he sounded "phony." For a long time, he didn't seem to understand what they were telling him. Finally, they got through to him. He said, "I see it. I've never said a true word in my life. I've been so busy trying to read other peoples' minds, and tell them what they want to hear; I don't even know what I think. From now on, I'm going to tell the truth."

He returned to group the next week very proud that he had told the truth. He had been out with a friend who was very sensitive about the size of his nose. In the middle of a conversation, he suddenly turned to his friend and said, "Gosh you've got a monstrous nose. I don't know how you can stand to look at it when you shave every day. If I had a nose like that, I'd run to a doctor and have it cut off as soon as possible." He sat back then and waited for the group to applaud.

Somehow, they weren't pleased. As they examined the situation, they agreed that he had been honest about what was going through his head, but the question was why that was going through his head.

As they explored, it was discovered that the "friend" had been his boss, and, he felt, had dealt unfairly with him. He returned to the man he had attacked and apologized, explaining that he had tried to hurt him because of various incidents in the past where he felt he was wronged. The other man told his side of the story, which hadn't been known to him. Eventually, they were able to become real friends.

- This story usually provokes thought and discussion involving recognizing that even truisms like "Truth is always good" are too simplistic to fit complex human interactions.

Perhaps, the most useful story I have used is an illustration of the tendency to resist an extremely pertinent interpretation by dissociation or "nodding off," not hearing, or not understanding a simple statement:

Once upon a time, a woman was describing to her group a compulsion which forced her to search through food she had prepared for her children, to make sure she hadn't accidentally dropped any needles or pins into it.

A man said (very gently): "You know, sometimes a fear masks a wish."

The woman replied: "I don't know what you're talking about."

The man said (still very carefully): "I mean that perhaps somewhere in your unconscious, where you don't know about it and are not responsible for it, there's some little urge to harm your children, and this compulsion is a defense against that."

The woman said: "Funny, I can understand each word you've said, but I can't make any sense out of what you're saying."

The man (making strangling motions, shouted): "You want to kill your kids, you want to murder them."

The woman, sounding very confused, mumbled: "Everything's getting foggy, I don't understand what's going on."

TYPICAL RESPONSES

Use of these and similar stories to illustrate points of interpretation have been very effective. In particular, the last one has had a lasting effect in the groups in which I have used it. Any time someone says, "I missed that" or "I don't understand" the other group members easily remind him or her of the story, the patient laughs, asks for a repetition, and listens very carefully.

CONCLUSION AND CONTRAINDICATIONS

These techniques of suggesting an interpretation through a story are quite easy to apply. If a therapist cannot find such illustrations in his or her own experience, it would be perfectly appropriate to adopt any of mine by adding the words, "I have heard of a person who. . ."

In relation to contraindications, when using any reference to actual patients, one must be careful that information is so vague or disguised that no one's confidentiality is ever compromised. It, too, is to be understood that whenever a therapist relates a story that it requires very delicate handling since the recipient of the story, whether an individual or the group as a whole, can easily perceive it as "blaming the victim." This can be avoided, if the necessary environment of safety and collegiality has been established.

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Chapter 3

Using Primary Language to Access Primary Affect

Jerrold Lee Shapiro

BACK TO ROOTS: AN INTERVENTION FOR ELICITING GREATER EMOTIONAL DEPTH

I have, for years, worked in a multicultural, multiethnic practice. In such environments, it is common for English (at least standard English) to be a second language. As an existential therapist, it is always my process to join with my clients where they are emotionally, intellectually, and interpersonally. Personally, I am a monolingual English-speaking therapist.

Many authors (Santiago-Rivera, 1995; Santiago-Rivera & Altarriba, 2002) have argued that emotion may be language specific and that emotional depth is most tied to the primary language of individuals. In short, people do not feel something in one language and translate it to another easily. In fact, some emotions are tied to and locked into a personal cultural context.

DESCRIPTION OF POPULATION

I work almost exclusively with time-limited, closed, clinical, and growth groups. However, this technique should work equally well in an ongoing open-ended group. It is definitely a technique that lends itself best to adults.

I have used the technique with individuals who spoke Japanese, Hebrew, Farsi, Spanish, Russian, Korean, Thai, Urdu, French, several

Chinese dialects, and pidgin English. In their lovely video demonstration, Gerald and Marianne Schneider Corey (2006) demonstrate this technique with a second generation Vietnamese woman.

A FIVE-STEP INTERVENTION

There are five steps to the intervention of this technique. Using standard descriptions of a four-phase group trajectory: Preparation, Transition, Working, Termination (Corey, 2008; Shapiro, Peltz, & Bernadett-Shapiro, 1998), this procedure is one that is best suited to the third or Working (also known as Treatment or Therapy) phase. It is designed for an increase in intrapsychic depth, once the group trust is sufficiently strong to support such an increase in affect.

Step 1

Working in English with an individual at a level of emotional depth that becomes truncated or limited by language

Step 2

Asking the individual if English is a secondary language (often this is very obvious) and if not what is the language of his or her childhood.

Step 3

Asking the individual if he or she would be willing to continue in his or her primary language. In my experience, this has never been refused. Provide the emotional space and time for them to shift into that language-related state of being (it often shows a marked change in demeanor or facial expression) and supportively allow them to continue with the issue, this time in whatever the language may be. It is important to tell the individual that it is okay if the group does not understand the language, only that he or she does.

Step 4

After the person does the work in his or her native tongue, ask him or her to debrief with the group in English.

Step 5

Asking the group members to describe what it felt like to be present while the individual was speaking another language.

In a recent growth-oriented, eight-hour marathon session with a population of mental health practitioners, one woman was struggling with two simultaneous issues: Feeling like an outsider in California, she was unable to communicate effectively her deeper feelings to her clients and her colleagues; being here with her husband and two children she was also quite homesick for her friends and extended family in Russia. She began to weep, but words were coming slowly and with difficulty.

I asked her (actually in Russian, but that is not mandatory) to repeat what she had said, only this time in Russian. Her countenance slowly became much more open and childlike. As she began talking about her pains of loneliness and fears that she would never make it in this country, she was able to also access a deep pool around issues of rejection and abandonment from her childhood. Although only one other group member understood what she was saying as she spoke in Russian, many of the other group members also had tears flowing.

During the debrief, she explained how she had been separated from her family for almost two years when she was a little girl and how she felt very alone during her medical training in the former Soviet Union. When she was done, the group topic shifted as several other members talked about their feelings as a minority and of loneliness.

CONCLUSION

This is a technique that extends another level of respect to clients, by telling them that their capacities are appreciated, albeit in a different form (language). It also reinforces the notion that cultural differences may be cherished in a group, rather than be reasons for exclusion.

There are at least two contraindications. First, the group must be sufficiently in the treatment phase to handle the level of affect the technique usually elicits. Second, the leader must be able to tolerate the ambiguity of not knowing what the person is saying for some time and rely on her or his ability to read culturally different tone and nonverbal cues.

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Chapter 4

How Can You Not See My Pain?

Steven L. Van Wagoner

WORKING WITH HIDDEN FRAGILITY IN GROUP MEMBERS

Ego strength of group members is a critical focus of theorists when assessing a patient's appropriateness for group. Although conventional wisdom dictates having group members with diverse problems and backgrounds, Yalom (1985) suggests that homogeneity of ego strength is particularly important when considering group composition. Rutan and Stone (1993) essentially agree that members should possess similar ego strength when forming a new group; however, they believe that differences in ego strength can be an asset in more mature groups. Indeed, Kadis, Krasner, Winick, and Foulkes (1965) suggest that differences in pathologies and ego strength can promote group movement so long as we carefully consider how these intersecting personalities might highlight interpersonal tensions and difficulties that produce opportunities for working through and growth.

Ormont (1994) introduced the term "insulation barrier" to describe the defensive structure that all people possess in relation to one another. Since many theorists think of ego boundaries as ranging from permeable to impenetrable, this concept has practical utility in appreciating the relative emotional impact that we and the other group members can have on any one individual. While Ormont (1994) uses the term to refer to a rather fixed structure in a person's defenses, I believe that in times of regression or great stress, the relatively well-insulated individual can also become overly vulnerable to toxic stimuli, or untouchable as a defense against extraordinary threat. Whether

a transient or relatively permanent condition, emotional underinsulation or overinsulation of a group member requires special treatment in group psychotherapy.

POPULATION AND PROBLEM

In a group that had been meeting for several years, a particular member had become increasingly withdrawn and silent, even though he had been an active participant for several years. Over the course of a couple of months, other members became increasingly frustrated with him as he withdrew from participation. On several occasions he attempted to alert the group that he did not feel attended to by them, or in the rare instances that they did acknowledge him, he felt quickly brushed aside as they moved on to other business. Several members criticized him for his neediness, and indeed this reflected some of my own feelings toward this member. They would criticize him for not more assertively asking for attention, or "jumping in" when he needed something, pointing out that he had done this many times before. No matter what the group or I did to invite his participation, he became increasingly withdrawn, but simultaneously resentful and seething with anger. At first I used my own induced feelings to explore possible feelings in the other group members (e.g., frustration, annoyance, a desire to leave the group member alone in his frustration), but realized that the only effect was to stimulate further frustration and withdrawal. After consultation with a colleague, I became aware that what I and the group were doing was attempting to penetrate the resistance, which only further stimulated greater defensiveness.

As I began to watch this person more carefully, I began to have the fantasy that he was engaged in a struggle to stave off what was increasingly experienced as an onslaught by the group. It became clear to me that the whole time I had conceptualized him as being overinsulated emotionally, he was in fact underinsulated. Rather than stubbornly withstanding the onslaught of the group with silence, it became clear that their criticisms were indeed finding their mark, and that he had deceived the group for quite awhile into mistakenly believing that they were having no impact. Upon realization of my flawed assessment, I now could reformulate a plan for intervening.

INTERVENTION AND GROUP RESPONSE

1. *Assess the permeability of the insulation barrier.* This technique requires understanding how and why a person uses certain defenses, and how he or she reacts to the group's attempts to penetrate the defenses.
2. *Provide an external insulation barrier.* If, as in this case, the person's ego is fragile (even if it is transient state of under insulation), we must step in to provide a temporary insulation barrier. I told the group that it seemed as if Dave was "against the ropes awaiting the knockout blow," when in fact what he might have craved most was "tenderness and understanding." The group became immediately defensive. They retorted that Dave is quite capable of hearing their input and integrating it as he had done on many occasions. I did not back down, however, and suggested that perhaps that has normally been the case, but that somehow it was different this time given his withdrawal and nonverbal, emotional reactivity.
3. *Use bridging to someone with similar defenses.* Find someone who is underinsulated, and employ the technique of bridging (Ormont, 1990), which is a method for helping one member establish emotional communication with another, around similarities as well as differences. In this case I consulted with "Daniela," who was more characterologically underinsulated, and asked if she understood Dave's withdrawal. I knew that she was experienced with feeling injured in the face of confrontation when all she wanted was "tenderness and understanding." She immediately empathized, and added that she felt hesitant to say anything because she did not want to be attacked like the group attacked Dave. She said that people in her life never understood how deeply their words and behavior could injure her. As she spoke, Dave welled up with tears, but at the same time nodded as if feeling understood for the first time in months.
4. *Continue to help the group explore the impasse, its resolution, and emerging feelings.* In this case Dave was eventually able to share how Daniela's empathy helped him rejoin the group. The group was surprised at the depth of Dave's feelings of being misunderstood and unrecognized. They shared their perception that Dave was quite capable relationally, and were taken aback

by Dave's apparent neediness. What they did not know, until Dave shared it, was that recently in his life, he had been feeling similarly misunderstood by friends and family, who he felt had always underestimated his needs because he was so adept at putting up a front of "being together."

5. *Be on the lookout for how a patient's past might contribute to a weakening of the insulation barrier.* I asked Dave if he ever felt his needs went underappreciated in the past, and he poignantly shared how he always felt like he had to be strong for his single mother, who was struggling to raise him and his brother and sister. As a result of serving as a parentified child, Dave felt as if he always needed to be the "adult," which the group enacted with him in the present.

CONCLUSION AND CONTRAINDICATIONS

Although Ormont's (1994) treatment of under- and overinsulated patients was referring to those whose insulation barrier (i.e., ego strength or boundary) was characterologically flawed, the concept can also be useful in working with group members who might experience transient over- and underemotional insulation. The intervention in the latter case proved to help Dave and the group work through an impasse that had the potential to hurt Dave and cause him to flee the group. Working with Dave's transient experience of being emotionally underinsulated by using myself as a temporary insulation barrier, which required that I correct my initial assessment of his being overinsulated, and to bridge with another member who was more characteristically under insulated, allowed Dave to feel an empathic connection and understanding that allowed him to relinquish his defensive posture in the group. Until I made the necessary diagnostic correction, however, the group and I worked as if Dave's resistance needed to be penetrated, which only further threatened him, and created the mistaken impression of overinsulation. The key to understanding that this was an incorrect conceptualization and technique was being attuned to how the group's confrontations were in fact penetrating him on a deep, emotional level

With group members who are underinsulated characterologically, this kind of work would have to be repeated and worked through numerous times before the patient's insulation barrier was more firmly

established internally. In the case of Dave, the intervention was more reparative than structure building, which was all that was required to bring him back into the fold of the group. What can be appreciated from the scenario, the use of the concept of emotional insulation, can be invaluable in crafting an appropriate intervention; however, its effectiveness depends upon an accurate assessment of the nature of the insulation flaw.

Although there are no contraindications to the intervention per se, it is imperative that the clinician accurately assess whether or not the member in question is under- or overinsulated emotionally. As was the case in this group, an initial misunderstanding of the nature of this patient's ego strength led to interventions that only strengthened the resistance. Once I was able to accurately discern the underlying insulation flaw, however, I was able to craft a more appropriate intervention.

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Chapter 5

Animal-Assisted Therapy with a Group of Young Children with Social Problems

Stanley Schneider
Chana Schneider

We may describe as "social" the emotions which are determined by showing consideration for another person. . .

(Freud, 1913, p. 72)

So there grows up in the troop of children a communal or group feeling. . .

(Freud, 1921, p. 120)

INTRODUCTION

Group therapy is an excellent medium for children with social withdrawal issues (Slavson, 1940) and shyness (Schaefer & Millman, 1994). Groups are natural settings for children (family, school, peers), and, therefore, well-structured therapeutic groups can be most beneficial for children who have difficulty expressing their individuality and consequently have difficulties with envy, competition, and normal feelings of anger. The group serves as a holding environment, allowing group members the possibility of regressing within clearly defined and protective boundaries (Schneider, 1990).

Since the pioneering work of Boris Levinson (1964, 1969), with his dog Jingles, and his coining of the phrase: "Pet Therapy," animal assisted therapy has become an important adjunct to our therapeutic repertoire. Although animals are used therapeutically in individual (Prothmann, Bienert & Ettrich, 2006; Fine, 2000), milieus (Holcomb & Meacham, 1989; Fine, 2000), and family (Sussman, 1985) contexts, structured group therapy with children utilizing animals and creative activities as a therapeutic medium, is a rarer phenomenon.

CLIENT POPULATION

This is a highly structured therapy group that utilizes animals and creative activities as a means to help five young children, ages four to six, who have social difficulties. The group meets for eight sessions. All the children are in group settings in schools (nursery/kindergarten), and the presenting issue is to help them with social readiness skills so they can integrate better in their educational and social contexts.

THERAPISTS

The "therapists" included a family of chinchillas (mother, father, and three baby chinchillas) and a therapist trained in a three-year animal assisted therapy course of study at the Hebrew University in Jerusalem.

DESCRIPTION OF INTERVENTION

Task at Hand: Becoming Part of a Peer Group Culture and Learning How to Make Friends.

Chinchillas are jumpy animals and react very instinctively to the emotional output of the handler, which is transmitted via smell and level of anxiety. They become "trained," and sensitized to the touch of a specific individual. As the child becomes more able to give of himself or herself, the chinchillas respond warmly. The children watch how the chinchillas interact as a family and how the mother

and father watch over their young and carefully monitor strangers. The group members observe how the chinchillas have sibling rivalry and how they learn to share.

Step One

In order to prepare the group members to work with these animals, the chinchillas are touched and fed while they are still in their large cage. As the children begin to see that chinchillas do not bite and respond by approach-avoidance behavior, the group members are willing to risk and be more outgoing, and, most importantly, to watch and learn from their peers.

Step Two

The chinchillas are taken out of their cage and are placed in a large enclosed compound where they run freely and the children sit as a group. The group facilitator puts a chinchilla in a child's lap. The chinchilla is passed from child to child, and the chinchilla responds to the warmth and interest of each child. The group members learn sharing and how to take turns.

Step Three

The children learn by their own trial and error as well as watching how the other children respond. As the chinchillas interact and "fight" for food and attention, group members learn problem-solving behavior by discussing how to reduce conflict among the siblings and how to resolve conflict: giving more food, separate the fighters, giving more attention, etc.

We begin to notice how each child helps the other with his or her experience of success. This also increases each child's feelings of independence, and sense of responsibility (feeding the animals, cleaning the cage, giving the chinchillas a bath in their special sand, etc).

Step Four

Parallel to the work with the chinchillas, the children then work in the expressive medium, and this reinforces what the chinchilla "therapists" have taught them.

The group members are offered various creative projects that enable them to express what they have learned. Some examples: making toys and games for the chinchillas, and drawing/writing a story as a group collage/activity. These projects allow the group members to see one another's feelings, and work together on joint projects, which encourages group interaction, camaraderie, and helps develop a safe peer culture.

CLIENT RESPONSES

In the initial stages, group members get caught up in their own narcissistic needs. As the group progresses, they move into sharing, learning from one another and, more importantly, how to utilize the group to move themselves forward.

The group facilitator needs to maintain clear boundaries, with a judicious sense of empathy and acceptance. The chinchillas, instinctively, know how to do this.

CONTRAINDICATIONS

This therapeutic intervention is contraindicated for use with very aggressive children. Chinchillas are sensitive to touch and can be harmed by being held/squeezed aggressively.

Those children who are withdrawn and shy can benefit greatly from this intervention.

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Chapter 6

"Am I My Mother's Daughter?" Eliciting Self-Awareness in the Transmission of Gender Roles Through Family Role Models

Leyla Navaro

INFLUENCE OF THE FAMILY ROLE MODEL

Family role models influence our conscious and unconscious attitudes, behaviors, and styles in which we relate in both our closest relationships and our relationships in general. We acquire them from our parents by simply living together, observing, or unconsciously copying them. Some are deliberately chosen and willingly followed, whereas many are unconsciously acquired. Group work helps to raise consciousness of these relationship styles through the processes of reflecting, inquiring, or mirroring.

GROUP PARTICIPANTS

This is a time-limited, psychoeducational group (twenty weeks) that has agreed to work around the transmission of gender roles by exploring family role models. The use of art material (colors, crayons, collage, etc.) is effectively applied to help accelerate latent unconscious material, which may not be elicited through mere cognition.

The group consists of eight women in their forties. Each is highly educated, socioeconomically comfortable, and is or has been profes-

sionally active in her career. Of the eight members, four are professionally active, two have taken early retirement, having left high-paid positions, and two are young mothers. Most are married with children, two divorced, one is single. Six members have had long-term group experiences and two are new to the group therapy experience. All members have gone or are continuing individual therapy, at the same time as their group experience. Thus psychological insight and maturity is expected.

INTERVENTION DESCRIPTION

A Four-Stage Approach

This intervention is introduced once cohesion and trust is sufficiently built in the group (more or less in the eighth week) to contain increased affect and allow for deeper emotional sharing.

Stage 1

Each participant has to represent her mother in a painting or collage. Various art materials are available in the room (papers, crayons, colors, collage material, etc). Thirty minutes are given to work personally on the subject. Each painting or work bears the name of the Mother that is represented.

Stage 2

When finished, each participant is asked to present her mother to the group. Who is this woman? What kind of a life did she have? How was she when younger? What was her childhood? How was she as a person, a wife or partner?

It is suggested that all the participants speak in the first person, stating the Mother's name, as if the speaker were her own mother. For example, "My name is . . . . (Mother's name) I am sixty-five-years old. My life has been . . . when I was a young girl. . . ." It was not uncommon for a few participants to speak in the third person and the therapist did not interfere. Yet the resistance was registered for further introspection.

Stage 3

Group interaction is encouraged, such as questions, requests for clarification, remarks, and feedback.

Stage 4

When each and all participants have completed this exercise the group reflects on the experience which it has shared. The therapist inquires, "What did we learn? Which parallels did you perceive between yourselves and your own mothers? Which similarities? Which differences? How do those realizations affect you in your personal lives at this time?"

PARTICIPANT RESPONSES

One of the most striking outcomes of this exercise is the realization of similarities in the mother/daughter dyad. Especially the realization of unwanted and unwished-for similarities, thus providing opportunities for striking self-awareness.

Examples of Participants' Responses

Jane, who was very critical of her mother, shared how displeased with herself she became when realizing that her own angered reactions were as aggressive and harsh as her mother's. This realization helped her to review her own angry behaviors and eventually try to modify them. At the same time, her self-awareness provided a decrease in her own feelings of anger toward her mother. Jane stated feeling a greater empathy toward her mother, after the exercise, with more understanding and acceptance.

Pat reported how saddened she felt about her mother's unsatisfied life. She realized that this sadness was unconsciously hindering her own pleasure and feelings of happiness in her own life. By identifying with her mother, Pat was not allowing herself nor her family to enjoy more in life.

Alicia reported that after this exercise her anger and rejection of her mother had diminished. She reported feeling more loving and admiring of her mother. Her resistance to her mother's remarks was less

acute. The group's empathy and understanding helped Alicia to become aware of her mother's life struggles and helped to enlarge her limited perspective.

At the beginning, Julie had presented her mother as a selfish, egocentered person, sparing more time for her own interests than for her family, an attitude always resented by both Julie and her sister. However, with the group's questions and remarks, an important reframing occurred in Julie's perception. She reported that now she could better understand her mother's joy and passion for life, and her refusal to comply with the traditional motherly roles. This understanding helped Julie to review her own compulsive motherly duties. She realized that as a reaction to her mother, she had adopted an overprotective mothering style which was quite frustrating and negatively affecting her existence. Julie decided to allow herself more time and space for her own interest areas.

CONCLUSION AND CONTRAINDICATION

This intervention aims to actively work on issues of separation/individuation in the mother/daughter relationship. "A daughter's identification with her mother contributes to a gender identity based on nondifferentiation and intimacy rather than differentiation and separation" (Chodorow, 1978, p. 109). As in the example of refusal of differentiation (Pat) separation, and individuation within the mother/daughter interaction is mostly an unconscious "oath of fidelity" in the girl's development (Lerner, 1988).

Examining a Mother's whole life span while presenting her to a group of strangers is a powerful tool in the objectification of the relationship. The internalized Mother figure, or the self-object (Kohut, 1977) becomes a "real" person with her assets, liabilities, strengths, and vulnerabilities. This opportunity and potential for awareness as the shift from subjectivity to objectivity is profoundly provided through the group interaction.

This intervention has limited contraindications but, this kind of exercise and intervention works most effectively in a mature group where participants have already acquired a certain degree of psychological growth and have been previously prepared for this kind of introspection. It is not advisable nor recommended for use in a clinical setting with borderline or psychotic patients.

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Chapter 7

Living with Dying: How to Keep the Group Alive When the Members Are Dying

Toby Ellen Newman

INTRODUCTION

Groups for people with catastrophic illness come together for many reasons: to gain support, to reduce isolation, increase social contact, access information, improve problem solving, and find hope and motivation to cope with the illness and its treatment (McKusick, 1992).

Therapy involves finding the balance between providing accurate information that may or may not be positive, trying to instill hope for the future, and acknowledging the possibility of a lack of future.

DESCRIPTION OF GROUP AND CLIENT POPULATION

The following paragraphs are based on the author's experience of fifteen years of facilitating groups with people with HIV/AIDS and ten years in facilitating groups of people with cancer. The interventions should be universal in any psychotherapeutic support group that assists people in dealing with potentially life-threatening illnesses.

These groups can be held in an outpatient therapy practice setting or in a medical facility. It is probably best, under most circumstances, to have patients together with other patients, or family members together with other families, and try not to mix patients and family members within the same group. While it is sometimes required by

the setting to have mixed groups, this therapist has found that, oftentimes, both patients and families try to "protect" their loved ones; fully honest communication is not always possible within a mixed patient/family group.

This author prefers to have a mixture of newly diagnosed patients together with longer-term survivors, but this could be a variable left to each therapist. Some settings divide patients by specific disease, e.g., only breast cancer patients, while in other situations, there may be a more general grouping.

THE FOUR-STAGE INTERVENTION

The *first intervention* occurs before the patients ever arrive and involves the therapist paying attention to the medical comfort needs of the patients. Patients with compromised immune systems may need to have bottled water available. Patients on multiple medications may need to have snacks to take medication during the group time, and they may need to have a convenient bathroom easily available. Patients may not be able to walk stairs or navigate large parking garages.

In the *second intervention,* the therapist sets the safety parameters by outlining that the group will be addressing difficult issues and personal stories. Confidentiality will be expected and individual members and their stories will be respected. Sometimes a written confidentiality contract will be signed by the patients. In addition, the therapist also needs to pledge to respond honestly to situations. For example, if dementia or a loss of cognitive functioning is a possible outcome of the disease or the treatments, the therapist needs to be the one person who agrees to discuss honestly what he or she observes and not surrender to platitudes like "everything is fine." Establishing safety and trust are of paramount importance in working with this population.

The *third intervention* involves having the clients introduce themselves, their diagnoses, and give some medical information or update, and psychosocial history, almost every session. It is important to have clients state their diagnoses and some understanding of what is involved with that diagnosis, whether it is considered treatable or not. For many group members, this is the only place they can talk openly, without shame or blame (if they have HIV/AIDS, or lung cancer),

without embarrassment (if they have prostate or anal cancer), and without "helpful" family members trying to insert their own comments.

The *fourth intervention* is active listening, reflecting back to the patients what they are saying and how they are feeling. The therapist should be nonjudgmental, open and accepting. The therapist should help members find a sense of belonging and connection. The leader should be able to guide the process of disclosure, be somewhat knowledgeable about the disease and treatment, and most importantly, be able to shift the discussion from the factual content of the disease and its treatments to the process of living and perhaps dying, with all the attendant emotions.

PATIENT RESPONSES TO INTERVENTION

Patients come into the room wanting to talk about their situation. These groups tend to start in the middle phase of expected group development because there is the sense of limited time in which to get things said and work done. Patients are frightened; they may feel alone, with their known world turned upside down. The therapist's calm demeanor and lack of fear in allowing the unspoken to be verbalized provides a calming frame for the work of living with dying to take place. Clients process the shame and fear, and most come out at end of the group and disease process with a greater sense of wholeness about their inner selves.

CONCLUSION

Illnesses that are considered medically critical, with the possibility of being terminal, take the patient to the point of perceiving the inevitability of the end of his or her life (Frank, 1991). Experiencing this realization, in relation to your patient, impacts not only on the patient but also on the therapist as well. This realization of the end of life, is a concept that can become a focal therapeutic issue, because it can elicit a reevaluation of the purpose and value of one's life. Group members may feel alive but removed from previous everyday tasks of living. They now have the opportunity to reflect on the life they had lived and how they would like their future to be, if in fact a future would be available to them. From his experiences and research, Frank

(1991) writes that "illness takes away parts of your life, but in doing so it gives you the opportunity to choose the life you will lead, as opposed to living out the one you have simply accumulated over the years" (Frank, 1991, p. 1).

Working with this patient population allows you to help your clients (and yourself) see the choices ahead in their lives. Dealing honestly with the issues of grief and death can allow some people the freedom to live more openly and to feel more completely alive.

The group members may or may not be sufficiently motivated to listen and hear and want to grow to find meaning in their life. They may feel too physically ill or be suffering from major depression, and be unable to fully participate with all their heart and soul. Or, one strong group member intent on returning to his or her former life just the way he or she left it may dominate the entire group discussion.

The group leader has to decide with the members how to handle termination issues, such as notification of deaths of group members, how much medical information to give, and whether to bring up the question of attending funerals. Each death diminishes the group as a physical loss, but also as a reflection of the coming loss of the self. At the same time, each remembrance reassures the other group members they will also be remembered.

CONTRAINDICATIONS

The predominant contraindication is in the person of the therapist. There are situations that require self-knowledge accessible on short notice. A member may discuss suicide or the cessation of active treatment. This can certainly cause discomfort, fear, and even anger for some of the group members who are focused only on survival. The therapist needs to examine his or her own beliefs, values, and ethics, in responding to this difficult, but vitally important group exploration. Keeping calm, buying time, assessing whether or not there is a viable plan are necessary while within the group. Therapist consultation is almost always indicated. Knowing enough about the critical illness at hand is not necessarily a discussion between choosing life versus death, but rather, at times, control of when or how the patient is going to die.

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Chapter 8

The Gambling Chair

T. Wing Lo

INTRODUCTION

"Gambling chair" is a group therapeutic exercise invented by the author to facilitate clients to relive and reformulate their problems in a dramatic form enabling them to face their concerns directly and immediately, in the living present. It is designed to encourage the expression of feelings that underlie personal problems of clients and their family through the use of psychodramatic techniques (Blatner, 2000; Leveton, 2001; Moreno, 1993). Thus, it emphasizes action therapy, not just psychotherapy. This exercise is used with one key client at a time, with other group members acting as helpers and supporters throughout the intervention. It is used during the performance or cohesive stage of a group when group rapport has been established and members' defensive masks have been removed. The intervention aims to confront clients with the negative effects of their behavior, handle events of emotional significance, uninhibit emotions, and gain insight into the client's own problems.

CLIENT POPULATION

This intervention was first applied in a gamblers' support group, but was later used more frequently in groups handling extramarital affairs and love relationship issues among young people. Group therapists may feel free to generalize its use to groups of a relevant nature.

The crux is that the clients must experience the "win" and "lose" sensations in the course of gambling with money or gambling with love.

GUIDELINES FOR THE INTERVENTION

Prepare a number of chairs that should not be too heavy so that the key client is able to pile them up one by one. The chairs should not be too light or else the dramatic effects would diminish when they fall. Then follow these steps:

Step 1

Help the client to recall his or her gambling experiences. If the client says he or she won once in gambling, ask him or her to put a chair in the middle of the room, signifying that he or she has won for the first time. Similarly, the therapist should ask the client to place the second chair on top of the first chair, representing winning for the second time. Then the third chair, indicating another winning. When four or five chairs are piled up, the foundation becomes unstable and the client should be cautious about every other move. Normally, the group atmosphere becomes serious and group members are silent. When the number of chairs on the pile reaches seven or eight, it is highly likely that the whole pile will fall. Ask the client to continue to put another chair on the pile.

Step 2

When the pile of chairs reaches a reasonable height or is at risk of falling, the therapist asks the client's feelings each time he or she adds a new chair to the pile.

Step 3

When the pile of chairs falls, the chairs may hit the client if the client does not escape fast enough. The therapist should ask the client why he or she was hit, even though he or she was cautious of the potentially falling chairs.

Step 4

The therapist then asks the client what he or she has learned from the exercise, and then invites group members to give feedback. The therapist helps members debrief the intervention and unfold the myth that no matter how much money the client won gambling previously, ultimately the client will lose.

Step 5

Suppose the client is in a family of four, living with his wife and two children. The therapist points to the fallen chairs, telling the client that this is his family now in ruin. The therapist takes up one chair from the ruin and invites a group member to sit on it and play the role of the client's wife (could represent the client's parents, colleagues, girlfriend, or any significant other depending on the unique case situation). Under the therapist's instruction, the "wife" discloses to her "husband" her feelings of suffering in the turmoil. The therapist has the liberty of inviting another group member to act as the wife if the first member could not perform the role properly. Then comes the next chair; the therapist takes up the second chair and asks a group member to act as the client's son. Then, the third chair— the client's daughter. Both son and daughter tell the client their feelings of living in a broken family and ask their father why he gambles.

Step 6

Now the three group members who acted as family members return to their seats, leaving three empty chairs in the middle of the room. The therapist takes up the fourth chair, saying that this is the husband's chair. The therapist invites the client to sit on it, facing the three empty chairs and answers the queries of his wife and two children.

Step 7

Based on the conversations between the four "family members," the therapist leads the group to discuss the negative consequences of gambling and share the feelings of family members.

Step 8

The last step is to debrief and "de-role group" members, in which they are helped to leave the role of family members behind and return to their own sense of self through mutual sharing before leaving the session. The therapist guides them to share both from the role they have taken and then as themselves (Holmes, 1998). The therapist also helps the client reflect upon what happened in the past, recognize what exists in the present and set goals for the future (Kellermann, 1992).

CLIENT RESPONSES

In any therapy session, I have adhered to a "4S" principle: **short, sharp, shock,** and **support. Short** represents the duration of intervention; **sharp** stands for sharp assessment and treatment focus; **shock** is the effect experienced by clients; and last, group members should receive mutual **support** before the end of the session. Normally, the key client is shocked when faced with the risk created by gambling or extramarital affairs; he or she is then further shocked by having to face the reality, i.e., a broken family, pressuring the client to change his or her undesirable behavior. Other group members, who have encountered similar problems, often express positive feedback because they have gained insight through observing the intervention as if seeing themselves in a "mirror" (Moreno, 1993).

CONCLUSION AND CONTRAINDICATION

Insight and change of attitudes and behaviors are more likely to occur when the client is experiencing a personal problem in its entirety rather than its verbalized version. The participation of group members serves as a self-treatment to other members. During the role-play, members internalize prosocial values (e.g., gambling would harm the family) that would counteract their gambling habit. In regard to contraindications, be cautious: be sure not to let the falling chairs hurt the client or any group members.

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Chapter 9

Bringing a New Member into Group: Marking a New Place in the Cycle

Joshua M. Gross

REGRESSION AS A NORMAL GROUP PROCESS

Process-based psychotherapy groups that last for any extended period of time are inevitably confronted with the problem of people leaving which presents us with the issue of bringing in new members. This is a normal developmental event in the life of a group and its implementation can significantly impact the quality of experience for both the new member as well as the existing group members. Group developmental stage theory tells us that groups will go through a series of developmental stages over time and that any changes in the group's membership will most often result in a regression in group developmental functioning.

Group Developmental Stages

Tuckman's (1965) four stages of group development tell us that we can expect a group to progress through a series of stages as members engage in interpersonal discourse and interaction. The initial stage of *norming* describes the group's overall press to establish the necessary community standards that allow for organized and predictable social interaction. Through the development of community standards, members become increasingly aware of their individual differences and are said to be *storming*. As group members become accustomed to their differences, opportunities emerge for new social roles, which is described as *borning*. When group members prepare to leave, they

are said to be *adjourning* as they engage with others through a process of termination. The life cycle of a group involves an ongoing series of cycles through these developmental milestones. Bringing in a new member most often regresses the group back into the initial stage of *norming.*

POPULATION

Process-based psychotherapy groups are most often focused on the discussion of experiences and perspectives of the individuals in the group. Open-ended process groups may run for many years with an ever-evolving membership as people complete their treatment and others come into the group. The addition of a new member is a common event in an ongoing process group due to the natural attrition in members over time.

SIGNIFICANT OR NEGATIVE INTERVENTION

The leader can have a significant positive or negative impact on the overall functioning of the existing group and the new member's introduction by providing useful structure. The selection of a new member for an existing group is a matter of finding a good fit, which is based upon the clinical judgment of the leader. This intervention goes further by considering the fact that the group will be regressed back to a new starting point with the addition of a new member. When we are faced with the task of bringing a new member into an existing psychotherapy group we have the opportunity to assist the existing group and the new member in making a transition that is consistent with the developmental status of the group.

Even in the case of a group that has existed for many years with a solid core of well-experienced members, the group composition is changed with the loss of an experienced member and the introduction of a new one. This point of time is at least temporarily marked by a change in relationships between members as well as the overall group-as-a-whole experience. By taking the time to prepare the existing group members, and assisting them to deal with the impact of a loss, they are better prepared to engage in the many accommodations demanded by this transition. By preparing the new member as to what

to expect and the group rituals they will be joining, the leader ensures that the transition will be less likely to cause distraction or resistance in the course of the work of the therapy group.

A Two-Point Approach

- *First point: the existing group.* When at the point of being ready to incorporate a new member, the group is should be informed as to how this process will occur. Usually, the therapist is in the position of making the selection of the new member and informing the group of the upcoming addition. The group will do well to be advised that this change will have an impact on how the group may feel toward members and that it is reasonable to have mixed feelings about the transition. Group members who have been through this previously are likely to know what to expect and can offer their opinions about the upcoming transition.
- *Second point:* the new member should be known to the therapist and the preparatory process for joining a group is best carried out in one or more preparatory interviews. The new member should be apprised of the group rules and agree to abide by them. The therapist can assist the new member to feel less anxiety by telling him or her what to expect in the course of the initial meeting and what will likely be discussed at that time. By preparing the new member in this way it is more likely that he or she will be able to interact with the existing group members in ways that will facilitate a positive initial experience.

At the start of the group meeting the therapist should acknowledge to the group and new member(s) that "we have new people in the room" and that this is an opportunity to review our rules. Upon completion of this discussion, the group and the new member need to all once again agree to the rules; this gives everyone an equal basis for entering together into the work of the group. Process groups should focus on the experiences and perspectives of the individuals involved and, as such, it is often useful to ask the group members to say a little about who they are, what they are working on, and how they feel about the group. This ritual is often comforting in this period of transition and assists both the existing members and the new member to work through their anxiety and address the work of the group, mainly, to talk about their experiences and perspectives.

EFFECTIVE OR CONTRAINDICATED

The major concern about termination and adding of new members is the impact on the working therapy group. The leader can anticipate that this is a regressive situation (Fehr, 2003) and avert resistance by preparing the group and the new member. The leader who does not make these preparations, or is unclear as to the impact of such a transition, is less likely to be able to maintain the safety and structure of the group intervention through transitions of membership.

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Chapter 10

The Crystal and the Stone: Use of Transitional Objects in Groups

Shari Baron

> The identity of the group and the individual is often symbolized by a totem. . .
>
> (Henderson, 1964)

THE TRANSITIONAL OBJECT

The concept of transitional objects to reinforce object constancy has been a long-established precedent in the study of child development and the psychodynamic model of psychotherapy (Baldwin, 1967; Stone & Church, 1973; Rutan & Stone, 2001). Yalom (1985) posited that in group psychotherapy, the individual client and/or the group as a whole might view the therapist as a transitional object. In my groups, I often utilize a small, inanimate object to serve as a transitional object that ties the client to the group when he or she is dealing with a particularly difficult situation outside of group. This object encourages the group member, as he or she goes through the days between group meetings, to remember the support and attachment he or she feels from and toward the group. This intervention helps and supports him or her through the tough times in the real world.

CLIENT POPULATION

This technique has been used successfully in several different types of groups. Specifically, I maintain two ongoing insight-oriented women's psychotherapy groups in my private practice where this transitional object concept was developed. I also facilitate mixed-gender weekly support groups with cancer survivors at The Wellness Community of Philadelphia, a center serving adults with cancer and their families, and I have utilized this concept there with significant success.

GUIDELINES FOR INTERVENTION

The group uses a glass crystal or small stone as a totem or transitional object. The item belongs to the group and, periodically, is passed around the room and then sent home with a group member who is feeling a particular need for support or encouragement as he or she faces the week ahead.

Genesis of This Concept

Pat was crying, chokingly describing to the group her anxiety about her upcoming visit to her parental home in a Midwestern state. Pat had experienced cruel physical and mental abuse in that home, and although she had done significant work in therapy and felt prepared to deal with the issues she might face once she was there, she admitted to feeling significant anxiety about leaving behind all of her support systems in Philadelphia. She was particularly upset about not having the support of her group for the two weeks she would be away. Just then, another group member dove into her large handbag and pulled out an old chandelier crystal. She offered it to Pat as a token of the group that she could carry with her on her journey. The group decided that, to make the crystal have even more power, we would pass it around the room and each member would hold it, symbolically putting positive energy into the crystal for Pat. Pat took the crystal with her on her trip and reported back to the group that having the crystal in her pocket helped her as she faced the old fears in her childhood home. The crystal then returned as the property of the group to be used again by others as needed.

After several years of using this and other crystals as transitional objects in that group, we also began a practice of giving a small glass crystal to each member as she leaves group.

Adults Dealing with Cancer

Fred had been doing quite well, with his cancer officially in remission for quite some time. Lately, he had been having some pain in his abdomen, and he was beginning to feel worried that something might be seriously wrong. He called his doctor who ordered tests and a follow-up office appointment. Fred came to group a few days before the tests, openly expressing his fear and anxiety about a possible recurrence of his cancer. The group offered him, in this case, the group stone that had lived in this group for many years, serving the transitional object purpose. Group members passed the stone around, each person holding it for several minutes to pray, symbolically give it energy, or whatever form of supportive thoughts or feelings that member felt appropriate. Fred then took the stone with him when he had his tests and doctor's appointment, reporting later that the stone helped him remember all the others in group who had dealt with similar scenarios with success.

TYPICAL RESPONSES TO THIS INTERVENTION

Although the group clearly uses the crystal as a transitional object, there is little discussion or analysis of the psychodynamic reasons for this practice. I have found that it is somehow safer for the group members to use the object when they do not think about the unconscious process that is in play. Most group members respond positively to the suggestion that they accept the caring of the group in this manner, and most report that having the crystal or stone in their possession somehow made their particular trials easier to handle.

CONCLUSIONS AND CONTRAINDICATIONS

The use of an inanimate object as a transitional object in group can have a powerful impact on the group as a whole and on individual members who may be experiencing particularly stressful out-of-

group events. The character of the object matters little; what is most important is the symbolic nature of the process by which a crystal or stone (or any small object) may become a support to a group member who is in distress.

Some members who are particularly concrete in their thinking or severely depressed have difficulty experiencing the supportive nature of the transitional object, and these members may report that the token was not helpful. The therapist might encourage this client to have a goal of being able to report to the group his or her disinterest in the crystal or stone. When he or she is feeling comfortable enough with the group to be honest about this disinterest, this client might actually benefit from refusing to accept the token.

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Chapter 11

The Vicissitudes of Power and Its Relationship to Money

Lise Motherwell

MONEY CAN REPRESENT POWER, LOVE, FREEDOM, OR SECURITY

Money can be harder to talk about than sex, especially in a group therapy setting where shame may be an obstacle, yet financial matters are important both in and out of the therapeutic setting. Individuals derive meaning of money from culture, class, family patterns, gender, and personality (Gans, 1992; Motherwell, 2002; Newcomb & Rabow, 1999). Money can represent power, love, freedom, or security; these relational concerns tend to evoke strong feelings and reactions in clients. The boundary issue of payment for psychotherapy defines the relationship between therapist and client. Each time fees are raised or lowered, negotiated, paid or unpaid, the boundary shifts and new feelings and meanings arise. Money issues in group therapy afford group members an opportunity to explore family patterns, individual meanings, feelings about the therapist, and assumptions about one another with regard to money.

DESCRIPTION OF GROUP

This technique can be used in time-limited group, or in ongoing therapy groups that periodically use exercises or techniques to enhance the treatment. The exercise allows members to know one another at a deeper level as they learn about their own relationships to

money. It works in mixed-gender groups, women's groups, divorce groups, and culturally diverse groups by encouraging members to share differences in how money is perceived and dealt with. Because the method builds group cohesion, it should be used in the early stages of group after the group has developed some trust. I have successfully used these techniques in ongoing psychodynamic therapy groups, and with psychotherapists who want help dealing with fees in their practices or want to work more effectively with their clients about money issues.

DESCRIPTION OF INTERVENTION

Physical objects play an important role in development over the life span. Transitional objects represent the relationship between the child and his or her most important attachments (Winnicott, 1971). The Teddy bear, blanket, or soft toy that the child takes everywhere represents the soothing relationship between Mother or Father and infant. The object allows the child to separate from the parent by reminding him or her of the nurturing parental relationship when he or she is alone or upset. "Evocative objects" have been used in both childhood and adulthood as "objects-to-think-with" (Papert, 1980; Turkle, 2007) and as objects on which to project thoughts and feelings. Like the Rorschach, an evocative object invites projection through which one can learn about the world, one's relationships, and oneself (Turkle, 1984). In this intervention, we use the evocative object to understand our relationship to money.

I ask group members to bring in an object that represents something about them, their family, and money. Such an object often evokes strong feelings of pride, shame, disappointment, yearning, sadness, and anxiety. Due to the deep sharing, this exercise tends to help the group cohere; indeed, it may become a metaphor for the group and its money matters in the group. In exploring one another's stories, the members can address issues of culture, gender, societal expectations, prejudices, feelings of shame and pride, greed and generosity, and deprivation and fulfillment, as well as intergenerational family patterns with regard to financial matters.

Step 1: Clients bring in an object that represents something about them and their relationship to money. I give each client a list of questions to consider as they decide which object to bring in:

- What do you, your parents, and your grandparents do for a living?
- What socioeconomic status did each generation grow up in?
- How/did your parents talk to you about money? What did they say?
- Were there any catastrophes in your family related to money? Any windfalls?
- Were there any secrets about money?
- Did money build or destroy any family relationships?
- Was there a family business? Did it get passed down and if so, how?
- Who had a job? Who didn't?
- Who (literally) paid the bills in each generation?
- Were there any surprises in the family's wills (either positive or negative)?
- Did anyone lose or make a lot of money?
- What myths about money did your family pass down? About whom?
- What have you taught your children about the value of money?
- What concrete tools have you taught your children (e.g., budgeting, about credit card debt, retirement accounts, loans, investing, etc.)?
- What were you taught (and what were your parents taught)?

Step 2: Before the group members share their objects, I ask them to write down three assumptions they have about the other group members' relationship to money.

Step 3: After I ask each member to tell the story about his or her object to the rest of the group, the other members share feelings, thoughts, or fantasies that come to them as they listen to the stories.

Step 4: When every person has finished sharing his or her object, I ask the group to look at their list of assumptions, and ask them how accurate their assumptions were.

Step 5: I encourage the group to talk about how they feel about my billing policies and my role in setting them.

TYPICAL RESPONSES

In a long-term psychodynamic group whose members were consistently late in payment, I asked the members to reflect on what meaning the lateness had to them as individuals and to the group as awhole. They resisted discussing the issue, so I asked them to bring in a physical object that represented something about them, their family and their relationship to money. My intervention was unusual, as I do not normally use concrete exercises in this group, so both the change in the group norm and the use of physical objects were provocative.

One woman who had not paid her bill in several months brought in her checkbook. She said, "I have never balanced my checkbook. I always guess as to how much money is in my account. Sometimes I'm wrong, and I bounce checks. My parents were irresponsible with money and eventually went bankrupt. I think I feel bankrupt myself, so I don't feel I can pay you."

Another woman brought in a bottle of expensive perfume. She cried as she said she felt ashamed of growing up in a wealthy family. She said she had not paid her bill because she did not want other group members to be envious of her ability to pay.

A man who had gone through an expensive and high-conflict divorce, brought in a photo of a red 1957 Chevrolet Bel Air convertible. He had a passion for cars, especially those from his teenage years. He remained bitter about his divorce because it was so costly and he had to sell his prized Bel Air. He was able to express his envy and anger toward me, whom he saw as successful and wealthy.

Each of these comments led to deeper discussion about the meaning of money in the group and outside. Toward the end of the session, I asked the members to reflect on what assumptions they had made about others in the group. Many of the members had been right about how much money people had, but most had no idea how others handled their finances, how they felt about money, or what meaning they made of it. The exercise allowed members to see how assumptions are often wrong or only part of the story.

CONCLUSION AND CONTRAINDICATION

The availability of a physical object on which to project one's psychology allows group members to talk about money in displacement, which can decrease anxiety and open the door for a richer discussion. The physical objects themselves are easy to remember and can often act as a group metaphor, which can be referred to again and again.

It has been my experience that this exercise does not elicit any contraindications. Money was a part of our past, is a part of our present, and will be a part of our future as long as we are alive.

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Chapter 12

Expect the Unexpected: An Intervention in a Psychodynamic Women's Group with Pregnant Women

Maria van Noort

INTRODUCTION

One ongoing group in my private practice consists of eight women who come together every week for ninety minutes. The indications for the women in this group vary from learning autonomy in intimate relationships, to standing up for oneself in conflicts, working on a more realistic relationship with their mothers, and functioning better in work situations.

PATIENT POPULATION

Diagnostically, these clients suffer from depression, identity problems, and borderline character difficulties. This ongoing group is closed. Only when a person leaves may a new one enter the group. Most members have been in individual treatment with me for a while.

The Issue of Boundaries

As a female therapist in an all-female group there is much emphasis on the special importance of boundaries (Oakley, 1996). This is due to the fact that so many women have experienced inner and outer boundary violations. Trying to prevent boundary violations does not

imply that they will never occur but certain precautions may be implemented to attenuate their occurrence. In order for group members to work on personal issues and feel safe within a group, these members need to know that there are boundaries in the group and this structure often helps to reduce anxiety (Nitsun, 1996).

The Group Contract

Groups as such are very much like an infant in the sense that a group needs to be held firmly together by boundaries; in this case the boundary of a group is developed in the group contract and is set by the therapist. Through working together, within this contract, the group develops a safe envelope, a "group skin" (Anzieu, 1989).

Therefore before new members enter the group they are informed about the group contract. In this group, like in all other psychodynamic groups, clear contract boundaries are discussed in advanced such as:

- Always meet at the same time and at the same place.
- The therapist and the group members give advance notice about vacations, cancellations, and payment.
- The profundity of respecting the confidentiality of other group members is paramount.
- It is important to arrive on time and verbalize what they feel and think. Group members must know what belongs inside of group and what belongs outside of group.
- Socialization is strongly discouraged outside of the group, but if it does occur, the patients are encouraged to bring into the group what was discussed during this outside meeting.

THE SITUATION BEFORE THE INTERVENTION

In the early spring, one group member shared her joy at being pregnant but she also felt discomfort that the baby was incorporating her.

Later that spring, another member told us she was pregnant. She had not yet let her mother know because she first wanted to feel separate from her mother. Her mother incorporated her too much. Before the summer vacation, a third member mentioned she was expecting her third child. She also had problems relating to her mother.

The group now had three pregnant women, which in itself begins to alter the dynamics of the group and, at times, brings in some unforeseen issues.

One evening, before the group started a group member called me. The following is a summary of the conversation. (The group member is represented by the initials "PT;" the therapist is "TH.)

PT: "I am so stressed! I want desperately to come to the group but my husband has not shown up yet to take care of the newborn baby." I heard tension in her voice.

TH: "See what happens, maybe he'll arrive soon and then you can come later."

(Twenty minutes later the bell in my office rang and there she was with her baby girl.)

TH: "Come in, hello. (I felt overwhelmed and touched to see in this first glance a small child with her mother.) "Do you need anything special for the baby?"

Everyone in the group admired her baby. The group members started to talk while I got nervous about my central heating, which was not working well that day. Was the room warm enough for the baby?

Group members explored positive and negative feelings about other issues in their lives. At this point, the group was developing into an advanced stage. A greater working-together stage Members were talking freely about relationships with their mothers, exploring voids in oneself, being angry toward me for not giving enough care, and jealousy toward one another's assets (Bernardez, 1996).

An unexpected event occurred during the group. The mother breastfed her baby, and then stood up quietly to comfort her child and let the child burp. The whole scene seemed very natural. The baby was in the group before in her mother's body and may have heard our voices. Yet my role as group therapist had been challenged. The new baby had come through the "group skin."

Three weeks later after getting a phone call that the second pregnant woman had given birth, I decided that I needed to address the boundary crossing which had taken place–bringing the baby into the group. A boundary needed to be formulated and a change in contract implemented. I experienced the multiple new lives in the protruding

bodies as a group within a group although I had never before had a subgroup such as this but I did not want three new members, either!

INTERVENTION

Addition to the Contract

Generally, we try not to change a group contract once the contract is in place. This can lead to difficulties within the group as a whole. Often, the request for a contract change occurs because a specific patient has certain needs that require this alteration but ultimately changing the contract for one member can work against the concept of equality of everyone in the group and alter the foundation that has already been established. At times, the group as a whole has in its totality a specific need that needs to be addressed and changed. For example, the group meeting time might be too early or too late for all the group members.

In the case related, an implementation was required to avoid difficulties in the future for both the patients and for the therapist. As the group therapist, I related this new addition to the contract.

> A couple of weeks ago when one of our group members came in with her little baby I was touched and somewhat overwhelmed. It was a "special" situation and I was worried and nervous because the heating had broken down and I was concerned how having the baby here might have affected all of you. I, also, felt that I could not be as attentive to your needs as I wanted to be because my attention was distracted. I propose that in the event that someone does not have a babysitter, that this problem will not be taken to the group but will be resolved elsewhere, which might include not being able to attend the group on that particular day.

CLIENTS' RESPONSES TO THE INTERVENTION

Pregnant and nonpregnant women found a common ground in this discussion about an addition to the contract. The childless woman in the group admitted she found it difficult but very helpful being in a group with pregnant women. She felt that she could be around preg-

nant women comfortably and she stated that this particular case had been an emergency.

The patient, who is not a natural-born U.S. citizen, and who brought her baby into the group disclosed that she would have never dared to do this in her country of origin, which opened discussions of what is appropriate and not appropriate for a situation.

This, also, opened an interesting conversation about the negative feelings some had felt about the event which led to feelings of ambivalence and how to take care of the little child inside of oneself.

CONCLUSION AND CONTRAINDICATIONS

This intervention was useful in an ongoing psychodynamic group. As a group therapist I found it important to show my own limitations as well as the need to take care of myself and of the group. Boundaries between self and others become more blurred during pregnancy and the group therapist needs to be consistently aware of this possibility occurring in this particular type of group.

The contraindications of this procedure are an aspect of the therapeutic process and lie within the professionalism of the therapist. My own vision of the group had become less clear as well. I had not previously seen or predicted a "group within the group." Once I became aware of its existence, I chose to draw the boundary and alter the contract around the women in the ongoing group "sans babies."

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Chapter 13

Using Dreams in Group Therapy

Robi Friedman

DIFFERENTIATING BETWEEN DREAMING AND DREAMTELLING AND THREE WAYS TO APPROACH DREAMS

A dream told in a group has a strong impact on its working culture, openness, trust, and deepens the understanding of individual and social unconscious processes. Although dreaming may be highly influenced by interpersonal stimuli, it is an autonomous, intra-psychic function. Dreamtelling is a social event, making it especially interesting in groups. Questions like: "To whom do we tell a dream and why? What is consciously and unconsciously expected from telling a dream and when?" may guide us to work with the difference between dreaming and dreamtelling (Friedman, 2002, 2004).

I use three approaches to a dream – the more familiar "informative" (Freud, 1965) and "formative," uses along with a new approach that focuses on its interpersonal and intersubjective aspects, which I call "transformative" of relations. A dream may interest us not only for its connection to its past or its personal or group meaning but also for its interpersonal and intersubjective impact on the future of the dreamer-audience relationship. Resonance and mirroring (Foulkes, 1965) are considered by me as identifications with powerful contents (Bion, 1963) and communication.

DESCRIPTION OF POPULATION

This population included a group of nine late-age adolescents with the mean age of twenty years, consisting of three young men and six women. Most of them were in individual outpatient therapy for different periods of time. Basically, they were fairly well-functioning college students with different problems in relationships. I worked with a female cotherapist in her late twenties for about ten sessions.

DESCRIPTION OF INTERVENTION

Descriptive Example

On the second morning of the group, one of the clients, whom I will refer to as "A," the most introverted, shy and somber male participant in the group, related a dream: "I'm part of a gang which consists of frightening strong men, who curse women."

Step 1

I suggested to the group that instead of interpreting the dream we could respond to the dream with our own experience, as if it was our own dream. This procedure, I said, included the dreamer.

Step 2

"A" says he often feels very attracted to this type of a gang and it is not his first dream about this particular topic, although in real life he has never experienced this situation.

Step 3

The first responses of the group came from client "M," a young and attractive woman, who told how she felt bullied in school. She felt so frightened that she refused to go to school for a while. Client "T," another young woman, described her loneliness. She could not really tell her mother how rejected she felt both in school and in her family, because she did not dare to be a burden on her. Client "U," a man who had made a beginning impression of being strong and spontaneous

started to describe his inhibitions with other people, especially with women. Whenever a woman is around he said he felt almost paralyzed, regardless if she is attractive to him or not. To him, every woman is attractive and frightening. Client "R," the third man, joined him by saying he felt very similar, only even more inhibited. He could never look someone in his or her eyes and he wished he was not so weak. He used to strengthen his body exercising but to no avail, as it did not help him to feel more open and secure. Client "A" related that he is often very angry at other people. The cotherapist asked him if he feels angry here in the group and he shouts and curses at us.

Step 4

Both the immediate and obvious responses to the dream as well as later communications, which are less evidently connected, are considered associations to its manifest and latent emotions. I make an effort to collect the responses, including my own, which was a feeling of sorrow and sympathy with the dreamer. I first summarize, aloud, some of the responses and conceptualize some of the contents for the group. I say something about being insecure and fearing the other sex. I describe how it must feel for a young frightened man to have to approach attractive women and how men often are threatening to women. This intervention, which conceptualizes the dream's ability to focus on the group's cross-gender occupation, goes on also in the next few sessions.

Step 5

This step involves the interpersonal use of the dream: at first I said that the dream had stimulated a lot of significant responses from everyone, and asked the dreamer if he felt understood by the responses. He said that he did not understand everything, but some responses were very close to what he felt. Then I asked if we had managed to set up a "Safe Space" for sharing dreams. They did not answer, but I felt my remark had opened another possibility for the group participants and was later corroborated by a second dream which was shared.

Next, I considered the relationships generated by the dream, between the dreamer and the group, and how its overt and hidden communications affected the sexes. My interventions concentrated on two processes in the group: (1) first the steps in A's emotional posi-

tions as a function of the development in the relationship in the group, moving from feeling aggression as a defense against loneliness, insecurity, and resentment toward threatening women to the uncovering of his pain; and (2) the process in the group relationship from his initial wish, conveyed through the dream, to frighten the female participants in the group with his potential violence and denial of their existence.

The women, in the group, actually responded anxiously to the dream's cursing communication, but soon enough they calmed down and their attitude changed to a less frightened, more compassionate one toward Client A and men in general. The strong feelings in both men and women initiated by the dream were used in the group to moderate and mature feelings toward the other sex.

CONCLUSION

In therapy I use a progressive interpretation technique that always begins with "dreamtelling" experientially. My interventions gradually shift from the content to the relationship created through the dream, trusting and using the group's significant reactions to it.

CONTRAINDICATIONS

There are at least two *contraindications* to interpreting: the individual's situation and the group's maturity must be judged by the therapist as sufficiently mature to handle deep and frightening emotional content. I evaluate the situation using the dream's structure, my knowledge of the dreamer's psychic conditions, and his or her relationship with the group. If the dream is fragmented, indicating that both the dreamer's situation as well as the group's relationships may be in jeopardy, I tend to use a "formative" approach. Although the "informative" approach deepens the level of dialogue, the "transformative" use uncovers the relationships generated by dreams; a "formative" approach first acknowledges the need to structure dreams with noninterpretative means. It tries to form a safe-enough space to contain the difficulties without threatening the emotional existence of the dreamer or the group.

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Chapter 14

A Ranking Task As an In-Vivo Experience of Negotiation Awareness in an Interpersonal Skills Training Group

Haran Wernik

INTRODUCTION

As therapists, we usually have a preconceived idea of what we hope our group participants will learn, and how they will grow and change through their group experience with us. The difficulty, which arises and probably daunts most dedicated therapists, is how to ensure that our clients receive what we hope will be of greatest benefit for them. As suggested by Fielding (1983) and by Chickering and Gamson (1987), the more actively involved the members are in a group the greater the chance for true learning to occur. Subsumed under this belief is that the group leaders steer the ship in the most positive and effective direction for the learning, growth, and change to occur.

The group that led me to use the task I describe here is considered to be a psycho-educational/experiential life skills group (Powell, Illovsky, O'Leary, & Gazda, 1988). We were working on interpersonal skills (Finch & Wallace, 1977), and in the sessions preceding the one in which we used the task; we approached the concept of assertiveness (Zappe, 1987). The next topic we were about to introduce was negotiation skills (Mueser, Levine, Bellack, & Douglas, 1990). Our previous session tipped the scale toward "educational" and we were looking for ways to move back to an effectively more "experiential" group process and create greater interpersonal and interactive experiences between the group members.

The task we devised and initiated was an idea suggested by my cotherapist (A. Stern, personal communication, March 15, 2007). Group members were asked to rank, in an agreed-upon manner, a set of meaningful stimuli, which in this case were elements effectively leading to recovery. There were no further instructions or guidelines given after what we requested them to do. This task promotes debate, requires negotiation, and provides, for the client and the therapist, insight into which group members are more passive and active in these kinds of interactions. Depending on the topic chosen for the task, it may be used to shed light on various aspects that can contribute to the group process.

CLIENT POPULATION

The intervention was generated for a life skills group in a psychiatric unit in a general hospital (fifteen to twenty inpatients staying for an average of three weeks). The population on the unit is diverse both in age range and in diagnoses. Although best suited for inpatient settings, with some adaptation, this technique can be used with most forms of skill-training groups, as well as with more dynamically orientated groups. The only requirement is that the group members have ability to communicate verbally.

GUIDELINES FOR INTERVENTION

Materials

You will need about ten pieces of 3 × 5-inch cardboard, each marked with one of the items to be ranked (e.g., Medication, Individual Therapy, Occupational Therapy). You need to write in large enough letters so the group members can see them from a short distance. Consider adding another two to three empty pieces of cardboard and a marker, if the members would like to create additional items.

When my group did this task they ordered the pieces according to their ranking on the floor. With a bit of extra preparation you can upgrade the project. You can glue Velcro strips to a standing board and patches to the backside of the cardboard pieces, and that would allow

the group to perform the ranking task on the board instead of on the floor.

Items to be Ranked

The importance of the items to be chosen is not in their content, but in their relevance to the group members. The topic must be one that has the potential of fostering different opinions and a passionate discussion.

My coleader and I led; we chose "elements that help recovery on the unit" as a topic for the ranking task. These included: individual psychotherapy, weekly meetings with the psychiatrist, medication, occupational therapy, talks with the nursing staff, group therapy, talks with other patients, a structured daily routine, being in a safe environment, and morning talks (not psychological).

Additional Topics

- Values (respect, honesty, etc.)
- Characteristics of a good friend (loyal, cheerful, etc.)
- Life goals (family, individual happiness, etc.)

Administration

1. *Introducing the task:* The true nature of the task is not readily disclosed by the group leaders in order to avoid creating any confounding variables thus altering the task at hand. Instead of disclosing that the task is intended to experience assertiveness and negotiation in a live manner, the task is described in terms of the topic chosen for ranking.

Another way would be to state that you want to introduce a new topic, but first you want to begin with a task that will lead to the chosen topic, thus initially withholding the title of the topic. In our case we told the group that we wanted for them to have a better idea of what is most important in the "process of recovery."

2. *The actual task:* Spread out the items in a random order on the floor in the center of the room (or on a board), and tell the group that their task is to rank the different elements in order of importance in an agreed upon manner.

You may want to give a time limit for the task. In our case we told the group they had twenty minutes to complete the task, leaving forty minutes for the following discussion. Try to avoid answering questions by group members that relate to how the task should be done. The only thing the group needs to understand is that they have to complete the rankings as a group. Say only as much is needed to get the activity started.

3. *Follow-up discussion:* The discussion begins once the allocated time is over, or if the group was able to complete the task before the time limit. In our case we followed the task by several leading questions that we deemed relevant, yet different questions might be useful depending on the group characteristics.

First, we discussed what the actual concept of the task was seeking. We further explained that the task was actually an introduction to our next topic, and asked the members to guess what they thought that topic could be. Then we disclosed that our topic is negotiation skills, and that the task is also relevant to most of the interpersonal skills that the group members accounted for when guessing the topic.

Next, we asked each member to share with the group their experience during the task in terms of their personal experience and their observations and reflections regarding the group process. During this phase additional questions were asked of individual group members. These were aimed at getting a better understanding of the roles each member took, the relevance of the role taken to other experiences in the group and in life, and reactions to behaviors of other members (cognitive, emotional, and behavioral). Finally, we asked in what ways the task could have been handled more effectively without evoking as much heated debate.

CLIENT RESPONSES

When initially presenting the task to the group, the members tended to flood the leaders with questions about how to complete the task. Withholding specific answers caused a certain degree of stress, but after a couple of minutes the group understood the idea and started working. In our case the task led to a heated debate between a few of the members. Some took very active roles, others seemed not to be able to find their own voice unless asked directly by another group member, and quite a few negotiations took place that allowed the

group to reach a final ranking. The fact that the task invoked passionate participation led to a lively discussion and perhaps also increased the motivation to learn about negotiation skills in the following session.

CONCLUSION

What seems to be most effective about this activity is that it can be tailored to a variety of settings and goals. Its strength lies in its ability to encourage the manifestations of specific behavioral skills and patterns in a psychologically safe environment thus eliciting behaviors and disclosures in what seems to be a natural manner of expression. Although this exercise was administered only once due to its recent inception, the feedback from the participants, as well as from the therapists working with individual group members, was exceptionally positive and very reinforcing.

As of this date, there seems to be no evidence of possible contraindications. It is not a frightening task for the clients but the therapist must be cognizant that the more active and verbal members may take over the entire discussion in the group. The therapist needs to help and encourage the more silent members to find their own voices if the other group members do not elicit that response from the nonverbal client. It too is suggested that the introduction of this exercise be implemented after the group enters into a viable working phase, where members are willing to try new group experiences.

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Chapter 15

Interventions in Groups with Clients Sharing the Same Critical Fact

Cristina Martinez-Taboada Kutz
Ainara Arnoso

WHEN SOCIAL REGARD NEEDS ADJUSTMENT

Among mental health professionals there is a tendency to gather a group of individuals sharing the same critical situation in their lives in order to empower their psychological capacities and social competences. It is a useful way to increase the potential for overcoming an issue(s) they share together.

The group process that is to be discussed is to introduce an intervention that is especially designed for clients who have already shared their personal emotions and have begun to understand what has happened to them. The aim of this intervention is to increase personal strategies related to some kind of social comparison and relationships, which they are expected to confront in their lives at any time.

The conceptual guidance is based on theories of social identity (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) as well as the model of psychosocial intervention (Martinez-Taboada, 1992; Martinez-Taboada & Arrospide, 1996; Martinez-Taboada, Gonzalez de Medibil, Arnoso, & Elgorriaga, 2006).

CLIENTS

The clients, in this particular group, are people who have a critical circumstance in their lives. For example, a diagnosis of chronic ill-

ness, parents whose child was diagnosed with a particular syndrome, widows, individuals in the early stages of divorce, etc. These groups could be formed with any group of people sharing a common bond and psychological task that makes them feel vulnerable, uncertain, or with an identity struggle that maybe in contradiction to the "norm." The clients should have as a basic premise a wish of overcoming their difficulties and have the cognitive capability to express and share their experiences.

This particular group matrix can be both time limited and open ended. This does not suggest with an open-ended group that clients can come and go as they wish but rather need to commit themselves to at least a certain period of time established between the client and the therapist.

INTERVENTION DESCRIPTION

We are in a room with a group of individuals who are sharing a specific situation in their lives that elicits suffering and with which they have been working together for a number of sessions. They have now gone through a phase of emotional relief in the group and they are beginning to perceive how their particular personal event has affected their present-day social relationships. They are now at a point where they feel the need to readapt their daily lives in relation to how they are being perceived by others.

In this case, they are aware that they are being perceived by others in a pitiful or commiserative way. This is the reason, they feel, that they need, above all else, to rebuild their situation with themselves and with friends, neighbors, and other interpersonal relationships. Furthermore, they feel they are being perceived as a person with their own specific characteristics that now include the self-concept of being seen as "ill or different." For instance, they are now being labeled by others as "parents of a child with Down's Syndrome, widow or widower, divorced individual, etc." This perception, from others, comes from the clients acquiring a different social status category which they feel places them out of the "norm." Due to this new perception of them, by others, they have internalized a sense of feeling different with concomitant feelings of low self-esteem.

A THREE-PHASE INTERVENTION

Phase One: Unveiling the Steps

A focused question is posed to the group to spur dialogue and interaction. *"How would you describe yourself apart from being a divorced individual, parents of a sick child, etc.?"*

Everyone is asked to describe at least three aspects of themselves apart from the critical fact that brings them into the group. It is advisable to ask them to do it on their own on a piece of paper, which would be provided for this purpose. This is a way to help them focus on their inner task and on what they have to write.

Afterward, the chosen aspects are held jointly. Probably, some aspects would turn up related to some characteristics as personal qualities and affections (friendly, kind, charming mother, shy. . .) as well as (professional careers, social life features such as being a good neighbor, good friend, nice partner, etc).

The professional proceeds to show that if there is a positive inside structure, the clients will be able to see themselves distinct from their shared critical fact and will not be stuck or stagnated in that fact or label. Therefore, their relationships would not be experiences of displeasure or social disappointment but rather ones of a sense of well-being.

Phase Two: Discovering the Aim

The next step will be to become aware of the process itself. Every member is encouraged to bring to the next session a second exercise. They are requested to describe and write down briefly a situation that had made them feel *good or bad* relating with their actual situation.

By this, we can analyze how they feel in social interactions. Talking about it in the group will permit them to redefine attributes and make proposals of how to get away from the perception of unfavorable situations and be able to reinforce the positive ones. Nevertheless, this negative perception is just a small part of their total identity.

The grade of perceived vulnerability is, above all, inside of the clients themselves. Neutralizing this negative affect allows a kind of emotional distance to readjust their social activities and social self-esteem, which should be, after all, a constructive ingredient in their lives.

Phase Three: Feedback

The last step of this intervention will be to put forward feedback with all the contributions of the group about the same issue.

We ask the members to share the most suitable strategies they have found, how they plan to use them, and also which ones they have been wondering about. Social self-esteem is needed in order to integrate the valueless perceptions into a positive way.

Therefore, the aim is to diminish the urge toward negative self-talk and to enjoy little daily things and to give importance to what deserves importance.

RESPONSE OF CLIENTS TO THIS INTERVENTION

Clients usually realize that coping with conflict with the group is a helpful way of dealing with it. They learn that when they are self-focused, most of all on themselves or specifically their condition, social interactions become more complicated as they introject what is transmitted by others, i.e., condolences, pity, and or affliction.

Speaking about it together inside the group elicits feelings of not being alone and the potential of other possibilities and strategies for personal interactions. The sense of elaborating, contrasting, and sharing makes it easier to put into practice these new strategies.

CONCLUSION AND CONTRAINDICATION TO THIS INTERVENTION

The purpose of this kind of procedure is to show that when one of our circumstances becomes a threat, it affects not only oneself but also one's social self-esteem as we are perceived by others. Through the use of group therapy of this kind, the client has the opportunity to improve his or her relationships with others and with himself or herself. In other words, this type of group gives clients the opportunity to become conscious of the interaction between social comparison, social identity, and psychosocial well-being.

There are not any contraindications in this kind of intervention but rather multiple opportunities for clients to grow and redefine themselves after an event that has changed their lives.

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Chapter 16

Bridging in Group Therapy Using Movement Improvisation

Joan Wittig

AUTHENTIC MOVEMENT

In order for a psychotherapy group to progress, each member of the group must be involved in expressing his or her thoughts and feelings. When some members are not expressing themselves, the therapist must intervene to engage those members who are not participating. Louis Ormont uses the term "bridging" (1990, p. 3) to describe the process of facilitating meaningful communication between group members, and to foster emotional connections. The therapist creates connections between group members by asking questions that help the members to talk to one another. For example, the therapist might ask Patient A why Patient B is so silent today. Or perhaps the therapist will ask Patient C what Patient D is feeling when she wiggles her foot like that. Bridging techniques are also useful in helping group members to identify, explore, and resolve resistances. The intervention described that follows involves an adaptation of a form of dance/movement therapy called "authentic movement" (Whitehouse, 1963). Authentic movement is a simple form in which one person moves in the presence of another. The mover waits for an impulse to move, learning to wait for the movement to come from within, and then follows where it leads. The form of authentic movement is adapted here to create an improvisational structure that can be used as a bridging technique in groups.

PROCESS ORIENTED GROUP POPULATION

The following intervention is best used in a process-oriented group in which clients are willing and able to think about their reactions to the behavior of others, report these reactions to the group, receive feedback from other group members, and use movement to explore their emerging thoughts about their own and others' behavior. I have used this technique in an ongoing weekly group for compulsive overeaters and in training groups for therapists.

A SEVEN-STAGE INTERVENTION

Step 1

The group begins with each member identifying verbally, one at a time, the issue that feels most urgent or present in this session.

Step 2

The group separates into pairs. Pairs can be assigned according to identified issues, or according to relationships between the group members, or can be randomly determined by the therapist, or by the group members.

Step 3

Each pair decides who will move first and who will witness first. The witness then tells the mover again what his or her issue is.

Step 4

The mover closes his or her eyes and lets the witness's issue run through her mind. The mover waits for some kind of an impulse in his or her body, and then uses this impulse as a place to begin exploring the issue in movement. The mover works for a length of time determined by the therapist, who acts as timekeeper. The witness sits or stands out of the way of the mover and watches.

Step 5

When the mover is finished, mover and witness talk together. The mover speaks about thoughts, feelings, images, sensations, and ideas that occurred to him or her as he or she explored the identified issue in movement. The witness then speaks about thoughts, feelings, images, sensations, and ideas that occurred to him or her.

Step 6

The mover and the witness switch roles. The witness becomes the mover and the mover becomes the witness. The process is repeated from Step 3, beginning with the new witness telling the new mover what his or her issue is and ending with the mover and witness talking together about their experiences.

Step 7

The group comes back together and uses the experiences in the pairs to further their work in the group for the remainder of the session. Group members will share as much or as little of what happened in the pairs as they feel will be useful to themselves and to the group.

CLIENT RESPONSES

Typically, clients are interested in and receptive to information they gather through working this way. Witnesses are often relieved that someone else is doing the work of exploring their difficult or painful or confusing issues. They tend to feel seen and understood by the other person. Movers are often relieved to be working with someone else's issues, rather than their own. They are usually relieved not to be in a role in which they are assumed to know something or to be an expert. They tend to be happy at the limited responsibility to share what comes to them in the movement improvisation. Clients are often able to engage in deep explorations during the exercise precisely because they do not feel attached to the issue; although, of course, their explorations are actually about their own relationship to the material.

CONCLUSION

Many variations of this intervention may be used. For example, if the group members are too self-conscious to move, the exercise may be done through imagination. The mover, instead of actually moving, may close his or her eyes and imagine the movement, including the way it would look and feel. Or rather than using movement, the therapist could substitute art or writing.

CONTRAINDICATIONS

This technique may be contraindicated for clients who are too self-conscious about movement in front of other clients; they would not actually be able to explore another client's issue. This would be difficult not only for the mover, but also for the witness, whose issue would not get explored.

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Chapter 17

"What's So Funny?" The Group Leader's Use of Humor in Adolescent Groups

Sean Grover

THEY CAN TALK ABOUT ALMOST ANYTHING

It is nearly impossible to run an adolescent group without a sense of humor. For teenagers, a group leader without humor is just another authoritative, critical, or disapproving adult, the last thing any adolescent wants. Creating a lighthearted and playful spirit in an adolescent group is an art (Malekoff, 2004). A skilled leader encourages humorous banter, often initiating and exemplifying it. When problems are approached lightly with teenagers, they can talk about almost anything. Word play, puns, story telling, jokes—these are important tools. If applied correctly, they sooth feelings of hurt and alienation that so often interfere with relationships and that play teenagers and adults against one another (Gadpaille, et al., 1968). Too much seriousness often plagues teenagers' emotional, academic, and social life; a positive group experience can offer much-needed relief.

AM I A HOSTAGE IN THIS GROUP?

Unlike many adults who choose to be in therapy, many adolescents enter treatment as "hostages." They did not opt to be in a group, their parents or school psychologist made the decision for them. Once deposited into a group, they are almost certain to feel uncomfortable

and to experience much anxiety and fear. Humor is especially important in the early phase of group. Our first task is to relieve anxiety and resolve resistances to participation, and for this humor is our most disarming instrument. After all, the ego of an adolescent has been weakened and made unstable by the massive psychological shifts and physiological maturation. As a result, adolescents confront feelings of uncertainty and insecurity daily. When they enter a group, these feelings often intensify and can easily develop into paranoia. At this stage, the leader employs humor to defuse their anxiety and tension.

INTERVENTION

Interventions are best made in the spirit of good humor and playfulness. Humor is also your ideal resort for defusing hostility that could become disruptive. The best way to convey humor is to model it yourself by being good-tempered, relaxed, and at ease. Above all, use humor to avoid the "know it all" attitude that would create a totalitarian state in the room. Instead, assume a lighthearted and curious stance, even if it means making yourself the butt of your humor. In doing so, you demonstrate that you, like them, are not perfect and the group is a place to explore insecurities in a playful way—not a place for judgments or criticisms.

EXAMPLES OF THE INTERVENTION

Example One: Humor Can be Used to Disarm Tension and Hostility

In an inner-city school, the decision is made to start a group in order to address the rising tensions between students and their teachers. The student population is composed of minority youths from low-income families; the school staff is nearly entirely Caucasian and from the middle class. At the start of the group, angry students are hatching a plan to harass a teacher and disrupt his class.

STUDENT: He hates us. He's evil.

LEADER: How do you know he's evil?

STUDENT: Because he is white.

LEADER: Oh, I know what you mean. My father was a white man.

STUDENT: So are you.

LEADER: Only on the outside.

STUDENT: You aren't black.

LEADER: You haven't seen my soul (laughter).

The students are perplexed. An adult joking while they lecture? As the banter continues some students begin to laugh along with the leader. The permissive atmosphere that ensues invites them all to talk and to put into words their feelings about racial and cultural differences.

The subject of racism is not an easy one. Without humor, serous tensions may have escalated and spilled out of the group into the school. Had this happened, the group may have done more harm than good.

The therapist's use of humor also helped the students to arrive at an important discovery: racial differences could be addressed in the school in a productive and non-threatening way.

Example Two: Remain Unflappable

Humor is also the ideal way for a therapist to cope with personal attacks. Every group leader is subject to verbal abuse and this is certainly true when you lead adolescent groups. You cannot possibly be popular with every teenager and many will transfer all their rage toward their parents or other adults onto you. When you are verbally attacked, never counterattack. Take it in stride; remain unflappable. In this way, you are modeling for the group members how they themselves can cope with hostility without becoming reactive.

In the following example, a group of teenagers addresses another loaded subject—homosexuality. Here the therapist uses humor to make it possible for the group members to discuss this taboo topic.

STUDENT: Are you gay or straight?

LEADER: I like to keep all my options open.

STUDENT: Well, are you?

LEADER: Am I what?

STUDENT: Gay or straight?

LEADER: I certainly could be.

STUDENT (exasperated): Why are you so strange?

LEADER: Why are you so normal?

STUDENT: I'm not normal!

LEADER: Finally something we can agree upon.

The student laughs and soon the group is on the way to a lively discussion, talking with much energy about a subject they previously approached in hushed tones or did not talk about at all.

Example Three: No Subject Is Off Limits

Spring break is over—the group sits in sullen silence. The leader suddenly announces with mocked seriousness:

LEADER: Okay, everyone look depressed. (Pause) Good job. You're doing great. (Pause) Tell you what; if you guys don't start talking I'm going to share the intimate details of my sex life.

(Several students laugh, while others cannot tell if the therapist is kidding.)

STUDENT (to the leader): You're probably still a virgin.

ANOTHER STUDENT: You mean like all of us?

A spirited debate begins about sexuality and soon energy flows into the room. The students begin to talk, not about the therapist's sex life, but about their own.

CONCLUSION

I have led adolescent groups in schools, clinics, and my private practice for over a decade and I continue to be enriched by the fun and playfulness that accompanies working with youth.

As Tennyson wrote, "Ever with a frolic welcome took the thunder and the rain," when a group leader adopts a stance of good humor he models how to approach life's challenges with ease and lightness

(Tennyson, 1986). As group members internalize these qualities they become better equipped to handle anxiety and resolve conflicts.

Too many young people are surrounded by chronically stressed out adults for whom life seems a fundamentally unhappy enterprise, something to be endured rather than enjoyed. With humor we model a very different approach to living, one that teenagers can readily embrace: if life is a roller coaster, why not enjoy the ride?

CONTRAINDICATIONS

Never use humor in anger or force humor in inappropriate moments. Teenagers are easily hurt. In addition, mocking or ridiculing a group member, by a leader or fellow member, is never acceptable and will destroy the spirit of your group. It may appear harmless but in time, attendance will taper off and the group will fall apart. I have seen this happen many times.

Keep it simple, stay light. Focus on connecting with teenagers and humor will flow quite naturally. Above all—be genuine. Do not use humor to win approval because teenagers in particular reject adults seeking to win praise or admiration.

And finally, never try to be funny; instead, work to create a playful and open atmosphere. Teenagers who feel accepted and warmed by a good-humored group leader are sure to look forward to group. More importantly, they will return willingly week after week. Soon you will find, as the teenagers are enriched by a positive group experience, you are well on your way to achieving your ultimate goal—awakening in them the hunger for more mature and satisfying relationships.

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Chapter 18

Using Grammar to Increase Immediacy and Affect

Martha Gilmore

DISTANCING FROM EMOTIONS

One of the common difficulties I face in my psychotherapy groups is the tendency for group members to intellectualize and distance themselves from emotions and from others through use of a polite and formal grammar. This often leads to confusion and boredom and keeps members stuck in their old patterns of relating. While grounded theoretically in a psychodynamic framework, I use a variety of techniques in my groups including many that stem from my early training in interpersonal Yalom-style (Yalom, 1995), gestalt (Polster & Polster, 1973), and redecision (Goulding & Goulding, 1979) group therapies. With these perspectives and a personal appreciation of language, I have found that close attention to subtle verbal interactions can often yield very fruitful results.

THE GROUP MEMBERS

This technique works particularly well with well-educated professionals with highly developed verbal and intellectual skills. This population tends to rely heavily on their intellectual and verbal skills for both achievement and as a part of their psychological defenses. They have been regularly reinforced for communicating in an objective, remote manner and usually fail to notice the impact of this on their personal relationships.

Besides these intellectually inclined patients, this technique works well with people with trauma histories who show similar linguistic tendencies unrelated to their educational level. In these patients, I see that this style of language serves to distance them from affect and muddy the attribution of agency. Thus it becomes difficult to know who has done what to whom, how anyone is reacting, and to follow any sort of story line as the listener drowses off in a dissociative daze.

THE INTERVENTION

The basic idea is to pay close attention to the verbal interactions of group members and to create norms of using immediate, emotional language that uses first-person pronouns and active verbs as much as possible. As I see this as an important group norm I address the issue early in the group in a psychoeducational way. Early in the group, however, it is important not to challenge the "we" or "the group" that indicates the growing formation of group cohesion and a group identity. This can be a delicate and important balancing act. Then, as the norm is fully established and the group matures, it becomes possible to address the defensive aspects of the verbal mannerisms more directly.

Early Group Stages

In this stage, give a cognitive explanation. Don't challenge "we" or "the group" at this point.

Example

Sarah continues to introduce herself to the group in the second session by saying, "You know, it's really scary to meet new people and wake up at night wondering what they thought of you."

THERAPIST: I imagine that you're speaking about your own experience after last week's group.

SARAH: Yes.

THERAPIST: Well, I want to point out that people will understand you better if you are really clear with what you say so that when you're talking about yourself, you use the word I.

SARAH: Well, I was really scared. In fact, I'm pretty shaky right now. (Others respond with resonating and empathetic comments.)

Middle Group Stages

In this stage, briefly point out verbiage.

Example

MARK: When Sarah said she was afraid of me, it felt frustrating—just like those times when my wife cringes away from me when I raise my voice.

THERAPIST: "*It* doesn't feel anything–did *you* feel frustrated?"

Mark sounding more irritated: "Yes, I felt frustrated. I feel like no one listens and tries to understand what I'm angry about in the first place."

THERAPIST: "So look at Sarah and tell her about your experience." (Be ready to intervene so that first-person pronouns are used).

Advanced Group Stages

In this stage, be alert for one-word pointers, or, if pattern persists, ask client to look at his or her resistance.

Example

DIANE: You feel so bad you just don't want to get out of bed?

THERAPIST: Who?

DIANE: "*I* feel so bad. It's hard for me to get anything done. It just feels better when you're lying there in bed and letting the world go by."

THERAPIST: "I notice how you're choosing to be passive in the very way that you talk about your passivity. What do you make of that?"

DIANE: "It feels out of my control. The depression just takes over."

THERAPIST: "I have a hunch that if you let yourself talk more directly about your experience you might have more feelings."

DIANE: "I'm scared of feeling out of control!"

Other words to watch for:

- "You" (no pronoun/everyone/no one): Is there somebody feeling/doing this? Who?
- "Make feel": Challenge this–can someone really make you feel something?
- "I think I felt": Why are they thinking/guessing about what they felt? Could they have a more immediate experience?
- Passive voice construction: e.g. "Yesterday there was a drinking binge." "The yelling got really out of control." Who drank? Who yelled?

TYPICAL RESPONSES

Usually group members initially respond to such interventions with compliance, laughter, and some embarrassment and without much processing. As the therapist continues to intervene, most members begin to see the impact of others changing their verbal habits and then they begin to enforce the norm on themselves and on others. Gradually, the negative impacts and defensive nature of this type of communication becomes clearer and is regularly challenged by group members.

In one open-ended group, "Mark" regularly complained about his wife's fear of him and minimized his own contribution to their dynamic. He would relate details of their fights using unclear pronouns so that the group became confused, frustrated, and eventually started to withdraw. My persistent pursuit of clearer language resulted in him gradually taking more ownership of his feelings and more directly expressing his frustration at group members for not understanding him. The group became able to quickly give him feedback when he was sounding quite angry and aggressive but seemed unaware of his affect. His awareness of his own anger and of the impact of his behavior and communication style increased.

CONCLUSIONS AND CONTRAINDICATIONS

I have found this to be a very useful technique for helping group members learn to clarify their communications, to have more imme-

diate experience of themselves and others, and to increase intimacy. I have found it quite useful with a number of populations with varied language skills. However, careful consideration of cultural and language differences is necessary since there can be major differences in different cultures' understanding and valuing of individual responsibility and agency.

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Chapter 19

Hardiness Enhancement: A Pathway to Resilience

Justin A. D'Arienzo

HARDINESS AS A CONCEPT

The concept of hardiness was identified by a twelve-year study at the Illinois Bell Telephone Company (IBTC) from 1975 to 1987, which was a time of severe corporate disruption and the deregulation of the communications industry (Maddi, 2007; Maddi & Kobasa, 1984). The investigation followed managers and executives who remained with IBTC as well as those who were laid off. Two-thirds of this group was stricken with an increase in violence, absenteeism, divorce, suicide, heart attacks, and other mental and physical health problems, while the other one-third thrived and survived without an increase of these issues. An analysis of the data determined that the differentiating factor between these groups was an attitude characterized by hardiness (Kobasa, 1979; Maddi, 2007; Maddi & Kobasa, 1984).

This hardy attitude was comprised of three perceptual dimensions: commitment, control, and challenge. The resilient individuals remained committed to their circumstances, desired to be involved in the current situation, and found meaning. They believed they had personal control of the outcome in obstacles and shunned passivity and powerlessness. In addition, they perceived change, whether positive or negative, as challenging and as an opportunity to acquire wisdom and growth. The study also found that having hardy attitudes led to hardy coping, hardy health practices, and hardy social support networks. Those with resilient attitudes faced problems and turned po-

tential disasters into opportunities, had positive interactions with significant others comprised of mutual assistance and encouragement, and prioritized physically healthy activities such as exercising, dieting, relaxation, and following their doctor's recommendations (Maddi, 2002, 2007; Maddi & Kobasa, 1984).

U.S. MILITARY POPULATION

I've utilized this psychosocial group therapy modality in the mental health departments of a U.S. Navy medical clinic and aboard an aircraft carrier. Group sizes have ranged from three to twelve individuals. All members were active duty military members aged eighteen to thirty and diagnosed with adjustment disorders, v-codes, and low- to moderate-grade anxiety and depressive conditions. An initial psychological evaluation indicated that an improvement in adjustment and coping skills was warranted, which could thus be acquired through hardiness training and enhancement. In addition, all individuals were deemed motivated to improve their condition and their ability to cope with their presenting stressor per self-report.

My original goal was to maintain groups as closed; however, flexibility was required due to the high frequency of patients needing this treatment. Groups met for one hour on a weekly basis and individuals participated in approximately eight sessions, but could participate in more sessions upon request.

AN INTERVENTION OF EIGHT STAGES

The orientation of groups was cognitive behavioral and included social skills training, cognitive restructuring, problem solving, and the curative factors associated with dynamic group psychotherapy (Wong, 2005). Cognitive behavioral principles and techniques were used to target the conceptual elements of hardiness so as to heighten one's tendency toward resiliency and improve current adjustment and functioning. The primary focus was on the here and now and on the future. Group sessions were in the sequential order as described in the following section.

Group 1

The therapist should welcome patients, discuss confidentiality, acquire informed consent, and perform introductions. Next, the therapist should define resiliency, provide a rationale for hardiness enhancement therapy, and provide an overview of groups that will follow. A description of the typical techniques of cognitive behavioral therapy that will be utilized and their impact on the interaction of cognition, affect, and behavior should follow. Also inquire about a general rating of each individual's confidence level (1-10) in improving his or her current situation. Introduce the concept of perceptions and the benefits of reframing realities and have the group brainstorm and share about others who have overcome significant obstacles.

Groups 2-3

Review the benefits of a hardy attitude to include the dimensions of commitment, control, and challenge. Use techniques such as weighing the pros and cons of the current situation and emphasize the positive aspects of change. Explore personal strengths and determine how to utilize them to create a positive impact. Help patients to steer clear of minimizing their power to make changes, even if these changes are limited to improvements about themselves. Have group members discuss opportunities that have been lost in the past but have led to new ones. This is done in order to generate an acceptance that change is normal and often exciting.

Group 4

Review how healthy attitudes lead to hardy coping. Use the group process to challenge each member to face their dilemmas and to make appropriate changes or improvements. Further, use the process to help members avoid blaming others and to take personal responsibility for their lives. Reintroduce reframing and have members reframe each other's situations if patients are at an impasse. Explore new meaning or purposes that are garnered by change or the current stressor.

Group 5

Discuss hardy health practices. Teach about the psychological and physiological benefits of exercising, relaxing, and following doctor's orders. Also instruct the group in relaxation exercises such as guided imagery and diaphragmatic breathing. Suggest that they participate in these hardy health exercises. Review their personal histories and emphasize the powerful benefits they received during physically healthier times in the past. Explore roadblocks to these practices or past failed attempts and develop problem-solving plans to improve those attempts in the future.

Group 6

Examine hardy social supports. Provide patients with psychoeducational material about the benefits of healthy relationships and what healthy relationships entail. Explore their personal support networks and encourage them to use each other for support as necessary inside and outside of the group.

Group 7-8

Finally, review the rationale for hardiness enhancement and the link between hardy attitudes, hardy coping, hardy health practices, and hardy social supports. Have the patients report their current confidence level in handling their current stressor and explore changes, improvements, and failures. Finally, patients should provide feedback to one another about progress observed.

TYPICAL RESPONSE

Patients have generally been receptive to hardiness enhancement therapy. It has appeared to be an effective intervention based on patients' feedback and their reported improvement in confidence levels associated with overcoming their presenting stressor.

CONTRAINDICATIONS AND CONCLUSIONS

Patients are suited for a hardiness enhancement intervention if they are psychiatrically stable, warrant an improved stress coping skill set, and are motivated to overcome or address their presenting problem(s).

Most individuals are inherently resilient and do not warrant professional interventions to cope with tragedy, problems, or stress. However, for those that do, hardiness enhancement group therapy is a valuable tool toward resilience and improved functioning as a result of hardy attitudes, transformational coping, supportive interactions, and healthy self-care.

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Chapter 20

Group As a Place to Practice New Behaviors

Myrna L. Frank

INTRODUCTION

The idea that the group is a microcosm of the world outside (Fehr, 1999, 2003; Yalom & Leszcz, 2005) leads us to explore how group members' behaviors and interactions in the group parallel their behaviors and interactions outside the group. It is proposed that the reverse is also true: that the group provides a place for new behaviors and interactions that can be paralleled in the outside world. The group thus can be experienced as a safe and secure environment within which its members can practice new behaviors before trying them out in their worlds outside. Although this intervention arose out of a psychodynamic-relational theoretical model (Greenberg & Mitchell, 1998; Rutan & Stone, 2001), it can also be conceptualized as a behavioral intervention and thus attests to the pragmatic value of an eclectic approach in group treatment (Fehr, 2003).

CLIENT POPULATION

This intervention is especially recommended in long-term therapy groups in which the process can unfold in a gradual step-wise fashion, and in which the group contract (Rutan & Stone, 2001) provides a safe structure within which to work. It may be somewhat less effective in a focused short-term group. It can be used with both adolescent and adult populations.

INTERVENTION GUIDELINES

At the preparatory stage, when clients[1] are being prepared for group participation, the notion of the group as a place to practice new behaviors should be suggested to them. The therapist should start by offering a general explanation that group psychotherapy provides an opportunity to learn with and from other people and to understand the patterns of behavior of oneself and of others. Members learn about themselves in group as they typically interact in that setting in ways that parallel their interactions in their lives outside. The therapist should then listen for responses from the client so as to ensure that this concept is adequately grasped. The therapist then suggests that the inverse also occurs, and explains to the new member that group members are encouraged to practice new ways of engaging with others in the group, and that typically when a member feels safe with the group, she or he will take risks that would be avoided in his or her world outside. The therapist should then suggest that she or he might want to think about behaviors that the client needs or wants to change and that she or he could try out in the group. It is important to use the word "practice" as its provisional (temporary/transient) quality offers clients a sense of security in not committing to change behaviors for which they may not be ready, thus bypassing resistance. For example, the therapist could say: "You have reported that you have some difficulties talking openly with your friends; over time you may feel comfortable enough in the group to *practice* saying things to peers that you would not normally say to your friends." It is not necessary to add to this until the client is actually in the group.

HOW THIS WORKS AND CLIENT RESPONSES

This intervention can work in many areas. I have found it useful especially in patients who have difficulties with (1) assertiveness, (2) impulsivity, and (3) trust.

Assertiveness

A patient with a history of vicarious trauma who abided by her mother's injunction to "be nice" lest chaos ensue, developed a disengaged style of relating to others in the group. After many months of

group work she was able to practice alternative ways of engagement. Initially very tentative, she would preempt her response to her peers with: "I'm going to try something new as I want to practice saying what I think so please let me know if this is offensive," and proceeded to offer her thoughts or feelings regarding another group member. Inevitably, the group responded with very positive feedback and with reassurance that her remarks were perceptive and quite helpful.

Over time she became significantly more engaged and developed a bold and articulate, yet still "nice" way of being. In one instance she bravely shared her sense of discomfort about a peer's crass language and promiscuous behavior, saying that she believed that this young woman was destroying her much-stated desire for a relationship. The other group members were clearly relieved that someone had spoken up, but the following week the young woman announced that she had decided to terminate group treatment, and that this was the first of her last four group sessions.[2] Although this event could have been experienced as proof of the original injunction regarding the horrible risks of not being nice, the group framework provided the time for her and others to explore and clarify feelings, resulting in the young woman's increased self-awareness, her subsequent decision to stay in group, and the "practicing patient's" reassurance of the positive outcomes of her assertiveness. Her interactions with group peers have since extended to her world outside where she has asserted herself initially with family members and then with friends, resulting in a sense of increased self-worth.

Impulsivity

A patient with severe impulse control problems for which he has paid dearly in the workplace was adept at alienating group members with his hurtful comments about which he had little insight. Following about six months of careful work in which the patient's connection to the group was strengthened, he began to practice what he termed "postpone-postpone." The patient recruited the group in his diligent efforts to delay his reactions; in this effort they would encourage him to "hang in" with his feelings and thoughts despite his urges to react bitingly to others. This patient's relationships with group peers has shown marked improvements as was demonstrated when he successfully struggled with his powerful urge to "tell off" a

new group member who was monopolizing the group session with constant and untimely advice giving. Although other group members may have been grateful had he done this dirty work for them, the group was left with the task of taking care of the new member's difficult behavior, and the "practicing patient" was left with a sense of increased self-control. Similar changes with this patient have begun to occur in his social relationships outside of group and are very gradually occurring in the workplace.

Trust

A female patient with a history of sexual abuse, after extensive individual work, felt ready to augment her treatment regimen with weekly group therapy. In the past she had participated in homogenous groups for women with similar issues. During the group preparation phase (Fehr, 1999, 2003) she expressed enormous anxiety that this therapist's groups were all mixed gender. The therapist was empathic about this concern but at the same time suggested that the patient had an opportunity to address this problem by using the group as a place to practice being trustful with men.

The patient was skeptical but felt encouraged by the safety of her own long-term relationship with this therapist. At her initial two sessions the patient was clearly anxious as she carefully watched the men's interactions in the group. At her third session she surprised herself by taking the risk of reporting her abuse history to the group, all the while eyeing the therapist who maintained a reassuring gaze. The male group members responded with genuine understanding and distress about her difficult history resulting in visible relief on the part of the patient. This interaction was experienced as profoundly reparative for her. It also had a significant impact on her previous knee-jerk stereotyping of men, and she repeatedly shares this "epiphany" with the group. This patient's practicing behaviors are followed up closely in her individual sessions where she is given ongoing encouragement about her successful efforts.

CONTRAINDICATIONS

This intervention has few contraindications and the question is more one of how effective it is. It seems that its effectiveness lies in its tim-

ing and the readiness of the patient. A premature intervention would likely be experienced as behavior focused, and possibly superficial.

NOTES

1. The terms "patient" and "client" are used interchangeably here; they are typically derived from traditional psychoanalytic and more contemporary Rogerian-originated theories, respectively.
2. The group contract includes a commitment to attend four sessions following a decision to terminate group therapy.

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Chapter 21

Counterresistance: Its Manifestation and Impact on Group Intervention and Management

Carla Penna

COUNTERRESISTANCE

The concept of counterresistance was introduced by Racker (1958). Often in analytic work we do not communicate to the patient some of our observations and our understanding of the psychodynamic process. Sometimes this abstention seems appropriate given one's understanding of group technique; at other times, an emotive factor is at play, which is not conducive to an intervention, since one perceives the risk of setting in motion an undesirable process at that moment in the treatment. Resistances on the part of the psychotherapist, referred to as counterresistance, usually coincide with the patient's resistance to the same situation, highlighting the most important areas of conflict for the patient. In other words, counterresistance is defined as the expression of an identification on the part of the analyst with a resistance of the patient, even when, at the same time, it relates to the analyst's own areas of conflict. It differs and is distinct from countertransference, since as a concept, it specifically refers to the manifestations of resistance that occur during treatment.

According to Zimmerman (1993), the phenomena of counterresistance in groups becomes more complex, since the clinician can establish unconscious pacts with part or with the totality of the group. Generally, these resistive unconscious pacts emerge when the group leader avoids certain topics or manifestations of aggression or sexual-

ity in the sessions while aiming to preserve some group equilibrium. The psychotherapeutic group can still make use of premature or pacifying interventions that would be at the service of a repressive act, preventing the free flowing course of group psychotherapy. In this way, the act of counterresistance on the part of the therapist can prevent group members from experiencing important group processes, thus not allowing fundamental empathic or reparatory experiences to occur within the group.

Utilizing the concept of counterresistance as a base, the author will attempt to describe, in a clinical vignette, how the perception of this phenomenon (by the therapist) and the accompanying clarifying intervention within the group can move the group process forward.

DESCRIPTION OF THE GROUP AND CLIENT POPULATION

This kind of intervention is effective with both time-limited and ongoing process groups. The group leader pay attention to the phenomenon of counterresistance in all types of group psychotherapy. Nevertheless, in groups with regressed, aggressive, narcissistic, borderline patients, as well as patients with serious problems relating to others, then one should be doubly attentive. Greater difficulties can surface and one's careful interventions require more skill on the part of the therapist.

RESISTANCE AND COUNTERRESISTANCE IN THE GROUP SETTING

A young-adult analytic group receives a new member, Lucy. After a while, two members leave the group almost at the same time and two new ones join the group. Lucy withdraws with the arrival of these two new members and when faced with experiences discussed in the group, Lucy deeply resents the situation, as she cannot identify with the problems brought in by the other members. She starts to miss sessions and her absence becomes the main topic of several sessions since other members take her no show personally, feel guilty about what is happening, and demand a more active role of the therapist in

relation to her. She justifies her absences during long and tedious phone conversations that she utilizes as individual sessions over the phone. The therapist tries to set limits on this new development. Even after having identified the extent of the patient's difficulties within the treatment, in terms of her resistance to attend the sessions, the therapist is aware of the group setting and the group frame including the decision regarding Lucy's status in the group. Whether she would continue on or not is acted out due to the therapist's enormous difficulty in calling Lucy. The therapist struggles with her own counterresistance to the patient's behaviors. Her countertransference is one of irritation with the patient's acting out, since after being warned, the patient behaves poorly, negatively impacting the functioning of the group. The patient resists showing up for group but does not leave the group, either. Her acting out and her resistance drains and depletes the work to such an extent that the group and therapist counterresist, responding in kind to her modus operandi. The group situation demands an urgent intervention given the risk of group dissolution.

THE INTERVENTION

The counterresistance works exactly as a resistance on the part of the therapist: resistance to intervening, to interpreting, to creating meaning, since it opposes the recommended therapeutic attitude expected of the group leader. Ultimately, counterresistance leads to silence.

Step 1: Identifying Counterresistance

The therapist must examine what she or he is resisting/feeling in order to identify her or his counterresistances and to clearly understand what is happening in the group process. In the clinical vignette, various reasons were given (by the author/therapist) for postponing the telephone call to Lucy until I realized that my behavior, revealing extreme irritation along with an excessive zeal for the patient, indicated not only countertransference issues but also the obvious presence of the counterresistance phenomena.

Step 2: The Intervention

After understanding her or his counterresistance, the therapist must intervene, explaining firmly and as clearly as possible to the patient/group what is going on, aiming for the restoration of the attacked setting. In cases of deviation from the group contract, its reassurance must function as a compass for the maintenance of the group process. The denial of the frame indicates important resistances/counterresistances in action. In those situations, clarifying interventions are fundamental therapeutic tools. Lucy was informed, without subterfuges, that if she does not come to the next group session she would be excluded from the process.

Step 3: The Interpretation

The comprehension and interpretation of the multiple resistances and transferences between the members of the group and their relations with the therapist are fundamental. Somehow they reveal unconscious pacts that work against group cohesion and its development. Lucy shows up for the next session and presents her reasons behind her absence. At this moment she is confronted by the group, who explains how her ambivalent behavior affects the group, presenting the consequences of her actions. I intervene with a clarifying interpretation, telling Lucy that the group members including myself have experienced some of the angst Lucy feels in relation to herself. She was doing to the group what she does with her life. The group and therapist are in limbo, just as Lucy is. She manipulates the therapist by resisting the proposed therapeutic frame, not showing up, and pushing others to give up on her. Her acting out and her resistance were paralyzing the group.

THE RENOVATED GROUP

After the intervention, the group can possibly move forward and understand that Lucy's absence and carelessness toward the group was eliciting ancient feelings of abandonment, anger, jealousy, rejection, and guilt for them. The members' ongoing questions regarding Lucy were revealing a genuine concern with the patient but also disclosing their subtle and veiled accusations toward me for not having

effectively handled Lucy and adequately managed the group. The group could understand that they were also making use of Lucy's behavior to resist and to avoid working on other issues that need to be addressed. On the other side, I restored my own status within the group, which moved along the group process.

CONCLUSION AND COUNTERINDICATIONS

The group therapist's attention to the counterresistance phenomena (in addition to countertransference) is crucial when facilitating group psychotherapy with an analytic approach. When the group therapist detects the presence of these reactions in herself or himself, she or he should utilize them as a compass, which will direct interventions and interpretations. Counterresistance in group psychotherapy is much more common than many clinicians might think and is intimately linked to the patients' resistances in group situations, which interferes with group transferences in its various levels, in addition to the obvious countertransference issues.

Counterindications to this process are found in the group therapist. If the group therapist presents any resistance to the unfolding of the group process, the tendency of the entire group will be to identify with that resistance. Therefore, the therapist should be able to tolerate and contain different levels of anxiety, in addition to manifestations of an aggressive or sexual nature that may surface in the group. If the therapist is not aware of her or his own resistance, she or he will make a mistake in avoiding certain topics or not interpreting them adequately. In this case, the therapist's interventions will be premature or pacifying, functioning only to preserving her or him and the group. Subsequently, the therapist may prevent free-flowing reparatory and transformative interactions and experiences for the patients.

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Chapter 22

Some Thoughts on Silence in Group Therapy

Bennett Roth

Silence in psychotherapy is both a regular occurrence and an unwanted phenomenon. The very nature of therapeutic exchanges between patient and therapist rely on spoken language and while pauses in speaking are common, possibly adding significance to what is said, any prolonged absence of speaking represents a form of basic fault in the communication having deeper psychic meaning. Although this is obviously true for dyadic therapy, I have learned that silence is a very different phenomenon in analytic group therapy.

SILENCE IN AN ANALYTIC GROUP POPULATION

After being a group therapist for a number of years I was actively engaged in the technique of not looking at the person speaking in the group, one that was counter-intuitive to my being a group member. In doing this task, watching the nonverbal and verbal responses to the speaker and not being in the thrall of the person speaking, I became aware that the other group members were as silent as I was. Put succinctly, the entire group was silent except for one person. In other words, in group therapy, there was more silence, more people silent than speaking from a phenomenological perspective. What was going on in the silence? What were their responses to what they were hearing? Why were they not responding to the speaker? I had no idea. Silence appeared to be the absence of a visual or verbal response to the words that were being spoken by one group member. If every mem-

ber of the group spoke at the same time it would have created chaos, a "Babel effect" of everyone speaking at the same moment. So it seemed that in that group of seven, plus one therapist, there was actually more silence than speaking! Since that time I have questioned a number of basic ideas about the nature of verbal group therapy and silence.

THE IDEA OF LISTENING TO SILENCE

Human beings communicate in various ways, and receive communication through different sense organs. The most common interaction in therapy are verbal and social rules of dialogue that usually require formal greetings; when one person is speaking the others remain silent, and, interruptions are rude. In group therapy, the social roles are resisted to some extent and there is a different pull on the group members to relate in a less cautious way so that they may explore their reactions and give feedback to the speaker. As pointed out, there are often many listeners silently attending to the person speaking. The obvious question occurs, what should the therapist be listening to, the patient speaking, the group silence, or both?

Let us assume, for our current purpose, that the person speaking is the manifest level of the group interaction and the listeners represent potentially different responses within that field of group interaction. While the speaker is the manifest level, the silent members operate at an unheard level. Reception of verbal information in the group field usually accompanies nonverbal reactions, facial gestures, and physical movements that may give the group leader some information about reactions to the manifest message. The group therapist, eager to have a flow of dialogue, will often ask about or note the nonverbal reactions in the hope of adding to the group dialogue. However, from a group analytic perspective, silence must be respected. This represents a particular dilemma for group: How long should they tolerate a total group silence without wondering out loud about both the silence and the silencing effect? Group therapy or analysis does not consist of a series of alternating soliloquies or dialogues between any one pair of people in the group. Every group has an internal need for relating and dialogue; total silence must represent some hidden mechanism that is counter to therapeutic group interaction.

THERAPIST SELF-INTERVENTION

For some time, I listened to the silence. I tried to determine what I could learn about it while I too was silent; I discovered a double task: listening to the group silence and listening to my own silence. Listening to the group silence takes some effort. It is possible, if the group therapist understands the input from one person, for the therapist to make connections on various levels between what is being said by one member and connect it to other members of the group, their histories, or conflicts that are similar. To the extent that this is true one must wonder again why then are not the others making the connections?

It is possible, and necessary, to take various views regarding the group's silence. Resistance to participate in the group process can be understood and therapeutically managed as a process of germination, which will eventually turn into something useful. Self-generated understanding may lead to possible insight, or, to understanding silence as a developmental fault indicating the absence of an empathic mirroring person or process in the person's early life. Assessing the quality of the group silence is dependent on the therapist's intuition and empathic capacities. At best, it is a problem, given the number of people in a group, to find one reason to explain the behavior of an entire group. Assessing the impact of the therapist's silence on patients, who have "relationship hungers" and often fill the void created by the group therapist's silence with powerful fantasies, is even more difficult: the group therapist must be guided by his or her attunement to the patient's needs as well as the group's reaction to that anxious/fantasybound patient.

When considering those prolonged silent moments, it also must be considered whether the group is putting pressure on the therapist to intervene, to speak, to take responsibility for the matters being spoken about, or to say something that individual group members cannot articulate because of defensive reasons. In this manner, the silence is like snow to Eskimos in that it has to be understood for its meaning, depth, texture, and (emotional) color.

If the group therapist is compelled to speak and understands the nature of the group silence it is best to make the comments general (Bollas, 1987). Here, we have an additional problem not found in the dyadic situation: discerning the nature of the "cause of the silence" must be determined.

A Clinical Example

Many years ago I had a male patient who was terribly socially uncomfortable when in any role other than his professional one. He suffered many inhibitions and, when emotional, was prone to exaggerated, frustrated angry outbursts. It seemed when he spoke that no one responded to him and he would soon turn his description into a factual speech that seemingly went on and on laboriously. I frequently commented on the absence of a response to his speaking and the group members responded over time that they sensed the tension underneath his words and were wary of drawing to themselves his anger. That seemed plausible enough, however, later I noticed that people often were not looking at him when he spoke and thought that odd. I said nothing about that event and it was not until much later that I noticed that he did not look at anyone when he spoke. He looked at a point on the wall opposite where he sat. Although the causes for his behavior were deep in his developmental history (as dialogue emerges from the mother-child unit), it seemed clearer to me that another contributing factor for the silence was the absence of eye contact between him and any member of the group. The group members were also made uneasy and silent by his talking and not looking at anyone when he spoke.

LISTENING TO ONESELF IN GROUP

Pressures for the Group Therapist

- to speak,
- respond to being spoken to, and
- answer questions and be pulled into behaving like a member of the group.

Even the factual areas of therapist responsibility can be used in the group or at its regular stopping points to have a special, (non group) relationship to the exclusion of the other group members. Freud (1912) and Bion (1970) have paid special attention to a special therapeutic form of listening that requires access to the group therapist's unconscious processes and it seems that every attempt to engage the

therapist is also an attempt to turn the therapist's attention to reality events and away from deeper emotional understanding.

CONCLUSION

What is listened for in the midst of the therapist silence, whether in the form of countertransference (Roth, 1990) or fantasy and reverie (Bion, 1970), are the products of the therapist being in the group and allowing the continuous projective and introjective elements to impact upon the deeper levels of his or her personality. It is sometimes compelling to respond to surface or manifest material in the group, to problem solve or "cheerlead" with patients, but these actions must also be understood as fostering a group climate in which the manifest/reality holds all the attention and power. The danger for the therapist of relying on himself or herself in the moments of silence is alleviated only by deeply understanding patterns of countertransference within the therapist and becoming familiar with the underlying concepts of cure or healthy functioning. No silent listening by any therapist is purely neutral. The therapist puts his or her subjective stamp (Ogden, 1996) on his or her group whereby subjective beliefs must emerge, which hopefully are soundly analytic: that is, in the patients' behalf.

CONTRAINDICATION

A danger is in the belief of whether the group therapist can also tolerate a multiplicity of meanings in which the therapist is but one of the group and group members can also have insight and put their subjective mark on the group experience. Another more profound danger is found when a therapist's silence repeats inadvertently the silence caused by the physical or emotional absence of a significant person in the patient's past. In those cases with traumatized patients the therapist must lend his or her personality or empathic functions to the group and later help it learn to acquire and use these abilities.

Finally, when the analyst is speaking, not only must he or she listen to himself or herself and the choice of words and rhythms of speech but he or she needs to be aware that the rest of the group is silently listening. They listen with acuteness and sensitivity to every element of

what the therapist says because in their silence they are making sense and confusion of his or her words.

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Chapter 23

"When Boundaries Breathe"

Richard Beck

THE FRAME OR BOUNDARY

We think of "the frame/boundary" in group therapy on many levels (Yalom, 1995). Most therapy groups are conducted in a regular clinical setting, be that in the practitioner's office, outpatient clinic, hospital, or agency setting. Establishing and maintaining this frame/boundary is crucial to the development of trust and safety in the group, regardless of the type of group, or the theoretical orientation of the group leader.

Disaster/trauma groups are unique in that these groups are rarely held in traditional settings and usually are led at or near the site of the disaster, be the disaster a natural occurance such as a hurricane or tornado, or an act of terrorism.

The author was privileged to lead therapy groups for people impacted by the terrorist attacks on September 11, 2001, and the devastating hurricanes Katrina, Wilma, and Rita. The intervention to be discussed in this chapter took place in one of the trauma groups led in New York City after the terrorist attack on the World Trade Center.

POPULATION

The group was composed of advertising personnel whose company had been based in the uppermost floors of Tower Two of the World Trade Center. In all, this company had lost over 250 employ-

ees, and the department whose membership comprised this group had lost over sixty of their friends and colleagues. The group met every Tuesday from 12 to 1:30 p.m. in their new temporary office location in Manhattan. I replaced the previous group leader of this group who had "burned out" after two months. The group location and composition was not of my choosing. Often we needed to hold the group in different rooms because business needed to be done in our group room, which took precedence over our "trauma/bereavement group." The membership of this group was mid- to upper-level managers in this advertising company, and attendance for this group was always voluntary. We had a core group of members who attended each session with me for the next three years, while other members could drop in and attend as they felt the need.

"WILL YOU DO THIS FOR US?": THE INTERVENTION

The group had been doing extraordinarily good work as we approached the first anniversary of the attack on September 11, 2001. The first anniversary in 2002 was on a Wednesday, and the group had been meeting every Tuesday since it began. It is impossible to describe the mood, not only in this company, who had lost so many employees, but also in New York City itself. The anxiety and tension in Manhattan alone was so palpable you could cut it with a knife. Nobody knew if another attack was planned for that day, but emotionally, it felt like every New Yorker expected something to happen. The week before the first anniversary, one of the group members asked me a question: "We have been meeting since 9/11 at 'Joe's Pub,' several times a week, which is where we truly mourn and grieve our lost friends and colleagues. We would like you to hold our trauma/bereavement group at Joe's Pub on the first anniversary, and we would like to invite other employees of this agency to come join us and grieve together. **Will you do this for us?**"

I was initially taken by surprise by this request, and told the group, "give me a moment to think this through, but either way, I am delighted that you invited me and included me in your anniversary ceremony." I thought about the "frame and boundary" issue again. Hold a

group in a pub? Was I not stretching the boundaries enough by working in their office space during their working hours?

SHORT DESCRIPTION OF THE RESPONSE TO THE INTERVENTION

I told the group that I would be delighted and honored to hold group in "their sacred space" and looked forward to meeting with them next week at Joe's Pub during the group time. The group met at Joe's Pub on Tuesday, September 10, 2002, and I had a beer with them, toasting the lives and memories of the dead in their department as well as all those who died in their company. It was a group experience that I will never forget.

CONCLUSION AND CONTRAINDICATION

This extraordinary group had taken me in and allowed me to share with them their grief in the place where their mourning took place. The members felt a greater connection to me; the leader, and the cohesion of the group became even more intensified. The group members felt well understood and accepted by the leader, who never judged how they mourned or the timing of their grieving process.

The contraindication in this intervention was in relation to me–the leader. In my decision to extend the physical boundaries of the group, I, however, felt a sense of shame about this choice to stretch the boundaries and meet in the pub. Yet when I discuss this scenario with distinguished colleagues across the country, the response has always been a resounding, "you did the right thing by holding the group in the pub," and that the group members would have been more wounded and felt more misunderstood had I rigidly stated the group boundaries. Boundaries, as Cecil Rice shared at an EGPS workshop in 2005, "had to breathe, otherwise under duress they became [sic] like chunks of hardened debris blocking therapy or in the words of my history, they became like clanging symbols, 'bereft of love'." So, too, were my feelings about the intervention of holding the anniversary group at Joe's Pub.

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Chapter 24

You Can Teach an Old Dog New Tricks!

Ava J. Kotch

Cognitive behavior group therapy emphasizes learning and conscious cognition and the adaptation of newly acquired behavioral techniques. It is well-suited for mood disturbances and has been researched and evaluated in terms of effectiveness in generative group therapy (Thompson, Gantz, & Florsheim, 1991). The group process includes identifying dysfunctional attitudes and distortions in thinking that create and exacerbate depression. Techniques utilized include but are not limited to:

- Helping patients identify their reactions and work toward understanding them in specific situations.
- Confronting and correcting distortions by reframing and realigning the meanings made by the individual.
- Determining the basic assumptions, and predetermined themes that underlie these reactions.
- Practicing alternative cognitive and behavioral responses to events that patient anticipates as stressors.
- Achieving mastery and maintenance of positive affects that help to create alternative and more appropriate and healthier objective assumptions (Rush, 1983). Depersonalizing, reducing dichotomous thinking, reframing, and focusing attention on partial positive outcomes as a way to counter cognition distortions exemplify this approach (Thompson, Gantz, & Florsheim, 1991).

GERIATRIC MAJOR DEPRESSION GROUP POPULATION

The group under study is open ended. The patients' ages range from seventy to eighty-five. All participants meet criteria for major depression and are on antidepressant medications.

INTERVENTION

Most of my interventions are based on statements coming from the patients. One of my goals in group therapy is to lead the patient toward understanding that his or her faulty cognitions are in fact simply a very negative cognition set which has caused the attenuation of self-esteem and underlying depression.

Verbatim Patient Disclosure

The patient states: "I've left two messages for my daughter . . . she doesn't call me back. I'm not surprised. . . I was at a dinner party and the seat next to me remained empty . . . no one likes me and it is always like that."

TH: Can you share with us why this means that no one likes you and why you generally feel that no one likes you?"

PT: That's just how I feel. When I don't get a call back it means no one likes me–it's what I think.

Multiple questions and statements are then asked and given by other patients in the group. My focus is toward guiding the patient to understand that he, (in this case), has an overriding negative belief system and that changing negative thinking into more positive thoughts will facilitate the recovery process. Following are examples of the types of questions posed:

- Why do you say nobody likes you? Can you name people who do like you?
- Can you think of other reasons why the seat next to you was empty?

- Could you have any other explanation as to why your daughter did not return your calls?
- Does your daughter ever do nice things for you?
- Do you ever miss returning a call?
- Your expectations of others are always very high. . . I think you set the bar so high so then you can be disappointed.
- You tend to set things up so you can be disappointed again . . . like a self-fulfilling prophecy of doom.
- Can you possibly reinterpret these events and say how you feel if you put a positive spin on these events?

Various group members become involved and share their own faulty cognitions and how they have worked at changing them. Some members recommend, through their past experiences, that changing a negative mind-set to a positive one can be accomplished through the use of exercises. The patient makes a list of negative thoughts on one side of the paper and then on the direct opposite side of the paper, the patient counters his or her arguments with positive responses. For example:

Negative Thought	**Positive Thought**
Nobody ever likes me.	Scott and Ellen like me.
No one ever calls me.	Yesterday I got a call from Toby.

It is suggested that the patients begin this list in the group and then take it home as homework and work toward finding as many negative thoughts as possible and then find as many positive thoughts to counter these negative beliefs. By doing this, the group therapist can evaluate a number of areas in which the patient is "stuck" in his or her negative thought and belief system when he or she cannot find a positive response to the negative belief.

CONCLUSION

A geriatric group requires that the therapist be very flexible in conducting the group. Differences between supportive, insight-oriented, cognitive-behavioral and reminiscent intervention paradigms can create boundaries that are frequently blurred. Most patients in the group are socially isolated and interpersonally alienated, have limited in-

terpersonal skills, and may have other difficulties such as some memory decline, hearing and vision decline, and gait disturbances. Regressive feelings, related to dependency are seen in this type group and the group serves to help them feel connected and not isolated and alone. The group, which ultimately becomes the family in one's later life, helps the patient feel again connected and no longer alienated from the world at large.

CONTRAINDICATIONS

This type of group therapy is contraindicated for patients who are suicidal, paranoid, and extremely aggressive. It is also contraindicated with patients who cannot attend to group process because of severe cognitive impairment, severe hearing loss, language difficulty, or for patients who constantly devalue others in an attempt to boost their own egos.

It is very important for the therapist to embrace the belief that older people can grow and make changes and to completely rid himself or herself of the negative belief, "You cannot teach an old dog new tricks." The therapist also needs to feel comfortable with geriatric patients and if the therapist is quite a bit younger than his or her patients, he or she must be consistently aware of countertransferential issues in which the group members may be turned either into parents or grandparents and not actually seen in reality.

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Chapter 25

The Fee Payment As an Aspect of Group Communication

Patricia Kyle Dennis

THEORETICAL RATIONALE

Money is a topic that is easily avoided by both patients and therapists. Often, the therapist will collect checks at the end of a group session, or outside of the session. Thoughts, feelings, questions, and other comments about the fee payment may never be verbalized in the group. When they are, the therapist may fail to encourage further discussion of fee-related material by the group, as if this topic is too personal and not really the group's business.

However, prompt and full payment of the fee directly affects the health of the group (Rutan & Stone, 2001). Group members will naturally have feelings about inaccurate, late, or missing payments and about the impact of these behaviors on the therapist and the group. To leave out discussion of these matters, as if they are individual or private concerns, is to beg the question, "Are there other reasons the group therapist may not want the fee payment to be discussed by the group?"

The fee payment is an essential aspect of the group's "frame" or structure, which enables the group to achieve its therapeutic potential (Langs, 1992). A healthy frame is set by the therapist who must be attentive to proper billing and collection procedures. At the same time, the therapist is alert to the meaning of group members' behaviors related to payment of the fee. These behaviors may be seen as a source of communication, both conscious and unconscious, about problematic aspects of the group experience. They may be rich with transfer-

ential meaning. When the therapist promotes open collection and discussion of the fee payment, much may be learned.

GROUP DESCRIPTION

This intervention includes interpretation as a technique and the unconscious mental life as a focus. These are hallmarks of the psychodynamic approach. Although the intervention could be adapted to any long-term psychotherapy group, the therapist should have a thorough grounding in this approach. Patients who have the capacity for psychological insight and the motivation to explore meaning and overcome defensiveness will benefit most from this intervention.

The longer the group has been in existence, the more effective the intervention will be. This allows members to accumulate learning and understanding through repeated experiences of paying the fee and analyzing the meaning of behaviors, thoughts, and feelings related to fee payment.

THE INTERVENTION

The intervention takes place in the context of the frame of the group. It is the members' attempts to deviate from the frame that are the focus of exploration and interpretation. Therefore, the therapist must clearly communicate to the members what is expected related to fee payment. A policy that includes all the elements of the following sample statement is part of the group agreement:

Sample Statement

> The fee for a ninety-minute session is (amount). This fee is a payment for your place in the group and is due for all scheduled group sessions except for three planned absences per year, major national holidays, and any session cancelled by the therapist. Requests for exceptions must be made in advance during a group therapy session. At the first group session of each month, please bring a check for the previous month, made out in advance, and payable to (therapist's name).

The policy is a reflection of the agreement by group members to be responsible for fee payment. The therapist avoids unhealthy behav-

iors such as enabling, coddling, harassing, reminding, and avoiding. Note that the therapist does not calculate or distribute a bill in advance. Doing so is not only unnecessary, but would also deprive the group of the chance to learn from conscious and unconscious decisions by members to deviate from the payment frame.

At the end of the first group session each month, the therapist collects a check from each group member. Before the next session, checks are reconciled against the therapist's calculation of each member's account. This gives the therapist time to identify discrepancies and nonpayments and to form hypotheses about the meaning of these phenomena.

At the beginning of the next session, the therapist informs the group of "overpayments" or "underpayments" and asks for checks from members who did not pay. The group is then invited to explore the meaning of these frame deviations. What is being communicated to the group therapist and to one another? In subsequent sessions, the therapist stays alert to members' behaviors related to correcting problems with the payment while continuing to encourage exploration and discussion.

The value of this intervention is found in proper interpretation of the meanings of behaviors related to payment of the fee. It is important to consider transference and countertransference, as well as the possibility of "no meaning." The therapist adopts a neutral, curious stance, encouraging free association and interpretation by the group members, and suggesting interpretations as needed. The therapist avoids judgmental statements that would compound feelings of shame that are often associated with money.

In the course of discussion, thoughts and feelings come to light that may have been demanding expression, but for some reason remain underground. Sometimes this is because of the members' reluctance to put them into words; often they are not in anyone's conscious awareness. Encouraging group free association to a payment discrepancy promotes the emergence of this important unconscious material.

RESPONSES TO INTERVENTION

When this intervention is introduced in an existing group that is not used to discussing the fee payment, the group members are likely to

express shock, outrage, and resistance. As in many families and cultures, the discussion of money may have been taboo, so that the status of fee payment, an essential component of the group's health, has become a group secret. Once the members see the benefits of this discussion, however, they are likely to participate more willingly. New members may be more open to the discussion, since they are given the opportunity to review the payment policy before they choose to participate in the group.

When a member pays less than is owed or does not bring a check, there may be a reason that the member feels that the therapist has not earned the fee that month. This may be a way to express frustration with therapist absences, empathic failures, frame breaks, withholding silences, and many other behaviors that the member experiences as "not good enough." Often these behaviors may be interpreted as transference, a re-experiencing of similar frustrations with significant caregivers during their formative years. Group members usually appreciate the chance to discuss and work through these feelings. Sometimes the therapist discovers that something needs to be rectified, from therapist errors to circumstances as minor but important as adjusting the lighting or replacing an uncomfortable chair.

When a member overpays, group members can help each other guess why a member might feel that the therapist has more than earned his or her pay last month. Sometimes members worry that their free expressions of negative feelings or their acting-out behaviors have injured the therapist or the group. They can benefit from hearing feedback about their participation. This is especially useful when the member has been venturing into more self-disclosure or participating in conflict. An overpayment may also be an unconscious attempt to establish oneself as a special favorite of the group therapist. Uncovering this wish can lead to a fruitful discussion of competitive strivings in the group.

Deviations from the payment policy can reflect many other meanings, for each member and for the group as a whole. A general wish to avoid anxiety and shame associated with money management may lead to a hasty, inaccurate calculation of the check, or "forgetting" the check at the first session of the month. Since group members are aware that the health and life of the group depends on the therapist being paid, hostile wishes toward the group or individual members as part of unresolved conflict may be enacted by delayed, short, or miss-

ing payments. When nobody pays correctly or on time, the therapist reflects on the general functioning of the group or the possibility that the group has experienced a trauma.

Of course, the therapist also experiences a variety of responses to fee payment and must be ever alert to countertransference reactions to fee payment deviations. These may be enacted by the therapist through failure to collect and process checks on time, inaccurate calculations of the amounts owed, and inappropriate comments or interpretations in the group session. The therapist may use countertransference reactions to understand what is being communicated, and to prevent and rectify problems in the group.

CONCLUSIONS AND CONTRAINDICATIONS

Open discussion of the fee payment is rare in general practice, which reflects a rarity of discussion of feelings about money in society at large. Therapy group members may demonstrate much resistance to the exploration of fee payment behaviors and their associated meanings. However, there are no apparent contraindications to the use of this intervention. Its value will eventually be expressed by group members, after they experience a deepening of the money discussion in the group and its application to their outside lives. They realize that the fee payment is an important aspect of communication in the group, which furthers intrapsychic and interpersonal insight as well as practical problem solving.

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Chapter 26

"What Do You Mean I Should Tell Her What I Think About Her?" Psychoeducation About Interpersonal Process

Anne M. Slocum McEneaney

A TEACHING TALE

Although the interpersonal learning that can result from psychodynamic psychotherapy groups has been shown by both patients and therapists as among the most significant benefits they derive from group treatment (Yalom, 1995), many patients present for a group screening without having a clear understanding of how this learning will take place. Once it has been explained that this occurs by sharing one's own experience of being in the group, including one's impressions of and reactions to others, and by being as open as possible to hearing others' impressions of and reactions to themselves, most patients are intrigued, but wary. Many, even if interested in this idea, are unclear how being open might impact on themselves or others, and how exactly this would translate into learning something new about oneself that might change future behavior and the quality of one's relationships. This intervention provides an example of a "teaching tale" that can be used to illustrate an incident of conflict, which led to interpersonal learning and growth for both primary participants and for other group members. It is useful to educate patients about interpersonal process, to demystify group psychotherapy (Rutan & Stone, 1993), and to serve as a model of growth-producing group behavior.

SLOW-OPEN AND TIME-LIMITED GROUP POPULATIONS

This intervention can be useful in any psychotherapy group in which members focus on their interpersonal interactions in the "here and now," so as to better understand and derive more from their relationships with others. It has been successfully used in both "slow-open" and time-limited groups, with both adults and teenagers.

A PSYCHOEDUCATIONAL INTERVENTION TALE

Once group process has been explained in conceptual terms, the leader then says, "Let me give you an example of what I mean" and shares the following:

> This happened many years ago, in a group of women with eating problems[1]. The members had met for five sessions and had bonded quickly around their similarities and the relief they felt at being understood and not judged. By this session, however, several had begun to wonder, "Where do we go from here? Can I talk about the things that I am not sure everyone does share and will understand? Is it safe to go deeper?"
>
> Naturally, people became anxious as they had these thoughts, and there were two members in particular who had very different ways of trying to manage their anxiety. One became very quiet and withdrawn, sitting all the way back in her chair; she was clearly paying attention to what others were saying, but just as clearly did not want to engage with others. Another member, very outgoing, became focused on wanting to connect to the others. She began to ask a lot of questions of the person to whom she felt least connected—who was, of course, the very quiet person.

So began the interplay in which one member peppered the other with questions about everything the second had ever previously said in group. The second, at first, gave brief answers, then monosyllabic ones, then said "leave me alone." The interrogator would or could not, and the tension in the room rose, as these two became increasingly angry, and other members increasingly uncomfortable. After a few more minutes, I asked each of the primary participants to stop and tell

the group what they had been experiencing, thinking, and feeling in this interchange.

Each said essentially the same thing: "I was anxious and when I get anxious, I get (quiet/try to connect). And I guess she doesn't like that, and I guess she doesn't like me, and I don't like her either." But, by hearing each other say this, each learned several significant things about themselves.

RESPONSES TO THE INTERPERSONAL EXCHANGE

First, each realized that she had been assuming that the other was acting as she was because the other did not like her. By hearing this, they each "got it" that the other simply acts in this way when she is anxious, and it really had nothing to do with her personally.

Second, each was able to see and acknowledge that this way of dealing with anxiety had consequences that they did not necessarily like or want, and that it had led to negative consequences for each in the past. Each had had prior experiences of being left out of social groups they wanted to join because they became anxious and so withdrawn or intrusive that others chose to leave them out.

Last, each member returned the next week and spontaneously said that if she had left last week feeling the way she felt during that angry interaction, she would have acted out her feelings in eating-disordered behavior over the next several days. But, because each was able to talk about the feelings generated and gain this new understanding of herself and the other person, they had not felt the urge to use the eating disordered behavior. The feelings had been processed on the feeling level and did not need to be acted on behaviorally.

Other members talked about this experience as being powerful for them both in terms of vicarious learning and in helping them address their own fear and avoidance of conflict (also discussed in the group, after the primary participants had spoken)

CONCLUSION AND CONTRAINDICATIONS

This sort of psychoeducational modeling of interpersonal group process can be very useful to help potential group members who have the necessary skills in abstraction and introspection, but may not be

familiar or comfortable with the (culturally incongruent) idea of sharing reactions and impressions (especially affective ones) with others, and may not understand the interpersonal benefit that may result from doing so in a psychotherapy group.

Such a therapy group may be contraindicated for people without these cognitive abilities. A person's inability to understand this story, and its interpersonal implications, may be useful in making such a determination.

NOTE

1. This example is relevant, however, to any psychodynamic psychotherapy group.

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Chapter 27

The Masks We Wear

Claudia P. Calabrese

USING THE CONCEPT OF THE PERSONA/MASK

Psychosocial theory poses that human development across the life span requires the resolution of a series of "psychosocial crises" in order for the person to be able to move on to the next set of developmental tasks (Erikson, 1968; Newman & Newman, 1998). In adolescence, identity development is the central task (Erikson, 1968) and biological, psychological, and societal factors come together to help shape and define personality. Identity and personality ultimately define who we are and how we relate to the world we live in, even how satisfied we are with our lives (Costa & McCrae, 1980). Therefore, in therapeutic work with adolescents, it is of paramount importance that interventions focus on supporting the process of identity formation and challenging them to avoid the allure of negative identity formation. This group exercise allows the participants to examine the idea of the mask as a role they take on—with peers, parents, in public—that prevents them from fully experiencing and interacting with the world around them.

AN ADOLESCENT POPULATION

This group activity is ideal for adolescents because they have an intrinsic understanding of Shakespeare's idea that "All the world's a stage. . ." as proposed by (Elkind, 1967) because of their egocentric perception of the world that is magnified through the lens of an imag-

inary audience. The premise of the exercise is easy for adolescents to comprehend and they readily examine the roles they play in their lives. This author has also used this exercise in substance abuse and anger management groups.

THE INTERVENTION

Materials

No materials are needed, although it is helpful to present a picture of the "tragicomedy" mask for reference. The picture then serves as an introduction to the concept of "the mask." Other materials that can be used with this exercise include paper and markers to draw masks.

Introduction

The group starts with a brief discussion of the masks and what they represent. Usually I will introduce the idea of how the masks were used in ancient Greek theater to distinguish between different characters. An actor would change his or her mask to represent characters that were either tragic (sad or pained expressions on the mask) or comic (smiling or leering). I then use the quote, "All the world's a stage/And all the men and women merely players," (Shakespeare's *As You Like It* [II, vii, 139-143]) to begin the discussion of how each of us plays different roles depending on our "audience." How we act and talk with our friends is different than how we speak to authority figures and how we act in different social settings.

Initial Discussion

I ask the participants to think about different roles they play in their lives. Going around the room, I ask participants to share how they act and talk when out with friends versus how they act when they are with their parents. I finish this segment by asking the participants to discuss how these different roles are helpful to them and to think about in which ways they may be destructive.

Central Discussion

Now that the participants are comfortable with the concept of the persona, (the roles we adapt to interact with people in different situations), I present the traditional idea of the mask: something used to hide one's identity. I now ask the group to think about one mask they use as a way of hiding their identity from the world. At this point, participants can draw their "mask" and present it to the group, act out their mask or simply describe it to the group. If the group is in the later stages of development, this is where the facilitator can lead a process discussion between group members about how they "present" to each other. Finally, I ask the group to discuss how their mask has prevented them from getting close to others in the past.

Closing Remarks

I find it helpful to end the session by wrapping up with the idea that masks can be useful for us in dealing with society and its pressures or that they can be counterproductive by preventing us from getting close to others. I use the participants' own words to describe this duality and I finish by asking the members to consider "putting down their mask" next time, instead of automatically reaching for it when they do not want to share their real feelings.

CLIENT RESPONSES

It has always been my experience that given the opportunity, adolescents love to talk about themselves. A therapist that approaches them with unconditional positive regard, but who is also able to challenge their assumptions will not find it difficult to work with adolescents. Most adolescents readily participate in this exercise and intrinsically understand the concept of the mask. Often, insights discovered in group are often brought up in subsequent groups ("You're wearing your angry mask again"), and serve as a relational tool in individual sessions. A group of clients in recovery from substance abuse related the mask to the role they play as addicts and the addictive behaviors that led to relapse. This was fertile ground for introspection and at the end of the session, most participants claim they

are ready to begin to "put down their masks," and start relating to people in more intimate ways.

CONTRAINDICATIONS

This activity works best in the middle or later phases of the group. Once group members know one another and have interacted for a few group sessions, they will be better able to use the process of the group to support deeper insights and greater self-awareness. I do not recommend this activity for a group whose members are just beginning to work together

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Chapter 28

Using Art Therapy Technique in a Psychodynamic-Oriented Group

Haim Weinberg

YOUR BODY-YOURSELF: DRAW YOUR BODY AND EXPLORE YOUR SELF-IMAGE

Psychodynamic-oriented group psychotherapists (Rutan & Stone, 2000) usually encourage verbal interaction in the group and work with words, not with action or art materials (Malchiodi, 1998). When they do use planned active interventions they find it hard to incorporate these techniques into their regular group process. The following technique is used to enhance body awareness (Cash & Pruzinsky, 2002), but also to deepen exploration of self-image. It is used not as a stand-alone technique, but as part of a psychodynamic group, and therefore the interaction between group members around the drawings and the feedback they receive from one another is an important part of using it. Beyond the specific "exercise" of drawing one's body, this demonstrates how to integrate any art and action exercise into a psychodynamic group.

CONDITIONS AND POPULATION

The following technique can be used in either workshops or continuous therapy groups.* When used in a therapy group it needs enough time to both create the drawings and work through their

*Thanks to Tami Elad for introducing me to this technique.

meaning. Therefore it needs more than the common ninety-minute session. It can be spread between several consecutive sessions or applied in a marathon session. It does not matter whether the group is short-term or long-term.

The participants do not need to have any artistic or special drawing ability. The group can be a general therapy group for mixed disorders or focused on body image and eating disorders. The important factor is that the therapist is flexible enough to change the structure and use action methods in the group.

Patients with eating disturbance disorders or people with problems in body image can benefit enormously from this technique. It is also recommended for people with low self-esteem.

DESCRIPTION OF THE INTERVENTION

Materials and Preparations

You need to prepare big sheets of paper. The size of the paper should be bigger than a human body. The paper can be bought in a store that supplies paper or art material in bulk, which you need to cut in advance into long pieces for each group member. You also need to buy several water-based paints (five colors is more than enough), and paint brushes. You also need as many pencils as group members, and adhesive tape (or any other method) to attach the drawings to the wall as in an exhibition.

Tell the group members in advance that they are going to work with paints, so they should dress properly. The group room should be spacious enough for all the group members to lie on the floor and not feel crowded. The floor should be smooth, no rug or carpet.

Instructions for Intervention

Step 1: Dividing into Twos

Ask the group members to choose a partner for the exercise. If the number of the members is uneven, the last person joins a couple into a threesome. There is no need to choose someone of own or opposite sex, just someone you want to work with on this group exercise.

Step 2: Drawing Your Partner's Body Contour

Each couple spreads the big sheet of paper on the floor, and one of them lies down on it in any position she or he wants to be drawn. The other partner draws the contours of the body of the person lying down with a pencil. This is done by marking the outlines of the body lying on the floor, as close as possible to the body without touching it. Then they change positions and the person whose figure was drawn, now draws the other person's body contour.

Step 3: Paint Yourself

Ask the group members to use color to paint themselves. The drawing should represent the painter's self-image. In this stage each group member works alone and uses the colors to paint his or her body outlines. This is the most important part and it needs enough time to let the participant become immersed in the work so allow for thirty to forty minutes for this stage. Tell members that the artistic quality of the work is unimportant and that the product will not be evaluated for its artistic value. People can use whatever colors they want in whatever form they prefer.

Step 4: Pictures at an Exhibition

When the colors dry, hang the pictures on the walls (using the adhesive tape), side by side, but with space between them (as an exhibition). Ask the group members to walk from one painting to another and absorb the impressions, without talking and without asking whose picture it is.

Step 5: Associations, Feedback, and Projections

The group sits in the usual circle. Ask a volunteer to bring his or her drawing in order for the group to work with it. The volunteer puts the picture in the center and group members are asked to associate about what they see. You need to explain that the request is not to interpret ("this drawing shows your low self-esteem," or "the black color in the area of the head shows that you have some dark thoughts"), but to associate ("it looks like a robot," or "the colors remind me of a butterfly," or "this is like a picture of a queen").

As it usually happens, some of the associations might catch some of the unconscious processes of the painter, and some are mere projections of the person who is associating to the stimulus. It does not matter. The person whose picture is in the center should just listen to the associations and let them in.

Step 6: What Did You Learn About Yourself?

The individual responds to the associations. The task is not to say who is right and who is wrong, but to connect as many associations as possible to meaningful personal issues, and issues previously worked through in the group sessions.

Step 7: Initiating Interaction

Now comes the time for integrating the individual work with the group process. Allow and encourage interaction between the individual and the group.

Step 8: Repeat the Previous Steps Until All Group Members Finish Working

As previously related, it might take a few hours or sessions to allow all the group members to do the work.

Step 9: Group Process

Discuss with the group how this experience worked for them and what they learned about themselves and their self-image.

CLIENTS' RESPONSES

This is a very powerful experience for group members and they usually see it as expanding their awareness of self-images, body perceptions, and how they come across to others. Drawing and painting is fun, and the group members enjoy it. Some participants use their fingers and hands to smear colors. Others are reluctant to get dirty, and their responses can be elaborated in the final stage. Some people choose interesting positions, such as cuddling like an embryo. The

work with the partner, drawing the body outline, is felt as very intimate, and should be discussed as well. If led in a nonjudgmental group climate, the associations of other group members are very meaningful. People are surprised how much they learned from an "exercise" that looked so simple and naïve.

CONTRAINDICATIONS

This technique is suitable for individuals with enough ego strength, and should be applied with caution among psychotic patients. It is not recommended to use this technique with known sexual-abuse patients, where touch is a delicate issue. It is also advised to apply this technique in the group-advanced stage, after an atmosphere of safety and group cohesion is achieved.

CONCLUSION

Although this technique requires tedious preparations (buying material, cutting papers, etc.), the results justify the efforts. This exercise echoes in the group for many consecutive sessions, enabling group members to work through issues that have not been touched before, from body image to self-esteem.

In addition, the description of the intervention can serve as a model of how to integrate any artwork into a psychodynamic group.

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Chapter 29

Advice Giving

Russell Hopfenberg

WHAT SHOULD I DO?

"What should I do?" is a common question posed by patients to therapists. Experiencing an empathic connection with the patient, the therapist may then think to himself or herself "What should I do?" The inclination might be for the therapist to attempt to give advice. However, prescribing action ahead of gaining some level of understanding of the nature of the patient's difficulty may ultimately be unempathic. Advice often fails to mirror the patient's internal reality (Alonso & Rutan, 1996). Their difficulties may in fact serve an undiscovered purpose in their lives. Therefore, thoughtful assessment of a patient's experience will be more helpful than a therapist directly answering the question "What should I do?"

In group psychotherapy, the therapeutic agenda of exploring and uncovering the full nature of the individual group member's difficulties may seemingly be undermined by other group members' maneuvers to quell the anxiety inherent in the process. Among methods that group members employ is answering the question "What should I do?" or offering advice. At first blush, this might seem to corrupt the very purpose of therapy and lead some group therapists to discourage group members from giving advice. After all, many patients have first sought advice from family, friends, radio talk shows, and self-help books. Thoughtful and caring advice has been ineffective in helping the group member resolve his or her issues. However, member to member advice given in the context of a therapy group can be an essential vehicle for furthering self-exploration.

PATIENT POPULATION

The intervention described as follows is used in a psychodynamically oriented therapy group. Patients treated in this modality characteristically have the cognitive ability to be introspective and integrate abstract concepts.

Case Example

Mr. A had been a member of an ongoing therapy group for about two years. He was divorced and had been embroiled in multiple legal battles with his ex-wife over custody and visitation of their teenage children. Mr. A had also been fired from his job but had some funds from savings and inheritance. He would ignore taking care of some of his household needs as well as attention to his career and social life. The group, and the group leader viewed Mr. A as someone who passively, and sometimes actively, was destroying his life and all were concerned about the direction that he was taking.

Mr. B joined the group and presented with marital and career difficulties. He had many jobs over the years but would become anxious and angry if he received criticism. Yet, he also experienced heightened anxiety if he found himself to be succeeding. In either circumstance, Mr. B would quit his job and find another, which was usually less fulfilling and less financially rewarding. This behavior led to incidents of marital strife. Both Mr. A and Mr. B had experienced overtly critical fathers who were, at times, verbally abusive. They also experienced their mothers as loving yet passively demeaning.

Mr. A obtained and began working at a job that he thought would be personally rewarding. The group members were supportive and encouraging. Over time, it became clear that Mr. A was unwilling, or perhaps unable, to fulfill some of the basic job requirements and was at risk of being terminated. He spent a great deal of time working on administrative tasks with little or no attention to the more important responsibilities. Mr. A avoided changing his behavior or the perspective of his employer. The group was supportive and encouraged Mr. A to try to understand the pattern that he was enacting. Mr. B then stated: "Here's what you need to do. You're obviously avoiding being responsible about your work. You need to make a bodily effort to help yourself. I mean, stand up on your actual legs, take actual steps to walk over to your boss' office and diplomatically ask for help and feedback." To this, Mr. A responded "I've gotten that advice before and I still find it almost impossible."

INTERVENTION

The basic flow of the intervention is as follows.

- Mr. A presents a difficulty.
- Mr. B offers advice.
- The group leader endorses the advice and indirectly recommends that Mr. B listen to himself.

In this vignette, Mr. B is presenting some sound advice but may be cutting off Mr. A's further exploration. Noting that Mr. B is presenting advice about a situation with which he himself struggles, the therapeutic intervention is, paradoxically, directed toward Mr. A. "Mr. A., this is important advice that Mr. B is giving and you should listen to what he is saying. And maybe, someday, Mr. B will listen to himself."

PATIENTS' RESPONSES TO THE INTERVENTION

To continue with the example, Mr. B responded, "Yes, I know. I do the same thing. I guess that's why Mr. A's story gets to me. I've heard the same advice too and I find it hard to follow." Mr. B and Mr. A, as well as the other group members then examined the historical resonance of their difficulties.

Patients typically respond to this intervention by examining their behavioral patterns and history. With the revelation that the group member offering the advice has a similar difficulty and "knows what to do," it becomes clear that the causes of the presenting problems are not issues of competence or capability. The unconscious purpose of advice giving is to avoid feelings inherent in examining the meaning of patients' struggles. This intervention counters the unconscious purpose of advice giving and the result is a heightening of group members' curiosity about themselves and each other.

CONCLUSION AND CONTRAINDICATION

Therapeutic neutrality has often been defined by what it is not. One of these negative definitions is that neutrality "is not giving advice

(Alonso & Rutan, 1996)." In a therapy group, although the group leader might not offer advice, it is difficult to prevent group members from doing so. Typically, a group member gives advice when the member offering advice resonates with the struggles of the member to whom the advice is offered. Using this intervention requires consideration of the group members' difficulties and historical issues. Although there are no specific contraindications, an indiscriminate application of the advice giving intervention can amount to group members experiencing the group therapist as being disingenuous. If the leader's assessment is that there is a mirroring of issues, the intervention described can open a dialog of rich exploration.

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Chapter 30

Bridging As a Tool to Avoid Scapegoating

Melissa Black

> A good scapegoat is nearly as welcomed as a solution to the problem.
>
> (Author unknown)

The concept of scapegoating, a unified dislike or hatred of one member by the majority of the group, is often misunderstood as a phenomenon that is done "to" a member of a group rather than a collusion between a group and a member's defensive patterns (Gans, 1989). The role of the scapegoat is often placed upon a group member by the remainder of the group as a way to disavow negative thoughts, feelings, or behaviors that they may be experiencing. For the scapegoat, unconsciously eliciting this hostility may be in the service of avoiding positive connection and often is a replication of his or her family-of-origin negative relationship patterns. If the scapegoat is allowed to take all of this projected hostility, the group members will run the risk of becoming stuck in the split and not working with their own negative thoughts and feelings. The member who is scapegoated will often simply flee the group.

The technique of bridging in group psychotherapy has been described as "any technique designed to strengthen emotional connections between members, or to develop connections where they did not exist before" (Ormont, 1992). As group therapists, we know that the more we are able to stimulate interactions between members, the more we create potential for therapeutic work in the moment and in

the future life of the group. Bridging is often used to move the focus from the leader to the members of the group. It is especially useful when a group is ready to move from its nascent stage of leader dependency into a more mature work group. But bridging is a technique that may be used throughout the developmental phases of the group. The following intervention demonstrates how bridging may be used to avoid a potentially destructive scapegoating situation during the later phases of group development.

INTERVENTION

I inherited a group patient, Doug, from an associate of mine who, for a variety of reasons, was terminating an existing group. Doug had been in four previous therapy groups, always finding himself the target of anger and hostility in the group. Although he did not see the pattern, this phenomenon was always brought about as he cavalierly brandished the tale of his multiple marital infidelities, his excessive gambling with his inherited wealth, and his ultimate declaration that he truly loved his wife. Upon entering my ongoing weekly group, this attractive and very verbal man began, almost without invitation, to tell his "story." As I watched the group's reactions I could see the self-righteousness in the other married men and the hostility from the women. I quietly observed Doug's reaction to some of the initial comments of the group. Statements such as "I can't believe your wife has stayed with you. I would have left you" were made from one woman with the nodding agreement of the others. One man responded with a lengthy narrative on the "moral commitment of marriage" and was met with approval from the group. Doug immediately launched into an emotionally defensive speech, rationalizing his actions. I began to feel the scapegoating starting and knew that the patient would be both relieved and disappointed that we would end up being the fifth group to "fail" him if I did not find a way to successfully intervene.

I knew that he could easily maintain the scapegoat role if I made a direct intervention. He would dismiss the group as not understanding him and begin to split me from the group as I would be the only one who truly understood.

So I chose the woman with the most outwardly virulent response toward his story and addressed the following comment, "Barbara, you certainly have reasons from your own history to feel such anger

and hatred toward Doug, but I wonder if there is anything else you think Doug is trying to accomplish tonight?"

Barbara was a beautiful, sensual woman in her early thirties who had often found herself in relationships where infidelity was present in her partner. The less obvious connection was the strong need that initially drove her into these relationships. Since her teens, she had used her beauty and sexuality to keep adoring men around her, flaunting them and playing with them to avoid the emptiness she felt inside. Men became expendable objects and relationships often had little reciprocity. The few occasions she engaged in what she believed would be "rescue-type Cinderella relationships," she was predictably met with infidelity. This would create yet another bout of loneliness, isolation, and despair and set into motion another assault on the hapless men in the city.

After my comment, she was quiet and reflective and then was able to say to Doug, "I know how scared and empty you must feel because when I fall back on my conquests, I am scared and alone. I hope this group can help you be brave enough to let us meet the real you sometime." This comment took the wind out of Doug's sail. He was speechless for the first time in the group. Another group member picked up the new theme and stated, "You have lived a soap opera–shallow, meaningless and always looking for the next ratings. That is incredibly sad for you."

The group let Doug be silent and absorb the abrupt change in the direction of the group. Many of the members joined in to talk about feeling scared to open up in group and scared to live their lives as themselves and even all the ways they had tried to make the group hate them or punish them. Eventually, Doug expressed his anxiety around not knowing what to do or say. This was met with approval from the group. The man who had been the most self-righteous and "moral" said, "Welcome to the real world, buddy."

RESPONSE TO THE INTERVENTION

When this technique works, the typical response is to change the flow and tone of the emotional matrix of the group. It is most effective when there is too much dependency on the group leader or when an individual or subgroup is setting up to become a scapegoat. It is important to bridge between people or groups who you believe will be

able to make an empathic connection, often based upon common defensive styles. Bridging can fall flat and actually increase the likelihood of scapegoating if the connection is rejected. In fact, in the intervention, had I chosen someone who had done less work on his own issues around intimacy and dependency, it may have increased the hostility in the group toward Doug. After all, who wants to join with someone who is admitting to such heinous behaviors and therefore, alluding to an implicit character flaw!

POSSIBLE CONTRAINDICATIONS

It is important to pay attention to the stage of group development both when creating bridges in the group and in working with scapegoating. In an early group where anger, conflict, or other negative affect exists, unless you are attempting to bridge group members together in shared anger directed toward the leader, it is best to work directly with the negative affect and draw it toward yourself as leader. Members in a young group may not have the separation and autonomy from the group leader to support another member if it is perceived as emotionally risky.

A member of a new group who is setting himself or herself up as a potential scapegoat will certainly need an intervention by the leader to avoid being ostracized by the group. In an early stage of group development, this intervention will be most useful for the group if it is direct, and between the leader and the group, to limit the projections rather than exploring the collusive relationship within the group.

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Chapter 31

Installation of Hope in Bereavement Groups for the Elderly

Mark A. Cohen

THE PROFUNDITY IN A WORD

Death. No one word in the English language may stir so many strong emotions. Now imagine yourself being older, elderly. Your spouse, your partner in life, your best friend and confidant, dies. You are alone. The scene is a large room in a senior citizens' activity center. The empty chairs start to fill with elderly people. They have all lost a spouse. They are alone. Anxious. Bereaved. Hopeless. Scared. They are attending a bereavement group for the first time. The session starts.

Based on my work in group therapy with the elderly, I have observed a number of healing and curative factors. These curative factors are: the installation of hope, acceptance, a decrease in social isolation, finding of a new identity and meaning in life, support, catharsis, amelioration of fears, education, assistance in processing and dealing with painful or intense feelings, and an opportunity to help others (Cohen, 2000). Individuals who have lost a spouse often feel hopeless that they can return to a life of happiness and joy. They may even feel hopeless that they will ever just stop feeling sad all the time. We will look at specific interventions in bereavement groups that exemplify the installation of hope.

THE LOSS OF A SPOUSE

The population for this group was elderly individuals in the community who had all lost a spouse. These techniques could also be extended to younger bereaved spouses and perhaps other bereaved groups.

A POPULATION WITHIN AN ONGOING GROUP

Mix the more recently bereaved with individuals who are further along in the bereavement process.

One particularly effective intervention in the installation of hope is to have bereavement groups that are mixed among people who are more recently bereaved and those who are further along in the bereavement process (Roy and Sumpter, 1983). Those who are more recently bereaved can see how those further along are finding happiness and joy again in life. They can also see how those further along are able to talk about the death and their loved one without the intense overwhelming emotions that are often present in the earlier stages of bereavement. Asking specific guided questions of those further along can highlight the possibility of hope to those less further along.

Identification by group members who are further along in the bereavement process with those more recently bereaved.

It is quite helpful to encourage group members who are further along in the bereavement process to disclose and identify how they can relate to what an individual who is more recently bereaved is experiencing. They can be encouraged to explain how they used to act/feel the same way, but through time and the help of the group they have come to learn to accept and effectively interact with the vicissitudes of life and find happiness and joy again. It also is of great help to hear that the intense feelings of sadness will dissipate with time this intervention process can also be an effective intervention for those who are further along, by helping them to see how far they have gone in the bereavement process and giving them hope that they can still go further.

Use stories and poems that encourage hope and a new future.

Having group members bring in stories and poems they have read or to write stories about hope and a new future can help to install hope in other members. One such poem, whose author is unknown, follows (in edited format):

I'm tired of gloom;
I'm tired of pain;
I want to rejoin
The world again.

Today I will try
To smile once more.
Death disappeared
And left my door.

I'll pick myself up
And try again;
I'll make the effort
To function again.

It won't be easy
As I well know,
But I won't give up
The change made me grow.

The pain in my heart
Will remain for a while
But yesterday's gone
Today I will smile.

Learn to do new tasks, things your spouse did, or to engage in new behaviors.

Asking the individual questions, such as what he or she always wanted to do but never had time for, or what he or she wanted to do but were never able to do because of his or her situation/spouse, can help the individual to look at ways to find new things in life.

Having group members encourage individuals to try new things that may be scary or different can be quite beneficial. It is not uncommon to find that group members may benefit from trying new behaviors together. For example, two bereaved women decided to take a cruise together because each was too fearful to go alone.

Asking a bereaved group member to explain some things his or her spouse used to always do that they would like to learn leads to a detailed explanation. This can then help them to see that they learned how to do the task just by observing their spouse do it so many times.

Visualize a new and hopeful future.

Another effective exercise is to ask group members to close their eyes and visualize themselves doing something enjoyable in the future and being happy. Using this visualization may help the members get in touch with something that can still bring them joy and provide hope that that they can still enjoy life again.

THE CLIENTS RESPOND

These interventions can evoke a variety of client responses. Frequently, for the more newly bereaved individuals, there may be doubt in their mind that there is hope for a better future. However, with repeated exposure to these interventions that doubt can change. Some may start to feel hopeful about the future but then experience guilt that they are feeling better while their spouse is deceased. This is an issue that can then be effectively worked through within the group.

CONTRAINDICATIONS

Due to the very serious and profoundly upsetting experience of spousal loss with its concomitant lifestyle change, this intervention would be contraindicated for individuals who are newly bereaved and still in the midst of intense mourning and hopelessness. The installation of hope, which may take time and patience, is a secondary intervention. The primary intervention is the acknowledgement of and the compassion toward the patient's loss. Jumping to the secondary intervention of trying to give hope is not only useless but indicates insensi-

tivity, impatience, and possible discomfort with loss in the group therapist.

Moving an individual from hopelessness to hope and the possibility of a future takes patience, sensitivity, and skill on the part of the group therapist. Its essence is like the phoenix rising out of the ashes. In words beautifully written by Dickinson, (1960) "hope is a thing with feathers that perches in the soul" (p. 68). Reaching what has become, for many, a dormant hope is the goal of the bereavement group therapist.

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Chapter 32

The "I's" Have It!

Margaret M. Postlewaite

HEIGHTEN AWARENESS AND RESPONSIBILITY

I ask members of my groups to begin every sentence using "I." The goal of this intervention is to intensify the exchange between members and to heighten their awareness and responsibility for their thoughts, feelings, and actions. This can be an intervention, on both basic and more complex levels. It can be used in groups with great effectiveness.

In today's society, people often speak about how "the other makes me feel. . ." or "he or she made me. . . ." These "other-oriented" statements detract from directness. I want to encourage group members to own their role in formulating their thoughts, acknowledging their feelings, and determining their own responses or behaviors. Using "I" increases the immediacy of the interaction. According to Yalom (1994), this "here and now" focus offers the greatest opportunity for interpersonal learning. The "I's," as I call this intervention, specifically enhance the "here and now."

MULTIPLE POPULATIONS

The "I" technique can be employed in all kinds of groups: process-oriented, therapy, training, workshop, communication skills, topic-focused, parenting, adolescent, parent-child, or family groups. This approach has the potential to be an incredibly powerful tool in a variety of situations, including individual, as well as couples' therapy and

counseling. Although this can be implemented early in a group's existence, I have introduced it at a variety of times, particularly when I notice a prevalence of "you" statements between members. When a group or individual blames someone else in the group, I intervene with the "I's." When they begin to point a finger at a family member or friend not present, I can intervene with the "I's."

THE INTERVENTION

In introducing this idea to groups, I present it as much larger than semantics. Rather than just altering the words, using "I" is a different way of communicating that can change the nature of the exchange between people. It makes for clearer, more straightforward communication.

I invite group members to practice phrasing every statement in the group (or for the next fifteen minutes) to begin with "I" rather than "you." As they struggle with this, I intervene to assist and help them rephrase. As time goes on and the group gets comfortable with this, my role diminishes enormously and the group can help each other with applying this idea.

Applying the Intervention

A variety of situations profit from this intervention. When members speak with strong emotion the therapist can model appropriate response:

GROUP MEMBER (to another member): "You made me so uncomfortable with your angry shouting!"

THERAPIST (modeling response): "*I* become very uncomfortable when you raise your voice. *I* hear it as anger."

When members give feedback:

MEMBER: "I think that you enjoy being the one in charge in here!"

THERAPIST: "*I feel* jealous when you speak with such authority."

When members want another member to change behavior:

MEMBER: "Can't you stop smirking? Don't look at me like that!"
THERAPIST: "When you smile, *I* see it as a smirk and *I* feel diminished. *I* want to know more about what you are feeling toward me."
(The other member might respond): "I'm smiling because I like you and I enjoy how you say things."

Later I might encourage the group members to explore their observations and feelings in response to this exchange, with the goal of members saying to themselves: "I'd like to understand more about what gets triggered inside me."

When individuals, speaking about their behavior, use "you" to describe what they themselves do:

MEMBER: "When *you* get angry, *you* want to explode, but instead *you* keep your mouth shut. Why can't *you* speak up?"
THERAPIST: "Try changing the *"you's"* in your statement to *"I's."*
MEMBER: "When *I* get angry, instead of exploding, *I* keep my mouth shut. I wonder if we might be alike."
(Therapist may ask group): "Take a moment and hear how differently it sounds just by inserting *I*. What do you notice?"

Over time, groups learn to listen for differences and respond with their own "I" statements. Because using "I" often feels less threatening to the other member, it provokes less resistance and increases the likelihood of members hearing one another Instead of asking questions of one another, the group uses the "I's" and carries on its dialogue.

Sometimes, groups need to be reminded that, if "you" is in the first four to five words, the statement rarely is an "I" statement. Usually, it is what Thomas Gordon (1975) describes as a "disguised-you message" (p. 121): "I think that you. . . . I feel that you. . . . You are. . . . I wish you would. . . ." Such statements as these, need to be rephrased using "I" followed by a feeling, or closely by another "I": "I feel deeply touched by what you just said;" "I think that I just avoided your gaze by making a joke when I really felt uncomfortable."

COROLLARY INTERVENTION

In conjunction with the "I's," another simple intervention that I use with groups instructs the members (including myself) to use statements rather than questions (Bernstein, personal communication, 1998; Roth, 1997). Behind every question there is a message. When members are asked to state the message in their question, this improves the openness, intensity, and clarity of communication between members. Using only statements, along with the "I's," reduces defensiveness and helps members become aware of their responsibility for their thoughts and feelings. By learning how one's behavior impacts others, and exploring together rather than inquiring, the group can achieve deeper understanding and joint problem solving. "I" statements, rather than questions, can allow for mutual exploration:

MEMBER: "Why did you tell us that story about_____?"
THERAPIST: "When you were telling us about your past, *I felt* sad about what happened to you."

Both these techniques work well together. Using statements also helps group members stay away from hiding behind questions.

CONTRAINDICATIONS AND RECOMMENDATIONS

The "I's" can be used in all situations from group therapy to everyday communication. The more practice I as a therapist have in utilizing this technique in my life, the greater my skill in applying the concept in my group communication. With even more practice, in highly charged emotional moments, I can assist the group more effectively. Very quickly, as therapists, we can discover the shift in thinking and expression provided with this technique. As therapists develop proficiency with using the "I's," we begin to "hear" most conversations through this "ear." Greater practice ensures greater expertise. Although I have found no contraindications for this intervention, it is important for the therapist to be aware of the ego strength of the group members.

I have come to recognize how infrequently our society utilizes this important skill. In the various groups I run, therapy, supervision, and consultation, using the "I's" has enhanced the work done by the group. The "I's" have it!

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Chapter 33

Therapeutic Play Reading

Barney Straus

THE HIDDEN ASPECT OF ONESELF

The reading of theatrical plays aloud evolves from a tradition of readers' theater and is often the first step in the rehearsal process when a play is to be staged. The process can be used with literate populations to great therapeutic benefit as it allows participants to discover previously hidden aspects of themselves through the reading of roles. For example, a withdrawn group member might find energy in a lively character while the structure of the script might lend temporary clarity to a group member who otherwise may be experiencing disorganized thoughts. All group members benefit from feeling that they are taking part in a shared experience. Yalom (2005) refers to interpersonal interaction as the engine of group therapy, and plays are just that, scripted interpersonal interaction. Having predetermined lines is especially helpful to socially isolated individuals.

Because of the time required for this intervention, it may fit best within a day-treatment or inpatient model. If a play is to be read within the time frame of a traditional therapy group session, a one-act play is ideal. The challenge is finding short plays of interest that have enough parts for all the group members. Some plays that fit this description are listed in the next section.

A LITERATE POPULATION

Therapeutic play reading can be used effectively with most literate populations. I have used play reading extensively in my work with seniors at a day-treatment program. Group members need to have the time and willingness to participate in this activity. It is best to use plays with roles that approximate the age and gender of group members. Nevertheless, exploring characters that are demographically different from themselves can be enjoyable and illuminating for readers.

INTERVENTION DIALOGUE AND IMPLEMENTATION

The group leader suggests that reading a play aloud might be an enjoyable activity for the group. A discussion will help to gage the group's interest in such an activity. If a majority of group members are interested in the activity, it can proceed successfully.

Selection of Material

The leader should explain that she or he has selected a play that has enough parts for all or most group members. The group leader explains that some roles require more reading than others. It is generally best to start by giving the more demanding parts to those who exhibit enthusiasm for the activity. This will allow those who are more hesitant to follow the example of more active group members.

Liveliness, length, and number of characters are all important considerations when selecting material. Ideally, the play should be able to be the read aloud during one group session. There should be enough parts so that every group member can participate if they choose to do so, and the play should be engaging. It is not so easy to find all three of these attributes together. Some of the plays that I have used profitably are:

Title	Author	Pages	# of roles
All The Comforts of Home	Howard Amend	10	2M, 4W
Hall of Healing	Sean O'Casey	36	3-9 M, 2-8 W (11 parts total)
The Mother	Paddy Chayefsky	33	2M, 8W

Waiting for Dr. Hamle	Doug Stewart	13	6M, 4W
A Wedding, or a Joke In One Act	Anton Checkhov	12	8M, 4W

Copying

Many plays, especially older ones such as most of those listed, are in the public domain and can be copied without any infringement issues. Make or purchase one copy of the script for each group member. Even those group members who are not reading a role should be given a copy of the script so that they can follow along.

Assigning Roles

Generally, simply asking who would like to read a given role works best. This way group members feel that they are involved in the decision-making process. If no one responds to a given role, then it is fine to request that a specific group member read it. This can be done with intention, as in assigning roles *with* or *against* a group member's own personality. Assigning roles that are consistent with group members' personalities will allow them to strengthen these qualities. Assigning against a client's manifest personality may allow group members to explore hidden aspects of themselves.

Sometimes, a group member will want to read the stage directions rather than a character. I suggest that only the overall stage directions (setting, description of characters, etc.) be read and *not* any stage directions that are specific to one line such as *(raising her glass in the air, as if to make a toast).* If readers want to try using such directions, that is fine, but reading them aloud diminishes the process.

Reading

Ask group members to project their voices so that everyone in the group can hear. You might want to start with a vocal warm up of some kind. This can include counting aloud (1 to 10 in one breath), tongue twisters, and the like. The group leader(s) should sit nearest to those group members who may have trouble picking up their cues.

This will allow the leader(s) to prompt as needed. The play is then read aloud.

Discussion

A discussion following the reading should focus both on the content of the play (relevant themes, application to group members' lives, reminiscence, etc.) and on the *process* of the reading. Ask group members what it was like to step into another role, albeit temporarily.

RESPONSES TO ACTIVITY

Group members usually respond very positively to this intervention. People tend to take ownership of their roles very readily and are often able to invest more energy in the reading of a part than they bring to their normal affairs. I have seen examples of very quiet group members becoming quite animated through play reading. I have seen depressed folks perk up, and I have witnessed disorganized people seeming to be clear and direct.

Usually, a play will be enjoyed by most group members and not liked by some. Welcome the difference of opinions and explore what people liked and did not like about a given play. Make notes about this for future use. Occasionally, a play will generate real excitement. If there is enough time and energy, such plays can be developed into full productions.

CONTRAINDICATIONS

Therapeutic play reading can be used to great benefit with groups that have ample time to spend together. Although there seem to be very few contraindications to this intervention, the most salient is in its preparation in relation to the group members as a whole. For example, it does require that group members have the ability to read efficiently. Some group members may need enlarged print. If there are one or two illiterate group members, or others who may have trouble reading for any reason, these folks may prefer to listen. If these group

members do not mind being prompted by staff, they may wish to take a role in spite of their deficit. The group leader should try to gage whether assigning roles to those who may struggle with the reading will cause them humiliation as this is to be avoided.

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Chapter 34

Women's Empowerment Group Using Art Therapy

Tal Schwartz

AN EMOTIONAL JOURNEY

Art therapy treatment is an "experience" emotional journey, which puts emphasis on the process of doing, as a path toward the final product. The use of an "experience" projective tool in women's groups stems from the view that the goal is attainment of a "final product," in which women will grow to a better place in their lives. A place of self-awareness, and high self-image (in order to study or work), involves focusing on the process and the journey in the world of emotions, unconsciousness, metaphors, and symbols (Jung, 1978).

The treatment is based on the artistic doing (activity), using creative materials, and also the ability of the therapist to lead the patient to self-dialogue.

Art is a nonverbal means of communication. Using art, the group members contact and exchange their emotional inner world with the rest of the group, without the necessary verbal intermediation as a potential space (Winnicott, 1995).

GROUP DESCRIPTION

The women's groups range in age from thirty to fifty years of age. The average number of women participants in each group is fifteen. Each group therapy commitment consists of twenty-five sessions.

The women's major occupation is house holding. They arrive with a feeling of unfulfillment, low self-image, and low self-assurance.

Due to their early age at time of marriage, they have not had the opportunity to build their own, independent careers. Their relationships with their husbands are characterized by economic and emotional dependency.

The intervention is appropriate for groups dealing with the narrative of a patient's life, to address and discover her creative and healthy parts. This type of group intervention can be prescribed to a general therapy group and is effective for both men and women.

INTERVENTION

I use art and its symbols as a thread, which connects past, present, and future as a personal and group experience communication element (Bion, 1961).

Materials

At the beginning of the meetings I take care of supplying the art materials, such as colorful papers in different kinds and sizes. The women are asked to bring pictures of their childhoods. During the group, the women are asked to bring materials to present their life story with characterization and metaphors.

The process of the sessions is divided into three phases: past, present, and future.

Step 1

In this first stage, the women associate to their private name, draw their name and color it, according to the way they feel, on a sheet of paper. Issues such as: "Where did I put my name on the page?" and other issues, such as: the proportion of the name versus the page size, full versus empty space, the chosen colors, the materials attached to the name—all have the capacity to arouse thoughts and feelings which lead to personal "checking." An example of such would be, "Where am I with regard to my life and the rest of the group members?"

Step 2

In the second stage, women are asked to bring a picture of themselves as a child. I generally photocopy these pictures, magnify them, and make copies: one in black and white, and one in color. The magnification helps them watch and see the various details of that child observed in the picture. The different pictures invite them to use and contribute to the symbols in their life story.

Step 3

In addition to the pictures, I give each woman a poem as a starting point with the past and a connection to the present. The poems are about the forgotten things of childhood.

I look for poems that talk about memories and sights, with no specific mention of time or place, so as to let every participant make her own associations to the central issue of the poem as a stimulus which returns the woman to that forgotten childhood. You can, also choose any song that talks about childhood that is relevant to the place or the culture of the patients.

Step 4

The women are asked to derive single words, or a related sentence, and create an emotional, conceptual integration between the words of the poem and the child in the picture. This step includes a group dialogue as well as a personal dialogue concerning the stories created from the association between the words and the picture. Issues such as: "What had the child left in her forgotten childhood? Who was she way back in the past? What were her dreams and expectations from herself? What was her place in her family of origin?" This part arouses nostalgia, smiles, and pain. In this part of the intervention it is important to check who among these women has social leadership skills, and what happened in her life's journey that made her leave all this behind, i.e., traumas, introjected, related family patterns.

Step 5

The link to the past touches the very intimate, delicate texture of the group, as well as personal lives. The women have to build a new

lifeline–a rope, which connects the past with the present, a symbol of the "the umbilical cord." This cord is translated to tastes, smells, prayers, and different textures that the women collect from their childhood environments and from their present. It is important to give this part a significant time space, as collections are created and presented as if in an exhibition. This part is especially exciting, since it involves a lot of effort, and confronts issues dealing with the reasons for the women's inability to carry out developmental tasks and progress.

Step 6

I use the term "curtain" to represent the situation of being stuck. This curtain stands between the self-fulfillment, i.e., between the desire, dream, and fantasy and their place in the present; a curtain, which they have to pass through in order to move to the other side.

The women have to metaphorically check and choose the various materials that make this curtain opaque, transparent, stiff, soft, etc. Different materials are then brought into the room: piercing thorns, nets with different density; the whole group contributes by looking at the unconcealed and into the hidden. At the end of this step, the women will have to go through the curtains and reveal their strength to cope with the past as a process of growing. They begin thinking about the future by searching for studying and working places, while still in the process of group therapy.

TYPICAL RESPONSES AND CONCLUSION

The work technique and the various steps in the intervention create within the women a sense of responsibility, involvement, discovering the self and the existing forces, which facilitate looking into themselves with new views. There is no need to know how to draw or paint, but it is necessary to have the motivation to revive the concealed self. The multi-sensual experience is empowered by the group experience and thus creates revival, strength, and empowerment.

CONTRAINDICATIONS

This process is viewed by the women as a positive, full of strengths and new discoveries about themselves and about the other group members. In fact, the only contraindication might be the new experience of using metaphoric language, and the world of symbols and imagination, but it appears that the women easily develop this ability with time and practice. For some of the women, their adult world had become concrete thus eliciting this initial difficulty of expressing their creativity but practice within this paradigm helps to remedy the transition from the concrete into the abstract.

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Chapter 35

Utilizing the Group to Counter Negative Identifications in Patients Finding Their Own Voice

David Cantor

THE UNCONSCIOUS PROCESS OF IDENTIFICATION

A process group is often about countering or disconfirming a patient's negative identifications and encouraging the individual to speak with his or her own "true voice." Group therapy helps the patient do this in a number of ways including exploration of the negative identification, confrontation of the identification, providing new sources of identification, and by encouraging the patient to gain healthier identifications (Rutan & Stone, 2001). McWilliams (1994) writes that it is the capacity of human beings to identify with new love objects that are the means by which psychotherapy, of any kind, achieves change. This is especially true in group therapy with its multiple opportunities for identification.

When patients enter psychotherapy, it is not uncommon for them to speak in a psychological voice other than their own. They speak with the voice of someone with whom they have identified. This identification can be with someone from the patient's past or someone from his or her present such as a spouse. The latter identification can be understood via the concept "identification with the aggressor." McWilliams (1999) writes that "identification with the aggressor" occurs in traumatic situations and operates as a defense against fear and the sense of impotence.

If the patient is speaking to the group from the position of the negative identification he or she will do so in a distinct manner and tone, which can be evident to the group and to the group therapist after a certain amount of experience with the patient. Also, when the patients speak from one of their identifications, a certain message about how they see themselves and how they expect others to see them will be communicated. In addition, a certain feeling/tone will also be communicated by the patient.

DESCRIPTION OF GROUP AND PATIENT POPULATION

The intervention of modifying the identifications with which the patient enters therapy is effective with most patients both in short-term and longer-term groups. In a shorter-term group, this intervention is best limited to the primary identification that the patient brings. In a longer-term group this intervention can be used to modify multiple negative identifications.

This intervention is best used with patients who fall within the normal range of intelligence and who have the ability to step back from themselves and observe their feelings and their behaviors. It is also most effective with patients who are able to receive feedback from others without being unduly hurt.

Therapists from different theoretical orientations including psychodynamic, cognitive, and humanistic/relational also can use this intervention. The cognitive therapist can use this intervention while focusing more on the patient's thoughts and/or schemas which are connected to the identification. The humanistic/relational therapist can also use this intervention while focusing more on how identifications affect relationships within the group.

THE INTERVENTION

The group intervention consists of five steps.

1. The therapist's self-exploration of his or her own feelings in the moment.
2. The therapist using that self-exploration to provide feedback to the patient on the issue of identification.

3. The therapist inviting the group to share feelings and thoughts about what the patient is saying.
4. The therapist inviting the group to share similar identifications.
5. The therapist inviting the group to confront the patient when he or she hears them speaking from that identification.

The *first step* of this intervention is for the group therapist to listen carefully to the patient to determine what identificatory role they are playing. The therapist can do this step in two ways. First, the therapist should try to be aware of his or her own feelings by simply asking himself or herself "How am I feeling about what the patient is saying?" Second, the therapist can also ask himself or herself what the group could be feeling in response to the patient. The feelings elicited by the patient in group therapy can provide a valuable clue to which identification the patient is speaking.

The *second step* of this intervention is giving the patient feedback about how he or she is presenting themselves to the group. This feedback should include information about what role the person might be playing and what reciprocal role is potentially being elicited in the group members. The purpose of this step is to give the patient an invitation to become mindful about how he or she is being perceived and how his or her presentation of themselves might be an identification with an important person from his or her past or present.

The *third step* is to invite the group to share with the patient what they are feeling and thinking in response to what the patient is communicating. The purpose of this step is multifaceted. It communicates to the patient that he or she is being listened to, which supports the patient's motivations in combating troublesome identifications. Second, this feedback from the group gives the patient a number of perspectives from which to examine this issue. Third, this feedback shows the patient that this particular issue or identification is observable to others and that if they look they too can see it, which helps the patient from sliding back into unawareness.

The *fourth step* is to have the other patients in the group relate to the patient about how they have or have had similar identifications. In every group there should be at least one or two other members who have or have had a similar identification to the one being worked on. This works to help both the patient who is working on the particular identification and also the rest of the group members. The group

members who are sharing how they have or have had similar identifications should also include the unique ways that they are transcending their own negative identifications.

The *fifth step* is for the therapist to recruit the group to confront or counter this identification when they hear it from the patient. During this confrontation, the patient should be encouraged by the group to speak in his or her own voice. They should also be encouraged to try out a different way of seeing themselves and a different way of presenting themselves to others. Multiple interactions around this facet of the patient's personality help him or her continue to be mindful about the problematic identification and how to counteract it.

A Short Case Example

> During the group session an adult female patient was discussing her impending divorce and the emotional impact it was having on her. Her husband was communicating to her that he saw her as a "loser" who could not make it without him and that she would never find another person to love her. She presented to the group that this was how she also felt about herself and she indicated to the group that this man was correct in his perception of her.

The first step in this process was for me to ask myself what was I feeling and then to ask what might the group be feeling in response to her story. The answer was that I felt angry with someone beating her up emotionally. I then realized that she was not expressing any anger about how this man was treating her. Her emotional presentation was incongruent with the story that she was communicating to the group. It became clear to the therapist that she was identifying with how her soon-to-be-ex-husband perceived her. She was "identifying with the aggressor."

The second step was communicating to her that I felt angry about how she was being treated and that most people who are treated this way feel angry. I added that I did not perceive any anger being expressed by her. I then invited her to look at how she might be identifying with her ex-husband in his assessment, of her, in order to deal with her feelings of fear and hatred of him.

The third step was inviting the group members to express their feelings and thoughts about what they were hearing from the patient. Fortunately, this was a group who was used to thinking in terms of identifications and who was also comfortable giving feedback to one another. They expressed to this woman their own anger at how she

was being treated along with their irritation at her for accepting her ex-husband's assessment of her. The group communicated to the patient that she was identifying with him, but that she did not have to do that anymore. They expressed to her that she could choose differently.

The fourth step was inviting the group members to share with the patient how they too had or have similar negative identifications. Fortunately for the patient, another group member had gone through a painful divorce and communicated to the patient how she had tended to be passive with her husband and accepting of his view of her until she realized that he was treating her with hostility. This generated anger, in her, toward him which then helped her break her identification with him. Others in the group also gave examples from their experiences with bosses, siblings, and parents.

The fifth step was inviting the group to confront the patient when they observed her slipping back or regressing into her identification with her soon-to-be-ex-husband. This step allows the group to creatively respond to the patient in a way that reminds her of what she is doing. Their creative response to this patient consisted of responding to her with the term "bull crap" along with saying her ex-husband's name when she would tell the group that no one would ever want her again and that she was worthless.

TYPICAL RESPONSE TO THE INTERVENTION

The intervention of utilizing the group to counter negative identifications has typically been very positive for the patients and for the group as a whole. Most patients typically can understand the concept of identification because it tends to be an experience-near type of concept. They also tend to respond well to feedback from their peers especially when their peers are able to relate to the patient that they too can and do have negative identifications. The group as a whole tends to respond well to this intervention because it invites them to work as a team thus building group cohesion.

CONCLUSION AND CONTRAINDICATIONS

Everyone comes into therapy with identifications that do not work for him or her. The group can be a powerful force in countering a pa-

tient's negative and maladaptive identifications. It can be profoundly effective in teaching patients how to find their own "true voice" and also effective in helping them use this voice in their interpersonal interactions outside the group.

Contraindications for this intervention include the problem of both the therapist and the group projecting onto the patient their own identifications. This is why it is so necessary that the therapist have undergone his or her own personal therapy. It is also crucial that the therapist continue working toward self-understanding and increasing self-maturation as both a therapist and as a person.

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Chapter 36

Eliciting Self-Awareness via Existential Fantasy Questions in a Half-Hour Group

Arnold W. Hammari

HYPOTHETICAL SITUATIONS

Arkoff (1995) and Yalom (1980) theorized existential psychotherapy allowed for examination of degrees of freedom, meaning, or absurdity of life, anxiety, the approach of death, intimacy, or isolation within one's life. By exposing the therapy group to fantasy or hypothetical situations, we can learn about their values, struggles, anxieties, and how much responsibility each member takes for making changes. By identifying these issues as "existential," clients come to see their unique experiences as part of the universal drama of human existence.

POPULATION

These existential fantasy questions have been used with juveniles in a corrections center in the western United States. Usual group membership is limited to eight boys, aged thirteen to eighteen, awaiting assessment before assignment to a long-term residential facility. Members come and go; stays in our custody last from a few weeks to a few months. The boys that reside here have been committed by a magistrate to receive help with a variety of problems from stealing, lying, drug abuse, rebelling against authority, aggression, gang activity, destruction of property, sex offenses, etc. We have found that even antisocial youths are willing to express themselves in this thought-

provoking manner. Examining existential issues is often very interesting to them. Existential issues might go even further with older adults since they have had more time to reflect on the meaning of life and frustrations they have encountered in attempts to make their lives meaningful.

GUIDELINES FOR INTERVENTION AND EXISTENTIAL QUESTIONS

This intervention can work in time-limited situations. Our group time is limited to about thirty minutes each morning with eight boys before we go to breakfast in the correctional center. This requires a very focused approach to give each boy an opportunity to participate and hopefully also exhaust the subject in the allotted time. I choose a different existential question to process each day. I introduce the subject as a "provocative question" they can respond to freely, without fear of censure (at least not from me). Useful existential fantasy questions may include the following:

1. If you live to be seventy, which decade of your life will be the most important to you? (e.g., meaning of life, approach of death)
2. If you were stranded on a desert island, whom would you want as a companion? (intimacy, freedom)
3. If you had thirty days to live how would you spend your remaining time? (anxiety, approach of death, meaning)
4. If you had to lose one of your five senses, which would you choose? Which would you never choose to lose? (degrees of freedom, death)
5. If you were deported from your home country, never to return, which other country would you choose to live in? (isolation, freedom, death)
6. If you could change one thing about your physical appearance, what would you change? (isolation, intimacy, identity)
7. What is one year of your life you'd like to skip; what is one year you'd never have skipped? (responsibility, meaning, intimacy)
8. Who is one famous person, historical or fictional, that you'd like to meet? (meaning, intimacy)

9. What is your greatest strength? Greatest weakness? (degrees of freedom, meaning)
10. What short message would you like written on your gravestone along with your name? (meaning of life, absurdity, death)
11. Given your present situation, what freedoms do you have left? (degrees of freedom, responsibility, meaning, death)
12. How will you know when you have become successful? (meaning, approach of death)
13. The most important relationship in my life will be with whom? (intimacy, meaning)
14. What invention would you like to create to improve the world? (meaning of life)
15. Which friend or family member would you grieve the most for if they died? (intimacy, isolation, death)
16. If you could choose another family to be born into, which family would you choose? (intimacy, isolation, freedom)
17. If you could commandeer the front page of the local or national newspaper, what headlines and story would you write? (meaning, isolation, freedom)
18. If you could control another person's behaviors completely, whom would you like to control? (responsibility, intimacy, freedom)
19. What would you be willing to give up in order to gain your freedom? (responsibility, meaning, freedom, death)

A daily question maybe: "If you could have complete control over another person, who would that be, and what would you have them do?"

TYPICAL RESPONSES

In relation to the daily question, one boy answered that he would choose to control the magistrate that ordered his commitment, get a release from custody, and move to Mexico. The next boy said he could not think of anyone he wants to control. The next fellow also wanted to control his judge to obtain a pardon. Another boy said he wanted to control his mother, so she wouldn't call his probation officer every time he disobeyed her. Another said he wanted to control Bill Gates so he could get some money. Finally it came around to me

and I said I would like to control my supervisor so she would appreciate me a little more and perhaps give me a raise.

In asking the boys about this existential question, they agreed it required some thought. They also agreed it was a fantasy to imagine being able to control someone else, because they had encountered great frustration in not being able to persuade judges or mothers from doing their duty (except for the boys from codependent families). This gives an opening for discussion on how much control we have over others, or how much control we surrender to others, and why we do it.

CONCLUSION

My aim is to get the boys in the group to realize that if they learned to control their own behaviors, then others would not have to control them. Then they would be more likely to accept responsibility for their own behaviors and not blame others for their misfortunes. Provocative, existential questions are nonthreatening and allow boys to elicit some self-awareness in a relaxed setting. If one boy gains an insight and shares it with his peers, it carries more weight than if an adult had said it. If the boys criticize one another, we can process the criticism, for that is the "stuff" that makes groups invaluable.

Thirty minutes is not much time, so the following day I present a new responsibility question from a different angle: "What sacrifice would you be willing to make to gain your immediate freedom?" The first boy said he would give up his drugs, another would give up television, another was willing to give five prior years of his life returning to the age of ten, another was willing to give up his pride—a different existential view than yesterday, indicating perhaps they could exercise some control over change in their lives.

CONTRAINDICATIONS

Basic contraindications for this intervention are related to certain requirements inherent in the client. The client must be of average intelligence, have abstract thinking abilities, and some capacity for insight as the prerequisites for ultimate success. Time constraints, in this type of facility, may also be a contraindication because we cannot get

more than thirty minutes each day, of group time, with these particular boys and their time-limited stay here.

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Chapter 37

From Silence to Frenzy: Resistance in the Face of Shame

Steven L. Schklar

SEEKING THE "CORRECTIVE EMOTIONAL EXPERIENCE"

The concept of the "corrective emotional experience" is to encourage a client to re-experience previously unfavorable circumstances which he or she could not effectively process in the past, then, bring those conditions into the present in order to help set free the adverse influences of those circumstances. In the present, the client will be met with positive environmental and intrapsychic factors that were not present at the time of the traumatic experience (Alexander & French, 1946).

It is a courageous offering, on the part of a client, and the goal of my groups is to encourage group members to disclose previously inhibited strong burdensome feelings. One of these strong feelings is shame. Shame can burden an individual throughout his or her entire life, unless addressed. It is generally accepted in psychodynamic psychotherapies that feelings pave the road to discovery and that a "corrective emotional experience," can in effect change the original traumatic or painful experience a client previously had and provide in its place a new experience of acceptance and understanding. This new experience has the power to enhance personal growth and interpersonal relationships (Yalom, 1985).

TYPE OF GROUP AND POPULATION

I lead weekly adult mixed-gender open groups (Yalom, 1985) in my private practice. In these groups I maintain the number of participants at a maximum of eight. When members leave they are replaced and the group continues. My clients are generally high functioning and I integrate various psychological theories, but most closely align my work with existential, relational, intersubjective, and self-psychological approaches. The overarching goal in my groups is to help participants relieve their suffering as they currently experience it. I assist them to articulate their thoughts and feelings in the "here and now," and help them focus on the interpersonal as well as intrapsychic experiences that occur during the group experience.

INTERVENTION RATIONALE

The goal of encouraging strong feelings or highly charged emotional material, in a group, can elicit multifaceted resistance, of which the group therapist must be consistently aware.

This resistance may take a variety of forms. Frequently, the entire group will go dead silent. At other times there will be a frenzied attempt to fix or take care of the person experiencing the deep feelings of shame. Indeed both of these reactions can occur at the same time with part of the group going quiet, while other group members rush to help or rescue the individual who disclosed those feelings of shame.

When these polar reactions to shame persist, I take this as a signal that an intervention is appropriate (Rutan & Stone, 1993). Both the silence and the frenzied help can defeat the goals of a psychotherapy group. This can lead to the avoidance of further feeling through rationalizations (offering help and advice) or the shutting down of "here and now" emotional experience (silence).

For the member who had disclosed his or her feelings, silent or frenzied resistances (acting out) will likely be a reenactment of the original shame-inducing behavior. In the manifestation of the strong feelings of shame presented, other participants may behave in ways to avoid connecting either with the bearer or to their own emotional experience of shame. Exploration of each of these phenomena in the "here and now" can help to lessen the resistance and provide a "corrective emotional experience."

My goal is to continuously monitor my attunement (Rowe and Mac Isaac, 1991) to each member in the group as well as my own moment-to-moment thoughts and feelings, while at the same time remaining aware of the group process.

The following is a step-by-step example of how I have intervened to help the group members move out of their resistance. When this is accomplished the group can proceed toward a goal of increased self-awareness and a loosening of unhelpful patterns in their interpersonal relationships. The repetition of this type of interpersonal communication between members will increase group cohesion and safety to move deeper into emotional material.

STEP-BY-STEP GUIDELINES

A Case Example

I have a friend who has stood by me in my times of illness and loss over the years. Now my friend is struggling with a life-threatening situation. She is quite alone and depressed. I can't stand to be with her, I can't take it; I make excuses for being absent. I'm weak, selfish and cruel. (client)

In this case, the client's voice trails off and her body sinks into her chair, head down. She appears to be waiting with trepidation. The group goes silent and remains that way for several minutes. Then several members begin very actively helping with their rationalizations about how she need not feel badly and how her behavior was not so awful. Their momentum builds and they begin a lively discussion of the reasons why the group member should not feel so ashamed. Some relate stories about how they had dealt with such feelings.

As the activity continues I notice the protagonist, though trying to listen and understand what is being offered, appears uncomfortable. Her face is blank, with a distant gaze in her eyes as if of shutting off from what is being offered. I become aware of the increasing energy in the group and my sense of their rush to avoid their own deeper feelings by focusing on her. In addition, I am aware that there are still two participants who remain silent and likely disconnected from the emotional content in the room.

Step 1

Step 1 involves making a group process comment to bring attention to the "here and now" response to the sharing and receiving of shameful feelings.

TH: There seems to be quite a lot happening in the group at the moment. Mary risked showing us some of her deep feelings of shame and right now the group seems to be having some strong reactions. What can we make of these reactions?

Step 2

Step 2 is working with the responses, either "silent" or "helpful," to assist individuals with their awareness of the feelings associated with their individual shame.

TH: Jim, as you relate your story you seemed to be very focused on details however, I am not getting a clear understanding of the impact of this story on you.

Or,

TH: Samantha, you have not spoken since Mary's feelings were expressed. I am wondering what you are experiencing?

Or,

TH: Rudy, you seem to really want to help Mary. How do you feel you are doing in that regard?

Step 3

In this step ask the individual for her experience of risking to share her shameful feelings with the group.

TH: Mary, it has been a while since you risked being open and vulnerable in the group. I am interested in knowing how you are feeling

right now and if you are willing to say, how the responses of the group impacted you?

Step 4

In Step 4, work with the group to explore the process and the "here and now" experience of what has just transpired.

TH: We have spent some time now exploring and experiencing how it is often difficult to express deep shame and to stay present with another's shame. We have also seen how various reactions impact on a vulnerable member. What are you now aware of?

TYPICAL RESPONSES

The most common response for the entire group is the realization of the group's ability to find its way to handle these "charged" events. To this end there is an increased sense of safety and closeness in the group for both the individual client and the entire group. Participants will often comment how important the session was or quite possibly the uniqueness and value of the group experience. Clients also disclose that they experience fear and vulnerability, at times, when there are "big" emotions in the room.

Frequently, the individual presenting the shameful feelings will first experience what seems like a reenactment of a childhood experience. This is ameliorated when others in the group validate him or her by connecting to their own shameful feelings thus providing the path for a corrective emotional experience to occur. The client no longer feels alone in his or her own thoughts and feelings and the process of guilt reduction begins to take effect.

CONCLUSION AND CONTRAINDICATIONS

This intervention can assist each group member to recognize his or her tendency to avoid (go silent) or attack (frenzied helping) when other group members present themselves as vulnerable and express deep feelings. It also demonstrates the possibility and the benefit of

staying connected to others when they wished to express their own deeper feelings. This intervention is appropriate for process groups in outpatient facilities, inpatient facilities, or private practices that are dynamically oriented.

A contraindication of this intervention lies with the therapist. Eliciting deep feelings and providing a strong enough container for the affect and resistances takes energy and courage. If the group therapist is not yet ready for the intensity of possible affect, or he or she is uncomfortable with intense affect, it would be better that the therapist does not implement this intervention. The group leader who uses such interventions needs to understand the emotional challenges to him or her and the group members before moving into this realm.

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Chapter 38

Degree of Structure in Group Format Toward Facilitating Group Alliances, Empathy, and Cohesion

Sharan L. Schwartzberg

INTRODUCTION

A practitioner's first exposure to group therapy becomes a template from which future practice is derived. In particular, the group format and the degree of structure imposed by the leader on the process are imprinted in the leader's clinical reasoning. Group therapies are commonly categorized as psychodynamic, interpersonal, cognitive, and behavioral. Each of these conceptual frameworks indicates the group's composition, leader role, and intervention principles. By carefully considering the degree of structure imposed, rather than follow implicit knowledge of past experience, the leader can more consciously shape group outcomes.

In this chapter, I propose a rehabilitation model, the functional group (Schwartzberg, Howe, & Barnes, in press), as a theoretical basis for determining the degree of structure as a component of the group design. The assumption underlying the model is that by changing the degree of structure a leader can facilitate outcomes such as group alliances, empathy, and cohesion. The processes used in the group have a direct bearing on the group outcomes and former aims both tacitly perceived and empirically known to be of a value. In a functional group the group and tasks are structured to achieve maximal involvement of members through group-centered action, sponta-

neous involvement, member support and feedback, maximal sense of individual and group identity, and a "flow experience" where the challenges for action are balanced with the members' capabilities and culturally orientation.

Elements of group structure include the group size, membership, group composition, and degree of process focus (Burlingame, Fuhriman, & Mosier, 2003). A group's size can range from small (one to four members), medium (five to twelve members), to large (greater than twelve). Group membership may be open for new members or closed. Groups are composed of individuals with heterogeneous or homogeneous traits, needs, and severity of problems. The degree of process focus can range from members being encouraged to interact freely to more leader-centered directed process.

A system for classifying degree of structure in group treatment has been proposed by Burlingame, Fuhriman, and Mosier, 2003. The degree of structure is identified by four types (p. 5):

- Type 1-Guiding force is therapist or manual.
- Type 2-Moving force is the client(s) or group, topic, or content.
- Type 3-Guiding force is the therapist or a specific model of group therapy that structures the treatment. Discussion promotes interactive, responsive group process on client(s) or group-as-whole-reactions, behaviors, feelings, with evidence of here-and-now orientation.
- Type 4-Moving forces are the client(s) or group created by the unique composition of the group. Discussion promotes interactive, responsive group process on client(s) or group-as-whole-reactions, behaviors, feelings, with evidence of here-and-now orientation.

When creating a new group I first assess the members' capability for self-direction around the group's task and then design the group experience to match member ability. I am concerned with a group member's ability to communicate, problem solve, have insight, and generalize from the experience. Upon assessment I rely upon a schema similar to the former classification system to grade the level of expectation and processes.

DESCRIPTION OF GROUP AND CLIENT POPULATION

I will use two groups as examples for how a leader can structure the format to influence outcome. One group is a process group for graduate students in a university professional program for certification in occupational therapy. The other is a community peer support group for posttraumatic head injury. These are only two examples. The basic premises hold true in group work found in natural, therapeutic, and educational settings. A relationship between group structure and outcomes cuts across all client populations, settings, and forms of service delivery.

DESCRIPTION OF INTERVENTION

For several years my co-instructor and I structured the process groups so that students co-leading groups in the community had a chance to try out activities with their peers. The students decide upon the week's activity, which co-leader pair will facilitate, and when. Inevitably we found ourselves bored with one tedious activity after another. The activities selected were parallel, Type 1 tasks, rather than ones that would facilitate group exploration and interaction, and Type 4. In order to move the groups toward more of a process focus we decided to divide the students into process groups randomly rather than with co-therapists. The hope was that the heterogeneous membership would force the members to interact with one another around issues of trust, power and control, and intimacy with one another, the faculty designated leader, and the group as a whole.

In the support group, the facilitator's role at first was somewhat open ended. The "laissez faire" leadership was problematic. The group was chaotic, members did not listen to one another, and there was yelling, absenteeism, and a high drop-out rate. The leader recognized members' cognitive difficulties such as short attention span, memory loss, and difficulty modulating affect. The leader decided to change the structure from a Type 4 to a Type 2 group. The leader set down specific requirements for participation in a pregroup interview and in the group. The group contract included being on time, putting thoughts and feelings into words, taking turns, and regular attendance. In the group the leader took on brain executive functions such

as limiting time each person could speak, encouraging turn taking, and asking members to leave if they did not stop yelling.

TYPICAL RESPONSE OF THE INTERVENTION

The structure of the group definitely impacts the outcomes. The group's phase of development also influences the type of structure and degree of success in facilitating member alliances, empathy, and cohesion. I find that it is very important to build in rituals to enhance feelings of safety early in the group. The beginning of any group requires more structure to provide a sense of boundaries and safety. I make sure there is the exact number of chairs needed for each member. I greet each person, including my co-leader, as they enter the room with a hello or a nod of acknowledgement. Each week the group's goals are restated. Rather than be confronting, I am more encouraging, clarifying, and supporting.

As a group becomes more able to tolerate more ambiguity I become less active. I structure the activities in a way to encourage members to be more self-disclosing. As the groups near their end, there is usually a natural return to more structured process.

CONCLUSION AND CONTRAINDICATIONS

A precautionary note is given about how much structure is sufficient and when does it become stifling to individuals and the group as a whole. As a general rule, I would offer as little structure as necessary. If the leader takes on too much responsibility for the group task, supporting members' emotional needs, it is likely that the group will remain dependent. On the other hand, if there is too little structure the members are likely to feel anxious, unclear of the group's purpose, and dissatisfied with the climate of the group. When the group is contained early on in a supportive, caring, and successful experience members will likely be able to tolerate the conflicts, personal disclosures, strong attachments, and ending of the experience.

Group structure, verbal interaction, and emotional cohesion are empirically supported treatment factors bearing on group treatment and the therapeutic relationship (Burlingame, Fuhriman, & Johnson, 2001). I encourage leaders to examine their theoretical model and

identify how the structure influences desired group outcomes. Each of the models have indications and contraindications regarding the type of structure to impose on member selection, group size, composition, and group processes.

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Chapter 39

Exploring Attachment in a Treatment Group for Men Who Batter

Steven Van Wagoner

INTRODUCTION

Programs for men who batter have proliferated in the last three decades, with ensuing debate on how to best treat this population. Researchers, practitioners, and activists have researched this population in an attempt to both explain why men resort to violence in their relationships and to devise effective treatment programs. Research suggests that shorter-term, structured treatment models presented simultaneously with court monitoring offer the most promise in reducing partner violence (Edleson & Syers, 1991). More recently, Saunders (1996) found little difference between cognitive behavioral, psychodynamic, and pro-feminist models when looking at main effects, but detected an interaction effect such that men with dependent personalities did better in a psychodynamic group. This latter finding, suggests that men with attachment difficulties might benefit from examining their attachment struggles, in addition to confronting inequality and abuse of power in relationships (i.e. pro-feminist, education models), faulty appraisal and decision making in intimate interactions, and learning non-abusive conflict resolution skills (i.e. cognitive behavioral approaches).

TYPE OF GROUP AND POPULATION

The violence abatement groups I have led typically consisted of 10-12 men who were court mandated into a 14 or 26-week treatment program that combined pro-feminist education and analysis, with cognitive-behavioral methods and conflict resolution

skill building. While the groups were structured with each week focusing on a specific topic and/or skill, as the group progressed, and instances of excusing, justifying, and minimizing abuse and violence had been well confronted, we gradually explored the quality of attachments in the members' relationships, and how those attachments might contribute to feelings of intense vulnerability. It is essential that in this exploration, there is a balance of empathic understanding for their vulnerability, combined with an understanding of how these feelings are often mitigated through the use of power and abuse as the men abdicate responsibility for their feelings, and externalize blame onto their partners. While empathetically holding them in their vulnerable feelings, we also help them to appreciate that they are solely responsible for managing their feelings and subsequent coping behaviors, and that to externalize blame is to head down the slippery slope of using abuse and violence to control their partners.

THE INTERVENTION

1. Identify attachment based dynamics in described interactions with spouse: Many of the men in these groups clearly exemplify one of three forms of insecure attachment: avoidant, ambivalent, or disorganized (Ainsworth et al., 1978). Typically, when listening carefully to the men describe relationship conflicts, the predominant attachment style comes to light. Men who are angry and abusive often react to attachment disruptions when abandonment or separation is threatened or occurs (Dutton, 1995; Holmes, 2001). The response is often an angry one, and an attempt is made to control the other who is seen as a threat to attachment. The avoidant attachment style is often displayed by men who deny vulnerability and present their grievances in a matter of fact manner. They are detached from their feelings, and justified their abuse and control. In the group these men display an air of independence while belying an intense need to make or restore some semblance of attachment.

Men exhibiting an ambivalent style often present in a confused, uncertain manner. At times their stories are presented without focus or clarity, and there is a quality of self-absorption that makes others in the group seem irrelevant. They attenuate their feelings through long-winded story telling, which keeps them detached

from the underlying vulnerability. For these men there is both a desire and fear of establishing intimacy, which can make them unpredictable in their relationships. They vacillate between intense need and intense anger when affect is stimulated, and can also fall into passivity as an attempt to regulate affect.

Men with a disorganized attachment style are overwhelmed by affect. They experience moments of intense rage, or disorganized emotional collapse. They are prone to dissociation, and are often remarkably forgetful of some of their most explosive episodes of violence. They regularly project their intense internal strife onto others, making others seem intensely threatening. Violence is often the result of dehumanizing the other, resulting in an empathic rupture that has a disinhibiting effect on their behavior. In the group, the therapist and other group members are often intensely affected by these individuals who portray an image of barely holding on.

At this stage of the intervention, we are assessing the men's attachment styles through their descriptions of their relationships. In the next stage, we actively explore their early experiences with their parents, and the determinants of their current attachment style. Keep in mind that with this intervention, we are scratching the surface of understanding. We are planting the seeds of early understanding, which can be deepened and explored throughout the group, but also in subsequent therapy for those men who continue treatment after the group.

2. Exploring early attachment failures: In this stage, men explore the antecedents to their attachment style. Many with the avoidant style describe parents who put little time into parenting their children. These parents were more consistently rejecting and unavailable, forcing the development of a pseudo independence in their children that continues into adult life. The men come across as not needing others, which is a way of avoiding the rejection that they expect. They will reject rather than be rejected, and in therapy often display a "help-rejecting stance," which is illuminated in the group process. We explore how their perception of their partners being unavailable or uninterested in attachment often triggers anger and abuse as a way of regulating closeness.

Men with ambivalent attachment styles describe more inconsistent early parental interactions. While parents could be intensely rejecting and harsh at times, these experiences were mixed with nurturing. As a result, these men tolerate some

rejection in order to receive the nurturing. How these experiences led to ambivalently held attachments in their adult relationships are explored and illuminated. Their pattern of relating to others through a vacillation of submitting to the demands of others, while simultaneously resenting the shame this submission brings (Holmes, 2001), is actively explored, especially as their shame and resentment can result in unleashed fury when shame reaches intolerable levels.

Men with the disorganized attachment style depict highly traumatic early experiences with parents who seemingly lacked their own internal resources for coping with the demands of interpersonal relationships, and in particular parenting. As a result, these men vacillate between desperately seeking emotional proximity to a primary object, and distancing, the former occurring when they perceive the other to be mis-attuned or distancing, and the latter when the experience of the other is highly aversive (Wallin, 2007). For these men, the therapeutic emphasis is on how they use anger and abuse as a means for controlling their partners who are felt to be the stimulus for their emotional deregulation.

These early attachment experiences are explored both in terms of their adaptive nature given their early environment, and of what they miss in present relationships as a result. How their attachment style affects their current relationship, and in particular how it provides a context for angry and abusive responses to their partner's perceived failures is also illuminated. We consistently empathize with the emotional challenges their experiences stimulate, but also confront how their perceptions can trigger a violent reaction, and how awareness of these triggers can provide choice points for non-abusive responding. Throughout the exploration, men are confronted if they use this understanding to externalize blame for their behavioral choices.

3. Managing the countertransference: Because of the intense affects that can be invoked in us as therapists with this population, a co-therapy team is extremely helpful in managing the inevitable countertransference feelings. Typical but not exhaustive of working with each attachment style, the avoidant group member can elicit resignation in the therapist as (s)he relentlessly attempts to break through the rationalizations and justifications; the ambivalent member can elicit boredom and fatigue as he anesthetizes the therapist and group from their feelings as he does from his own through monotonous story telling; and the

disorganized member can elicit intensely disorganizing experiences in the therapist and other group members through powerful projective processes. Group leaders must rely on each other to manage these countertransference feelings, often by bridging to other group members about what they think the member in question might be thinking or feeling. In many cases, we use the bridging technique to have other members make sense of what is going on in the interactions between particular group members and the leader (Ormont, 1990; 1991, 2001). For example, if one leader is caught in an enactment with an avoidant member in the group, relentlessly trying to break through rationalizations, the other leader can turn to another member and ask "Why do you think that Dr. Van Wagoner won't let this drop with Carl." This can lead to further exploration of the interaction, the underlying attachment difficulties fueling the conflict, and how this person impacts others. Soliciting the feedback of others also helps break the impasse between therapist and member, which at times can replicate what happens between the member and his partner when he feels attachment threatened.

THE GROUP'S RESPONSE

In my experience, this exercise is often very powerful for the men in the group. They connect more intimately around shared early experiences, and some are able to normalize their seemingly adaptable responses to impossible, early interactions with parents. In addition, many group members find this context-building exercise a relief, not in the sense that it provides excuses for their abusive responses, but rather a framework for understanding the intolerable feelings that emerge when attachment is threatened in their intimate relationships, real or imagined.

CONCLUSIONS AND CONTRAINDICATIONS

Exploring attachment style in men who batter can be a powerful and emotionally provocative technique designed to help men understand triggers from and to the intolerable affects that in the past have led to abuse and other forms of control over their partners. This exploration, while not designed to resolve early traumas in the context of short-term groups, can plant the seeds of

understanding for further therapeutic work. More immediately this exploration can provide a framework for understanding how attachment styles affect relating and attempts to regulate emotions and emotional proximity to significant others. One contraindication of this technique is that with this population, great care needs to be taken not to provide the men with another way of excusing their behavior (i.e. "See, it was my past that makes me abusive!"), and so group leaders need to be ready to confront such attempts to externalize responsibility for their abusive behavior. This exercise should only be employed once denial, justification, and minimization have been thoroughly confronted in the group, and the men, not just the therapist, take responsibility for confronting one another.

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Chapter 40

The Use of Group Processes for Alleviating Teachers' Stress Within a School Setting

Roberta L. Slavin

INTRODUCTION

For many years I worked as a school psychologist for the Board of Education in New York City. Our chief psychologist, the late Dr. Rachel Lauer, immediately began to teach new psychologists the positive effects of group work in almost any environment and encouraged us to form groups with teachers, students, and parents. This chapter describes one of many workshops I conducted. It was specifically created for elementary school teachers and ran for five years. The first step toward creating the workshop was the request made by the principal to form such a group. She also agreed to respect the group's confidentiality.

Some of the conditions creating anxiety for teachers are: differences in behavior, attitude, and beliefs of the students and their families; exposure to problems for which they can offer little or no assistance; classroom management to balance discipline and academics; internal emotional pressures related to their own physical and mental well-being; unresolved conflicts with important persons both in and out of school; and others.

However, despite the challenges, members of all types of groups (therapy, classroom, outpatient, and others) have a need to bond with one another, seek common purposes, and create a safe haven where

they can be open and honest without fear of reprisal (Winnicott, 1965; Yalom, 1995).

DESCRIPTION OF GROUP POPULATION

The initial group consisted of six black teachers, two Hispanic teachers, and two Caucasian teachers; three Caucasian out-of-class personnel, a social worker, an educational evaluator, and the leader—a school psychologist. Ages ranged between twenty-five to fifty-five years. The different participants came or left at times during the course of the group's life. However, no men ever attended. The group was held in an elementary school in an economically deprived area of the Bronx, New York, during a lunch period in which the majority of attendees were available.

INTERVENTIONS

I adapted a leadership style that would conform to fifty-minute periods, which was the amount of time allotted for each school period, and maintained positive relationships with administrators and nonparticipating personnel. I worked to help the group create a safe holding environment (Winnicott, 1965) by being noncritical, showing interest in what was said, and emphasizing the value of each member's contribution (Yalom, 1995). I also helped the group recognize support, feedback, hope, as part of the group functioning (Yalom, 1995), and relief of stress, or as Freud (1966) defined it "anxiety." Other issues included deflecting undue scapegoating and developing methods for resolving impasses (Ormont, 1992; Spotnitz, 1985).

Case Example One

In the initial stage of the group the members dealt with the setting of group norms, and ambivalent feelings of loyalty and trust toward the members and the leader (Yalom, 1985). One particular meeting during this phase began with awkward silence, furtive glances at the leader, and a reluctance to open the conversation. I silently considered the members' insecurity in a new, strange situation, and their need to feel protected. Shortly after, a mem-

ber described the stress caused by the lack of access to supplies locked in the principal's closet (emotional nourishment). Other members nodded in agreement. Not having this access made them feel like aliens, feeling like they were not given the same consideration as the teachers in regular classes. They felt like supplicants who had to beg. Administrators were experienced as not being on their side. Would they also have to be supplicants for emotional nourishment from the group leader?

A lively discussion followed in which the group debated: "Will she do something?" "Can she do something?" "Can the leader protect them and keep them safe?" At that point I expressed empathy and relatedness to their feelings of being overwhelmed, frustrated, and helpless (emotional support in the form of accepting their feelings). I asked if the "outside stress" might have reflected their concerns about the leader and the group, as an intervention toward developing a focus on the group as a whole (Slavin, 1993, Yalom, 1995).

There was a notable sigh of relief. The group began to share experiences. Knowing that other people experience the same problems helped the members feel less alone, or embarrassed.

Case Example Two

A session illustrating the transition from dependence to interpersonal relationships found the members focused on the competitive aspects of their relationships with one another. A discussion, which began with the remark "the kids are getting out of hand," was followed by a confrontation between two members in that one accused the other of bombarding her with unimportant stress issues. The argument accelerated and the tension continued to build. At that point other members spoke again about kids getting out of hand and wanting to throw chairs. I asked "what was making the group feel like 'out of hand' children?" The following issues were defined: My issues are as important as yours. We all have to recognize our anxiety. The members felt that even though the truth may hurt at first, honesty gave them a better perspective on important issues among themselves. Cohesion began to develop (Yalom, 1995).

CONCLUSION AND CONTRAINDICATIONS

This workshop is an example of the successful use of group dynamic techniques with a teaching staff within a school setting (Slavin, 1997). The participants built a trusting relationship with the leader that enhanced their relationships as teacher and psychologist. They began to feel understood. Other successful workshops have addressed

elementary school students (Bany & Johnson, 1964), and high school students (Laquercia, 1977; Slavin, 1997, 2002; Welber, 1977).

As a possible contraindication, teachers are used to discussing material presented to them and they would feel less challenged if they were not approached right away to disclose personal information. In an inexperienced, untrained teachers' group, I would start off with a tape describing good and bad stress and stress relief, and use this tape as a stimulus for discussion. I, too, would discuss the issues of lateness and early leaving as forms of resistance. This would be done privately, with each group member, before bringing it up in the group, as there are many sources of interruption in a teacher's schedule, which require the group leader to be more flexible than in private practice.

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Chapter 41

Diminishing Dissociative Experiences for War Veterans in Group Therapy

Vivien Henderson

THEORY

Dissociation is one mechanism that is used by the ego as a way to maintain its integrity for survival, and is a response to severe trauma (Gabbard, 1994). Research suggests that childhood physical abuse may be an antecedent to the development of combat-related post-traumatic stress disorder (PTSD) (Bremner, Southwick, Johnson, Yehuda, & Charney, 1993).When doing group therapy with a veteran who is known to dissociate it can present a number of challenges for the group therapist. In particular, it is important for the therapist to be able to hold the patient's unbearable mental states of mind in mind for the patient (Hinshelwood, 1994). Having worked with war veterans for eight years, a case will be presented as a descriptor of the dissociatve experience.

Freud's theory of repression and memory disturbance provides the therapist with valuable insights for working with these patients (Freud, 1896). In addition, Klein (1975) uses the clinical approach of working with the leading anxieties, and Bion's concept of "container" provides essential knowledge for this work (Bion, 1961). "Bion's *Experiences in Groups* served as a mandate to investigate primitive affects and object relations in groups" (Schermer, 1994 p. 15).

DESCRIPTION OF THE GROUP

In the earlier years, the groups were residential in the hospital for the first four weeks. The program was intense, providing both psychoeducational groups, individual therapy, and group psychotherapy. Attendance was daily with home visitations for the weekends. After the four-week intensive phase, the men then came one day weekly for eight weeks.

Although the program has changed over time, with the shift being toward non-residential programs it still remains a time limited one of twelve weeks with a maximum number of eight members in the group.

THE INTERVENTIONS

Brief Case Example with Concomitant Intervention Procedures

One day during the group process, there was a sudden loud banging noise in the ceiling and workmen shouting information to each other. This was a sudden unexpected event for all of us. Our dissociative patient leaped up from his chair, his eyes looking around wildly with terror; he could not decide whether to go up into the ceiling and attack the workers or run away. I took the entire group down the hallway to the kitchen where we continued with the work over a cup of tea, talking about the effects this sudden intrusion had upon all of them. By providing structure and containment (being in a smaller safer space with the whole group together) this man began to calm down and stayed until the group time came to an end.

Dissociative Patient As Barometer of Group Anxiety and Necessary Intervention

I use the patient who is clinically diagnosed with a dissociative disorder as a barometer for measuring the level of anxiety in the group.

To reduce the increased levels of anxiety, greater structure is implemented, through a number of options, within the group. The therapy moves according to the level of anxiety manifested by this patient. When the level of anxiety escalates to the degree that the risk of

dissociation becomes prevalent with the concomitant possibility of a "flight or fight" response—structure needs to be implemented.

When the patient took "flight" out the door, I held him verbally, and took the group to the kitchen down the hall, on this occasion, to provide the necessary structure and containment and change away from the immediate environment.

Another measurement of anxiety with this man was the rate with which his memory began returning. Initially, he had almost no memory of things having occurred in his past. As his memory began to return, he described it as being like a board, with "pegs" popping up on it. This is exactly what we wish to occur. The reliving of the traumatic event(s) as a cathartic release for this patient's journey into recovery.

CLIENTS' RESPONSES TO THE INTERVENTION

Following the traumatic intrusion into the group room, a state of chaos prevailed initially with a very high level of arousal amongst the group members. This was especially prevalent with the dissociative man in particular as being undecided whether to "fight" or "take flight." Although verbally "holding" the dissociative man, the group members began to calm down once a decision was made to move them all to the safe space of the kitchen down the corridor. They began to feel safe and relieved by the added structure and containment.

The dissociative patient managed to stay with the group. His level of anxiety was an excellent mirror of the group members' anxiety. Managing the anxiety level of this man and the anxiety of the group members was paramount. It also instilled a higher level of trust of the patients toward the therapist who was seen to be like an officer and able to cope with the unexpected in the "battlefield" and lead them to safety.

CONCLUSION AND CONTRAINDICATIONS

The dissociative patient can find a group program to be most helpful in the recovery process provided his level of anxiety is kept at a reasonable level. As a patient's memory begins to return he begins recalling events from many years gone by which increases his anxiety level. Prior to our program, this patient's memory was mostly a blank.

It has also been demonstrated that when exposed to extremely stressful traumatic situations, containment for the reduction in anxiety through structure, and change of physical environment can contribute to maintaining the integrity of the patient's ego functioning in the "here and now." This provides the patient with the opportunity of multiple options in coping with sudden and unexpected trauma. It is hoped that upon repetitive experiences with these new options, the patient will be able to implement same when he begins to feel the increase in futures anxieties during his road to recovery.

A salient contraindication is that it is not advisable to work in a group setting with such patients outside a Hospital setting unless one is a very experienced clinician. The possibility of sudden decompensation and dissociation is not always predictable and could present considerable difficulties for the neophyte therapist.

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Chapter 42

I Am Part of the Group Matrix

Ben Rippa

THEORETICAL CONSIDERATIONS

Foulkes (1964), the creator of group analysis, defines group matrix as the network of all communications in a group. It represents the conscious and unconscious expressions between the group members, including the conductor. Foulkes introduced the term *conductor* which compares the group therapist to the musical conductor, who is not the composer who wrote the music, but the interpreter of the music. The group analyst, or conductor, is part of the group and yet can observe it from the outside. Group matrix is a theoretical construct of the operative dynamic interaction in the group process. It is also possible to approach the group matrix as a creative building process of the web of communications. Like a colorful tapestry, each member participates with his or her special needle and thread color (Rippa, 1998). Emphasizing the creative quality of the matrix, Cortesao (1968) points out that in Latin, "matrix" means a mother, a womb, a place of origin and growth. The group matrix is intimately related to the attitude and contribution of the group analyst.

Understanding and Activating the Group

1. *Point out the "mirror" phenomenon.* The client sees himself or herself reflected in the interaction of other group members. He or she sees them reacting in a way similar to himself or herself or in contrast to his or her own behavior. He or she also gets to know himself or her-

self by the effect he or she has on others and the picture they form of him or her (Foulkes, 1964).

2. *Create awareness of "resonance" expressions.* Members of the group respond to a stimulating input with deep feelings discovered inside, so that the group as a whole, as a result of this input, may intensify a working-through process on the relevant issue (Roberts, 1984).

3. *Encourage the group to express insights and interpretations.* The group analyst does not adopt the role of unique expert. The analyst expresses his or her thoughts and feelings in a personal language, revealing himself or herself, within ethical principles (Foulkes & Anthony, 1989).

DESCRIPTION OF GROUP AND CLIENT POPULATION

This type of intervention is more efficient for clients who are capable of introspection and insight. Among those are therapeutic and training groups in clinics, therapeutic communities, institutes, and private practice. It is applicable for groups in organizations like groups of teachers or top managers. It is also effective for social issues such as addiction, probation, couples and family conflicts, and community problems.

It will not succeed with clients with poor ego strength and low internal resources. It is not recommended for very depressed clients or those in life-threatening conditions, or very isolated, or very antisocial clients.

DESCRIPTION OF INTERVENTIONS

When I am conducting a group, I sit on a chair similar to the other chairs in the room. I intervene verbally only after discussions or expressions of group clients and go along with the flow of interactions and respond with empathy to the points being discussed. I never impose an issue for discussion nor do I judge any disclosure(s) of group members.

I avoid summing up or presenting long interpretations and explanations. My aim is to avoid being the center of interaction. I respond to the group as a whole and, when necessary, I can work with individ-

ual problems. I watch for symptoms or expressions indicating a possible dangerous antigroup response (Nitzun,1996). These antigroup responses may manifest themselves in behaviors such as scapegoating and acting out. I specifically am cognizant of the possibility and actualities of negative manifestations that can harm the group as a whole. My assumption is that the interactions will enrich, in a spiral movement, a deeper understanding of relevant repressed issues.

CASE EXAMPLES

A Small Group of Students

Ada, a member of the training group, was very active since the beginning of the session. She shared a dream she had had the previous night, and continued focusing most of the attention on her unresolved problems with her parents, and cried from time to time. Close to the end of the session, Lily, a quiet client, made a personal remark saying that she (number eight of twelve children) feels sometimes neglected by her parents. Ada rejected abruptly Lily's intention to start a dialogue saying that there is no similarity. Lily, talking to Ada, said that she feels, again, a closed door and arrogance in Ada's attitude. Ada said that she doesn't know what Lily is talking about. At this moment I intervened asking Ada to try to look at Lily as a mirror that reflects what Lily sees. Three women participants continue to reflect to Ada what they see of her selfish and narcissistic attitude. Ada was astonished and remained silent until the end of the session.

A Small Group in an International Workshop

I conducted a small group of nine qualified European professionals, six women and three men. At the beginning of the second meeting, one female participant, Christine, a German psychologist, said that she remembers the end of an unpleasant dream. She was in a small airplane ready to land, but something went wrong and instead of landing, the plane began to shake and the passengers were anxious. When she woke up she was still afraid. Some colleagues tried to help her, unsuccessfully, to grasp the possible personal reasons for the anxious and insecure feelings. Goran, a Swedish psychiatrist, remembered a painful similar experience when flying, years ago, to London. The free associations continued, involving most of the group members who expressed their concerns to disclose personal issues that were aroused after Christine's dream. I said that I am also in this plane. I worry too, as the pilot, how to make a safe landing. I am a qualified "pilot," and I believe that in this trip everybody is involved. Claudia, an Italian participant, expressed her shame at her inability to speak because of her poor English, and I, the only one in the group who understood some Italian, translated

her valuable interventions. In this friendly atmosphere, suddenly, Christine looked at me and said, "You know, my husband is from Israel. We are living in Heidelberg now, but he insists to go back and I don't know..." Other members opened new problems and discussed important conflicts. There was a readiness to share concerns. The group had a safe landing.

TYPICAL RESPONSE TO THE INTERVENTION

When clients are used to assuming a very dependent attitude, confusion and a sense of chaos often prevails during the first group sessions. A more direct intervention was expected from me. Many of the group members expressed their criticism openly and aggressively and I welcomed this behavior in order to show that it is possible to challenge authority and to be ready to confront frozen concepts about relationships and interpersonal communications. In future groups, the flow of interactions becomes easier, the silences shorter, and the silent participants less stubborn.

CONCLUSIONS AND CONTRAINDICATIONS

This type of intervention can be felt as leading to a "laissez-faire" group, that is, without any boundaries. It may appear so, but for me being part of the group matrix does not mean being an equal part. As the conductor, I watch the boundaries and hold the group together. I do not lead the group in a direction planned beforehand. I do not stand outside the group, but I help from the inside by interpreting and encouraging interpretations from clients in order to enhance their mutual understanding.

To be the conductor as part of the group matrix is a demanding task. I have to make certain that I am not crossing ethical boundaries and have to accept the uncertainty of not understanding everything. My emotional, sincere involvement in the flow of interpersonal communication may stimulate members of the group to attack me, pointing out aspects of my character that are sensitive for me. For example, when a client attacks me for being too mild or unassertive and stresses that this is why the group is stuck. A quick introspection on the countertransference situation brings me back to the role of conductor of the group. I have to rely on my own capability and experi-

ence and feel secure in my knowledge and be ready to be part of the continuous building process of the changing group matrix.

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Chapter 43

To Err Is Human: Turning Our Mistakes into Useful Interventions

Dave M. Cooperberg

THERAPIST AS HUMAN

"You're my therapist and you forgot my name!" Some people in particular seem to need to see us as infallible-the One with the Answers. So what happens when we inevitably do make a mistake? This can be particularly difficult for the new group therapist whose sense of his or her own competency may not be as firm (Van Wagoner, 2000). How therapists handle their own, inevitable mistakes can define how well the group proceeds from there.

By mistakes, I am focusing on errors visible to the group that therapists make, not internal ones in our thinking, nor the ones the group members themselves will make. This could include anything from forgetting something significant about a member like their name, misinterpreting a member's expression or feeling, expressing a judgment that one or more members find hurtful, or even loudly passing gas. When a therapist makes a mistake that is obvious to the group, whether it reflects an objective or realistic countertransference to clients' personalities, or our own subjective transference to the client (Ormont, 1993), it still presents a useful opportunity if it can be worked in the group.

Therapists compound an error if they rush into putting it onto the members using verbiage such as, "And how do you feel about that?" without taking some personal responsibility. It is part of our job to help people be in touch with their feelings, but not when we use it as a defense. A public mistake creates an opportunity to role model

healthy ways of dealing with errors and embarrassment, as well as revealing what issues are triggered for different members.

GROUP CLIENTS

The groups I have worked with for the past thirty years have been outpatient, in-depth, ongoing, mostly process groups with members in the normal-neurotic range, and a few borderlines. My private practice has specialized in working with groups for gay-identified men. I believe working with visible therapist errors works well with a variety of therapy and support groups in this range of functioning.

The examples come from a small outpatient process group of six gay-identified men. Most have participated for over two years, one for two months, and one only three weeks. The newest member is aged twenty-eight, the rest are in their forties and fifties. The group starts with a brief check-in process, in which members express how they are feeling that evening as well as reporting anything significant that has happened during the prior week. Not having a waiting room, I put a sign out asking latecomers not to ring the bell, but wait until I get them.

THE INTERVENTION

Mistakes happen. I am not suggesting intentionally doing something in order to elicit reactions from group members. In many ways this is about role modeling honesty, humility, and vulnerability as well as showing respect to members affected by the event. The ideal is to authentically take responsibility and use the event to help expose not only members' feelings in the moment, but any transferential expectations that were either re-enforced or contradicted by our behavior.

Step 1: Acknowledge Something Happened

One evening, soon after the initial check in, there was an interaction between long-term members Ralph and Ronald, which also served to avoid something upsetting one of the newer members had mentioned in check in. I started to comment on it and got their names reversed. Suddenly, I could see by their expressions that I had done

something. An instant review made me realize that I had reversed their names, so I rolled my eyes in comedic recognition. Both started to laugh, followed by other group members. Taking the cue from their response, I continued by asking in a humorous way, how they felt now that I had exchanged their personalities.

This was both playful and serious. Ronald was clear there was no exchange of personalities, while acknowledging the pleasure he took in seeing my mistake. Ralph was typically less responsive, but also dismissed any difficulty with it, commenting on similar mistakes he had made. I then acknowledge, at times, showing some dyslexia, for some reason confusing their names—not their personalities—simply because both names start with an R. That helped Vince, another long-time group member, who is severely dyslexic, express how he feels when he makes such mistakes.

I had acknowledged the error, checked on responses, and could then have explored other issues such as embarrassment, any transferential emotions as well as the effects of the subgrouping of these two men. However, a new member had brought up a serious issue that was being skirted around. After acknowledging my mistake and checking immediate reactions, I chose to refocus back to what the group had been avoiding.

Step 2: Attend to the Transference and Other Projections

Members will have a variety of reactions. In taking responsibility for our actions, we do not want to inhibit members from recognizing and exploring their projections. In the following example, my error triggered basic feelings of inclusion/ exclusion in everyone, particularly in the person who was left waiting.

Peter was late for group, so I put the "Please Wait" sign out and the group began their check in. The last to check in was Juan, who had learned that morning that a friend had just died. Juan had joined the group two months earlier, three months after his mother's death, and one month after the end of a relationship. The group got involved in addressing his reactions, and I forgot to retrieve the sign. Unknown to me, Peter was waiting outside. Half an hour later, Peter rang the doorbell, reminding me to let him in.

Peter had been in the group for about nine months, working with major issues around intimacy and his feeling as if he did not really be-

long anywhere. I briefly apologized, and agreed when he asked, that it was my practice and responsibility to let people in after check in. He acknowledged some anger, but claimed it was about his issues, at first unwilling to directly address his anger to me.

After briefly checking in with Juan, I then turned to the group for reactions to what had happened to Peter. Members readily stated they would have felt very hurt, some more angry than hurt, if they had been forced to wait out there. A few added it would have been hard for them to ring the bell; after all, the sign had asked them not to do so.

Knowing that Peter had more feelings to express, I pointed out how I had reenacted one of Peter's worst fears. That freed him to more fully express his anger toward me, and relate more deeply what it triggered from his past. Other members empathized, discussing their own difficulties with feeling abandoned or rejected, as well as how difficult it was to confront an otherwise supportive authority. At the end I suggested to Peter that by ringing the bell, he not only avoided carrying his rage home by confronting me, but also asserted his membership in the group.

RESPONSE TO INTERVENTION

When I can acknowledge my mistakes the group responds positively in the following ways: (1) the group is more willing to process what my errors generate for them; (2) members feel more able to confront me as an authority, hence exploring more aspects of their transferences; (3) members feel more bonded with one another in dealing with me, making them more willing to hear one another rather than turn to me as the authority; and (4) members feel safer acknowledging their own mistakes to the group.

CONCLUSION

In terms of outpatient, higher-functioning groups, when, as therapists, we acknowledge our own mistakes as well as process the group's reactions to them we appear human and less mystical. This is dependent, of course, on the therapist's self-awareness and willingness to be transparent. In doing so, we turn our mistakes into rich op-

portunities to explore transferential and other issues, as well as role model how to accept interpersonal responsibilities.

CONTRAINDICATIONS

No doubt there are individuals who are fragile in ways that they need to see us as strong and in control of all group dynamics, whereas seeing us stumble too soon could be frightening and destabilizing. Because of this, while it still can be appropriate, therapists need to be more cautious with visible mistakes when working with more dysfunctional populations.

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Chapter 44

The Ability to Verbalize One's Needs Clearly in a Geriatric Population

Toby Berman

INTRODUCTION

The ability to assert oneself appropriately is extremely important to good communication and leads to better mental health. The converse is true: individuals unable to assert themselves, clearly and appropriately, often suffer with poor mental health, (Corey, 1995; Fehr, 2003; Yalom, 1975). Appropriate assertiveness can be taught in a group setting. Reasons verbalized for inability to assert oneself are excellent springboards for dynamic psychotherapeutic group work.

DESCRIPTION OF GROUP

This particular group is open ended, having continued for over fifteen years with patients entering and leaving based on their own growth and particular needs. It is a geriatric group, with an age range of seventy to ninety-six years. All participants have had serious psychiatric illness such as major depression and bipolar disorder. There are no schizophrenics in the group. Most have been hospitalized for depression and about 25 percent have been treated with ECT. All are on psychotherapeutic medications.

The group fills multiple purposes: it offers a meeting place for very lonely people and allows them to feel connected. They feel cared about by me and other participants.

PATIENT'S STATEMENTS ELICIT THE TYPE OF INTERVENTION

Most of my interventions are based on statements coming from the patients. One of my goals in the therapy is to lead the patients toward understanding the contributing factors that made them behave in inappropriate ways. I try to make these reasons conscious so that the patients can become more aware of their behaviors and change their behavioral patterns. I encourage the patients to reexamine underlying reasons for their behaviors.

GROUP PROCESS

A patient has just come home from the hospital following treatment for major depression in a psychiatric unit after a radical mastectomy. She states:

> I can't stand it in my home. Three nephews are there and there is a tent in the living room with two dogs and three cats. My cousin is there too and they have to move and we are waiting for checks to come in.

TH: Can you share with us why you are allowing this?
PT: They are my family. I can't tell them it is too much for me.

Multiple questions are then asked by other group members. My focus is toward the inability, of the patient, to assert herself and get her needs met. Some questions that could be asked:

- How do you feel when you speak up?
- Are you afraid to hurt_____?
- Do you feel they won't love you?
- Are you able to speak up in other situations?
- What do you think would happen if you asserted yourself?
- As a child were you encouraged to speak up?
- Who in your family system encouraged you to assert yourself?
- Did anyone?
- What did your mother/father say if you spoke up?
- Did your family system value assertiveness or see it as selfish?
- What is self-love?

Various group members support the patient and her need to be able to assert herself.

Inquire into the consequences of assertiveness and role-play:

- Will you feel good, bad, kind, unkind and to whom–yourself or others?

Role-playing is done in the group with further exploration and explanation of feelings with the patient playing both sides in order to determine if the patient is projecting her personality onto others. This could be one of the inhibitory factors for the patient not disclosing to others how she is feeling. She may believe that on hearing what she feels, the other person would experience the same narcissistic injury the patient would experience if someone said that to her.

The discussion, after role-playing, considers how it feels to speak up, emphasizing self-love, self-care, appropriate assertiveness, and communication skills.

CONCLUSION

Geriatric groups are often bonded together by mutual caring and by advanced age, disability, and concerns regarding helping one another to avoid further decompensation, hospitalization, falls, and ultimate death.

There is a sense of hopefulness within the group; they pray for one another (for the forthcoming surgeries), recurring concerns, etc. In short, they have become a family and I am part of their family, sharing in and showing that the human condition is part of all of us and not just the patients. Most members come very regularly but some come only when they can get transportation. None of them come in their own car and all are dependent on other sources. Many never miss group and it is their most important outing and connection to people and the outside world.

CONTRAINDICATIONS

Due to the nature of this particular patient population there is a very real contraindication, that is, the possibility of patient decompen-

sation. Care and judgment should be utilized. During these events, patients are encouraged to avoid self-blame and are encouraged to use new behaviors and bring feelings and reassurances back to the group. Another serious contraindication, although obvious, is that the clinician must enjoy working with a much older population. If the clinician does not enjoy or feel comfortable with an older population, there is the possibility of therapist elder abuse.

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Chapter 45

Modeling a Nondefensive and Empathic Acceptance of Group Resistance in a School-Based Anger Management Group with Urban Adolescents

Ellen Decker

"OTHER PEOPLE'S CHILDREN"

Some call them "other people's children" (Delpit, 1995, p. 137). They are a unique clinical population not only because they are adolescents, but because many of them come from high-risk environments where extreme emotional reactivity is the norm. Gangs are prevalent in their urban neighborhoods. Some have seen family members shot in the street. When they come to school, some of them are ready and eager to learn, and appear to have made sense of the trauma that is part of their daily existence. Others, however, come laden with firmly set defenses and seem more ready to fight than to learn.

GOALS OF THE GROUP AND GROUP COMPOSITION

The goals of the group are to prevent and reduce the frequency and intensity of angry outbursts and to assist group members in finding alternatives to inappropriate expressions of anger. Critical competencies and skills necessary for a successful mastery of the transition from adolescence to adulthood are incorporated into a supportive and therapeutic environment. A positive peer culture is stressed. Although the group is designed for schools, it can easily be adapted to community settings.

Described as an "anger management" group, and part of a larger school counseling program, the group is comprised of female students who have been referred to the school counselor because of frequent angry outbursts toward staff and peers. Some of the students are self-referred and others are referred by teachers or staff. A few are referred by their parents. Parent/guardian permission is required for group participation.

The school population is comprised primarily of African-American students. Group members are between the ages of twelve and fourteen. The group is gender specific and tailored to the unique issues adolescent girls face. The students themselves have requested that the group be for "girls only" and very clearly stated that they would feel self-conscious if the group included boys. Mixed-gender groups appear to make it difficult for girls to explore intimate and sensitive issues.

GROUP DESIGN

The group meets once a week for one hour. The setting is the school counselor's office in an environment that is welcoming and relaxed. The group model integrates psychoeducation, cognitive-behavioral therapy techniques, relaxation training, journaling, and the processing of feelings related to normative life transitions. Group can be scheduled during the school day at a specific time or can be conducted after school. Group planning plays a large role in group success and before starting the group, the leader must do a thorough job of group selection. Brigman & Goodman (2001) provide a very helpful pregroup interview outline that can be used when making determinations of group composition.

THE INTERVENTION

Modeling a Nondefensive and Empathic Acceptance of Group Resistance

This section describes a group intervention intended to help members of a school-based anger management group gain skills in understanding and regulating their feelings. The goal of the intervention is

to foster the development of empathy among group members and diffuse the anxiety resistance by modeling empathy. *The leader's skill at modeling a nondefensive and empathic response to resistance in the group forms the crux of this intervention.* By demonstrating empathy "in vivo" within the group, members may begin to experience the group as a safe and supportive enough environment where the corrective emotional experience can occur. Internalization of the corrective emotional experience by group members can begin to chip away at the nonproductive defenses young people from high-risk backgrounds carry around with them. Although clearly not a technique that lends itself easily to a "how to" format, when using the modeling of empathy as a group intervention it is helpful to keep the following in mind:

1. *Resistance* is always going to be a part of any group, including adolescent groups. It serves a function of regulating group tension and defending against anxiety. It is the task and duty of the group leader to understand this concept and develop a way of being in the group that reframes the resistance.

2. *Therapist self-awareness* is the first step in modeling empathy in groups. It is imperative that the group leader take some time to explore his or her underlying, culturally learned assumptions, as well as identifying the cultural backgrounds of group members.

3. Developing skills in *"reading" a group member's emotional message* is an important part of enacting the intervention. Keep in mind that behind the adolescent's resistance in group is a feeling that is too difficult to confront. Use clinical skills to accurately interpret the emotional trigger and respond empathically. Ask questions based on empathic understanding.

4. The group leader should make a conscious effort to *weave empathy into the group* experience by encouraging and nurturing group members. By modeling a reflective listening style that mirrors an expressed emotion, the leader provides group members with an "in vivo" example of how to acknowledge and support what others have said.

5. When responding to group members' expression of feelings, *utilize a structured listening approach* such as the one developed by Levine (2005).

This technique can also be taught to group members as a means of effectively responding when members self-disclose. Levin suggests asking the following questions:

- What happened? (identify the event)
- How is the person feeling? (an understanding of the other person's feelings leads to empathy)
- What will I do? (decide on a specific action to respond to the event)

The group leader can teach this structured listening approach and demonstrate how it can be used effectively in group. Group members are more likely to respond to one another with empathy after being encouraged by the group leader to ask these three questions.

6. *Be conscious of physical space in the group.* Empathy can be modeled in group by physically orienting oneself toward the group member who is speaking.

7. *Be consistent in providing a structured, limit-setting yet supportive stance when acting out in group occurs.* Adolescents can say and do things that may be hurtful to each other and/or to the group leader. Validate feelings without condoning behavior that is harmful to themselves or others. Working with adolescents takes tremendous personal energy and patience. Take the time to reflect with trusted colleagues or a supervisor when countertransference reactions appear to be impeding group growth.

8. *Reinforce empathic responses* given by group members to one another. For example, when a member makes a self-disclosure that displays a parallel experience ("me-too" disclosures) (Fuhriman & Burlingame, p. 501), or in another way verbally confirms an understanding of another group member's experience, the leader can reinforce the response with an encouraging verbal comment and/or a supportive look or nod.

CONCLUSION

Modeling a nondefensive and empathic acceptance of resistance in adolescent groups is an intervention that can enhance adolescents' empathy and prosocial behavior. In order to effectively carry out this intervention, the group leader must ascribe to the paradigm that resistant behavior in the group is a part of the group's developmental need, and as such, must be responded to with a positive connotation (Hurley, 1984). Equally important is a stance that incorporates the dynamic of "power and otherness" (Delpit, 1995, p. 134) when communicating

across individual and social differences within the group. Power differential, stereotypes, and other barriers can "prevent us from seeing each other" (p. 134). "Seeing" each other forms the core of the empathic response, and when modeled by the leader in group, can be an effective technique when working through the resistance of adolescents.

CONTRAINDICATIONS

Contraindications to group membership include combining girls who are of the same chronological age but at different cognitive or social developmental levels. If these differences are not taken into consideration when forming the group, peer rejection and feelings of frustration may impede the growth of the group and the acquisition of critical anger management skills. Consideration of these contraindications leads to a greater probability that the group environment will be one in which members will learn practical and healthy ways of relating to their peers and gain understanding of their own feelings and behaviors.

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Chapter 46

Saying Goodbye: A Termination Ritual

Jondra Pennington

CONNECTEDNESS

Group work creates connection. However, many times the group does not encourage maintaining these connections outside the therapy room. Nevertheless, the bonding of members can be intense and they usually want some way to hold on to their group experience once it is over.

In the lives of many patients, endings have not necessarily been positive experiences. They can stir up unresolved issues around loss and separation (Fehr, 2003). Termination rituals give patients a new, different, and corrective emotional experience that they can take out of the group room and into their lives (Shapiro, Peltz, & Bernadett-Shapiro, 1998).

This particular goodbye ritual provides patients a means to not only receive a new goodbye experience, but, also a tangible touchstone, if you will, with their group experience that they can literally carry with them for years to come.

CLIENT POPULATION

I was introduced to this ritual at an inpatient eating disorders facility in groups made up of women aged eighteen and older. The group was process oriented and met every morning for ninety minutes at the beginning of the treatment day. When the facility had a full census the group had eight patients with two therapists facilitating. Although

this intervention was used in an inpatient setting, it is just as useful in an outpatient setting where patients move beyond the superficial level of interaction by sharing and processing at deeper levels. This would be a very appropriate intervention with adolescent groups, as well.

DESCRIPTION OF THE INTERVENTION

You will need to create a small collection of interesting rocks to keep in your office. The rocks should not be too small or too large, but of a size that allows them to be carried in a person's pocket or purse, and it should have some interesting characteristics.

Step One: Selecting a Rock for a Patient

Notice the rock's characteristics: sparkly, shiny, smooth on one side, rough on the other, perfect except for one small flaw, multicolored, sharp, soft, small yet heavy, larger yet lightweight. Consider in what ways the characteristics of the rock remind you of the patient–the more you can connect the characteristics and "feel" of the rock with the patient, the better.

Step Two: Beginning the Ritual

The session opens with the therapist announcing that the group is saying goodbye to a peer that day. The therapist then takes out the rock and is the one who begins the ritual. It might go something like this:

TH: Martha, one characteristic that made me choose this rock (holding it up for others to see) is that it is seemingly perfect, expect for this one tiny flaw. Yet, notice that the imperfection does not detract from the rock's beauty, but actually enhances it. We all know how you struggled with perfectionism and how, during your time in group, you have come to accept yourself, warts and all. When you look at this rock and recall that its beauty is not detracted by the imperfection, but, it is the imperfection that makes it beautiful, I hope you will apply that to yourself and continue to embrace your own beauty and uniqueness.

If you look closely, you will even see that that the rock has a certain sparkly quality. When you first got here, you were quiet, shy, and withdrawn. Now, as you prepare to leave and I reflect on how far you have come, I see a woman who enthusiastically reaches out to her peers by being helpful and supportive. You allow yourself to have fun and as a result, your own sparkly personality shines through. Your effervescence is one of the things that I will always remember about you.

Step Three: Passing It On

Once the therapist has spoken, the rock is then passed to the person beside her, who then shares his or her thoughts with the patient, talking about the progress they have made, how their time together has influenced them, or anything else that summarizes what the two have shared while in group together. The rock is further passed around the circle for every member to speak. The "patient of honor" must simply listen to the comments until all have had a turn.

Step Four: The Departing Patient's Turn

The rock will eventually return to the therapist after making its circle around the group. The therapist then places the rock in the departing patient's hand. It is then the patient's turn to address each member of the group, including the therapist(s), sharing his or her experiences and what the group and their time in treatment together has meant to the patient.

Step Five: Ending the Session

This intervention will probably take up the entire group time. If your group has a regular closing ritual, close the group as you normally would.

VARIATIONS ON A THEME

This same intervention can be used with shells or any other element from nature that is not fragile and will last. In addition to the feedback element of the ritual, each person can also "endow" the item

with some characteristic that the patient needs to get by in the world. For example, "In parting, I put into this rock the gift of self-esteem with the hope that you always remember how valuable and worthy you are."

CLIENT RESPONSES

The emotions in a group are often heightened at termination, even if only one person is leaving. The relationships formed have a deep level of intimacy and this intervention allows the patient to leave the group with a tangible symbol of his or her experience and the healing changes they have made. Typically, the departing patient will be uncomfortable being the center of attention. Often patients are not used to receiving this extent of positive feedback at one time, about how he or she has changed, grown, and the impact the patient's being has had on other members of the group. Tears are common as the individual begins to experience leaving in a completely new way. After the group ends for the day, it is typical for members to take turns hugging the departing peer and, because of this, leaving the group room usually takes longer on "goodbye days." Patients' self-reports indicate that they become quite attached to their memento and carry it around with them, at all times, or give it a place of honor in their home or office.

CONTRAINDICATIONS

This ritual, due to its emotionality, calls for depth of knowledge of the patient by the therapist and the group members. It will not have a profound effect if the group was at a point where intimacy had not yet been attained. Therefore, the most favorable predictor of its outcome will be in clinical settings where personal information is disclosed and trust had been built between the clients. Psychoeducational groups, due to the parameters of their particular paradigm, seem to be the only contraindicated group for this intervention because of the oftentimes superficial level of personal information that is typically shared.

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Chapter 47

Norm Repair

Joseph Shay

THEORETICAL ORIENTATION

All groups have norms. But different groups develop very different norms. Norms, simply put, are the shared implicit and explicit rules of a group, and comprise a major ingredient of the culture of the group. They include the stated rules such as "you are expected to arrive on time," and more implicit rules such as "do not sit in the therapist's chair." Some norms are simple, such as "wait for someone to pause before you speak," while others can be more complex, for example, "do not express too much angry affect because the group gets frightened by it."

How do norms get established? Group members often carry into group therapy the norms of society, since norms are ubiquitous in society: "Social norms are the 'rules' that govern behavior within each society" (Agazarian & Peters, 1981, pp. 96-97). In this regard, new members to a group often expect to be welcomed as though they were entering a social situation as guests. If unprepared for the fact that this is not typically a group norm (especially in psychodynamic groups), they may feel rejected or mistreated.

Part of the therapist's task in group therapy is to initiate constructive norms and to recognize and modify disruptive or nontask-related norms, some of which are promoted by group members. Yalom and Leszcz (2005) write, "Norms of a group are constructed both from expectations of the members for their group and from the explicit and implicit directions of the leader and more influential members" (p. 122). Rutan, Stone, and Shay (2007) state, "Since the therapist is a

potent initiator of group norms, reinforcement through interest or noninterference serves to communicate and establish appropriate ways of interacting within the group" (in press). Ulman (2005) remarks, "I try from the outset to encourage the development of group norms that foster curiosity about everything that happens in group" (p. 94).

Norms can vary—some can evolve and change over time, while others become entrenched and difficult to modify. A particularly difficult situation arises when a norm is established inadvertently, and then ingrained, out of the conscious awareness of therapist or group members. These norms can be especially difficult to modify. The intervention described in the next section was developed to address one such situation.

DESCRIPTION OF GROUPS

This intervention can be used in groups of all kinds since norms exist in all groups, and can go awry in any of the various group settings. In long-term groups, norms can, of course, become more entrenched and therefore harder to modify. The intervention was, however, used in a long-term open-ended co-ed group, with the intervention made about one year into the life of the group.

THE INTERVENTION

In this long-term group of eight, five females and three males, aged thirty to fifty-two, members had developed a real facility for deep exploration of problematic or affect-laden situations, including situations in their daily lives as well as powerful experiences within the group itself. I viewed this group as an extremely high-functioning, successful one in which members routinely addressed core aspects of their lives, and worked hard to take responsibility for their thoughts, feelings, and behaviors. It was also a group in which members commonly got in touch with very painful dysphoric affects, with tears common in many sessions. Typically, after a member had begun to cry, other group members were attentively silent, with some of them tearing up as well in empathic support. The member who had been crying might then continue his or her discourse, and then respond to

comments or associations from the other members. At times, however, when a member was experiencing acute emotional distress—sobbing or wailing, for example—the members remained silent, seemingly not knowing what to say. At such times, I often felt a need to be overtly supportive to the pained member, and would make one of several comments. These comments ranged from "take your time," suggesting there was no hurry to stop crying, to "how painful this is for you and perhaps for others in the group," to "when you are able, perhaps you can put your feelings into words." These interventions typically resulted in deepened emotional expression by the group member after which the member would begin to speak, and to elaborate on the experience.

Although I felt satisfied with these kinds of interventions, there were a few occasions where I thought that it would be better if the other group members intervened first, either with empathic statements, or questions, or their own associations. So, I let the silence linger. And it lingered, and lingered, and lingered—as the group waited for *me* to respond. I then realized that I had inadvertently shaped a complicated group norm: *when a group member is in deep distress, Dr. Shay will respond in a compassionate way. And I don't need to respond because he will.*

Recognizing this, and feeling uncomfortable with it, I decided to reshape the norm. At first, I tried outwaiting the group members as they were watching me and waiting for me, but this not only felt uncomfortable for me—because I was changing the norm without articulating this to them—but also uncomfortable for them, and more importantly might be experienced as abandonment by the acutely distressed member. I finally decided to use a more active intervention to reshape this norm.

At the start of a group, after the usual announcements about attendance and upcoming absences (another group norm), I said, "I want to begin by apologizing to the group for having made a mistake which I am now aware of. And I want to change this. As we saw last week, and in many previous groups, you all work very hard in this room and have developed a real ability to support each other, challenge one another, and feel deeply for other people in the group. When one of you becomes distressed in here—last week it was Ann, two weeks ago Bill, and last month Dave and Carol, but most of you have been there—I realize that I have often been the first one to speak when there is high

emotion in the room. I think I have accidentally "trained" you to wait for me to be the first to speak, and I think that is my mistake because we now have this as a norm—wait for Dr. Shay to break the silence and then others can speak. This is a mistake on my part because I believe that you are capable as a group of being as supportive and helpful as I try to be, and in fact, my responding may have gotten in your way. So, I want to own responsibility for having shaped this norm, and now I'm owning responsibility for telling you that I'm going to try to change it. At first this might be uncomfortable for all of us, but I think this is for the best and I'm glad to hear any reactions."

TYPICAL RESPONSES

I have used this approach in various groups to modify other norms I have inadvertently shaped, e.g., too little attention to member lateness, members eating food during a session, so the responses to this situation above are typical in groups.

One member said, "Wow, Dr. Shay. You never say that much at one time." Another member followed, "I like it when you're the first to make a comment when someone is crying. I don't really know what to say." A third said, "I actually noticed how we always get quiet, but that was fine with me." And a fourth added, "I guess you think we can really do this." After a silence, I said, "I *do* think you can. And I think the group as a whole can find its own voice when someone is distressed, although it may feel awkward at first. If there are more reactions or feelings now, I'm glad to hear them, or even at a later point in the group when we see how it goes." A fifth group member then took the floor and spoke about how no one in his family even seemed to notice when he was upset, leading to a productive exploration for this member and for the group as well as they reacted to his story.

In subsequent group meetings—not in this one—group members did indeed respond to distraught group members, often after an initial silence, recognizing I trusted them to do so.

CONCLUSION

Group therapists are fundamentally responsible for shaping—and reshaping—group norms, although the group actively participates in

this process, typically to support a norm but at times to sabotage it. The key for the therapist is to be consistently aware of the norms that have been and are being established, some intentional, some inadvertently, and decide what to do about those that work against optimal group functioning. At times, an indirect approach to reshaping a norm can work nicely, e.g., when the therapist simply draws attention to a particular area of concern, e.g., group lateness. At other times a more direct approach is called for.

CONTRAINDICATION

There is one relative contraindication for the use of such a direct approach. When groups are in an extremely oppositional phase of the group's life, this may cause a direct approach to fail. With a solid therapeutic alliance, however, this contraindication is mitigated.

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Chapter 48

Using the Group Power for Interpretation

Dan Raviv

A PERSONAL STYLE OF INTERVENTION

There are many approaches to the art of conducting group therapy (Fehr, 2003). However, interventions by the therapist are used in most of those approaches and are among the most important tools used for affecting change. Over the years I have attempted to use various approaches which probably reflected the way I perceived the world at different periods in my life. Over time I have found myself settling into a more consistent, eclectic approach that seems to express my comfort zone at the present time. Therapists need to find the style of intervention that suits them and are appropriate to the situation in the group at the time they make the intervention (Yalom & Leszcz, 2005; Caligor, Fieldsteel & Brok, 1984). Interventions while conducting group therapy, are very important moments in the process and when done correctly and appropriately, can create the impact that can change a person's life. The most powerful interventions that seem to typically affect group members are the interventions that draw insight from the here-and-now, group-as-a-whole experience in the room (Agazarian, 1989). Those interventions seem to cut through resistance because they are experienced in a very authentic way when the timing is just right.

CLIENT POPULATION

This type of intervention tends to be effective with clients who possess average and above-average cognition capabilities since it requires some abstract thinking. Clients who tend to be concrete in their perception of the world may become too defensive as they may perceive the intervention as an attack or may not be able to see a connection between their issues and the issues of other group members.

INTERVENTION GUIDELINES

The group therapist needs to listen simultaneously to the individual member as well as the mood in the room. Experienced group therapists are aware that often the silent group members are "carrying" the feelings that are not expressed by a talking member. On many occasions during the group process a person who is expressing certain frustrations are talking from their heads but not necessarily from their emotional base where old pain is lodged. The goal of treatment is to move the focus from the head where the problem is theoretical in nature and therefore not resolvable, to that elusive emotional base where the pain is hidden and needs to be released. By allowing the frustration causing pain to be fully felt there is a chance for resolution.

Example

A forty-year-old single woman who has been in the group for about three years was talking about the recent admission of her alcoholic brother to a rehabilitation facility. She spoke in length about her awareness that the rest of her family will not act honestly when they are called to a family treatment session as is required by the rehabilitation facility. She felt that she would need to take care of her family members by protecting them from having to face the truth about their own contribution to her brother's addiction. She was also worried about being attacked and isolated by her family if they felt too threatened by her approach to dealing with her brother's addiction issues. While she was talking, the rest of the group members were mostly quiet with occasional concrete suggestions as to how to respond to her family members.

Therapist Intervention: A Four-Stage Process

Stage One: Seeking the Core Issue

It is the role of the therapist to be able to extract the core issue from the many words and feelings that the client(s) in group therapy disclose. In this case, one of the co-leaders asked her if she thought about her own needs and who will take care of her.

Stage Two: Clients Ponder But Are Often Interrupted by Other Group Members

She thought for a minute but was interrupted by a group member who wanted to give her advice as to how to deal with her family and she did not respond to the therapist's question.

Stage Three: Observation and Analysis of Group-As-a-Whole

As I observed the process I realized that the entire group was becoming numb and slowly fading away. I realized that the issue in the room was the inability to ask for one's own needs. The group members were all identified with the unparented child who needs to take care of his or her parents to make sure they will survive and to take care of himself or herself.

Stage Four: Appropriate Timing and Reframing the Interpretation to a Group-As-a-Whole Issue

At that point, I said that I am aware that everyone in the room is a caretaker and no one is allowing others to take care of them. That stopped the discussion and changed the process to focus on what makes it so difficult for the members to allow themselves to receive care, etc.

The timing of this interpretation was powerful because everyone was so busy focusing on the member who was talking about her family that they dropped their conscious defenses against their own difficulties in accepting support from others. During the rest of the session the members focused on being "trained caretakers" who are not comfortable in receiving care and their need to change this tendency.

CLIENTS' RESPONSES TO THE INTERVENTION

Clients were able to refocus their attention on the reasons many of them enter therapy in the first place. Once their defenses were lowered by the focus being on another group member, they really heard the therapeutic message, which allowed them to reflect on avoiding old behaviors and its consequences while considering new behaviors that may be more in sync with their true needs.

CONCLUSION AND CONTRAINDICATIONS

The group therapist needs to work on at least two levels. She or he needs to listen to the content and at the same time listen to the emotional mood in the room. The content is important since it provides the substance for the verbal interaction, but the emotional mood provides the true unspoken and possibly unconscious issues in the room. A well-timed interpretation may make this unspoken and/or unconscious material available for exploration by the group members and may lead to growth.

A contraindication of this intervention is a poorly timed interpretation, which may create a hardening of the defenses and close off potential openness for growth (Yalom & Leszcz, 2005). If the interpretation happened too early in the session the group members may not have considered themselves to be in the same "camp" with the member who spoke and not connected emotionally to her particular tendency to avoid being nurtured.

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Chapter 49

The Values Auction

John Mendez

VIOLATING A CORE VALUE

The chronic and progressive nature of addiction eventually leads the individual to violate one's core values as a person (Perkins, 1997). Motivation to change increases when there exists a sense of dissonance between one's ideal self and one's behavior (Festinger, 1977; Aronson, 1999). Individuals are more likely to make an argument for change when they begin to experience incongruence between their stated goals and their behaviors (Miller & Rollnick, 2002). A confrontation of the individual's incongruent behaviors may lead to increased defensiveness and discomfort with the change process (DiClemente & Velasquez, 2002).

DESCRIPTION OF THE GROUPS

This group activity can be used with any group whose main focus is to change behaviors. These can be substance abuse groups, anger management groups, batterer groups, and groups for individuals with co-occurring disorders. The author has used this exercise with many of these populations and it has been helpful in assisting the group members to identify the core values that have been violated.

THE INTERVENTIONS

This group activity requires that the group leader take more of a facilitator role. The group facilitator should be willing to be dramatic and convey enthusiasm and energy for the group members in order to be effective.

Activity

The group facilitator tells the group that today we will talk about core values. At this point, the group leader should be standing and writing the group members' answers on the board. Elicit a definition of what a core value is. The definition is agreed upon by consensus.

The facilitator then requests that the group members take five minutes to think about which values they hold most dearly. After the five minutes have elapsed the group leader will ask each group member to share his or her answers.

The facilitator needs to be skilled to elicit specific core values. For instance, if a group member gives the answer that family is a core value for them the group leader will ask for the details. An acceptable answer would be: Being trusted by my family is a core value. The group facilitator's task is to elicit and write the responses on the board. By the end of this part of the exercise there should be at least double the amount of core values as there are group members.

At this point the group members are provided with an imaginary $1,000 credit limit with which they will be able to bid on the values on the board. The group members are encouraged to outbid one another in increments of $100 in order to do the math. For instance, the core value of having a sense of integrity could be "bought" for $300. If John Smith buys this value his name is placed next to the core value along with the cost. John Smith would have $700 on his credit limit remaining. This process continues until all of the core values are bid on by the group members. The group facilitator can mimic the speech of an auctioneer and feel free to use the expression, "going once, going twice, going three times . . . sold to Mr. Smith for $300."

Once all of the values have been bid on, the group facilitator questions each owner of the value on how his or her substance use has violated this core value. Enough time is allowed to process these answers among the group members. At this time the group facilitator should be seated as in a traditional process group. It is important for the

group facilitator to provide support and encouragement to the group members as they begin to realize how their behaviors have violated their core values.

TYPICAL RESPONSES

The initial response from group members would be one of reluctance to participate due to a sense of embarrassment. After the second or third core value is bid on, group members begin to feel more comfortable. Friendly competition among group members may manifest itself. Group members may brag that they were able to buy what they really wanted or they may verbalize disappointment that they were outbid by a peer.

Group members will tend to become more serious as they speak about how they violated their core values. These group members may begin to verbalize feelings of guilt and shame regarding their core values. The skilled group facilitator will be able to help the group members change from a sense of discomfort and guilt into a sense of increased motivation to change his or her behavior by providing support and encouragement. The group facilitator helps to elicit arguments for change from the group members. For example, what would happen in the future if this behavior does not change? What concerns you about your violation of your personal core value? How important is it for you to change this behavior? How confident are you that you will be able to change this behavior? If not, what has to happen in order to make this happen? These are just some of the examples of the type of open-ended questions that can be asked in order to increase motivation.

CONCLUSION AND CONTRAINDICATIONS

This group activity can assist in engaging group members into a greater understanding of how their behaviors are ego dystonic, thus producing motivation to change behaviors. It is also a good diversion from the traditional process group.

This group activity can be used with any population that is able to have a minimum level of abstract reasoning. Individuals who are severely impaired in this area may enjoy the auction part of the activity

but they may not be able to ultimately make the necessary connection between these abstract core values and their own behaviors.

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Chapter 50

Individual Psychotherapy in the Context of a Group: An Intervention

Joan E. Childs

INTRODUCTION

To better understand the following intervention, it would be necessary for me to explain the format I developed over the thirty years I have been in private practice. I often include individual experiential psychotherapy in the context of the group. This approach is commonly used in inpatient treatment centers where group therapy is the therapeutic modality of choice. When an opportunity presents itself to work with a client within the context of the group, I first ask permission, (e.g., "Would you like to do a piece of work?") This approach not only provides insight and/or resolution for the participating client, but also promotes processing and feedback for both the individual and other group members. Often, other members are triggered into their own unresolved conflicts while being a benign witness to a working member and can benefit greatly from this process.

I employ an eclectic approach combining many therapeutic modalities, but in this particular intervention I predominantly used the principles of guided imagery. Guided imagery is an effective and simple relaxation technique used for meditation and/or hypnosis that helps to manage stress, reduce tension, and induce regressive and/or repressed memories. I also use neuro-linguistic programming (NLP), a communication technology that utilizes the work of Milton Erikson, MD, founder of the American Society of Clinical Hypnosis and one of the most widely acknowledged and clinically successful psychiatrists of our times (Bandler, Grinder, 1975; Bradshaw, 1988; Zeig,

1985; DeLozier, 1977; Dilts, Ginder, Bandler, & DeLozier, 1980). NLP employs the three most influential components involved in producing human experience: neurology, language, and programming. Used together with Eriksonian hypnosis, these modalities provide experiential processes, rather than "talk therapy," which impact the amygdala, (where I believe trauma and stuck states are lodged, thus helping individuals to release repressed negative thoughts, feelings, and compulsive behaviors that are preventing them from moving forward in their lives.)

GROUP DESCRIPTION

This particular group is newly formed. It consists of eight participants–five women and three men. The group is time limited and requires a six-month commitment in order to participate. The members have the option of continuing at the termination of the six months, with another six-month commitment. No new members are permitted entry during the six-month period. The focus is primarily an experiential, process group. The members are high functioning, all having the ability to be introspective and open. They are selected from my client population. Each member has been in treatment for at least six months.

PRESENTED ISSUE

A client disclosed sadly that her cat of fourteen years had suddenly passed away. Over the weeks, she had revealed that a new relationship had usurped her time with her pet, as all her available time after work had been dedicated to developing this new romance, leaving little time and attention for her animal.

This client holds a high professional position. Her job is demanding, quite often she keeps longer hours than her staff. Due to the pressure of the job and her new boyfriend, the cat was left to fend for himself, which was a deviation from the fourteen previous years as her one and only pet.

The client related that her animal had an ingrown nail that went clearly unnoticed until an infection caused her to take him to the vet. The vet assured her that the procedure of removing the nail was not

dangerous, stating that she would be called as soon as he was ready to go home.

Hours later, she received the unexpected phone call that her animal had died. The vet was shocked. The client was horrified and felt responsible. She felt she had done to him what her family had done to her: a reenactment of abandonment.

When she shared her loss with the group, her affect was flat as she reported the event and circumstances leading to his death. Her inability to emote prompted an intervention. It occurred to me that she was indeed in a state of grief and remorse, feeling responsible and guilty for her cat's demise, but her defenses prohibited her from releasing the appropriate emotions. Asked if she wanted to do some work with this loss, she accepted the offer without contemplation.

THE INTERVENTION

I began with the use of guided imagery, (Bandler & Grinder, 1975; Bradshaw; 1988), and asked the client to close her eyes and go to the last time things were well with her cat and her. I had her visualize that moment. In only seconds, the tears flowed. I asked her to tell her pet that this would be the last time they would be together. The group watched in awe as her state transformed into one of deep grief. Her head held in her hand, she began to weep. I prompted her to tell him whatever she needed to say to have the closure she so desperately needed. "Look into your cat's eyes and tell him how sorry you are that this happened. Tell him that you hope he will forgive you for not being there as much as you used to be. Imagine that you can touch his back, feeling the fur that coats his body; imagine that you can put your face close to his and feel his presence; allow yourself to be present and tell him how important he was to you."

All this was done in silence through her own neurological system. I prompted her with the words that would provide her with the healing she needed. I had her complete stem sentences such as:

- "What I will miss the most about you will be. . ."
- "I will treasure and cherish. . ."

As she did her internal processing, she was encouraged to say whatever else she needed to say to complete this work. As she processed these moments in silence the tears and sobbing exacerbated. I encouraged her to release her pain.

"Let it come up," I said, encouraging her to allow her feelings to emerge. Some of the other members encouraged her as well. They identified with their own losses. Soon the sobbing became louder, and her guttural cries resounded in the room. She cried for her cat. She cried for herself as a child. The intervention took about ten minutes. I encouraged her to release the energy that had been frozen in her since childhood.

RESPONSES TO THE INTERVENTION

The response of both the client and the group to this particular intervention was perceived according to each member's own history. Some shed their own tears; others sat in silence caught up in their own memories and thoughts. I asked the client to look around the room at the faces of all the others. I asked her if she wanted some feedback. She observed their empathy and sensitivity to her pain. I asked her to first state her own feelings about what had just occurred. She described her experience as a release of long pent-up emotions, and felt grateful to the group and me for the time and validation. After she disclosed her feelings, each of the members gave her feedback. At the conclusion, we talked about grief and loss, each member relating his or her own experience: a healing for everyone.

CONCLUSION

In conclusion, this particular technique is very effective for providing feeling work, catharsis, (especially for grief work), and the opportunity for the client to realize that the client is not alone, (Yalom, 1975). It allows for feelings to be expressed, acknowledged, and honored. It is part of the healing work or original pain work (Bradshaw, 1988).

CONTRAINDICATIONS

Individual experiential psychotherapy must be handled and utilized cautiously. The clients must be high functioning, have good ego strengths, and willing to receive feedback from the other members. It is important to be careful about who is chosen as a member. Certainly anyone with borderline personality features or disorders, antisocial or narcissistic personality disorders would not be a candidate. Severely depressed clients with poor ego boundaries, active substance users or anyone with marginal intellectual functioning would not be appropriate. In addition, no one should be forced to participate if they are not willing to do so. However, when choosing members for this type of group experience, that is already a consideration.

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Chapter 51

The Rope Exercise to Experience Process in the Group

Edward W.C. McAllister

EXPERIENCING THE VARIOUS STAGES OF GROUP

Groups move through various stages of development. Many theorists have described these stages (see Fehr [2003] Chapter 7 for an overview of some of the theories). In working effectively in a group, it is useful if the group members have some idea about what to expect while in the group. Shultz (1973) has a theory of group development that will help group members to understand some of the phenomena that they will experience in a group. He bases this work on three interpersonal needs of inclusion, control, and affection.

> Inclusion refers to my feelings about being important, significant or worthwhile. Control refers to my feelings of competence, including intelligence, appearance, practicality, and ability to cope with the world. Affection revolves around my feelings of being lovable, of feeling that if my personal essence is revealed in its entirety, it will be seen as a lovely thing. (p. 38)

As members of groups learn to look for the manifestations of these needs within the group, it helps them to understand their own behavior in the group and the behavior of their fellow group members. The issue of *inclusion* generally arises at the first stage of the group and creates the feeling that you are in or out of the group. The second

stage develops when the issue of *control* arises. Each group member tries to establish a position in the group. Are they near the top or the bottom in the group in competence, appearance, and influence? The third stage begins when the issue of *affection* arises. Do members of the group feel close or distant to others in the group (Schultz, 1973)? The development of these stages is not linear and the stages may continually cycle during group sessions. However, if group members are able to recognize the need behind the behaviors in the group, the process may be expedited.

A creative technique to help group members experience some of these issues and group stages involves the use of a long rope. Jacobs (1992) stated that the reasons for using such techniques are to make concepts more concrete, to heighten awareness, to dramatize a point, to speed up the counseling process, to enhance learning because people are visual learners, to enhance learning because people learn through experience and to focus the session.

DESCRIPTION OF THE GROUPS

For many educational, growth, or short-term outpatient process groups, this intervention might help to provide experiences that demonstrate the issues and stages that are involved in group work. The group should be high functioning so that members are able to verbally process the physical and psychological experiences that occur during the intervention.

GUIDELINES FOR THE INTERVENTION

Materials

In order carry out this exercise in a group of about ten, you will need a rope of about fifty feet in length and at least three-quarters of an inch thick. (The operating guideline is about five feet of rope per person.)

Procedure

Step 1: Bring out the rope and explain the exercise

Bring out the rope and explain to the group that the exercise is designed to create some physical representations of reactions and feelings that they might experience in the group. Tell them that they are going to all work with the rope at the same time and create a group that is simultaneously holding the rope.

Step 2: Setting the group to hold the rope

Ask each member of the group to form a line and have everyone face in the direction selected by the therapist. Take the rope behind the line of people and ask each person to hold a section of the rope behind them about belt high. Each person should hold the rope across his or her back at the belt line with each hand facing palm forward. This means that each person will receive the rope with his or her left hand, palm facing forward, run the rope across their back at the belt line and then hold the rope with the right hand, palm facing forward. The rope then extends on to the next person who holds the rope in the same manner. When the initial preparation is complete, everyone should be holding the rope across his or her back at the belt line with two hands and about two feet of space between each person.

Step 3: The first movement

Tell the group that you are going to give them some directions to move and that you will tell them what to do. Ask each person in the group to carefully move about the room in any direction that they choose *without letting go of the rope* for about five seconds and then tell them to STOP. Next tell them to each move again in a different direction for about five seconds and then tell them to STOP. (If the group members had all moved in the same direction on the first move ask them to be sure to go in different directions on the second so that they are NOT all going in the same directions. Also remind them to not let go of the rope.)

Step 4: The second movement

Ask the group to keep holding the rope behind themselves at the belt line with both hands and to now form a circle keeping about two feet of space between them. When they do this they should all be in a circle facing the center of the circle with the rope going around the back of each person in the group. Ask the group to move together in a circle. Do not tell them which way to go. Once the group is moving in a circle smoothly for about five seconds tell them to STOP and remain in place.

Step 5: The third movement

Place a chair just inside the group at some point in the circle. Ask the group to continue holding the rope and ask them to resume going in a slow circle. As the group is moving, select a person who has just passed the chair and say, "Mary (use the person's name) the next time you come to the chair sit down on it." When Mary comes to the chair and sits, the group will likely stop and Mary may let go of the rope. When Mary is sitting with or without holding the rope, tell the group, "Okay, let's resume moving in a circle now." The group will either move on without Mary if she has released the rope or if she is still holding the rope, she will likely get up and move with the group.

Step 6: End of the exercise

After the group has made another revolution around the room tell the group to STOP. Ask them to let go of the rope, remove it from the group and ask everyone to find a place and to sit down. Tell the group that you now want to explore what happened during the exercise.

1. First ask the group members what it was like to try to move around the room connected to the rope. Next, ask if they had any feelings about any of the other people or other people's behavior during the first movement.
2. Ask the same questions about the second movement where they went together in a circle.

3. Ask the same questions about the third movement starting with the person that you asked to sit in the chair.
4. Ask the group member reactions to the overall exercise and to the people along the rope with them.

In working through each of the questions, the therapist is centered on interpreting the responses from the group members using the issues of inclusion, control, and affection. Did group members express feeling *in or out* of the group in each of the movements? Did they feel that their competence or power was *top or bottom* in various movements? Did they develop any feelings of *close or distant* during the movements? After the initial response reports, the therapist should give an overview of the stages of *inclusion, control and affection* in groups. Discuss how these issues are continually active in a group with the most success occurring when the majority of the group members are *in, top and close.*

RESPONSES TO THE INTERVENTION

The skill of the therapist in identifying the issues of inclusion, control, and affection is key to the success of the exercise. In the first movement many people will describe feeling restricted or inhibited. They are feeling *in* the group since they are attached to the rope but restricted by the rope so at the *bottom* in power. Some may say they went along with some other person's movements (bottom) or they just moved as they wished and let others follow (top). In the second movement there may be more reports of feeling like they were moving together (in) or that they were dragged along (out and bottom). In the third movement, the person who sits may say they felt they moved out of the group or that they had the power to stop the group (top). Those in the group might report feeling stopped by the one who sat (bottom). Responding to the overall exercise there might be reports that lead to in or out, top or bottom and even close or distant feelings.

CONTRAINDICATIONS

The main contraindication to carrying out the exercise is the issue of safety. The therapist must be aware that people need to move with

some care and not become too exuberant lest people fall or get injured. In working with adolescent groups or those with individuals who may be easily frustrated the therapist should consider if the intervention would be appropriate or should take extra steps to ensure that no one violently or suddenly pulls on the rope. The rope that is selected should also be of concern to be sure that it is smooth and not rough on the skin.

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Chapter 52

Let's Talk

Susan J. Mendelsohn

EFFECTIVE COMMUNICATION

The concept of effective communication between two humans seems so simple; yet communication—or ineffective communication—is at the crux of what tears relationships apart. Furthermore, Markman (1981) identified premarital communication as one of the strongest predictors of future marital distress.

Communication is so healthy, yet we do it so rarely. Between e-mails, memos, text messages, faxes, and Blackberries, we can go an entire day, or even days, without talking to a single person. Effective communication is so much more than merely getting your point across. It's about listening, empathizing, and allowing ourselves to be open enough to become vulnerable all in the name of reviving relationships and enhancing self-esteem.

In this sense, self-esteem refers to whether one accepts oneself, respects oneself, and considers oneself a person of worth and assertiveness training (AT) is thought to enhance one's self-esteem, self-confidence, interpersonal relationships, personal fulfillment, and internal locus of control (Delamater & McNamara, 1986; Mendelson, 2007).

THE GROUP

This particular intervention is effective with both time-limited and ongoing process groups. These skills are recommended for clients

with at least average intelligence and those who have the ability to be introspective. These skills are not likely to be used with clients that are psychotic or intellectually challenged. These skills can be practiced within the group setting as well as outside group therapy with a partner or in a mirror for enhanced proficiency.

DESCRIPTION OF INTERVENTION

Before learning the skills of effective communication, I empower my clients with a list of basic human rights. We carefully review this list together and pinpoint those statements that the clients find challenging. Reviewing this list provides insight, which allows the clients to realize that they, too, deserve to be treated with dignity and utmost respect. Most of my clients have the belief that they are selfish if they place their needs before the desires or requests of others, hence, their difficulties and disorders grow worse and worse over time. Learning these interventions will assist them in not only healing themselves, but also provide more assistance to their friends and loved ones with enhanced effectiveness. I often use the example: If the plane is going down and you hand out oxygen masks to everyone else, you have no life left. But, if you give air to yourself first, you can provide subsistence to everyone else and all can thrive.

Working through this in the group setting provides the members with a sense of universality and allows them to work through their personal conflicts together. I teach my clients that if they want respect they must first respect themselves. If they believe they must be "sweet" at all times, they will invite being used. In the same sense, if they behave as if they are incompetent, they will invite others to be critical of them. In the following section are the basic human rights that the group members are armed with and must believe in prior to gaining the skills of effective communication (Mendelsohn, 2007).

I Have the Right to:

- Ask for what I want.
- Say no to requests or demands that I cannot meet.
- Express all of my feelings, positive or negative.
- Change my mind.

- Make mistakes.
- Not have to be perfect.
- Follow my own values and standards.
- Say no to anything when I feel I am not ready, it is unsafe, or it violates my values.
- Determine my own priorities.
- Expect honesty from others.
- Be uniquely myself.
- Be angry at someone I love.
- Feel scared and say I am afraid.
- Say I do not know.
- Not give excuses or reasons for my behavior.
- Make decisions based on my feelings.
- My own personal space and time.
- Be playful and frivolous.
- Be healthier than those around me.
- Be in a non-abusive environment.
- Make friends and be comfortable around people.
- Change and grow.
- Have my needs and wants respected by others.
- Be treated with dignity and respect.
- Be happy.

After the group members have learned and processed their human rights together, they are ready to move on to effective communication skills. At this time, the group leader reviews the following tips for proficient assertiveness communication. They are as follows:

- Agree on a time and place that is convenient for you and the person to whom you are making a request.
- Make sure your requests are clear, direct, and nonjudgmental.
- Speak clearly, audibly, and firmly.
- Keep tone of voice moderate without implying blame or attack.
- Maintain eye contact. Looking up and down and all around is passive behavior. The listener will lose respect for you if you cannot look at him or her directly.
- Make request small enough to avoid major resistance.
- Keep request simple, specific, and understandable.

- Be objective by communicating the facts rather than fighting the personalities involved, providing the opportunity to state your case.
- Be honest, not cruel. This is not about winning, but communicating to be understood and to experience the realities of others.
- Describe your desires in terms of behaviors, not attitudes.
- Keep arms and legs uncrossed so as not to put the person to whom you are talking on the defensive.
- Do *not* apologize after you have made your request. This only negates your entire request or feelings, keeping you passive and wishy-washy.
- Focus on the results. Mention the benefits of having your request fulfilled rather than the disadvantages. You do not want to appear manipulative.
- Use *"I"* messages that express your feelings without blaming others. This gives you personal power and does not attack the other person.
- Connect the feeling statement to the behavior of others, rather than to the person. People are not "bad." It may simply be that their actions dissatisfy you.

Once this list is reviewed, the group breaks into pairs for rehearsal. Later, each pair will role-play in front of the other group members and all members will constructively critique the group members' skills. If the clients are timid at first, the group leader can model the assertiveness skills initially with a "courageous" group member.

TYPICAL RESPONSE TO THE INTERVENTION

My clients feel a renewed sense of self-esteem in nearly all aspects of their lives as their skills improve. They feel hopeful that they can conquer obstacles that come their way without retreating into a world of fear that has paralyzed them in the past. This is evidenced by observing the group members using their newfound skills appropriately week after week during group sessions with decreased anxiety.

Interestingly, I have noted a secondary benefit to this training not only for the communicator, but for the listener as well. The group members who typically shied away from being confronted are now able to accept being confronted without recoiling back into their fear-

ful and passive stances. In other words, when a group member asserts himself or herself, the former "scardy cat" is no longer personalizing what is being said and rather gaining a better understanding about what is happening. Hence, the previous "scardy cat" has gained the tools to step up to the plate and communicate more effectively as well, allowing for a more healthy exchange.

This type of intervention assists my clients in all aspects of their lives, providing a sense of self-esteem, self-worth, pride, and overall well-being.

CONTRAINDICATIONS

This intervention may have contraindications if the client is not fully educated about the purpose of the skills training from the start. The client must understand that assertive communication is for the sake of the client and not for the sake of changing others. Clients must recognize that standing up for their rights and expressing their views will provide them with a greater sense of freedom, enhanced self-esteem and self-worth, and assist him or her in eliminating self-destructive behaviors by uncovering some of those pent-up thoughts, feelings, and desires. They will feel more empowered to overcome obstacles, which in the past they were too fragile to overcome, simply by getting it "off their chest" rather then consciously suppressing their thoughts and feelings.

If the clients irrationally believe they are going to change the response of others simply because they are speaking up, there may be unnecessary frustration that would cause the clients to withdraw, once again, into a world of self-destructive thoughts and behaviors.

Another contraindication to learning this type of skill is a possible loss of a current relationship. It is sad but true. For example, in the case of a marriage or other intimate partner relationship, the more dominating partner may have chosen the more passive partner for obvious reasons: control. Once this passive partner becomes more assertive (hence enhancing his or her sense of self-esteem), the more dominating partner may not appreciate this newfound sense of self-worth on behalf of his or her partner and become frustrated and experience feelings of insecurity due to the loss of control and anxiety over the new direction in which the relationship has begun to develop.

Therefore, both partners should learn this technique together. If both partners are not willing to learn this skill together, this may be the very reason that one partner came in for therapy, in the first place, that is, to learn how to speak up and find a voice. I strongly urge the clinician to use a disclaimer prior to beginning of this type of skills training by explaining to the client the benefits and consequences of enhancing his or her sense of self-esteem through this method. Obviously, the long-term benefits certainly outweigh the short-term consequences for the client. Living in passive fear will only hinder striving toward one's greatest potentials, and the loss of a current abusive relationship is hardly a consequence to gaining a skill that will enhance the client's future in all aspects of his or her life.

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Chapter 53

A Transitional Exercise from the Didactic to the Experiential in a Group Therapy Class

Daniel S. Schoenwald

INTRODUCTION

Many mental health graduate programs require classes in group psychotherapy. Like all forms of groups, student groups are unique in their specific set of challenges, mainly as a result of its format. Although variation exists among programs and instructors with respect to design, most group psychotherapy classes, in addition to didactic portions, necessitate that the students conduct process psychotherapy on one another over the course of a semester or longer. Learning group psychotherapy and process must be achieved experientially (Fehr, 2003). This task presents as a challenge for many students, as transitioning from the didactic to the experiential format requires that they engage in new roles. In order to aid in this process, I introduce a particular exercise which is also designed to strengthen the bonds among them, fostering a more emotionally based setting.

A GRADUATE STUDENT POPULATION

The intervention is proposed for mental health graduate students (social work, master's/doctoral in clinical psychology, psychiatry) taking classes in group psychotherapy and process. By definition, these are time-limited groups. However, this particular intervention

can be adapted for use in any format of clinical group, depending upon the needs that the leader views as necessary.

DESCRIPTION OF INTERVENTION

I format my group psychotherapy class to have didactic sessions and chapter presentations during the first half of the semester. These presentations are conducted in a therapeutic circle and are thus, an introduction to the group psychotherapy sessions, which occur during the second half of the semester. This particular intervention, which inviolves students presenting the chapters in the book as their initial experience with learning how to create dialogue in a group, was taught to me by my professor in graduate school. The initial class meeting usually entails a mixture of both anxiety and excitement, and then proceeds for several class meetings with intellectualization as the prominent feature.

With the intention of introducing more emotion to the class environment, I introduce a "special exercise" at the halfway point of the first half of the semester, toward the end of the didactic portion of that particular class. Previous to this point in the semester, on the first day of class, I mention that the 2002 American Psychological Association's ethical guidelines outline that students are not required to disclose personal information about themselves (APA, 2002). A developing sense of cohesion at this point typically allows for the exercise to be effective. The instructions, which are adapted from Irvin Yalom's *Theory and Practice of Group Psychotherapy* (Yalom, 1995, p. 7), are as follows:

Exercise

I begin the exercise with these instructions: "Please take out a blank piece of paper. Without showing anyone, I would like you to write down the one thing about yourself that you would be most disinclined to share with the class. When you are finished, fold your paper in half." Usually one or more students will ask me what I intend to do with the papers or push for an elaboration on the exercise. I respond by simply repeating the instructions. After everyone has indicated that they have completed the task, I collect the papers in an empty coffee can (personal choice).

Naturally, the anxiety level is significantly elevated at this point, as the students anticipate the fate of their comments. After mixing the anonymous folded papers, I walk around the classroom and ask each student to remove one from the can, instructing them not to unfold and read them until I tell them to do so. After each student has received one, I ask them to unfold the papers and not to mention if they have received their own. Following, I ask each student to individually read the written portion of his or her paper aloud to the class.

As each student reads this written portion, I mark each response under an adapted category/theme as initially described by Yalom (1995). These categories are written on a board in front of the class (but not until each one is represented), with each additional response fitting of that category marked by adding a number next to the theme. Yalom (1995, p.) initially stated that invariably, the most frequent "revelations" include "*basic inadequacy, interpersonal alienation,* and *sexual secret.*" In my adaptation, I have termed the themes as: *personal flaw, difficulty with intimacy,* and *sexual concern.* These three themes are indeed the most frequently described. As the initial responses are expressed, I suggest the aforementioned themes that I believe are the most cogent, while requesting input from the students with respect to these categories. I find that most are in agreement with the suggested themes, allowing the students to evaluate subsequent categorizations on their own. When disagreement exists among students to the specific categorization, I allow for a response to be placed under multiple themes. Following a brief period of silence to allow for absorption, I ask the students for their reactions to and feelings about the exercise.

TYPICAL RESPONSES TO THE INTERVENTION

Previous to the exercise, students often ask aloud, "Is this a group, or is this a class?" As the answer is "both," many members experience anxiety as they attempt to bridge the gap in this blurred boundary. Common statements such as, "After all, we have to see each other outside of class, in the halls, and in other classes this semester and in later semesters" reflect their concerns about possible confrontations among their classmates in the group setting. A discussion/debriefing period following the described exercise is imperative, as strong affects (the desired goal) are likely to have been generated. Appropriate

processing of these feelings is necessary. Naturally, different personality structures have different responses to the experience. However, like the themes, a number of typical responses are likely to be expressed.

Many students express feeling relieved. Upon elaboration, they say that their "secret" had always felt shameful or frightening, but hearing it read aloud anonymously by another person seemed to demystify the power. Others acknowledge that the relief is found in knowing that others in the class have similar concerns.

CONCLUSION

The intended goal of the exercise is to allow students to experience their connection to their fellow group members as they transition to the experiential from the didactic. When a significant number of students, who are likely to be of varying ethnicities, genders, and ages, express similar fears about themselves, a bond is created and members feel less alone. As stated by Yalom (1995, p. 7), "this method usually proves to be a valuable demonstration of universality, empathy, and the ability of others to understand."

CONTRAINDICATION

Like most interventions in psychotherapy, timing is an important factor in this exercise. An instructor must rely on intuition to feel that the class trusts him or her as this will be the driving force behind students' ability to trust that the exercise has educational and therapeutic value. As previously noted in the literature, trust is an essential theme in the formative stages of group (Fehr, 2003; Rutan & Stone 1993; Yalom, 1995). If the exercise is pushed upon them too early before trust is developed, they may withdraw from fear of further wounds. Conversely, if the exercise is engaged too late, an overintellectualized norm may be established due to a missed opportunity for interpersonal bonding.

In contrast to privately led therapy groups, instructors of group psychotherapy do not have the luxury of choosing their members. While many students are equipped to succeed academically, some maybe less emotionally fortified and this intervention may represent

a threat to their ego integrity. Properly addressing the APA's guidelines (APA, 2002) regarding student disclosures may aid them in deciding how to proceed with the exercise, as students are no longer required to engage in this practice.

Finally, blurred boundaries in the format of a group psychotherapy class also affect the instructor. As one navigates between the teacher and therapeutic roles, a dual relationship is created, and the instructor must be aware that student reactions to the class and/or to himself or herself can lead to strong countertransferential feelings. Addressing these issues within oneself or with a colleague is recommended when such conditions arise.

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Chapter 54

What and Who Belong in the Group? Managing Early Crises

David Glyn

> Being a respected and effective member of the group, being accepted, being able to share, to participate, belong to the basic constructive experiences in human life. No health is conceivable without this.
>
> (Foulkes & Anthony, 1965)

A GROUP DEVELOPS

The group psychotherapist's interventions reflect her or his assumptions about how a group may best develop a therapeutic process. Often, the therapist's ideas about this are different from those of other group members. Early interventions may be directed toward providing group members with opportunities to discover what sort of group the therapist has in mind.

In the early phases of a group's life, everyone is trying to discover how things work, and will work, around here. Inevitably, for some, this is a period of great anxiety and there will be all sorts of challenges and tests to be negotiated during the formation of a working group culture. Such challenges do not generally declare themselves as such, but the group psychotherapist will recognize that they are occurring because she or he will experience pressure.

One way in which the therapist may notice this pressure is when the belief forms that a particular individual's problems cannot be

managed by the group. Often, it is the therapist's own belief in the capacity of the group to both contain conflict and to maintain a reflective attitude that is being tested. How the therapist then intervenes will have a significant impact on the future course of group development.

A UNIVERSITY SETTING

These particular groups are comprised of young people in a university setting; in other words, adolescent, or postadolescent groups. Many of the group members have presented with difficulties in dealing with social situations, interacting with their peers, and managing intimate relationships. The struggle to reconcile individual needs and impulses, with the longing to belong can be intense and painful. Most members have only taken a few steps away from families of origin and all the feelings relating to family failures and conflicts are fresh and pressing; they suffuse current attempts to establish, and think about, new relationships.

Initially, in these groups, there may be discussion of difficulties at home, in the seminar room, or with a sexual partner. However, before very long the group is likely to find a way to create its own "domestic" crisis.

Example

Around session five of such a group, Ms. A arrives in a manic state; previously depressed, she now reports that she is feeling much better. The reason for this is that she has started to cut herself again. No one else in her life, apart from those of us here in the group, is aware that she harms herself. And she feels great!

Ms. A is wild-eyed and her repeated declaration that she is feeling very, very good, worries the therapist. This feels like a crisis and it is the first that the group has produced, so it is at a sort of crossroads.

Some group members seem to withdraw into themselves; others are ready to respond as though they interpret their task as one of advising and influencing Ms. A. They offer reasons for not cutting herself, strategies for refraining from doing so when the impulse arises, and so on. However, these are not well received by Ms. A, who has become the focus of considerable attention. Indeed, the therapist is

aware that she has repeatedly told the group how wonderfully effective is the self-harming behavior; it makes her feel great.

One by one, the group members give up. At the same time, the therapist feels an increasing sense of anxious responsibility: Ms. A is going to need more help than this group is capable of providing. Perhaps she will have to be referred elsewhere. At the very least the therapist will have to see her individually, in order to try to address her dangerous self-harming behavior. He or she feels angry with Ms. A and afraid that the group will disintegrate.

At moments like this, the therapist's own state of mind may be a good indicator of what issues are being worked out in the group. Generally, when we experience a sense of crisis, it suggests that very basic conflicts and fears are being dramatized; here, it would seem to be the conflict between individual and group needs.

Attention is focused on an individual whose problems seem intractable and "too much" for the group. The therapist feels he or she has made a grave misjudgement and is losing faith in the group's ability to manage Ms. A's disturbance. He or she becomes aware of the attention focused on him/her: everyone else is at a loss, so what can the therapist come up with?

A SIMPLE INTERVENTION

A simple intervention is proposed: a type that a group psychotherapist may make in many different circumstances. Here, its significance lies in its being a response to the perception that everything is combining to encourage attention to the individual in crisis. There are any number of ways of saying it, but the essence of the therapist's contribution is:

> *"I wonder what others in the group are feeling as they listen to what Ms. A has been telling us?"*

There are a number of factors that support this sort of intervention:

- it provides an antidote to the temptation, which the therapist may feel, to try to reassure the group by demonstrating his or her own ability to treat Ms. A–a response that would tend to reinforce doubts about the value of the group;

- it shifts the perspective so as to suggest that, in order to understand Ms. A's communication, there is a need to see it as part of a larger picture; and
- it introduces group members to unfamiliar ways in which their own responses–negative as well as positive, belong in, and form part of, the group's life and so begins to extend the general sense of belonging in the group.

What may emerge, in response to the therapist's enquiry? Initially, group members may respond by returning to the scenes that Ms. A has been describing, renewing their attempts to find ways to correct the perceived problem that she has presented. If this occurs, the therapist may try reiterating the question, in a different form, so as to put emphasis on feelings about the situation in which group members find themselves, *in the group.* The purpose of the intervention is to make available, to the group, as much information as possible about what has been happening, during this session. Expressions of sympathy, helplessness, anxiety, anger, feeling rejected or ignored will all help to build a picture of the scene that is being played out. Some will undoubtedly contain resonances for Ms. A and it is important to find ways to include these.

CONCLUSION

At any moment, the preferred intervention reflects how the therapist understands prevailing group-developmental tasks. When the group is trying to lead us to the individual, we should be most alert to the needs of the group. From the writer's perspective, the individual's problems cannot be made sense of, outside the context in which they manifest themselves. The therapist's efforts are directed toward creating as effective a demonstration as possible of the group's ability to function as a 'working model of the world'.

It is desirable for group members to learn to report supposedly unhelpful and even unsympathetic responses, as well as more obviously helpful ones. In order to understand the meaning of an act or utterance, we need to discover the sorts of responses that it evokes in others. For members of a new group, the fact that "unwanted" feelings can be received as a valuable contribution to the group's work may be a surprising discovery–one that begins to change the terms of

belonging and group membership. Rather than conceiving of the group as a problem-solving instrument, this intervention seeks to foster a sense of the group as somewhere to think about the context in which a problem has its place, within a nexus of relationships. Ms. A may, initially, be dissatisfied with the shift of focus; in particular she may feel angry, or disappointed, believing that the therapist has taken from her that which she is seeking. However, by shifting the focus away from her, we begin to create a situation where she can find other ways to express the feelings involved in her secret acts. Given time, she may come to feel that there is a place for these feelings, in the world, and thereby extend her own sense of belonging.

CONTRAINDICATIONS

During the assessment process, we need to be alert to our own responses: Is this a person with whom you can imagine working, in a group? Do you look forward to it? If you are aware of anxiety or reluctance, what makes you imagine it will be different for others and for whom in particular? One of the great benefits of groups is that they contain more resources than the therapist's alone, but it's neglectful to disregard our own feelings. If in doubt, give the assessment process a bit longer.

However, sometimes we find that we have just got it wrong. We have missed something in an assessment or the disturbance that an individual is bringing into a session; is it too much for others to respond to at that particular time? The group is not ready to take it on or becomes overwhelmed with anxiety. In such cases, the therapist will have to look for ways to preserve the group and to attend to the needs of the individual in a different way.

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Chapter 55

Alchemy and Transformation: The Disturber in Group

Avraham Cohen

EXPOSE THE GOLD

Most every group will have at least one person who is a "disturber," an individual who is pressing and persistent in ways that consistently disrupt the group, the process, and the leader. Such individuals are frequently the catalyst for much hair pulling, sweat, and anxiety for the leader. The tendency to diagnose and look for ways to suppress or remove such group members is very high. The DSM-IV (American Psychiatric Association, 2000) is full of labels that will find a home with these people. When I used to work with seriously disturbed adolescents in a residential treatment setting many years ago, oppositional defiant disorder was a very frequent and popular diagnosis. What this translated into is that the identified teen did not agree with staff on a frequent basis, and that this disagreement took a very disagreeable form. Although we have a whole new set of labels now, I believe we are still up against the same problem. We still have those who are disturbing in the world and in our educational and psychotherapy groups.

The idea that will be identified for this intervention is that the disturber is part of the alchemy of any group and to follow the metaphor a little further, has the potential to transform "base" material into gold. In other words, the disturber carries information that the group needs. The problem is that the signal that indicates the gold is not easily decoded. The individual who disturbs is the one that draws the tendency to shun, exclude, marginalize, and/or diagnose. The inter-

vention that will be described is how to identify the disturber and how to "expose" the gold.

AN EDUCATIONAL OR PSYCHOTHERAPY GROUP

This intervention is responsive to disturbance and perturbation that is initiated in the group by an individual. It has proven to be effective in both educational and psychotherapy groups. This intervention is beneficial for the individual who disturbs. It provides the opportunity to receive personal validation for the message that he or she carries. The disturbers feel included rather than their more usual experience of marginalization, and they gain some experience to convey their thoughts and feelings in a more skillful and effective way. An additional benefit for the whole group is to see the potential within "shadow" material and to learn about the process of transformation.

DESCRIPTION OF INTERVENTION

Example

A student in a counseling class complained consistently and constantly that the class was not "very real." She talked about the fact that everybody was being "too nice." She was so persistent with these comments that it was evident that other students were getting frustrated and not saying anything. They were avoiding her at breaks. I overheard comments and had some comments said to me directly about her being a "problem." One day she again began to talk about how unauthentic everyone was and how could we expect to be role models of real human beings if we were all so fake. She implicated me by saying that real leadership would not allow this phoniness to go on. I watched and saw eyeballs rolling, nervousness, and frustration. I felt that we were at critical mass.

I said to the group:

> I am observing a lot of physical movement in the group. I wonder if anyone would care to put some words to their experience. There is silence. Finally, one student says, "I am really frustrated that we keep

hearing the same complaining over and over." Another student said, "I wish you (looking toward me) would do something. I think there is too much time in this class devoted to people's problems and their feelings.

Inwardly I could feel a little tension mounting in me. Mutiny and rebellion seemed to be in the air. A number of other students spoke along similar lines; each with their own slightly different view of things. I said nothing about what was said. I did encourage students to speak with the odd word and with nonverbal cues. The disturber student finally spoke. She said, "I still don't hear any real honesty." The proverbial pin could have dropped at this point. I wondered if anyone would move to kill her. I turned to her and said, "Thank you for calling things as you see them. I would be very appreciative if you would be so kind as to demonstrate the kind of honesty that you are speaking about. I don't feel that even you are really saying what you really have to say."

Again silence, but this time a little briefer. Her eyes were darting here and there. She spoke again.

I think that people are very mad at me and I also think that there are issues between people in the group. And, I think everybody is being nice to me or avoiding me, being nice to people with whom they are annoyed, and that we are all being fake. I want us to get real. If someone has something to say to me, I would like you to say it.

Now a very pregnant silence. I spoke:

If anyone has something to say, I invite you to say it *and* (this next part is said in a tone that makes clear this is a conjunction and emotional safety reminder, and not an admonition to be silent) I want to remind you of the ground rules. No name calling. Speak for yourself. Speak to the person you are addressing directly. Take responsibility for your thoughts and feelings. If you have something to say to someone, check with him or her whether he or she is willing and able to hear it.

The room was thick with a mixture of anxiety and excitement. Clearly, something real was happening. I will not go into the details but a lot of students had a lot to say and not just to the disturber student. The atmosphere changed from what could be described as "as-if" to "as-it-actually is."

Format for Disturber Inclusion

- An atmosphere and culture is nurtured that encourages genuine openness and honesty.
- So-called problem students or disturbers are encouraged to express their thoughts and feelings rather than remove or suppress them.
- A culture must be established that provides a container within which an "other" person can be himself or herself.
  —This is done by the appropriate and authentic metadimensions (Cohen, 2002), expressions by the group leader along with the content of these expressions that explains that it is immanently acceptable to share in the group unpopular and potentially disturbing views and ideas.
  —The leader's modeling of acceptance is central to creating emotional safety and the culture of inclusion for group members, including the disturber.
- The group leader must watch for and jump on the earliest signs of a disturber, rather than the more common responses, which are to ignore, marginalize, and hope that she or he will not do "that" again.
- Early responses from the group leader send important signals to the group:
  —this group will be different than what most of you have experienced previously
  —safety will be attended to by acknowledging what is usually marginalized
  —individuals will be valued for their contributions, even when that contribution is in an unusual form
  —scapegoating will not be a part of the group, other than as material for the group's work

TYPICAL RESPONSE TO THE INTERVENTION

The initial response to this intervention is surprise and even shock. For a leader who is new to this type of intervention, it is important to work with your own anxieties and feelings about the person who is disturbing and the group as a whole. You do not have to be perfect in

your responses, but it is important to be aware of your experience and be ready to bring into the group as part of the intervention and for modeling purposes. I cannot emphasize too strongly the importance of demonstrating authenticity in our responses.

As the group begins to transform its culture to one of acceptance, curiosity, and interest in the disturbing, unusual, and previously marginalized, a new way of being and possibility appears. Group members report feeling empowered rather than helpless, angry, and victimized by those who are different and difficult for them.

CONTRAINDICATIONS

Most contraindications can be attended to by skillful selection of group members. Selecting out individuals who are extreme in their responses, very fearful, and either unable to demonstrate self-awareness or incapable of making any use of the awareness that they do have will probably not be able to participate meaningfully even with this inclusive and supportive approach.

Occasions may present where it is important to identify disturbing expressions that must be dealt with intrapsychically prior to and sometimes along with the inclusive intervention. The contraindication here is that the skill of attending to all these dynamics simultaneously may be more than the leader is equipped to handle without further training and supervision in the use of this intervention.

CONCLUSION

This intervention depends on the leader's ability to work with a number of experiences simultaneously. Inclusion in this real way of so-called disturbers, promotes and teaches ideas of deep democracy (Cohen, 2004), which have implications beyond the classroom and therapy group. Such learning has a great potential for a *ripple effect* on those who are close to students and clients in the group and to those who are close to those who are affected by the ripple outside the group. The role of the teacher/group leader is central as facilitator and role model.

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Chapter 56

Family Member Association

Carol Scott Drury

THE POLITE AND THE NOT SO POLITE

I have the fortune or misfortune, depending on your perspective, to work with primarily very nice and gracious clients. However, that is not always an enviable position when trying to facilitate a group of highly passive and respectful adults in a psychodynamic psychotherapeutic group. The issues arise on how to encourage them to confront one another with honest feedback; how to ask for honest feedback and expect to get it; how to practice new behaviors like assertiveness or even some of their lifelong *forbidden* emotions like anger; or how to get them to become fully integrated personalities that encompass the polite and the not so polite.

This intervention is a safe way to start that process, especially for clients who are not comfortable with negative or hostile emotions. This will be particularly important as the group moves from the second stage to the third stage in the development of the group. According to Yalom (1995, p. 303) "the group embrace will seem ritualistic unless differentiation and conflict in the group are permitted . . . [and] . . .when all affects can be expressed and constructively worked through . . . does the group become a mature work group . . . ."

CLIENT POPULATION

I work with open-ended process-oriented groups, as well as support groups, and couples groups. I have used this technique in my

open-ended heterogeneous group, closed men's group, open-ended divorce support group, and closed couples group. All my clients are private-practice, self-pay, and fairly high functioning. I believe the technique is simple enough, however, to work with most populations in most types of groups.

GUIDELINES FOR THE INTERVENTION

There are several variations of this intervention, but use your imagination to come up with any number of others:

1. If someone in the group is having an issue with a relative (or coworker) I may ask them if anyone in the group reminds them of that person. I will then ask them if they would like to practice with the group member. We then process what it is about the group member that reminds them of the family member or coworker.
2. Sometimes when it is quiet in the group, I may say, *does anyone in the group remind you of a family member?* We then process what the similarities are, allowing both group members potential insight.
3. Ask members to reconstruct their family of origin with the other group members.
4. As part of a psychodrama exercise, I may ask a group member to select another group member who reminds them of a family member to play the role of the family member and then process the similarities after the psychodrama exercise. This allows both members potential insight.
5. For group members who do not have large immediate or extended families to draw from and may still have difficulty confronting directly I may ask them to relate to characters from history, movies, and literature rather than family members.

TYPICAL RESPONSES

A woman who had a very difficult time with confrontation wanted desperately to tell her critical brother-in-law to stop finding fault with everything she did, but was intimidated. I asked her who in the group

most reminded her of her brother-in-law. She selected the group "grump" and was willing to practice on him, and he agreed, as well. What was interesting was not that she selected him, but the group discussion that followed. It was the first time the group had addressed the grumpiness and negativity of the grumpy member directly. It had always been there, but treated as a cute idiosyncrasy, when, in fact, it was obviously annoying to everyone.

During a quiet time in the group, I asked if there was another member who reminded them of a relative. One woman immediately raised her hand and said "Oh yes," as she pointed to the well-dressed and always in control professional young man sitting across from her. "You remind me of my arrogant uncle," she continued. He appeared to be stunned, as did the rest of the group for this was perhaps the first hint of negativity whispered within the confines of this group. As the group progressed, it became quickly apparent that the young man had no idea that he might be perceived this way, especially when other group members chimed in and supported the initial observation. It was an enormous risk for the first member, a huge step for the group, and it opened the door for further exploration on the young man's part on how his utter sense of control might be perceived by others.

CONCLUSION

I have never used a variation of this technique without a surprising response. I cannot predict exactly what the response will be, but it has never failed to move a member or the group forward – sometimes in small ways and sometimes in big ones. The intervention is easy to apply and could be used in various groups at any phase of the group, but I have found it most powerful in the transition from the second to third phase of the psychodynamic process-oriented group.

CONTRAINDICATION

Like any intervention there is always the possibility that there might be a contraindication. In this particular one, the contraindication would be in the form of an inexperienced clinician. It takes experience to know when to use it and when to just sit and let the group do

its own work, but I do not think this one can be harmful. At worst, it could be overused or it could seem inappropriate or trite if used at the wrong time.

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Chapter 57

Building Self-Esteem Using Assertiveness Training and Props

Sheila Sazant

EQUALITY IN HUMAN RELATIONS

For many individuals, group therapy provides special skills to deal with problems in social situations. Among the difficulties experienced by clients is the inability to ask for acknowledgment of their personal rights and needs. The foundation of this problem may be a resistance to express both positive and negative feelings, a lack of confidence to be direct, and a judgment that their requests are unreasonable and unacceptable to others. Alberti and Emmons (1990) suggest that "Assertive behavior promotes equality in human relationships, enabling us to act in our own interests, and to stand up for ourselves without undue anxiety, to express honest feelings comfortably and to exercise personal rights without denying the rights of others" (p. 7).

The group experience provides for clients a forum for which they can reflect upon others' responses to their words and actions. It creates an opportunity to see themselves through the eyes of their group brethren and allows them to respond to their issues in ways that disclose their feelings and promote more direct responses. As a confidence builder, group therapy provides a safe environment wherein an insecure individual can practice intimidating interactions and learn various perspectives from others in similar situations. Support and reassurance from the group can be very empowering.

As a therapist now dealing with clients reluctant to advocate for their personal rights and feelings, I am reminded and often reflect on

an intervention suggested to me while I was a member in group therapy many years ago.

INTERVENTION: ATTENTION! ATTENTION! NOW HEAR THIS!

Joining a group was both a frightening and stimulating prospect. The group experience exposed me to a cross-section of society, which included professional men and women, married and unmarried, and parents living with and without children.

Among the most salient of challenges was my fear of venturing out of my "comfort zone" to self-actualize in an area outside my homemaking duties and find a job in the workplace. One of the difficulties of achieving and living a more psychologically healthy existence is the resistence of family members who prefer to remain unchanged by a new lifestyle of one of its pivotal members. Comments such as "I have not had a good meal in many weeks!" to "There is no orange juice" were expressed on a regular basis. Success in this arena meant my own acceptance and value of these achievements and my assertion that things have changed and that others in the household were now responsible for their daily living conditions. Being assertive at home and in the workplace required a skill that demanded practice and rehearsal, which the group experience supplied.

Exercise

My therapist suggested that I go around the group and tell each individual how I felt about him or her. The therapist instructed me to address each individual going around the group clockwise. The tendency to analyze, intellectualize, and give details was discouraged. For example, I would look directly at Bob and say, "Bob, I feel very safe and secure with you in group. I feel that I can trust you and value your input." "Cindy, it's difficult for me to take advice from you because you are very punitive and mean spirited." Their responses were not necessarily required, however should they want to respond they could do so after the exercise. Expressing myself released emotions and allowed me to address my discomfort and inhibition at dealing with unpleasant feelings. Avoiding redundancy and being sincere especially with negative feedback toward others was intimidating.

To embolden my position and help reduce the anxiety I felt at having to confront my issues with my family, it was suggested that I carry a megaphone, which was presented to me one night in group. Laughter is sometimes the best stress reliever! Armed with confidence, and a prop, I declared to my family that from now on "they were on their own!" Furthermore, the power of group involvement and support cannot be underestimated. Knowing that one has made a commitment to oneself and to group prevents the shirking of this responsibility. Coming back to group with a successful outcome, or at least a successful attempt at meeting the challenge, is self-affirming—a confidence builder on its own.

THIS CLIENT'S RESPONSE TO THE INTERVENTION

In addition, our group leader consistently encouraged me to confront individuals with whom I had a strong transferences and stimulated interaction between those that had disagreements with me. Gradually I developed the ability to be more fluid in expressing issues and defending myself when challenged.

One's verbal ability is only part of the way in which to demonstrate assertiveness. Alberti and Emmons state that "the manner in which you express an assertive message is a good deal more important than the exact words you use" (p. 27).

CONCLUSION AND CONTRAINDICATIONS

The group's coaching provided support but self-efficacy is more achievable when the accomplishment is internalized and more likely to generalize outside of group. The theory of self-regulated behavior suggested by Bandura (1977), illustrates this: "intrinsic reinforcement that comes from self-evaluation is much more influential than the extrinsic reinforcement dispensed by others" (p. 333.)

Creating new patterns at home was an achievable goal provided consistency was maintained. The group experience provided positive and negative reinforcement when lapses in my behavior occurred. Donigan and Malnati (1987) suggest that assignments outside of the group help reinforce group behaviors, which were learned and practiced within the group.

In relation to contraindications for this exercise there are very few, if any, although it is important that the therapist be acutely aware of the ego strength and developmental stage of the client involved. The salient question posed to the therapist by himself or herself is "Is this client ready to take on this task in an environment where the client is now alone without the support of the group?" If the affirmative is decided, the client becomes aware that the therapist and the group have belief in his or her abilities to succeed with the task at hand, which is in itself a powerful reinforcement.

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Chapter 58

Horseback Riding Workshop for Increasing Self-Awareness

Tal-Li Cohen

THE HORSE AS A POWERFUL THERAPEUTIC MODALITY

Yalom (1985) writes that the major impetus for learning is the therapy group. The structure of the group is a microcosm of the patient's cultural world. Through repeated experiences in the group, group members learn about interpersonal relations. Feedback from the group and observation allows interpersonal relations to reach higher levels. Through this process group members learn repeatedly that part of their former perception of themselves is distorted. Yalom (1985) holds the view that insight and transference have less therapeutic value than the "corrective emotional experience" of the authentic interpersonal reciprocal relations taking place in the group.

In this group supervision workshop, we use the horse as a powerful therapeutic modality. We use the unique characteristics that are experienced in the relation between the rider and the horse. Emotions directly influence the body and the horse senses the rider through the tension of his or her muscles, the posture of the rider, the way the hands hold the reins, and the overall communication the rider has with the horse. The horse interprets these multiple cues immediately and gives immediate feedback to the rider. This immediate response forces the rider to respond within a very short time, measured in seconds, in order to get what he or she wants from the horse. All this produces authentic behavior patterns on the part of the rider, and affects the issues of control, giving trust, and the capability of devotion.

During group work we make use of the sensitivity of the horse and the herd model "as a model for copying and communication by the members of the group who have closed ranks as a 'herd' around mutual aims" (Cohen & Lifshitz, 2005, p. 86). The "herd" elects a leader and acts in accordance with social codes that resemble to a great extent the communications between humans: they obey the leader, tend to play, attach importance to their private domain, communicate with the horses close to them, and when they are not answered they respond with threats and even with violence (Morris, 1991). These characteristics resemble what Bion (1992) wrote regarding human social relations.

The group experience is intensified via the relations between the individuals in the herd. The therapists are the leaders of the group and the herd. Since the horse is an animal that serves as prey it needs the protection of the herd; and it needs a leader as a shield and one who makes decisions for everyone. The individual rider represents for the horse both part of the herd and a personal leader. It expects the rider to lead it and is very dependant on the messages received from the rider.

The link created between the rider and the horse and between members of the group gives us a miniature picture of the interpersonal relations and provides insights into intrapersonal life.

THE PROFESSIONALS AND THE GROUP PARTICIPANTS

The group was directed by a clinical psychologist who is training to be a riding instructor, and aided by two riding instructors. The work was clearly divided between the professionals. The psychologist conducted the group utilizing therapeutic process and also developed the workshop working with horses; the riding instructors provided assistance at the technical level of learning how to ride.

In this particular group there were ten participants with an average age of thirty-five years. All of these participants are professionals in the mental heath profession. The group had been meeting weekly in peer group supervision over a three-year period. The group members wanted to participate in an experiential process that would intensify feelings of self-awareness through horseback riding, and would help in the process of consolidation of the group and building its identity. Some of the participants had experience riding, most did not. The group met eight times, three hours each time.

The Goal of the Self-Awareness Intervention of the Group Supervision Workshop

The goal of the group supervision workshop is to enable group members to identify feelings experienced while riding and how these feelings impact and influence their inter-personal relations.

The group sessions took place at a ranch/riding school. All the horses were well-trained and were used to "working" with beginners. Each meeting was divided into two parts: the riding experience and a processing session utilizing group dynamics and expressive therapeutic tools.

FIRST STAGE: FAMILIARIZATION

This stage involves familiarization with the facilitating environment (the work area) on the ranch, and with the horses. Group members are taught the horse's body language, and how to recognize how/when the horse reacts. Group members are taught the basics of "leading" and riding a horse. The initial direct contact with the horse produces anxiety in members and the fear that they might not succeed in mounting the horse, and that they might lose control. The success of some group members gives encouragement to the others to make the attempt. Some openly express their fears, while others experience this in an indirect manner, such as by asking: "Are you sure that I'm not too heavy for the horse?"

At this stage, a gradual process of familiarization takes place, with the unfolding of patterns of behavior relating to new situations. Group members are self-absorbed and their link with the group is weak. Only at the end of this stage is more attention paid to the group-as-a-whole, probably due to a greater feeling of confidence with the horse.

SECOND STAGE: DEVELOPING AN INTERPERSONAL RELATIONSHIP WITH THE HORSE

At this stage, riding is combined with handling and taking care of the horse. Riding lessons included galloping while standing up and sitting down, as well as maneuvering the horse around obstacles

which demanded more precise handling of the horse. Handling and taking care of the horse included brushing and washing of the horse, and putting on the saddle. The group members also cleaned the stables. Greater emphasis was placed on group work, which involved "rubbing shoulders" with one another and addressing interpersonal situations. At this stage attention was paid to feelings of trust, readiness for devotion, and assertive behavior. Intimacy in the group increased and it appeared that this was facilitated by the decrease in the level of anxiety.

THIRD STAGE: THE MIDDLE PHASE OF GROUP PROCESSES

The riding process entered a "middle phase" in group process, where greater independence developed regarding the treatment of the horse and the interaction between and among the group members. In addition, learning new tasks and skills did not create anxiety regarding the potential responses of the others, and there was greater support among group members, through offering of advice based on experience.

Not always having the same horse enabled group members to experience riding horses with different personality characteristics. This enabled group members to have additional emotional and experiential experiences.

This stage was characterized by deeper personal and intimate interactions. Parallel to the confidence felt with the horses, group members also felt more comfortable toward one another, thus permitting greater risk taking with the possibility of helping one another.

An example of this was the sharing by one of the group members that she was suffering from cancer. This occurred shortly after the beginning of the technical aspects of the group. The issue arose around the strong somatic feelings she experienced during her "meeting" with the body of the horse. She felt her body responding strongly, which was in total contrast to her not experiencing her body during the initial course of her illness. The group was surprised by this new information, but was able to provide support, containment, and understanding.

FOURTH STAGE: TERMINATION

This stage was the preparation for termination. The group planned (decision making) a field trip in order to provide a proper finish to the riding experience, which would permit them to reflect on the group process in both the fields of riding and of inter- and intra personal relationships.

PARTICIPANT RESPONSES TO THE INTERVENTION

Some group members terminated by announcing that they intended to continue to take riding lessons. Others found difficulty in ending the process. One person said that she could not participate in the final meeting on the pretext of family commitments. However, after clarification and understanding of her difficulties, she did come to the final meeting.

Working with the horses enabled the group to relate to deep emotional issues that came out of the interface between body and soul. The group process developed from the stage of familiarization, through that of intimacy, to that of terminating. During the course of the group work the group members underwent personal experiences and learned about patterns of interpersonal systems, and also addressed intrapersonal issues.

CONCLUSION AND CONTRAINDICATIONS

The horse is an animal that is sensitive to others, and is a herd animal. These two elements were successfully utilized during work on the intensification of self-awareness regarding intrapersonal experiences that influence interpersonal relations. This method of working is suitable for all group process activities, with teenagers and with adults who are not necessarily professional therapists, but who wish to increase their personal awareness.

This type of group experience is contraindicated for participants who have severe psychological disturbances, as working with and around animals of this size requires a certain degree of awareness and the ability to communicate effectively both on a verbal and nonverbal level.

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Chapter 59

Leaving the Room for the Sake of Connecting

Uri Amit

ALONE IN A PHYSICAL WORLD

Group therapy affords participants the opportunities to end a protracted process of believing that one is all alone in his or her physical world (Fehr, 1999, 2003). Connecting, among the believers, of being "the strangest" is a mean proposed by Ormont (1992).

SEX OFFENDER CLIENT POPULATION

This particular intervention is appropriate for groups of sex offenders who (1) do not display psychotic processes, (2) are preoccupied with atypical sexual fantasies, and (3) have been working together for at least one year with the same therapist(s) in an inpatient treatment facility.

DESCRIPTION OF INTERVENTION

Case Example

Wy is a Caucasian, six feet, two inches, 240 lbs. man who was in a group of ten men that I and Dr. E inherited from two other therapists. For nearly two years, Wy has been mostly a silent group participant occupying the seat by the room's door. Despite his silence and expressed disinterest in a process that, according to him, was conducted by two of the state's "hired guns" (Dr. E

and myself), I never ceased asking him for his thoughts and feelings about the material presented by others. A common reply to my urgings was that he is repulsed by people and prefers the company of small animals. To add oomph to his common reply, he mentioned on numerous occasions that he tends to entertain fantasies of physically torturing people who affronted him and thoughts of sexually tormenting women. In fact, his offenses include extreme sexual sadism, and one of his fantasies included (and perhaps still includes) penetrating a woman with a mammoth dildo attached to a "f—k machine" turned on to its highest speed. The group respectively was leery and yet interested in Wy. The wish to "get into your [Wy's] head" was voiced by a few of the men on various occasions. He has also been viewed by them as a "weirdo."

On several occasions, Wy labeled me as a "weird doctor" and received support for the diagnosis from a few other members. On one such occasion and after having him in group for nearly two years, I asked the group if there are other "weirdoes" in addition to Wy and myself. Zi, a six foot, 200 lb. African-American man with a history of three rapes and a pervasive "I don't give a f—k" attitude announced that "I am like Wy. I don't trust people. I don't trust mental health."

THE INTERVENTION

- I asked Zi to contact Wy directly rather than talk to me about him. Silence befell the room when Zi told Wy that, "I am also a weirdo."
- After a few minutes of silence, I informed Wy and Zi that, "us voyeurs would leave the room for few minutes so as not to disturb your date." I immediately added "a straight date" once I realized the stares I received from some of the heterosexual men.
- I got up and left the room with the rest of the group following me.
- About five minutes later, I knocked on the door and announced the group's return.
- Once inside, I proceeded to tell the group Hans Christian Andersen's tale of *The Ugly Duckling* and concluded, saying: "enjoy the beauty of your shared ugliness."

RESPONSE TO THE INTERVENTION

I have acted twice in the manner described, once as recent as in early January, 2007 and once in the early 1980s in a different institu-

tion for a similar population. In both cases I left people with no option but to speak with each other and find a common ground for connection. The common ground has evolved from expressing mistrust in the therapeutic process to talking about the offense committed and engaging in the examination of psychological expressions inherited in the offending. As was evident over time, a dialogue of two expanded to include others. At present, group time has been used for "floor taking" by members to speak to the crimes committed and achieve cogent understanding of the forces that compelled them to sexually aggress against others.

CONCLUSION AND CONTRAINDICATION

It is strongly suggested, especially with this particular population, that having knowledge of clinical theories is necessary but not sufficient to working with a population displaying severe developmental arrests. The natural flow of humor, the readiness to act clinically albeit uncommonly, yet ethically, and the tenacity to connect and reflect compassion of ten elicits respects from this particular population. Due to this respect these individual are willing to try out recommendations made by the therapist.

In relation to contraindications with this particular population, a group therapist must be able to free herself or himself from judgment and outrage at the acts committed by these individuals, and suspend personal moral issues. One must feel comfortable with her or his own oddities, trust her or his intuition and, above all, see the "good in the bad."

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Chapter 60

Poetry As a Projective Technique and Springboard for Dialogue in Group Therapy

Scott Simon Fehr

". . . And that has made all the difference"

(Frost, 1969)

THE LANGUAGE OF EMOTION

The language of emotion is often manifested in the words of poetry. It can be a natural resource for healing and, historically, its medicinal properties have been effectively used in every country and every language (Leedy, 1973). Poetry can be both a stimulus for eliciting emotion in one's group, which furthers dialogue, and a projective technique helping the group leader further understand, perhaps, the unspoken meaningful historical events in a client's life (Fehr, 1999, 2003). This intervention is especially effective for the novice group leader, the seasoned clinician who wishes to include group therapy into his or her practice and is anxious with initially promoting dialogue with group members, and the seasoned clinician who desires further and varied interventions in his or her work.

PROCESS ORIENTED GROUPS

This intervention can be used with almost any type of group that is deemed process oriented. It too could be effectively used with groups where the intent is to demonstrate individual differences in order to reduce judgment and increase sensitivity. It does not matter if it is time limited or long term. The only two requirements are the person has to have the ability to read and the ability to have a certain potential to be introspective; its success is, in great part, dependent on the client having a subjective experience with the stimulus of the poem. It is not recommended for concrete-thinking clients or clients who have very loose associations.

GUIDELINES FOR INTERVENTION

Materials

The materials for this intervention are quite simple. You will need to hand out pencils with erasers and a print out of the poem for each group member. If your groups are not around a table on which the clients can write you will need to give them a clipboard.

Selection of Poem

The selection of the poem that is to be used is of paramount importance. If the poem is to be effective, only one person truly will understand what it means and that is the author who wrote it. All other interpretations of the poem are projections on the part of the readers and in this case the clients. It must be an open-ended poem that does not lead the clients to a logical conclusion. In this case, a logical conclusion means that after reading the poem all the readers will relate similar themes or conclusions. An open-ended poem means that each person will relate entirely different scenarios including feelings and thoughts to the poem stimulus. Correlating the poem to classical music is of help to understanding the concept of open-ended. In classical music the listener is without boundaries to follow his or her own thoughts and feelings while listening to the music. In fact, the music is the stimulus to the inner world of the person listening and in group therapy the poem will be the stimulus for the inner world of the client

as observed in the projections. An example of an open-ended poem is provided as follows. You may use this poem if you so choose. I have found it to elicit incredibly diverse and interesting responses.

What is it that I feel?
Is it new, is it real?
Has it been with me before?
Is it here to teach me more?
What is it, it has a name?
Inside of me, I'm not the same?

Scott Fehr

INSTRUCTIONS FOR ADMINISTRATION AND DIALOGUE

Step 1: Handing Out Materials and Explanation

First and foremost it must be explained to the clients that this is not a test of intelligence nor is there any right or wrong answer to what is being requested of them.

Step 2: Actual Task

Ask them to read the poem, to themselves, and to write under the poem what they feel the author is feeling. After that ask them to write a title for the poem and also ask them to write whether they felt the author was male or female.

Step 3: Disclosure of Written Information

When all group members are finished writing ask them to individually disclose to the group what they had written. I think you will be quite surprised at the many varied responses.

Step 4: Initiating Dialogue Within the Group

After everyone has finished disclosing their information, you as the group leader can do further inquiry into the responses of the cli-

ents and, depending on your creative ability, can encourage dialogue within the group about each of the group members' contributions.

Step 5: Discussion of Individual Differences

It is here that the group therapist can explore the meaning of individual differences between people with exploration into the rainbow of responses from the poem. This can lead into a discussion of how dreary and dull the world would be if everyone was identical and predictable and these individual differences, in others, are not to be feared but rather embraced as they enhances one's life and relationship with the world.

CLIENT RESPONSES

Due to the fact that the clients often perceive this intervention as safe, they are usually quite receptive to taking on the task. Most have found the exercise to be interesting and enjoyable as they had the opportunity to learn about the other members of the group and about themselves. It is not uncommon, for me, to see in the following week's group clients bringing up information not only about themselves but also about the other group members, which obviously they have thought about during the week.

CONTRAINDICATIONS

I have never found there to be any contraindications to this exercise with the clients. The only possible contraindication that might occur, could be found in the group leader and that contraindication would be that the group leader did not do anything therapeutic with the information projected onto the poem. Usually a wealth of information can be found in these projections. It needs to be explored in future groups when the group itself has become comfortable as a viable unit and the members' fear of rejection or being judged has been reduced due to their comfort level, with one another in their individual differences.

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Chapter 61

A Symbolic Meaning of Money in Group Therapy

Gregorio Armañanzas Ros

THE MEANING OF MONEY

Money in group therapy has a lot of connotations and evocations (Fehr, 2003; Gans, 1992; Motherwell, 2002). This chapter will explore the symbolism of money in private practice groups.

A Dual Perception

The Therapist's Perception of Money

Therapists are people too. We need to earn money to pay for things, to be compensated for our efforts, our time, our investment, as a symbol of recognition, etc. In this cluster of needs can be included the need from the therapist to have clear compensation for his or her work and dedication. The fees established must be enough for the therapist not to feel a personal demand for gratitude or to place on the patient an emotional debt which must be paid for the therapist's efforts.

The Patient's Perception of Money

Money is a symbolic subject in which the patient gives to the therapist many messages within the therapeutic space: resistance to work, aggressiveness, call to attention about the implication of the therapist, need to be fed without feeding, testing the dependence of the therapist, (not paying, delaying the pay, or paying less in a mistake); feel-

ing of debt not resolved, excessive submission (deciding to pay in advance, paying more in a mistake); acknowledgement, gratitude, freedom from the debt, etc.

Because of these two very different perceptual sets, it is necessary for the therapist to have clarity of differences between both areas of money when he or she speaks or thinks about money and its relationship in therapy. We must have this clarity in mind when and if we are speaking about money. Is the money related to perception 1 or is the money related to perception 2?

It would not be uncommon for there to be an overlap for some interventions, which could engulf both areas, for example, the therapist's approach to confronting the patient's lack of payment. Due to this possibility, it is of the utmost importance that the therapist have the aforementioned clarity to separate the two perceptions in order for him or her to work effectively when this topic is approached with the patient. Specifically, if the therapist has a strong need for money, he or she will confound the therapeutic dialogue with greater personal needs than professional inquiry.

PATIENT POPULATION: WHO IS RESPONSIBLE FOR THE BILL?

Initially, it is obvious that the discussion of money would be in relation to who is going to be responsible for the services rendered. If it is in the case of a minor, the discussion would be with the parents or guardian of the child but in this chapter the concept of money is related to adults, specifically who are in group therapy. For a discussion of money to occur, the patients appropriate for this type of group therapy would be intellectually cognizant of actions and reactions and have the ability to understand abstract concepts.

THE INTERVENTION

I always make an arrangement with patients in group therapy about how to pay for services rendered. In this agreement I ask for payment to be made directly to me. I discourage payment being made to my secretary, by bank transfer or credit card, nor will I accept a check. The reasons I approach this form of payment are as follows:

1. We can clearly explore the therapeutic relationship without external, intervening variables such as, "I did not know my bank did not transfer the funds." We can explore the patient's attitude to the actual therapy, which ultimately will bring to light his or her relationship with both the therapist and the group.

2. By paying directly to me, both of us can see the money that comes between the patient/group and myself. This is a part of the relationship that must be present. It constitutes a key element of the work in private practice. It is important also in public practice, but in that environment there is more which is concealed. If, for example, the payment is made by a bank, or indirectly as in public practice, the fantasy of gratuitousness can grow in both therapist and patient with negative consequences in therapy.

3. We can manage easily all the events around the money because it happens between group/individual and the therapist, without other people in between.

It is necessary to establish a clear contract with the patients about the conditions of payment in order to know the limits and not confuse our need for money with the perception of money of the patient, which can be the manifestation of a symptom.

Case Example: The Context of an Experience

A new group was started in private practice. The group was comprised of four women of middle age, and me. All of them had previous experience with me in individual therapy. It was determined that we would work in group once a week for an hour and a half. The techniques used would be group analysis and psychodrama. The minimum therapy commitment to the group was a year. After this, people could end the commitment with a month's notice of termination. It was a "slow open" group: more people could also integrate the group at any time.

I previously informed the group members individually and during the first session about the amount of the payment. I decided to establish a payment based on a fixed amount for each person and session. I doubted whether I could establish a fixed amount per session no matter how many people would be in the group. I felt this kind of contract could increase the feeling of belonging to the group, but that it would put a lot of responsibility on the members if one of them stopped the experience. Also, the incorporation of a new member and the size of the group could be strongly conditioned by the money/fee. I choose for myself the economical consequences by the size of the group and place the payment responsibility on the individual patient thus liberating the patients of the burden of being responsible for the group as a whole.

The Actual Group Experience

During the first sessions I asked the group about how they would like to pay, when to pay, and if the group as a whole would assume the responsibility of paying the total amount or if each one would be individually responsible for her bill. Three of the four members answered clearly that they would like to pay at the last session in each month and that each one will take the responsibility of paying her amount. The fourth member did not assume a clear position. In the last session, of this month, one of the members did not bring her part of the money. One patient brought her money in an envelope with her name but added to her part the money previously owed for an individual session. Others put the money envelopes on the table, in front of the group, without their names.

Therapeutic Concerns

I was concerned with this contract: should I discuss the payment of the monthly group to each individual separately, or discuss the payment to the group as a whole? I needed a clear system in which I could confront clearly in the group the mistakes, delays, etc. I do not like to make particular communications, out of the group session, by confronting a mistake in payment. This would mean taking out of the group, information that is pertinent to the group as a whole. I too felt that individual dialogue with a group member could possibly give individual relevance and I did not want to reinforce that type of intervention.

My need, after the first month's payment of the group, was to confront a nonpayment situation in order to achieve the two aforementioned perceptual needs.

- First: my right but also my obligation to claim the money in the established contract.
- Second: the lack of implementation, of the contract, in the group and its meaning.

Implementing a Direct Intervention

In the next group session I put the money on the table that was given to me in the previous session. I disclosed that this was not the

money that the group owed, because, in this type of intervention, my "patient" was actually the group as a whole and monies were still due to me. I too related that only monies for the actual group would be accepted and monies for individual psychotherapy would not be accepted at the same time.

Patients' Responses to Direct Confrontation in This Intervention

The group felt moved and reacted aggressively, saying that I made just as much as I had wished. The member that had not paid the previous session brought her money and placed it on the table. One of the members stood up and added further monies, which she put in an envelope. This movement split the group between submission (to order and put all the money in an envelope) and rebellion (rejection of this movement). These responses are actually the ones we wish to occur. It is through these defensive reactions that we as therapists come to understand many underlying components in our patients' personalities and certainly their relationship not only to money but to personal responsibilities.

CONCLUSION AND CONTRAINDICATIONS

It is highly suggested that in private practice a clear contract concerning payment for services rendered is established including details about how to pay. In order to do this, the therapist must consider all the different situations and how, if problems emerge, could they be resolved considering the two perceptions of money. If there is a breach of contract, the therapist must:

- Confront in the group all the deviations from the contract and encourage the group as a whole to investigate its meaning.
- Make the money physically present in the group, which gives it a sense of reality. A difficulty could arise in this particular process if the payment is sent indirectly through a public health service, insurance, or another agency. The money then becomes a ghost. In order to be able to work therapeutically with the ghost in a group therapy situation it is suggested that:

—This invisible payer is made visible by reference to its existence in order to avoid future problems. Refer to it and make it become a conscious entity and a topic for discussion.

Another situation is when the therapist does not receive payment for his or her services and the therapist is working pro bono. In this case, it is suggested that the therapist seek some kind of payment by the group in order for the group members not to feel indebted, which could ultimately alter the way they relate to the therapist and the other group members. This payment would have to be discussed with the group as a whole and a decision would need to be reach which then would become part of the group contract.

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Chapter 62

Visualizing Connections and Disconnections: A Social Diagram of the Group

Carol Lark

> People nowadays will disclose their sexual fantasies more readily than they will discuss how they feel about each other in terms of preference.
>
> (Gershoni, 2003, p. 110)

THE MOTIVATIONAL FABRIC

"Where do I fit in? How do I find a safe place for myself within or outside this (or any) group and what does it cost me to stay there?" These very human questions form part of the motivational fabric of any group. The answers are complex, weaving together earlier relational experiences, current social concerns, and the present moment of group life. Staying in the moment of group encounter long enough to examine these questions can be difficult, however, requiring the ability to be both aware of one's feelings and willing to explicate those feelings.

The following exercise is a helpful tool for groups that are either too stimulated by interpersonal encounters to maintain an optimal self-observational level, or too avoidant to be able to identify their interpersonal connections and disconnections. It is based on sociometry, which is the study of the valences within a group and exam-

ines the questions, "To whom am I drawn and from whom am I moving away? Who is drawn to me and who is moving away from me? Under what circumstances do these movements take place?"

THE GROUP

This intervention can be used with almost any type of group in which the group members would like to learn about themselves as relational beings. The theoretical orientation of the group leader can range from process-oriented to psychoeducational, but the leader and the group must be open to examining the interpersonal encounters within the group. It is best used within a relatively stable group frame where group members have made a commitment to continue in the group. (See "Contraindications.")

GUIDELINES FOR INTERVENTION

Materials

Materials for this exercise include: pencils with erasers and two sheets of paper per person; a larger sheet of paper (18" × 24" if possible, or a sheet from a flip pad) for the group; a clipboard or something else for each participant to write on if a table is not available; and a box of markers or crayons sufficient that each person will have a unique color for himself or herself.

Methodology

The use of a sociometric technique can evoke a mixture of excitement and some anxiety in the group. The strategy makes the more or less covert relationships, desires for connection and the disconnections in the group visible. This exerts pressure on each member to make clear statements about his or her position(s) in the group, and to listen attentively to the statements of the others. It challenges the members to accept both connections and rejections. It is important for the group leader to have a clear set of boundaries, especially regarding desires to rescue or gloss over difficult moments in the process. It is important that the group leader remind the group that these are fluid

choices influenced by many factors in the moment in the group, and that these positions can help the members to reflect on their habitual and habituated positions in their personal lives, their family of origin, current intimate and social relationships, and at work.

Instructions for the Task

Step 1: Preparing the Group

Explain to the group that you will help the group figure out "each member's relationship to the others in the group." Each member will create a personal *sociogram* (Blatner & Blatner, 1988; Hale, 1985) of the group. This is a diagram of the relationships within the group as each member experiences them personally. It is important that they be as honest as possible.

Step 2: Directions for Phase One

Pass out the pencils and smaller papers. Tell the group members that the edges of the paper are the boundaries of the group, and that they should write their name somewhere inside that boundary where they feel themselves to be in the group as a whole. They should then write the names of each of the other group members, including the leader, placing each name in a position on the paper in relationship to the other group members including the member whose sociogram it is.

Finally, similar to creating a genogram, they should draw a double line *toward* those with whom they feel very connected, a dotted line to those from whom they feel distance or disconnection, and a jagged line to those with whom they feel conflict or uneasiness. These lines should end with a directional arrow toward the other. Explain that this must be done as honestly as possible in order to get the most information from the experience.

They should create similar lines *from* the names of the other toward themselves with a directional arrow at the end. Explain that some of these lines may feel one-directional to them. That is, they may feel warmly *toward* another group member but experience less warmness or even conflict *from* that member. Some of their lines may end with a directional arrow both toward the other and from the other. These are the natural valences, or lines of energy within the group as each member perceives them.

Step 3: Directions for the Phase Two

When all group members are finished with their personal sociograms, put the larger piece of paper in the center of the room. Invite them to place their own names on the paper where they experience themselves to be in the group. They should use their personal color (crayon or marker) for this part of the task.

Next the group leader asks each member to draw a line, using his or her color, toward the group member(s) they feel a sense of closeness to, then jagged or broken lines toward the group member(s) toward whom they feel conflict or disconnection. At this point, the group composite sociogram will become a colorful representation of the group's perception of itself.

Phase Two usually increases the anxiety in the group. This is when members declare themselves very visibly, and there may not be congruence between what they expected and what is actually depicted on the larger group-constructed sociogram.

Step 4: Processing the Work

Where there are lines of closeness, conflict, or disconnection on the group composite, the leader should invite the members to describe their positions relative to the other, and assist them to encounter one another and clarify meaning and relationship. It will be tempting to "solve" the attractions and avoidances or conflicts, however, it is very important simply to let them be seen and stated. There may be a sense of relief or affirmation in knowing clearly where one stands relative to the others.

As in a family genogram, the leader may want to help the participants notice and articulate dynamics such as triangulated relationships, dyadic relationships, and isolates in the group. These dynamic tensions can be viewed as replicating to some degree the family-of-origin dynamics.

It is rare that a group will have a "perfect" sociogram; i.e., one in which all the connections and disconnections have been accurately depicted by every group member. The complexity of the group sociogram and the reactions of the group members to it will be good "grist for the mill" for some time to come.

THE CLIENTS RESPOND

This is a highly stimulating exercise that can evoke high levels of feeling, especially feelings of being exposed and vulnerable. The format helps to contain these feelings, and to anchor the experience of being in the group in a concrete way. Usually clients have felt relieved to be able to "confess" their sociometric experiences. They also discover that interpersonal relationships can be fluid and open to change once the underlying dynamics and tensions are exposed and worked through, offering hope to the group members.

The Phase Two task and subsequent processing can be too explicit for some groups and/or group members to tolerate. The group leader should be prepared to discuss the dynamics of direct encounter in general and what holds the group back from explicating their relationships, rather than proceed with Step Two and/or processing of Step Two if the anxiety has become too great. Step One may be all the group can tolerate in the moment. (See additional contraindications.)

CONTRAINDICATIONS

Sociometric strategies such as this one can be way too explicit in early-formation stages of a group and/or in a group with vulnerable, traumatized, or very frightened group members. In order for this strategy to be effective, the group must have some level of trust in the leader's capacity to hold conflict and in their own abilities to hold strong feelings while also processing sometimes difficult feedback.

The group must also have the opportunity to continue processing in subsequent group meetings. Unless this technique is heavily modulated with didactic information, such as in a training workshop, it should not be used in groups that meet only a few times, as it takes time for the impact of the exercise to be metabolized by the participants.

Finally, this is a task that can have adverse effects on *work* groups if there is little or no follow-up or sustainable process for working through the relational tensions that are revealed in the sociograms and/or insufficient sociometric criteria have been included (meaning that the personal preferences of the group members have not been identified for the group's work task, such as "who would you most trust to fly with on a dangerous mission," etc.).

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Chapter 63

Unexpected Consequences: Maintaining the Boundaries in a Therapy Group for Older Adults

George Max Saiger

OUTSIDE CONTACT IN A GERIATRIC PSYCHIATRY GROUP

Psychotherapy groups for older adults present the therapist with a dilemma—more exactly, with a contradiction. Older adults often suffer from social isolation; often they are attracted to group therapy because this is a modality, which relieves isolation (MacLennan, Saul & Weiner, 1988; Saiger, 2001; Leszcz, 1977). Juxtaposed against this reality is the position that group therapy is best conducted when the boundaries are firm; i.e., outside socialization is discouraged if not banned outright. There is good reason for this, even with older adult groups: outside contact allows for acting out rather than talking, partial resolution of issues that are then not brought back into group, and establishing subgroups that are shielded from therapeutic inquiry (Fehr, 2003; Rutan & Stone, 2001).

MEMBERS MUST BE OVER SIXTY-FIVE YEARS OF AGE

For about a decade, I have conducted on open-ended, personal-growth-oriented therapy group for seniors using an interpersonal model. Members must be over sixty-five years of age; in practice, almost all members have been seventy to eighty-five years old. The group meets weekly in my office. For some members, I am also the

treating psychiatrist, providing medication and/or individual psychotherapy. Others are treated by outside providers with whom I stay in open contact. Most members remain for about two to three years. Inclusion criteria include that no two members have an outside relationship, and members are cautioned not to establish outside relationships with each other after joining the group.

The group continually wonders about, and challenges, "Dr. Saiger's rule" that there is to be no outside contact. There are often extended conversations in the parking lot after group, which the members will refer to in the group—sometimes with good-natured ribbing and sometimes with an air of serious challenge to my authority. To my knowledge, there have not been social or sexual assignations taking place at remote locations or at other times.

CASE HISTORY

As often happens in groups for seniors, one of the members, Ms. A., was absent for two weeks due to surgery, in her case for cataracts. The surgery did not go well, and for some weeks thereafter, she was unable to drive. She could not reasonably afford cab fare to and from sessions (her fees are paid by state medical assistance) nor did she have available family. The group members frequently asked about her medical progress, and they grew uncomfortable with her extended absence. Why, they asked, could we not bend "Dr. Saiger's rule" this once and allow Ms. B., who lived near Ms. A., to drive her to and from group? Ms. B. promised not to discuss anything of importance during these rides. It seemed like a reasonable request to me, though I was distinctly uncomfortable with this weakening of agreed-upon boundaries. I consulted colleagues, including Ms. A.'s individual therapist, who was unequivocally in favor of the enterprise. Finally, still harboring qualms, I acquiesced. The group members were unanimous that this was the right decision.

At the next group meeting, the group members were pleased indeed to see Ms. A. again. Ms. C. hugged her warmly and enthusiastically. Ms. A. had brought a handmade quilt as a gift for her driver, and Ms. B. insisted that the gift be presented in the group, not in the car. It was, however, not mentioned nor did I notice the hand-off of the shopping bag containing it.

The group had other matters to discuss, of course. Foremost was that a new member, Ms. D., had made her debut. She introduced herself by complaining about the neglect she felt from the daughter she had moved here to be near. Her story prompted Ms. A. to talk about the neglect and disdain she had experienced earlier in her life from her own husband and mother when she had suffered a miscarriage. This represented a deeper sharing than she had done at any time prior to her absence.

At the next group, Ms. C. reported that, although this group is the social highlight of her week, the one place where she feels a sense of belonging

and acceptance, she had left the previous week feeling alone and excluded. She had responded by phoning Ms. B., hoping for some reassurance! I had no idea that the two had ever exchanged numbers.

Ms. B. was not at home; when she heard the phone message she thought that the best thing to do would be to meet Ms. C. for lunch and shopping, but, remembering "Dr. Saiger's rule," she did not call back.

Ms. C. was still upset as she recounted this tale. It seemed to me most likely that the "special" relationship between Ms. A. and Ms. B. which was created by the ride-sharing experience led Ms. C. to feel excluded. I still think that this is true. Ms. C. thought otherwise. She recalled Ms. A.'s story of her miscarriage, and reported, with great emotion, how she had experienced the same constellation when she was a young, frightened, inexperienced bride. Those feelings of aloneness had been reawakened in the here and now.

The group ended with Mr. E. commenting that the whole issue of outside contact was so unimportant that we should not be wasting time on it. Then Ms. D. asked if she could use my phone to call a cab. Ms. B. and Ms. C. quickly said, "Leave Dr. Saiger out of this. He doesn't need to know how we get you home!" And they bustled her out the door. Their sense of proud autonomy was palpable but the group boundary may have been weakened beyond repair.

CONCLUSION AND CONTRAINDICATION

Groups for older adults present a dilemma with no easy answers when it comes to the issue of outside socializing. In the case presented, there were clear benefits and equally clear costs to the intervention made. The therapist should not undertake it lightly, stopping to evaluate the group dynamic and the psychodynamics of the principles. But at some point, one must act. When one does, one must be ready for unexpected consequences.

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Chapter 64

Shape: A Kinesthetic Approach to Building Healthy Boundaries

Danielle L. Fraenkel

A RELATIONSHIP TO ONE'S BODY

The question of boundaries comes up in many group therapy situations from territorial disputes regarding conversations outside of group, subsystems within the group, and personal space, to ethics, identity development, and the interpersonal challenges precipitated by the vicissitudes of group processes (Agazarian & Peters, 1981; Fehr, 2003; Gans & Counselman, 1999; Minuchin & Fischman, 1961; Ryder & Bartle, 1991; Scott, 1993).

The common understanding of boundaries are as limits or borders. How interactions between and among group members evolve depends on both the strength and the flexibility of each group member's boundaries. Shape, one of the main movement parameters in the LivingDance~LivingMusic approach to group work, provides a kinesthetic sense of the body boundary that lays the foundation for many kinds of sharing—from confrontation to divulging painful or intimate realities (Fraenkel, 2003; Fraenkel & Mehr, 2004). Group psychotherapists who recognize that changes in the relationship to one's body affect changes in one's relationship to self and others, will find attention to shape in two dimensions: the horizontal and the vertical; it can have a profound effect on both individual and group processes.

UNLIMITED PATIENT POPULATION PROFILES

I developed this exercise more than twenty years ago while working with men and women who were struggling with eating disorders—anorexia, bulimia, and compulsive overeating (Franks & Fraenkel, 1991). With time, I learned that attending to shape benefited nearly all people—including children, adolescents, and adults faced with the challenges of severe mental illnesses, to normal neurotic individuals seeking to self-actualize. For a particular group I adapt the basic instructions provided to meet the developmental, cognitive, and emotional needs of group members.

A KINESTHETIC INTERVENTION

A Step by Step Approach to Sensing Your Shape (2-D)

Step 1: Use touch to heighten awareness and prepare for kinesthetic sensing.

To prepare for the exercise, center yourself with a simple calming exercise of your choice. Put your nondominant hand on a flat surface. Trace your hand with the index finger of your dominant hand, starting at the wrist on the little finger side of the hand. Concentrate on the skin, your physical boundary, your first line of defense. If you prefer, you can start by using a crayon to outline your hand.

Hold your hand in front of you. Looking at the back of your hand, use your imagination or mind's eye to outline the hand. Be aware of your wrist, fingertips, and the places where your fingers attach to the palm of your hand.

Look straight ahead and away from your hand, and visualize the complete outline of your hand. Be sure to look straight ahead and not to follow the outlining process with your mind's eye. Just sense the outline.

Move your hand in any direction or make figures in the air still looking straight ahead. When finished, note how your nondominant hand feels compared to that of your dominant hand.

Follow the same process with your dominant hand (Steps 1-6).

Step 2: Involve more of your body.

Outline other parts. (The rate at which you do so depends on client needs, group processes, and time.)

Step 3: Sense the whole shape: Make use of the horizontal and vertical planes' links to trust, autonomy, identity development, and boundaries.

The ultimate goal of this technique is to be able to sense your body as a unified whole. When that happens, your attention will be equally distributed around your body. If you focus only on the moving part, your attention will collect in one spot. You will lose the sense of wholeness that comes with the sense of your shape.

Outline the silhouette of your entire body with touch. Using your hand, start at the top of your head and trace the outline down one side and up the other. Were you a stuffed doll, it would be your seam. *Note: Clients who are uncomfortable with self-touch can use a feather, paintbrush, or equivalent.*

Use your mind's eye to sense your shape, e.g., imagine tracing your shape with a laser beam, crayon, etc.

Move one body part without watching the movement to see if you can stay aware of your seam, holding onto the sense of your whole self. Using your hand as an imaginary needle, touch the spots where you lose your awareness to "sew up the holes" in your seam.

Move more than one body part. Notice once again where you need to sew up your seam. The task is not to seek perfection, but to identify your vulnerable spots, the holes in your seam. Once you know where they are, you can focus on them, or touch them, to claim or retrieve your shape.

Step 4: Play with the sense of your shape (make, merge, and reclaim your shape).

Identify the feelings that emerge as you move in and out of your shape. Notice what happens to you, your role in the group, and the group as a whole when you have the sense of your shape. Share your experiences with others in the group.

CLIENTS' RESPONSES TO THE INTERVENTION

Case Example

Conversations between people in group change once people understand the concept of shape. Paula and Rita belong to an open group that meets for six hours once a month. It does not have rules about socializing outside of this monthly meeting. After an intensely intimate interaction with Rita in group, Paula could not contain herself. She wanted to pursue the relationship and phoned Rita asking if they could get together. Rita turned her down. When Paula and Rita talked about their interaction at the next meeting, each woman referred to her shape. Paula said she had her shape when she called, and did not fall apart, even though she was disappointed when Rita turned down her invitation. Rita said that being in her shape had helped her say no. The group was thrilled. Everyone knew that Rita believed that hurting anyone's feelings was an anathema. In addition, it was Rita who suggested that they talk in group about whatever it was that Paula wanted to share. Paula told the group that she had been worrying about doing so, and that she had her shape. She was ready to talk about her attraction for Rita and her fear that it would upset her life as wife and mother.

CONCLUSION AND CONTRAINDICATIONS

As a dance/movement therapist who has applied movement analysis to the creative dance concept of shape, I use shape as an improvisational tool to make concrete the abstract notion of boundaries. However, you do not have to be a dance/movement therapist to introduce this exercise to members of your groups. Even therapists who are uncomfortable dancing can combine kinesthetic sensing and the simple movements described to access their sense of shape. In doing so, they literally embody the seemingly intangible concept of psychological boundaries, which is often so hard to explain. To be sure that you are comfortable with the task, follow the directions yourself before you give them to anyone else. You need to know how you respond to kinesthetic sensing, touch, and simple movement, particularly if you have group members who fear self-touch or have such distorted body images that they cannot separate themselves from their negative self-assessments. Since awareness of shape will help them in the long run, take the time to prepare them for the intervention as it has the potential to counter the somatic distortions that govern their lives.

As long as you attend to the affective, cognitive, behavioral, and developmental needs of group members, there are no obvious contra-indications for engaging the shape to foster healthy boundaries. Once group members have identified the vulnerable spots in their boundaries (the holes in their seams), and sensed their shapes, they will be able to take more responsibility for their contributions, or lack thereof, in group. Therapists who can sense their shape will be better able to remain present and congruent.

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Chapter 65

Trauma Therapy: An Integrative Approach

Norman Claringbull

LIFE-THREATENING TRAUMATIC SITUATIONS

Since the Twin Towers attack, (9/11), the possibility that large groups of people might be adversely affected psychologically by being somehow involved in life-threatening, traumatic situations is becoming more and more publicly recognized. Unfortunately trauma victimization is nothing like a new phenomenon and 9/11 only served to dramatically highlight the problems that such unfortunates have been facing for many years. Among the better-known dramatic incidents are Hurricanes Katrina and Wilma, the Pakistan Earthquake and many, many similar events such as the tragedy at Virginia Tech in the spring of 2007.

The natural human response to such situations is to try and help. The problem is how? One of the superficially easy ways to do this is to throw resources at the situation and this often includes providing the supposedly *"expert"* help of the therapist who, it is hoped, will be able to deal with all the awkward bits of the problem, especially those involving any emotional discomfort, that might be discovered in either the victims or the assistance providers. Authors such as Bessel, Van Der Kolk, McFarlane, and Weisaeth, 1999; Scott and Stradling, 2006; and Warren 2006 and many others give us lots of clues about how therapists might go about such a task. So, how can therapists best help, and given that most of these events inevitably produce large numbers of potential victims, how can we help on a "mass-production" scale? Surely the very being of the therapist, especially that of

the group therapist, lays in a supposed ability to multi-task the delivery of therapeutic inputs to multiple-populated client groups? If we can't help then who can?

DESCRIPTIONS OF THE CLIENT POPULATION

Basically, the traumatized client population includes just about everybody; all ages, all types, all nationalities and all backgrounds. Given this variety of demand, it is not even possible to say, for example, that a U.K. therapist will typically meet a U.K. population, that U.S. therapists have particular issues and clients who need a special "USA twist" or that a therapist from more or less anywhere will have any especially foreseeable problems, (with the possible exception of language difficulties). Bearing in mind the heterogeneity of most national populations and the global village nature of today's world, trauma therapists need to be prepared to meet the needs of whoever presents, from whatever background, from any origin and under whatever circumstances happen to be predominant at the time.

THE INTERVENTIONS

There are lots of arguments about the best ways to help such client groups. These range from the long-established, but now heavily criticized, technique of debriefing, (Dyregrov, 1997; Mitchell 2004, 1983), to the very modern approaches using such cognitive-behavioral techniques as eye movement desensitization, (Shapiro, 2001), emotional freedom therapy (Hartman 2000), and so on. At the core of all these approaches, at least in the immediate aftermath of a traumatic incident, is the need to address the disabling cognitions, the distorted beliefs, and the maladaptive thinking that the traumatic experience has engendered. Put simply, whatever views therapists might hold about best practice for the long-term approaches to helping traumatized clients, in the short-term, normalization appears to often be the key early need for clients and this usually means focusing the therapeutic interventions at core cognitive levels. Cognitive processing of a traumatic incident means keep on linking the clients thinking processes back to what they perceived as happening as the incident progressed. It is a circular and an iterative process.

In my own psychotherapy consultancy practice I get involved as a "trauma expert," (if there really is such a calling), in the aftermath of quite a lot of serious and dramatic events. In my experience, even the aid professionals have difficulty in handling the emotional needs of the traumatized victims. Indeed, they are often not much better at handling their own psychological discomforts either! Following is an example.

Background

In October 1999, just on the outskirts of London, thirty-one people died and hundreds were injured when a Thames Trains service went through a red signal and collided with a Great Western InterCity Express. One can only roughly estimate how many people were directly, (passengers) or indirectly, (relatives, colleagues, friends, etc.) suffered emotional damage. The figures run to at least the low thousands. In addition, major psychological effects were discovered in many of the emergency service workers. I was tasked to facilitate two groups of passenger survivors, none of who had any significant physical injury. However, they all apparently felt sufficiently emotionally pained to prompt them to voluntarily take up the psychological therapy. In Group 1 there were six women and three men, of various ages and in Group 2 there were five men and seven women. In neither case did I ever learn anything striking or of any significance about their backgrounds, origins, or personal circumstances. We met in a small conference room in a hotel that had been requisitioned for the purpose. Their presenting emotional conditions ranged from anger, through deep sadness to ongoing terror.

Group 1

To begin with, I asked each participant to describe their entire day, from when they got up on the morning of the crash to when they got to whatever or wherever represented a safe place for each of them. I wanted each of them to tell me their story. This was not done on a one-by-one basis that started at breakfast time and went through to bedtime but one that was undertaken on a horizontal time-slice basis that took all of the participants in turn through the first segments of their day, then all of them through the second segment and so on. Although we wanted to hear from everybody, the trick was to keep the

group focused on the individual task in hand while at the same time not wanting to suppress anybody's need to urgently express themselves if necessary, whether or not it was their "official" time to tell part of their own story. What became obvious at an early stage was a need in some of the participants to deal with their own feelings by sabotaging the emotional "downloading" of other group members. For example:

> Participant A: "As I cowered by the track side, I kept on worrying about getting home in time to pick up my dry cleaning as I was going to a PTA meeting the next day and I didn't want to look scruffy and let my children down"
>
> Participant B: "My immediate worries were for everybody else. I had already probably saved one guy's life by dragging him clear and I knew that the most important thing was to care for the injured"

Looking at Participant A, I could see that she was starting to feel ashamed of herself. Possibly she was feeling personally diminished by only having such apparently trivial worries when "Mr. Hero" was rushing round selflessly risking life and limb in the service of his fellow victims. The danger was that A, and possible other group members too, would be silenced by their awe of B's apparent heroism. The essential element in working in this way with traumatized clients is to keep bringing them back to the "what were you thinking—what did that happening mean to you"? This is because such an approach is consistent with the classic principle of any cognitive therapeutic intervention in that the thinking *precedes* the action or the feeling.

Thinking, including maladaptive thinking, is the *cause* of perceptions, emotions, and emotional discomfort; it is not the result of inappropriate emotions or perceptions. In the case of the exchange, by asking both A and B what their individual thoughts were, *at the time that they each were referring to,* we could get their responses into proportion. In addition, and probably most important of all, they could both learn to understand themselves and to normalize their own cognitions. As it happened, it turned out that A had been thinking about how the crash might affect her immediate family and B had been thinking that he was in immediate danger and so he found that displacing this fear into activity helped him to cope. It is clear from

this example that the trauma therapist's early stages interventions need to be targeted at continually "closing the loop." This concept is perhaps better illustrated by one of my experiences when I was working with Group 2.

Group 2

This group of victims all described a common scene from their experiences:

> There was a huge bang; a huge jolt and the train went all over the place. I was thrown around all ways and there were incredible noises—screaming, crunching, banging, explosions and the sound of huge pieces of metal crashing together. It was like hell had opened up. Then it stopped and I found myself outside the train sitting on the track. There was a hush, no noise, and no sound at all. Then from one direction I heard a mobile phone starting to ring, and then from somewhere else another phone joined in, then another and then another and another and another. Gradually the air became full of the sound of phones ringing. It was the sound of life!

This is a hugely dramatic story and, as some of the survivors talked about this experience it became clear that its power was putting all of us, everybody in the room, back at the crash site. It filled our being and we all were there, at the actual event, at the actual time. Now let's get back to therapeutic reality and see if we can close the loop. Put simply, the story wasn't true! The crash happened on a busy mainline train junction, under a crowded airport flight path and in a busy, heavily trafficked London suburb. There was no period of silence—and that particular survivor's story existed only as a perception, albeit an incredibly powerful one. What was the real situation? It had to be one of noise, shock, and fear. Where did the belief come from that all was quiet? After all, this was real life at a major, and still ongoing, disaster. With hindsight, my best professional guess now is that this misperception probably had its origins in some erroneous thinking patterns, (cognitions), that if noise equals danger then silence equals safety. Therefore, in order to save themselves, my storytellers had to create their own reality because the real life situation that surrounded them was far too threatening. So how did I intervene? In this case I didn't—I was overwhelmed too! Sometime you just can't avoid go-

ing with the flow. Sometime the best intervention that a therapist can make is simply not to make one!

CONCLUSION AND CONTRAINDICATIONS

Obviously, there are powerful humanitarian reasons to try to help the traumatized as soon as practicable. This is especially so in the case of the major disasters. Nevertheless, the fact remains that the majority of people who experience traumatic or critical incidents recover within four to six weeks. Therefore, in most cases, early intervention is either uncalled for or is likely to be counter-productive. It is a psychological process that is akin to grief in that it is a normal human reaction to a distressing event and one that simply has to be "gone through." Emotional pain, like physical pain, is sometimes an unpleasant but a necessary response. Therefore, in many cases the best treatment for the traumatized person is often to do nothing! However, it is very common to hear on the news that after a particular traumatic event has occurred "counselors were immediately made available." This might be comforting to the authorities and probably to the rest of us, all of whom want "them to do something." Whether this is always actually helpful is far from clear!

As psychotherapists, we too will find ourselves under urgent pressure to rush to the aid of the critically traumatized and here I am particularly referring to those affected by immediate, high-impact, high-profile events. The question that we have to ask ourselves, as ethical therapeutic practitioners, is, "Can we find the strength within ourselves to sometimes refuse to respond to a plea for help?" After all, what did the Javanese fishermen who lost their livelihoods in the 2004 tsunami disaster need most—psychotherapy or new boats?

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Chapter 66

Creative Use of the Group Contract in Long-Term Psychotherapy Groups

Melissa Black

THE GROUP CONTRACT

The group contract in a long-term psychodynamic therapy group is an explicit agreement between therapist and group members about the expectations and conduct for successful group membership (Fehr, 2003). It covers topics such as logistics of group meetings, fees for group therapy, confidentiality, and expectations about the minimal duration of group treatment as well as more intangible issues such as the necessity to explore the relationships within the group, particularly with the therapist. The contract also brings emotional issues, which are often difficult and avoided, such as money, sexual feelings, and anger, to a conscious space within the group member and highlights the importance of working with these issues as a vital part of the group experience. The idea that group is meant to be an avenue for *verbal* exploration of both intrapsychic and interpersonal conflicts is specifically spelled out in the contract. The directive to "put thoughts and feelings into words and not actions" is always an explicit part of my own group contract. Of particular importance in this intervention is the agreement that there is to be no contact between members outside of group.

Therapeutically, the group contract has several purposes. Initially, it provides a uniform set of expectations to each of the group members. Although there is nothing "democratic" about the contract, it is generally accepted as a benevolent directive from the group leader, which ultimately has the health of the group member at the heart of

the document. Since the style of leadership in psychodynamically based group psychotherapy is less active than many other forms of group, the contract often provides the only structure for a beginning group. It is often the first shared experience of the group (Rutan & Stone, 1993). With group membership comes the inherent agreement that all will abide by the directives of the contract. The sense of predictability and safety these "rules" imbue in a new group can be a life raft for anxious new members.

Although the group contract feels predictable, safe, and comforting to a new group or even a new member in an open ended group, over time the group contract can take on many other meanings and purposes. The following intervention will illustrate one such manifestation of the therapeutic usefulness of the group contract in the later stage of an established group.

A PSYCHODYNAMIC OR INSIGHT-ORIENTED POPULATION

Although I believe that all types of groups need a contract, the content and use of the contract will vary according to the type of group and population. The following intervention is best suited for a psychodynamic or other insight-oriented group. Consistent with psychodynamic psychotherapy groups, the group members will have the capacity for self-reflection and insight and be seeking increased intrapsychic and interpersonal knowledge. The following group intervention occurred in a mixed, open-ended, long-term psychodynamic group that had been meeting once a week for approximately two years.

THE INTERVENTION

Margie was a new member who had entered the group three sessions prior to the intervention. She was taking the place vacated by a very beloved member, Tina, who had terminated successfully after being a vital and passionate member of the group since its inception. Margie, like Tina, was an attractive, vivacious, and energizing woman. She was experiencing warmth, encouragement, and acceptance from the group members, with the exception of Doug, who was treating her

with cool disdain. No matter how often Margie attempted to make genuine contact with Doug, she was rebuffed. During this particular session, Doug became especially hostile and finally shouted, "Who needs another beautiful woman in this group? I've written to Tina and I know she will e-mail back. All this group has ever done for me is keep me from experiencing love."

Doug had been sitting on his feelings of love and attraction for Tina throughout their shared time in the group. His inability to share them in real time with her had him acting out and unable to open himself to the possibility of another intensely sexual or loving relationship in the group. Much like the bitterness he carried forward from his fairly recent divorce, he was unable to love, but unable to let go. As the therapist, I was struck by the opportunity in the moment to help Doug and the rest of the group appreciate the difficulty and benefit in expressing the very real love that can be experienced safely in the group.

I had to think quickly through my intervention options. I could have quoted the contract and pointed out the "rule violation" and reinforced the need to put feelings into words and not actions. I could have made an interpretation for Doug relating to his life and relationships and hoped that others would pick up on it and generalize, but I decide to use the group contract to make this a group as a whole issue instead.

Questions for the Group

- Having a new member in the group is always a great time to think about how we are all using this group. This is an interesting situation.
- What do you all think about a relationship between Doug and Tina? Can anyone remember having a wish or fantasy to break the rules and talk or even get together with another group member outside of group?

The invitation for everyone to share their fantasies of a different kind of connection with group members led to a lively discussion of many of the group members' unspoken wishes to be Tina's lover or friend but with an awareness of the "contractual agreement" not to act on the feelings. Some members felt betrayed by Doug for breaking

the boundary and contacting Tina, while others related his anger at the restrictions that group placed on the ability to have "real" relationships with one another.

I then posed the following question.

- It seems like there were many possible suitors for Tina in this group. Could there be any current cases of undisclosed love or wishes for friendship between members of this group today?

This was the impetus needed for the group to start discussing wishes for pairings to play golf, go on a dinner date, watch a movie, vacation together, and even become lovers.

The final piece of my intervention:

- All of those ideas sound wonderful and exciting, but I wonder if anyone can explore what they might all have in common?

After a period of silence, it was Doug who responded, "We all want to love each other." Margie finally joined in saying, "It sounds like you already do." The group followed this path to finally accept that, even with the limitations of "real contact" or maybe because of the limitations, they were free to experience true feelings toward one another.

THE RESPONSES

The effective use of the group contract as more than a beginning frame for a therapy group is dependent upon the group's readiness for deeper interpretation of their behaviors. Like any premature interpretation, at best, it will fall flat and not be understood, but it can also result in hostility toward the leader for his or her perceived lack of understanding or even be seen as a punitive judgment by the leader. When this type of intervention is used correctly, it will easily move the group beyond the specific behaviors to an exploration of the emotional connections around the behavior choices.

CONCLUSION AND CONTRAINDICATIONS

In an established, long-term, psychodynamic group, the group contract can become a metaphorical member of the group. Rather than simply a set of rules to live by in group, over time it takes on a personality of its own. Each member has a relationship with the contract. How that relationship progresses will influence all of the other relationships in the group. Doug's acting out and awareness of not abiding by the contract foreclosed on his openness to forming other relationships in the group. Left unexplored, Doug would have eventually used his "misbehavior" with the contract to recreate the deep sense of shame that has been pervasive around vulnerable emotions in his life and likely lead to a premature termination of his group membership.

Using the group contract as a piece of the relational matrix of the group allows the therapist yet another set of relationships to explore and understand. It is important to note that there are times when even the deepest understanding of contract violations does not negate the damaging aspects of the behavior on the group. One example of such destructive behavior is a sexual liaison between group members. Obviously, this will require not only intense exploration, but it ultimately must lead to one or both members leaving the group if the outside relationship continues.

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Chapter 67

"After the Group Has Ended": Imagery to Vivify Termination

Miriam Iosupovici

Endings are either too long or too short.

Miriam Polster (personal communication)

ENDING RITUAL

In all situations in which a group process has been established, the existentially imperfect process of termination may be one of the most important stages of an ethical group process, requiring considerable therapist skill (Mangione, L., Forti, R. & Iacuzzi, C.M. 2007; AGPA, 2007). To avoid colluding with avoidance of the feelings stirred up by ending in clients, and therapists, thoughtfully timed rituals may be useful.

Guided imagery, a form of trance, can vivify the actuality of ending prior to the event. Imagery, including directive suggestion, supports a more powerful group termination process. Functions such as prescribing the resistance, working through as yet unarticulated issues, and/or expression of gratitude and progress or their opposites, some of which might not have otherwise come to awareness sufficiently to be dealt within the group, can be accessed in this and the remaining sessions.

POPULATION AND CONDITIONS

This intervention may be used, in both short- and long-term groups, when the entire group is terminating. It is important that the therapist be comfortable with the use of guided imagery and is able to explain the justifications for its use to group members. Moreover, imagery may create various levels of anxiety in some members and a permissive style is crucial: for example, no group member needs to close his or her eyes unless he or she is comfortable doing so and any member can choose not to actively participate. (Resources are suggested in the Bibliography for therapists who wish to explore imagery and trance further [Klipperstein, 1991; Yapko, 2003].) If unfamiliar with utilizing guided imagery or trance, it is suggested that the therapist write out the script and/or practice the intervention (including timing) prior to the group.

A GUIDED-IMAGERY INTERVENTION

- Using your own language, introduce the imagery by explaining to group that as they will be ending in ____ weeks you would like to take them on a journey of imagination to a time after the group is actually over.
- Secure verbal permission and/or head nods to do so, after answering any questions that might come up about guided imagery. Give group a time frame for how long the imagery portion will last, usually about ten to fifteen minutes.
- Make certain that enough processing time is left in the therapy session, at least forty-five minutes but preferably an hour. You can refer back to the imagery in subsequent sessions.
- After utilizing an approximately five-minute induction of your own choosing (Yapko, 2003) create a scene one month following the end of the group; utilize all senses and incorporate seasonal information. Remember to speak slowly, softly, and distinctly. Leave pauses (see the following example) for members to develop their own imagery and access their memories.

Example

> Allow yourself to imagine sitting on the beach on a beautiful, sunny day in July. . . It is warm but not too warm. . . . A breeze is gently blowing and you can feel the sun's rays on your skin. . . .You smell the tang of the salt air, the scent of sunscreen. . . . The sound of the waves gently washing onto the shore is like background music. . . .You watch the people playing in the water, enjoying their pleasure. . . .You sit comfortably, supported with the warm sand. There is nothing you have to do, nowhere you need to go, . . . you are comfortable, relaxed. . . . You notice, to your surprise . . . that the muted sound of the voices of other people on the beach brings you back to a vivid awareness of this group, like you were watching a video.

With that video playing in your head, you allow yourself to look carefully at each face in the group. . . . Allow yourself to be surprised at what you notice . . . for I do not know and you do not know just what this awareness might be for you. Be aware of who you wish to look at further, just like when you were in the group, perhaps noticing who you may find it easy . . . or difficult to look in their eyes. . . . Imagine each person looking at you . . . and because this video has sound, you can hear each member speaking. . . . You can allow your mind to drift deeper and focus on what is most important to you in these images. . . . Perhaps you are relieved that you did not avoid the ending of the group because it may difficult to say goodbye or may have reminded you of other endings in your life. . . . Allow yourself to be fully aware of how you felt in the group with each of the members. . . . Who, if anyone, did you feel attracted to and who did you feel you needed to have distance? Allow yourself to be aware of how that experience happened. . . . Did anyone in the group remind you of someone in your "real life" and did this affect how you interacted with them? You can gently notice if you told members of their impact on you, either positive or negative or in between? If not, how did you make that choice? . . . Who do you wish you had supported more? . . . or confronted? . . . . How did you make those choices to hold back? . . . . Perhaps you kept yourself from getting more of what you wanted out of group? . . . Or, did you worry that you had asked for "too much"? . . . Allow yourself to imagine what might happen if you talk about these feelings. . . . As you continue this fantasy, be aware of any

unfinished business. Imagine having attempted to work this through. . . . And, as this imagery begins to end: From whom did you learn? And what was that awareness? . . . and what have you learned from the group as a whole? What has been said, and experienced that you may wish to take with you into the rest of your life? Take a minute to review these experiences . . . allow yourself to hold them in your memory for the future . . . (leave a full minute of silence) . . . and now, come back to this room, with your awareness that our group is not yet over in reality and you have an opportunity to use this guided imagery experience to deeply utilize the rest of the time we have together. . ."

Optional

Is there anything that the (use name's/leaders) did that helped you open up and use the group? Anything that the therapist did or said that led you to shut down?

Note

After making sure all group members are fully awakened (counting backward from 5 to 1 works well), begin processing in your usual manner. Although there will usually be group members who have an easier time disclosing and may volunteer to begin, make sure to bridge to all members of the group if the participants do not do this for themselves. You can use the questions in the trance for prompts. It is also possible to refer back to the experience in subsequent groups.

CONCLUSION AND CONTRAINDICATION

In our underritualized culture, group therapy provides many opportunities for experiment and learning, including the processing of termination. Although caution may need to be exercised in groups of clients with high degrees of dissociative processes, utilizing well-timed and directive, guided imagery can significantly enhance this crucial last step of group life.

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Chapter 68

An Angry Outburst: Responding to Aggression

Robert A. Berley

INTRODUCTION

Aggressive feelings are part of our human experience, and they are called into play whenever we feel frustrated or threatened. Early experiences, of course, will powerfully influence exactly what is felt. Even the "flight" part of the fight/flight response can become quite complicated, emerging more as a flight of mind that leaves the body frozen and quite vulnerable. For many, anger has become disconnected from data, such that the intensity of the response does not match the actual level of threat. Thus the conscious awareness and communication of aggressive feelings can contain elements of dissociated lack of awareness, anxious denial, fearful withdrawal, paralyzed inaction, various forms of modulated expression, as well as explosive activation accompanied by powerful impulses to act out.

Of course, individuals unable to manage feelings who are likely to explode require specific groups focused on self-control and should be carefully evaluated before being included in a therapy group with more diverse goals (Brabender, 2002). But because questions regarding appropriateness for group can be difficult to determine with any certainty, and because therapists are often loathe to reject a potential member without offering some opportunity to see if there might be a beneficial fit (Fehr, 2003), members with circumscribed concerns that could elicit such an outburst are often invited to participate.

Therapists are, of course, typically more comfortable with patients likely to exhibit too much self-control rather than too little. So it is es-

sential to have some way to think about the more distressing situation in which a group member erupts, threatening another member or the group as a whole. Many therapists include a an agreement to "put feelings into words rather than actions" in their group contract (Rutan & Stone, 2001), so even though the threat may be explicitly not one of physical harm, the intensity of the expressed emotion may still be difficult to mange.

THE EVENT

A (co-led) group for adults had been meeting for many years with a fairly stable membership. One of the two female leaders had left to have a baby, and a new therapist (myself) had recently come in to fill her role. Shortly thereafter, a new member was introduced into the group. This was Sara, a single woman, aged twenty-five with a drug and alcohol history whose mother had somewhat reluctantly agreed to help her daughter pay the group fee. Her first session was uneventful. At the second meeting, Francis, the longer-standing therapist, was absent and I conducted the group myself. The issue of disappointment in various caregivers arose, with the overt content centered on the ways members had been shortchanged by disinterested or self-absorbed parents. Sara remarked that she didn't think of her mother that way at all. In fact, she felt more the opposite: that her mother tended to be intrusive and overly concerned about her. Several members laughed at how they wished their parents had been that involved. Sara seemed to darken as though feeling unheard, and reiterated how her mother's oversight of her life was a burden. At this point, Jane, a longstanding member, became irritated and began needling Sara for being unappreciative of her mother's efforts on her behalf. Phrases like "What do *you* have to complain about?" and "You have it *so* easy!" were delivered with an increasingly forceful and demeaning tone of voice. Feebly, Sarah tried to defend herself and her feelings, while the other group members seemed to retreat into the background.

Feeling protective of a new member finding herself badgered by a more senior one who was also a generation older, I began to note Jane's seeming lack of self-observation and the probability that something was arising out of her internal world rather than anything actually about Sara. But, after just a few words from me, Jane turned

toward Sara and exploded, furiously accusing her of being ungrateful, selfish, and self-centered. The group seemed shocked into frozen isolation, and Jane's disregard for my effort left me feeling momentarily irrelevant and impotent. After a breath, Jane continued to harangue Sara, whom I rapidly became concerned would be driven from the group.

COMPONENTS OF THE INTERVENTION

The initial challenge in these situations is to explore one's own internal experience and locate a stance or space from which thinking is possible. This is not an effort to suppress (countertransference) feelings, but to work with them in a creative and flexible way. It is thus not only essential as a therapist, but also good modeling for members. From that stance, a number of important considerations may be examined to help the therapist decide what might be going on and in what direction the group needs to move.

As usual, the overall trajectory we have in mind includes helping the individual and the group develop an increasing tolerance for affect, developing a capacity for empathy and mutuality, and eventually moving toward self-observation and reflection and thus here-and-now learning. This sequence can be facilitated if the therapist can:

1. *Lean in:* The first objective is to protect the group while attempting to link up with the affect expressed. Aggression is a signal of frustration or threat, and here Sara is triggering something in Jane that is invisible as a source but terribly apparent as an effect. The therapist must "lean" toward Jane, identifying with her emotional state and providing an effective structuring (that is, empathic) response that conveys deep understanding and thus the capacity to tolerate the feeling evoked. In this case, I sat fully upright and moved physically forward toward both women, offering protection to Sara by getting into Jane's line of sight and containment for Jane by clearly being willing to engage with her no matter what her level of intensity.

2. *Make room and jump in:* As the most powerful individual and most important transference object in the group, I needed to be included in the situation and demand I be taken into account. Addressing Jane, I said very directly and forcefully: "Jane! I think right now you are having feelings about Sara that make you upset," a phrase that had to be repeated a second time in order to get Jane to address it and

me. Her reply was a scornful "Well, yeah!" but it did force her to speak to me and I could now keep working at giving her something to think about. (This is a version of directing aggression toward the leader that others in this book have noted, but begins with affect rather than content.) Once I had Jane's attention, I could move on to saying "I think you are angry at Sara for her mother's interest because you're angry at Francis for bringing me into the group and paying no attention to your wishes." It is less relevant that this be insightful and accurate; it should carry the kind of emotional tension the member is expressing. Engaging and getting the patient's attention are the more basic objectives; accuracy will come later, when dialogue can be established. So, when Sara replied "That's stupid!" I did not take her retaliation personally but was ready to keep her mind engaged by saying "She not only left you and brought me in to cover for her, but she also brought a little sister into the family." There was a pause as she began to think, so I added "and you're upset with me because you're not getting enough from me, and it seems like Sara is getting so much from her caregiver." Again, accuracy is desirable, but affect matching or "pacing" is the true goal here.

3. *Titrate, but do not defuse!* The goal is to find a way for the entire group to remain engaged. Defenses will be aroused and titration may be necessary, but the whole group must work with the situation without anyone feeling their reaction is overwrought or meaningless. Too rapidly attempting an interpretation that moves away from the here-and-now of the interaction to archaic "explanations" tends to infantilize the group and implies the group is too immature to explore their own reactions. The experience of tolerating affect successfully helps develop what might be described as a tougher "skin" or insulation (Ormont, 1984), as well as increasing cohesion and trust in the group's ability to weather storms together. It should also be obvious that trying to defuse a situation by overpowering the angry member (especially through shame or humiliation) is a poor choice and will lead to mistrust of the leader even if the situation is "successfully" de-escalated. So once I had joined Jane and "paced" her affect, I noted how furious she was because "It makes you angry to see Sara get so much when you felt you got nothing," and then to the group "and I think everyone kept their hands off because they, too, were jealous of the one who seemed to get it all."

4. *Pursue meaning:* Following the expression of intense feeling, the central character as well as group members who pulled away may feel shame. Pursuing meaning thoughtfully and respectfully communicates a basic tolerance of and interest in emotional dynamics. One specific way to support the growth of "skin" is to investigate the affect (fear, anger, etc.), and see if members can imagine responding nonthreateningly in spite of it. Members who were "too scared to say anything" might be invited to imagine speaking anyway, despite their fear of retaliation.

There are many potential forms of meaning that could become available as members finally contemplate their experience together. In this case, members eventually admitted to fearing retaliation from Jane if they were to object to her treatment of Sara (or even note that she's acted this way before), and envy of Sara (e.g., identification with Jane), which made them collude to have Jane attack and demolish the "fortunate" new member.

CONCLUSION AND IMPORTANT CONTRAINDICATIONS

Working with intense affect makes demands on both members and the leader, and the therapist must assess both the group's capacity to tolerate feelings and engage in thought as well as his or her own. Resistances are often discovered in the therapist (Billow, 2001), and it is part of professional training to seek consultation and perhaps further personal therapy to help resolve them. Assessing the group's capacity is not a black-or-white decision, however, as any group will become more cohesive and self-assured as the skills of emotional engagement are put into practice. Obviously, there will also be a limit, which must be respected by the leader, lest a traumatizing and possibly escalating process (fueled perhaps by scapegoating or unexpressed anger at the therapist) emerge.

Interventions or techniques are not, however, to be applied as though following a recipe. There is too much complexity in the intertwined feelings of leader and members, too much contributed by their shared history, and too much of the leader's own emotional constitution to thoughtlessly apply a formulaic response. Even something that comes recommended by a colleague must be carefully considered, assessing the situation and one's own therapeutic self for good-

ness of "fit." The reader is thus encouraged to consider the ways in which the proposed interventions might be adapted to a response that would feel organic to his or her own temperament and therapeutic stance.

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Chapter 69

Painting Verbal Images

Mary Jago Krueger

Her head fell back, her shoulders lifted; her eyes turned to opaque pools of water as she gazed up at the ceiling as if at any moment relief would sweep in and ease her pain. Another member of the group inquired, "Where are you?" She whispered "I don't know how to explain it. I don't have the words."

USING FIGURATIVE LANGUAGE AS A TOOL IN GROUP THERAPY

Figurative language offers us the opportunity to create images that stimulate the senses (Barlow, Fine, Pollio & Pollio, 1977). Creative verbal imaging can provide a perspective from which a shared experience can elicit visceral responses about a moment in the group process. The use of figurative language in psychotherapy is a means of communicating sensitive material aimed at interpreting defenses in a personal manner (Yeomans, Clarkin, Altschul & Hull, 1992). A metaphor is hatched or an analogy is constructed all in the service of translating a defense or demonstrating mutuality between group members.

GENERAL CLIENT POPULATION

Figurative language may be used with any type of group to illustrate a point, make an observation, or convey a concept. It can also be

a gentle and rich method for interpreting process in a psychotherapy group or addressing points of difficulty without prejudice or judgment. The requirements are that the members of the group share a common understanding of the language or phrases used for the interventions and have the ability to think abstractly, even if it is at a basic level.

TIMING AND SAMPLES OF INTERVENTIONS

My orientation to group work is integrative with significant influences from psychoanalytic and existential theories. The groups which I work with are predominantly closed ongoing, long-term adult psychotherapeutic groups. I have found that the use of figurative language can be used strategically as a tool in any stage of group development.

A Sample Metaphor

The use of metaphors as an intervention has been highly effective when a member of the group becomes resistant to the immediate process in the group resulting in the group as a whole seizing to a halt. Common metaphors or colloquialisms also have been very effective to gently observe an event in a working group that may need to be addressed, as well as, similes to explain a parallel process in order to avoid jargon.

A sample metaphor that is commonly heard and understood by group members is the observation: *"Just now, you look like a deer caught in the headlights."* This metaphor combined with the inquiry *"What was happening for you when you heard Judith tell her story?"* offers the group insight into what was observed while not diverting attention away from the member.

A Sample Analogy

The following analogy has effectively moved the group from an impasse between two members. Two of the group members were in deadlock due to the manner in which they were relating to each other. The intervention at that moment was the simple phrase,

"As I hear Kim talk to Jeannie, I cannot help but picture Jeannie as a scared kitten backed into the corner taking swipes at Kim as she keeps trying to pick her up."

This indirect, easily identifiable feeling for most people, was highly helpful in providing the opportunity for the two group members to disclose their actual feelings which ultimately moved them out of their cognitive dueling into their actual feelings.

CONTRAINDICATIONS

Possible contraindications for using figurative language would be with a group in which there are members who are highly concrete or when the primary language being spoken in the group is a second language for some of the members. In these cases, the nuances and abstractions of figurative language may be alienating or distracting to part or all of the group members.

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Chapter 70

Awakening Social Consciousness

Chad V. Johnson

> True peace is not merely the absence of tension: it is the presence of justice.
>
> Martin Luther King Jr.

INTEGRATING SOCIAL JUSTICE INTO GROUP THERAPY

Amongst virtually every mental health discipline, the call is going out for integrating social justice into practice. Many fields such as psychology, counseling, and social work are imploring practitioners to take seriously the task of addressing inequalities and injustices faced by their clientele. As Prilleltensky, Dokecki, Frieden and Wang. (2007) eloquently stated, "if we don't challenge the status quo, we tacitly support it, and if we concentrate exclusively on intrapsychic dynamics, we run the risk of neglecting the social origins of suffering and distress" (p. 20). Tragically, mental health treatment suggests a trend toward neglecting the social origins of emotional distress and shifting the primary emphasis to brain disease (Albee, 1998). Helping professionals have begun to recognize the need to address both our clients' pain and the social injustices that help create it. First, as therapists we need to raise our awareness to how counseling theories and practices serve the status quo of oppression and injustice rather than challenge it (Albee, 2000; Katz, 1985). Second, we need to help increase our clients' awareness of the ways that they are contributing to or being victimized by forces of oppression. Third, we

can help our clients articulate how their suffering results, at least in part, from sociopolitical factors. Finally, we may collaborate with our clients to ameliorate injustices in society and, subsequently, in our own lives.

AN OPPRESSED CLIENT POPULATION

This intervention may be particularly useful with groups consisting of those generally recognized as oppressed—e.g., domestic violence survivors, those in poverty, or racial/ethnic/sexual minorities. However, this intervention is intended for any short- or long-term process-oriented therapy groups including those in private practice, mental health agencies, and college counseling centers. It is not recommended for clients who may be sensitive to retraumatization through the experience of recognizing ongoing oppression in the here-and-now of group.

A 10-STEP INTERVENTION

Step 1

Make a commitment to develop multicultural competencies and social justice awareness in your practice (see Arredondo et al., 1999).

Step 2

Work diligently to recognize sources of oppression, prejudice, and injustice in the theories, practices, and systems of healing and mental health (see Albee, 2000 and Katz, 1985) and in your clients' lives.

Step 3

If beginning a new group, consider informing potential members that one of the tasks of group will be recognizing and exploring how sociopolitical realities are reflected in group and affect group process and attainment of therapeutic goals. If this is an existing group, consider introducing this idea as something worth exploring together as a group from this point forward.

Step 4

Develop a framework or template for recognizing instances of power, oppression, competition of resources (e.g., the leader's attention), etc., in the group process. For example, ask yourself the following types of questions: "How is the group process reflecting injustices (or oppression, etc.) in our society?" "How may this conflict between members reflect sociopolitical conflicts and tensions?" "How am I as leader a symbol (or actual source) of oppression and how might this be influencing the process?" "Whose voice is being silenced and who is doing the silencing (e.g., the leader, the group, particular members)?" "Who is being privileged by the group and why?"

Step 5

Recognize and illuminate positive ways the group shares power, gives voice, recognizes oppression, and takes action to eradicate it in their personal and social settings.

Step 6

Consider first identifying your own actions as contributing to injustice, unearned privilege, or oppression in group when it occurs. This may help alleviate fears about this process and prevent the group from going on a "witch hunt." However, if a witch hunt or active censoring ensues it is another instance of how oppression dehumanizes and creates conflict (Freire, 1970/1995). Thus, this kind of experience is grist for the mill of group discussion and exploration.

Caution: **Leaders may become a scapegoat in the group for initiating this type of discourse. Be open to criticism, be willing to hold these types of accusations, and actively explore any reactions members may have. Demonstrate your willingness to engage actively in searching out your own contributions to injustice and oppression. Emphasize for the group that no one is immune and that you are fellow sojourners when it comes to eradicating oppression from our personal lives and society.**

Step 7

Identify the various sociopolitical roles that members enact in group and facilitate bringing these roles to the groups' awareness. For example, if one member continues to "talk over" another member, in addition to addressing the interpersonal issue, use this as an opportunity to explore the phenomenon of silencing or "power over" in our culture. Of course, like with other group interventions do this gently and without judgment recognizing that we all partake in different types of oppressing and being oppressed.

Step 8

Invite exploration of the subjective and interpersonal experiences for each sociopolitical role. Examples: "What is it like to be silenced?" "How does it feel to be seen as receiving unearned privilege in group?" "Martha, what are you experiencing as you talk over Cindy and appear to dismiss her contributions to group?"

Step 9

Translate these experiences and insights to growth and action through helping members connect their suffering to social and political forces and through being empowered to make changes in their personal lives and in their communities to eradicate these forces.

Step 10

Consider making a commitment as a group to a community service project in whatever arena most closely aligns with a particular member's pain or a group issue.

CLIENT RESPONSES

Expect initial resistance to this type of intervention from some members who may be threatened by language such as "oppression" or "injustice" and/or believe this type of discussion conflicts with their personal and political views. Like discussions of sex, members may perceive dialogue about social and political processes as taboo.

Group leaders may avoid much of this resistance through using inclusive language such as "silencing" and "control" rather than "oppression" and "power." I find that an emphasis on promoting full personhood and eradicating dehumanization in our personal, relational, and communal lives helps prevent defensiveness. Most have found the experience of exploring personal and social experiences of oppression and injustice illuminating, healing, and empowering. Once a group increases its awareness along these lines, it becomes equipped with another powerful resource of healing, growth, and action to complement other group methods such as psychodynamic, existential, relational, or cognitive-behavioral.

CONTRAINDICATIONS

I have found few contraindications for this intervention and believe it is a powerful adjunct to successful therapy. Occasionally, a member might have experienced severe trauma that becomes activated through intense exploration of oppressive processes in group. This does not preclude utilizing social justice interventions, but may mean postponing this intervention until such time that the member has sufficient resources to effectively work in this way.

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Chapter 71

The Empty Chair As a Tool to Promote Self-Awareness and Interaction in Groups

Thomas A. Glass

THE HOT SEAT

Early in my training in Gestalt therapy, I became acquainted with the dual-chair technique, originally introduced by Frederick (Fritz) Perls, founder of Gestalt therapy. I was struck by the versatility and power of this method, not only to increase self-awareness but also to promote interaction among group members (Glass, 2001). As originally practiced by Perls, an individual indicated his or her willingness to engage with the therapist by taking the "hot seat," a chair facing the therapist. An additional "empty chair" next to the client was used to imagine the presence of a significant other, or a disowned or denied part of self for the purpose of initiating a dialogue.

For example, if the client was in conflict within a part of himself or herself, e.g., one part had expectations for high achievement and another part procrastinated and made excuses, (a particular personality split that Perls labeled "top dog/bottom dog") the therapist might suggest the client have a dialogue between these two parts. This technique involves the client moving back and forth between the two chairs, speaking alternately from each position. As the interplay between these polar opposites is heightened and thereby more fully experienced, integration through greater self-acceptance becomes possible.

Although Perls originally practiced Gestalt therapy primarily as an individual form of treatment, others subsequently have expanded the approach to working with groups in a way that encourages more interaction among group members (e.g., Glass, 1972; Feder & Ronall, 1980). For example, using the empty-chair technique, invite an individual who has only shown his friendly, "nice guy" persona in his interactions with other group members to put his critical, judgmental side in the empty chair. After giving this side a voice with accompanying affect, the member is then asked to experiment with engaging others in the group from this perspective, expressing criticisms and disagreements as may be appropriate to his relationship with each group member. Group members are then asked to respond, leading to more authentic group interaction. Additional examples can be found in discussions by other authors (Woldt & Toman, 2005; Yontef & Jacobs, 2005).

APPLICABILITY TO A VARIETY OF CLIENTS

The empty-chair technique has broad applicability to a variety of clients and types of groups. It can be successfully implemented in personal growth groups, therapy groups, and training groups. It is probably best to introduce it after the group has developed some familiarity and a degree of trust, since identifying less accepted parts of self may require a measure of risk taking, self-disclosure, and a willingness to explore unfamiliar territory. The method assumes a willingness by participants to work on unfinished relationship issues, past or present, and to seek more authentic interactions with others. Also needed is a willingness to experience strong affect in the presence of others.

GUIDELINES FOR THE INTERACTION

In working with the group, I watch for comments, behaviors, nonverbal cues, or interactions that suggest hesitation, ambivalence, avoidance, or conflict as members interact. For example, one member sits on the edge of the group, hugging her knees, and seems afraid to get involved. Another member rolls her eyes and challenges everything others say. A third member says he doesn't feel safe in the group.

Step 1

Invite the member to focus on the behavior, posture, or feeling that drew your attention. Ask member to pay close attention to how it feels, e.g., hug your knees; roll your eyes; focus on feeling of not being safe.

Step 2

Ask member to repeat, exaggerate, or intensify the experience. For example, the member hugging her knees reports she feels like she's hanging on for dear life; the one rolling her eyes says she's disgusted with everyone's complaints, whining, feeling sorry for themselves; the one who feels unsafe says he's convinced that if he doesn't take care of himself others will exploit or take advantage of him.

Step 3

Invite member to put a projected, opposite, or disowned part of self in the empty chair. For example the part that is holding her, supporting her, keeping her together, not letting her fall apart; the part of her that is whiney, complaining, and feels sorry for herself; the part of him that's exploitive and takes advantage of others.

Step 4

Once the person has moved to the empty chair, ask him or her to give a voice to that part, speaking in the here-and-now, first-person present tense as that aspect of self. For example, "I am holding you and supporting you; I won't let you fall apart; I'll make sure you are okay and will take care of you.;" "Oh, I've got so many problems and no one seems to care about me;" "You're all a bunch of losers; the only way to survive is to take what I need."

Step 5

Ask the person to focus on and report how it feels to take this position, paying attention to thoughts, feelings, posture, and body sensations.

Step 6

Ask the person to speak to one, or several group members in turn, from this place. For example, "I am strong, capable, and able to take care of myself;" "Oh, please pay attention to me–unless I make myself out to be pathetic, you won't even notice me;" "The only way to survive is for me to look out for myself and take what I need from you."

Step 7

Using two chairs, have member dialogue between the part identified in Step 2 and the opposite or projected part identified in Step 3. For example: the helpless one and the caretaker; the one disgusted with others' need for attention and the one who wants attention; the one who fears being taken advantage of and the exploiter of others.

Step 8

Invite the member to reflect on his or her own experience and to request feedback and reactions from others in the group. Ask others in the group to notice any identification with the issue at hand and to share related experiences with the member who did the dialogue.

TYPICAL RESPONSES: RECONCILIATION OF CONTRADICTORY ASPECTS

Almost invariably the exercise enhances empathy, identification, and appreciation for the member's openness, honesty, and trust in the group to deal with the issue at hand. One person's work frequently serves as a stimulus for others to open up more themselves, and enhances group interaction. Members frequently report that they feel more accepting and less judgmental of some of the contradictory aspects of self they were dealing with.

CONCLUSIONS AND CONTRAINDICATIONS

I have found this technique to be effective if the therapist is willing to trust that meaning and integration will occur if the client is guided

to finding his or her own discoveries without feeling the need for either therapist or client to interpret, explain, or theorize about what the work means. Gestalt therapy is grounded in the belief that by attending to present-centered awareness and immediate experience, the clients will discover important understandings that are helpful to them.

If there are any contraindications, they may lie in the fact that Gestalt techniques can release intense affect. Clients who are severely disturbed or who lack impulse control may be overwhelmed by the emotions that emerge from identifying with disowned or unintegrated aspects of self. If there is insufficient ego strength or group support, this technique may generate a level of affect that is hard to contain or integrate.

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Chapter 72

A Spiritually Informed Approach for the Group Leader

Robert L. Weber

THE SPIRITUAL DIMENSION

In the past four to five years I have encouraged and welcomed a spiritual dimension to enter my groups in more explicit ways; prayer, worship, and spirituality are and always have been vital to my own personal life and psychological growth. Part of me was influenced by the bias of Freudian tradition and a concern about how I would be viewed by professional colleagues if I made this aspect more manifest. Another reason for avoidance was the awareness that, for many group members, spirituality and religion are very problematic issues that seemed extraneous to the presenting psychological concerns. Now, perhaps as a function of my aging, spiritual, existential, and ultimate concerns such as these, including mortality, have become more predominant.

LONG-TERM OPEN-ENDED GROUPS

All four of my groups are long-term, open-ended psychodynamic groups (Rutan & Stone, 2001) with a strong emphasis on the "here-an-now" interpersonal dimension (Yalom & Leszcz, 2005). All are heterogeneous in gender and age. I view these groups from three theoretical vantage points and base my interventions on them: (1) *group as object* (using whole-group interventions); (2) group as *setting* (applying individually focused interventions); and (3) group as *agent* (using process-oriented group interventions) (Kauff, 1979).

A FIVE-STEP INTERVENTION FOR ELICITING SPIRITUAL AWARENESS IN THE GROUP LEADER

Step One: Be Clear About Your Own Spiritual Orientation and Its Importance

Before working more explicitly with spiritual concerns in groups, it is essential for the therapist to consider the place of spirituality and religion in his or her own life and to be very clear that the goal is neither to proselytize nor convince anyone of its importance, nor to emphasize a particular tradition or practice specifically. This requires personal reflection, consultation, supervision, and therapy in order to develop "cultural competence" in the area of spirituality (Abernethy, 2004; Bartoli, 2007).

Step Two: Be Clear About Your Definition of Spirituality and Religion

The therapist must next give considerable thought to his or her understanding of the meanings of spirituality and religion that he or she will use to describe these phenomena to group members. I read widely and choose to define terms for my patients in ways that are inclusive without being imprecise.

Definitions That Meet These Criteria

Spirituality encompasses a search for meaning, for unity, for connectedness, for transcendence, and for the highest of human potential. Religion is a (more or less) organized search for the spiritual associated with a covenant faith community with narratives that enhance the search for the sacred (Emmons, 1999).

In other words, although there is a strong connection between the two phenomena, the understanding of spirituality and the context of it varies from individual to individual and may or may not connote religion per se. Furthermore, it may denote a theistic or non-theistic orientation. The group leader's function is neither to prescribe nor proscribe an individual's specific approach. Rather, it is to foster this dimension on the individual's own terms.

Step Three: Be Clear About Your Understanding of the Interrelationship Between the Spiritual and Psychodynamic Dimensions to the Work

Having set the stage for inclusion of the spiritual aspect, the next step is to work with it as it manifests itself in the dynamics and process of the individual and the group. There are various ways to frame this; however, I will place emphasis on one dimension I find particularly relevant to group members. This is the area of self-development, especially what can be called searching for the "true self" (Winnicott, 1960) in psychodynamic terms, or responding to one's "vocation" (Merton, 1965), in more spiritual terms.

The chief complaint of many group members is a lack of self-esteem and a profound sense of shame about themselves. Often, in lieu of a real or "true self," a person develops a "false self" and loses connection with himself or herself in the service of survival and protection of the "true self" (Miller, 1981). For many, this is the great tragedy of their lives underlying the presenting complaints. So, what does this have to do with spirituality?

At the heart of my own approach to life and to therapy is the notion that the individual's fundamental "vocation" or task in life is to become who he or she truly is (Merton, 1965). If there is a place for the word "holy" here, its implication is "wholeness." This is not to imply that there is a preestablished mold into which one must fit. Rather, it is a lifelong process of continual efforts at self-understanding, rooted in mind, heart, and spirit, and decision making that actualizes this understanding by good decisions made in freedom.

Step Four: Make Explicit That You Welcome the Spiritual Dimension into the Group Process

My own practice is to invite this topic during the first two individual meetings I have with a prospective group member; the goals of these meetings are as follows:

- To get to know the person and his/her hopes and goals for the group work in a preliminary way and to determine whether there is a mutually good match for the work

- To prepare the person for entrance through discussion and written materials that inform and educate him or her about the ways to get the most out of group

Up to this point the content of our meetings has been generic and psychodynamic. My first introduction of spiritual-religious content occurs when I point to a four-legged table in my office. I ask people to consider the four legs of the table and think of them as the "Four Legs" on which all our lives are built and on which we will be working in group. I call the legs: love, work, play, and pray.

After giving some elaboration to the first three legs, I turn to the pray leg. My mention of the pray leg is often surprising to people because many people who come to therapy do not expect a therapist to inquire into this area. This area may also be very problematic for many patients who have had bad and even traumatic experiences during their religious upbringing. For these reasons it is essential to define and describe my inclusion of this dimension in a way that is more far reaching than the traditional confines of religion.

I tell the person that "pray" might be taken in a more literal sense by some individuals, making use of specific prayers or prayer forms, within a specific religious or spiritual tradition. However, it might also be taken in a broader sense as (1) a philosophy of life by which one lives; (2) a particular spiritual practice or path within a tradition such as Buddhism; (3) a meditative practice such as mindfulness; or (4) the values or principles by which one lives and orders one's life. My point is that we are all searching for some meaning in our lives and this goes to the heart of what spirituality and religion are all about. This is very close to what Yalom (2005) calls "existential factors" in his list of "group therapeutic factors." It is also reflective of what others call "the psychology of ultimate concern," which involves "an ultimate vision of what people should be striving for in their lives" and the strategies to reach those ends (Emmons, 1999).

Step Five: Address Spiritual Issues in the Group

Now when I lead a group I am very aware that I view the members and the group process with a vision I characterize as psychospiritual. This vision is binocular, engaging a dialectic that oscillates between a spiritual view of the work occurring and a psychodynamic conceptualization of what is happening, each mutually informing and reinforc-

ing the other. Let us consider one such focus that, in psychodynamic terms, can be self-psychologically conceptualized as the establishment of the true self, and, in spiritual terms, can be considered the work of seeking one's "vocation." Both involve a full and rich integration of all aspects of our humanity, the good, the bad, and the ugly.

Practically, what occurs in group is that an individual begins to open up about his or her self-worth. Gradually, as trust in the group and leader increases, the individual invites us into his or her life at a deeper level, overcoming the initial reluctance to do so. A spiritually informed response is: it is not because we are perfect that we are worthy of love, but because we are human that we are worthy of love.

CLIENTS' RESPONSES TO THE INTERVENTION

To give people a better picture of themselves and in order to enhance self-understanding and to correct distortions in self-perception, I encourage individuals to "try to see yourself in our eyes," mine, and those of other group members. Although the person may object, e.g., saying that I am paid to say things like that or that group members are just trying to be reassuring, gradually, genuine responses and feedback begin to take root in the person. As group members face themselves with others they can face their internal shame, which ultimately elicits changes that will give them richer, fuller lives.

CONCLUSION AND CONTRAINDICATIONS

In summary, the milieu I wish to create in group is one that is psychospiritual in nature without being heavy handed about either side of the polarity. First, I do this by welcoming the spiritual into what is a psychological domain in my preparatory work for group treatment. Second, I use my own understanding and experience of the linkage between the two to foster and encourage that in the group members. I do not proselytize or convert people to my view. Third, I seek for a common language and phenomenology that interconnects the spiritual and the psychological, in this case, I emphasized the notion of self and its development.

My job then is to serve as a psychospiritual guide, assisting the individual to a place of acceptance and integration by first emphasiz-

ing the universality of his or her pain and shame, saying for example, "Isn't that true for all of us?" This statement is more inclusive and reflects the reality of our shared humanity, which is more alike than not. A spiritually informed stance reflects the reality of an underlying belief that God, the transcendent, the sacred one, is kind, compassionate, forgiving, and accepting of the fact that we are sometimes all too human and that we encounter this God through our basic humanity and human experience.

This perception must necessarily involve the full picture of the individuals, their shortcomings, and "bad" aspects. If group members and the leader can bear to be flawed and limited in the presence of one another, change can begin to take place.

In general, there appear to be no contraindications about dealing with religious or spiritual issues. Although addressing such issues with more severely disturbed clients seems contraindicated, there is clinical evidence that addressing spiritual issues with this population can actually be therapeutic (Kehoe, 1999). The one instance when caution must be exercised occurs when such issues arise in groups with members who may have experienced abuse or trauma from religious authorities or due to the organizational structure of their ecclesiastical institutions. In such cases one must wait for indications that the individual is ready to engage such issues productively.

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Chapter 73

Integrating Cognitive Behavioral with Psychodramatic Theory and Techniques

Thomas Treadwell
V.K. Kumar
Joseph H. Wright

This brief chapter combines psychodrama and cognitive behavioral therapy (CBT) techniques in applied group settings. We illustrate the application of some CBT techniques that were found helpful in the three phases of psychodrama with college students and patients diagnosed with mood, substance abuse, anxiety, and personality disorders, Although both CBT and psychodrama models stress the discovery process through Socratic questioning, the use of certain structured CBT techniques (e.g., the Dysfunctional Thought Record) provides additional ways of stimulating the development of self-reflection and problem-solving skills. The group cognitive behavioral therapy (GCBT) model focuses on identifying upsetting situations, automatic negative thoughts, triggered moods, writing balanced thoughts to counter negative automatic thoughts, and recognizing distortions in thinking and imprecise interpretations of difficult situations. The GCBT environment provides a supportive and safe climate to practice new thinking and behaviors (Treadwell, Kumar, & Wright, 2004).

Although traditional psychodrama is conceptualized in terms of three main techniques—warm up, action and sharing—there is no dearth of techniques that may be applied in those three phases (see Treadwell, Stein, and Kumar, 1988, Treadwell, Kumar, & Stein, 1990). The versatility of psychodrama stems from the variety of tech-

niques that have been borrowed or adapted from various individual and group psychotherapy modalities. With the increasing popularity of cognitive behavioral therapy (CBT) techniques, especially those developed by Beck and his colleagues (see Beck, 1995; Beck, Rush, Shaw, & Emery, 1979) in the treatment of anxiety and depression in individual psychotherapy, we found incorporating these techniques within a psychodramatic environment produced persuasive results. Thus, the blending of the two models yields a complementary eclectic approach to multiple problem-solving strategies.

CLIENT/PATIENT POPULATION

This particular intervention has proven to be effective with college students and patients diagnosed with mood, substance abuse, anxiety, and personality disorders.

GUIDELINES AND INTERVENTION FOR A GROUP COGNITIVE BEHAVIORAL THERAPY (GCBT) PSYCHODRAMA

In applying the various CBT techniques within the context of psychodrama, it is important to devote the first one or two sessions (at least three hours each) to educating the participants about the GCBT model (cognitive behavioral and psychodrama) to create a safe and secure environment in which individuals can share their concerns freely with group members.

The initial didactic sessions convey the notion that the group format is, foremost, a problem-solving approach for working through various interpersonal, occupational, educational, psychological, and health-related conflicts. Group members receive instruction about the nature of the structured activities so that they have realistic expectations about how the group will be run. At the outset, the therapist introduces the group members to the significance of completing the Beck Depression Inventory-II, the Beck Anxiety Inventory, and the Beck Hopelessness Scale on a weekly basis. Diagnostic instruments, which are completed before the start of each session, are stored in their *personal folders* to serve as an ongoing gauge of their progress in the group.

In addition to the Beck inventories, group members complete Young's (Young, Klosko, & Weishaar, 2003; Young & Klasko, 1994; Young, 1999) schema questionnaire(s), which allows therapists to obtain additional data on early maladaptive and dysfunctional schemas/core beliefs. A list of dysfunctional schemas and core beliefs with definitions are given to participants during the initial session. The Social Network Inventory, similar to a genogram, (Treadwell, Stein, & Leach 1993) is utilized to map and quantify participants' relationships with family members, significant others, groups, and organizations. Each group member signs an informed consent form and an audiovisual recording consent form. The audiovisual recordings establish an ongoing record of group activities and serve as a source for feedback when needed.

APPLYING CBT INTERVENTIONS AND TECHNIQUES TO PSYCHODRAMA

Dysfunctional Thought Record (DTR) or Automatic Thought Record

The classic psychodrama techniques of role reversal, doubling, self-presentation, interview in role reversal, mirroring, future projection, surplus reality, empty chair, and other action techniques (Moreno, 1934; Blatner 1996; Kellerman, 1992) can be applied directly to situations indicated in the DTRs. During the initial didactic sessions, we found that it is extremely helpful to teach the group members how to complete a DTR. It is important to introduce the DTR as a self-reflection strategy for recognition of automatic thoughts that occur within and outside the therapy sessions and for improving problem-solving and mood-regulation skills.

Automatic Thoughts (ATs)

Automatic thoughts usually contain one or more *cognitive distortions* (Greenberger & Padaskey, 1995). The auxiliary ego and the therapist may help the protagonist discover the possible cognitive distortion in the protagonist's stated AT. For example, for an identified "all-or-nothing" cognitive distortion, the therapist develops a scenario to explore the distortion in an action format to get an in-

depth, concrete explanation of the protagonist's thought processes. Additional auxiliary egos or the self-presentation technique are used to represent the many conflicting selves to facilitate working through the cognitive distortion.

Downward Arrow Technique

The downward arrow technique consists of challenging the protagonist by repeatedly asking the questions: "If that were true, why would it be so upsetting?" and "Being upset means what to you?" The technique can be used during any stage of psychodrama to explore a deeper understanding of the core beliefs/schemas underlying an AT.

The Case Conceptualization Technique

This technique is applied as an ongoing therapeutic tool. After three or four sessions, the therapist explains and teaches the main ideas behind the technique to group members and asks them to complete the case conceptualization form on an ongoing basis as the group progresses. A member discusses his or her completed form with the group on an assigned day.

Case conceptualization may help the group member reflect on their various rules, conditional assumptions, beliefs, and means of coping. It is also a good way of introducing the cognitive triad to group members who characterize their situations to reflect themes of loss, emptiness, and failure. Beck (1995) referred to such bias as the negative triad, viewing oneself ("I am worthless"), one's world ("Nothing is fair"), and one's future ("My life will never improve") in a negative manner. This view is usually distorted and the purpose of designing a case formulation is to challenge the patient's views of self, the world, and the future.

CLIENT/PATIENT RESPONSES

Initially, we found clients/patients to be hesitant of the GCBT model. In contrast, once they are taught the basics of the automatic thought record and understand what an automatic thought is to them, they then realize this technique yields real-life data that are not terribly threatening. They show signs of relief and begin to see that auto-

matic thinking is what "we" all do. In addition, they recognize "their" core beliefs and schemas in relation to "all" people across their life span, that negative situations activate schemas/core beliefs and this now has a calming effect. This knowledge serves to normalize the group cognitive behavioral therapy process allowing group members to feel at ease. Patients/clients have found this model useful in combination with individual therapy, either at the same time, or in sequence.

CONCLUSION

From our experience, integrating CBT with psychodramatic techniques creates a powerful and effective group process enabling participants to address problematic situations with the support of group members. Students and clinical populations respond well to the CBT techniques and find them helpful in becoming aware of their habitual dysfunctional thought patterns and beliefs systems that play an important role in mood regulation. Therapists can use advanced CBT and psychodramatic techniques, not illustrated in this brief chapter, to address intricate problematic situations. The basic and advanced cognitive behavioral coupled with schema-focused techniques merge nicely within the psychodramatic framework. Therapists can expect some resistance from group members, especially with regard to their not completing DTRs on time or their unwillingness to share their DTRs initially with the group. We found, however, that group members quickly begin to see the usefulness of the various structured CBT techniques and adapt accordingly.

One of the most important elements of GCBT is that it is *data based*—group members keep track of their dysfunctional thoughts, depression, anxiety, and helplessness scores from week to week. They are able to see changes that result from group therapy that make the therapeutic process a tractable one. The GCBT model promotes dynamic group interaction, experiential participation, provides opportunities for catharsis, and facilitates basic group psychotherapeutic techniques. The integration of CBT techniques allied to psychodrama help provide a balance between an exploration of emotionally laden situations and a more concrete, data-based, problem-solving process.

CONTRAINDICATIONS

Therapists need to be skilled in both cognitive behavioral and psychodramatic therapies before attempting to implement group cognitive behavioral techniques. We suggest avoiding using psychodramatic techniques during session one and focus on psychoeducation. From our experience, the preferred size of a group is between five and ten members with sessions lasting two to three hours. The duration of treatment can be brief, fifteen weeks or extended. Patients need to be screened before matriculation into the group.

Based on our observations, the following exclusions are recommended: (1) individuals with self-centered and aggressive disorders display strong resistance to group work, especially when assuming auxiliary roles. They tend to lack spontaneity and are rigid in their portrayals of significant others; that is, they either insulate or attempt to dominate others in the group; (2) it is better to rule out individuals with narcissistic, obsessive compulsive (severe), and antisocial personality disorders since individual therapy is more suitable for them; and (3) individuals with Cluster A personality disorders and impulse control disorders, such as intermittent explosive disorders, have difficulty functioning in a group composed of individuals with different diagnoses.

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Chapter 74

Preparing Members to Fully Participate in Group Therapy

Rebecca MacNair-Semands

CREATING NORMS FOR GROUP MEMBERS

There is strong consensus that pre-group preparation can be profoundly beneficial, not only for prospective members but also for the group as a whole (Rutan & Stone, 2001; Yalom & Leszcz, 2005). Group norms such as confidentiality, attendance, punctuality, socializing with other group members, and contact between group sessions should be repeated often and reinforced frequently throughout the life of the group. Norms for therapy groups can be infused by the leaders at almost every moment, starting with a pre-group meeting between prospective member and group leader(s). The initial meeting also develops member expectations for group, which may help the entire group stay focused on treatment goals.

Group members who are prepared prior to entering group therapy may experience greater group cohesion, deviate less from tasks and goals, be more committed to attend meetings, have less anxiety, better understand their roles and behaviors in the group, and show an increased amount of faith in the group as a whole (Bednar & Kaul, 1994; Piper & Ogrodniczuk, 2004; Yalom & Leszcz, 2005). There are three primary methods used to prepare members for the group experience: cognitive learning, vicarious experiencing, and behavioral practice. It has been found that a combination of modalities (e.g., verbal, written, experiential, audiovisual) is most effective (Piper & Perrault, 1989). This chapter will emphasize the first two methods of pre-group preparation interventions to assist leaders in creating high

functioning therapy groups. There are also numerous recent examples of written preparation materials that leaders can access in the CORE Battery-R (Burlingame et al., 2006), the American Group Psychotherapy Association Ethics Curriculum (MacNair-Semands, 2005), and various journal articles (MacKenzie, 1997; Rutan & Alonso, 1999).

DESCRIPTION OF PSYCHOTHERAPY GROUPS

All forms of group treatment, regardless of duration, setting, or theoretical model generally benefit from group preparation for members (Budman, Demby, Soldz, & Merry, 1996; MacKenzie, 2001; Rutan & Stone, 2001). The pre-group preparation interventions presented here are designed to develop individuals to be fully participating members of process-oriented general therapy groups. Such groups emphasize the here-and-now to guide interpersonal learning and are specifically designed to be heterogeneous rather than theme-based or problem-based in nature (Yalom & Leszcz, 2005).

A PRE-GROUP INTERVENTION

The pre-group meeting is an opportunity for group leader and candidate to discuss the benefits and scopes of the group. During this meeting, the candidate should be given the opportunity to interview the group leader and ask questions, allowing the candidate to form a judgment and make an informed decision about the group. A pre-group meeting can also be considered a type of mini-group experience to assess how well the candidate may interact in the group setting. It is recommended that the following information is conveyed in both written and verbal formats to provide repeated reinforcement of norms. Verbal interventions are put forth in the next section, followed by written comments that can be incorporated into a handout adapted for a particular clinical setting.

The following examples of initial introductory comments can be presented by clinicians that describe the group therapy experience to potential members.

- In group, you can go a step further than *talking* about the way you relate to others; you can actually practice *changing* the way you relate to others.
- Group has been shown to be an effective treatment of choice for your specific issues—people like you do well in group.
- An individual therapist is often unable to observe your interpersonal style that you feel is not working for you; in group, these dynamics can become clear to you as others observe you.
- One of the nice things about groups is that you may work through a problem merely by listening to another group member struggle with your issue. Without speaking at all, you may gain insight and healing. You do not have to do all the work by yourself.
- Your problems are similar to those of other clients in group counseling; although your situation may be unique, your underlying feelings will be remarkably similar to other group members. People often describe feeling less alone and isolated once beginning group therapy with others who understand difficulty.
- You may feel nervous about the first group session. As you hear others disclose and you begin the process of letting people get to know you by revealing yourself, you may be surprised at how quickly you feel more comfortable. The people who are able to share things in group often get the most benefit.

Written handouts with information specific to therapy groups can greatly benefit clients' understanding of the group process. Such handouts and can be utilized to clearly communicate group norms and help create a healthy group climate. These handouts may be given prior to the pre-group meeting to help prospective members begin to absorb the concepts.

The following statements are easily incorporated into a written format for handouts:

- You are encouraged to talk about your feelings and experiences, particularly in areas that are emotionally uncomfortable or risky for you. You will make the most progress if you allow yourself to experience and discuss your true feelings and reactions to others.
- It is normal to feel some anxiety as you talk about your personal feelings, thoughts, and experiences with others. Share these dif-

ficulties or concerns at a pace that is comfortable for you rather than forcing yourself to disclose too quickly in group.

- You will be challenged to relate to one another without superficial conversation, social amenities, and other forms of social distancing in order to be as direct, frank, and spontaneous with your thoughts as possible. Questions should be rare, but the thoughts and feelings behind your question will be important to explore.
- Confidentiality is mandatory; it is extremely important to help you feel safe in discussing personal issues in group. You may talk about your *own* feelings and growth experiences with someone outside of the group but you may *not* discuss other people or reveal the identity of any group members. Please do not use Internet forums such as Facebook or MySpace to discuss your therapy group experience or reveal the identities of other group members.
- When you have reactions to something another member says, it is helpful to share those feelings in group directly with the person. A good way to do this is to use "I" statements, such as "I can relate to what you are saying because I also feel afraid when. . . ," etc. Giving advice, labeling someone, or criticizing are generally not productive in group.
- We make every effort to begin and end group on time. Please be on time for the group sessions, and if you have to be late or miss a session due to an emergency, please call and leave a message ahead of time for one of the leaders.
- We ask that you not have social relationships outside the group with other group members. All members are encouraged to let the group know if you have had a significant conversation outside of group. This helps to keep the group relationships therapeutic.
- Attendance is mandatory in order to keep the group feeling cohesive and safe.
- If you decide you need to leave before the ending of the group, please inform the group and give a minimum of two weeks notice.

ANXIETY ABOUT THE UNKNOWN

Group candidates often come to pre-group meetings with a significant deal of anxiety. Typically, clear guidelines reduce this anxiety but may also raise new questions for the members. Questions related to how they will be perceived by the group and whether personal needs will be met often surface during the pre-group session. It is helpful for leaders to communicate a solid sense of hopefulness about meeting treatment goals through group therapy while also assisting the member in voicing concerns and addressing how leader(s) will help protect and serve the client throughout the process. Leaders can ask candidates to identify what barriers or behavioral patterns might impede the group process, and then leaders can gain verbal permission to push or encourage members when such resistances surface.

CONTRAINDICATIONS

Groups are more successful when a clear and thorough orientation is provided to potential group members. There are generally no contraindications to conducting pre-group preparation sessions, but clients who feel easily rejected may need a compassionate and thoughtful explanation of why a particular group is not a good match for a specific candidate. Overall, most leaders find that pre-group meetings build a strong beginning for developing trust in the leader(s) and an understanding of the group process.

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Chapter 75

What to Do When the Group Is Falling Apart

Steven L. Van Wagoner

THE IMPORTANCE OF RESISTANCE

The study of resistance in group psychotherapy and what it reveals about the member's core conflicts and interpersonal difficulties is central to psychodynamic and analytic group psychotherapy (Fehr, 2003; Ormont, 1992; Rutan & Stone, 1993). Because resistances in group can also be thought of as transference resistances, we must be prepared to work through these transferences from the members to the therapist, and to each other (Ormont, 1993). This requires the willingness of the group members to work in the "here and now," communicating their immediate reactions (thoughts and feelings) to one another and to the therapist, and the ability of the therapist to foster, through whatever interventions at his or her disposal, this kind of group work. Often, transferences in groups generate intensely negative feelings, which members resist communicating verbally. In this instance, it is essential for the group therapist to help members communicate these feelings verbally, before they become entrenched and threaten the very survival of the group (Rosenthal, 1976).

THE GROUP IN CRISIS

A mixed-gender adult psychotherapy group had been meeting for approximately two years. Up until this phase, in the life of the group, members had learned to express both positive and negative feelings

toward the therapist and one another, and reflect upon their thoughts and feelings toward one another in the "here and now," but suddenly this began to change. Communication in the group quickly became devoid of real feeling, almost lifeless. People talked solely about problems in their lives outside of group, but it was as if life outside the group had sucked the life from within the group and between the members. In addition, a couple members were either periodically late, or did not come, often offering seemingly reasonable excuses. It was the pattern, not the absence per se, that was suspect. Attempts by the therapist to explore members' reactions to one another or to the absences were met with either silence or feigned acceptance. The group-as-whole seemed to thwart any attempts by the therapist to intervene. Finally, one member announced that he was leaving, which led to two others expressing that they felt similarly. Suddenly the group was in serious trouble.

THE INTERVENTION

Examine Induced Countertransference Feelings

One of the more important things I can do, as a group therapist is to examine the feelings I am having about what is occurring in the group. With this group I was feeling particularly frustrated with the lifelessness of the group, but more with what I thought was a group-as-whole resistance toward me and the contract. Becoming clear about these feelings through consultation with a colleague helped me appreciate the high degree of frustration in the group members that was being induced in me. Could it be that the members were also feeling frustrated with one another's deviations from the contract? With this understanding I was the intervention.

Stay Mindful of the Contract

My group contract not only identifies patterns but is able to decrease the intensity of my own emotional reaction and extract myself from my own counterresistance to breaking the impasse. Thus it proceeds with defining lateness and absence as a form of nonverbal expression of feelings (i.e., "Put all thoughts and feelings into words, not action"), but also encourages other members to confront devia-

tions from the contract as they occur. The contract can be a starting point from which to identity resistance.

Confront the Group with Behavioral Observations About the Resistance

Avoiding interpretation and speculation when sharing one's assessment of a group's destructive resistance is essential if the members are to be able to look directly at their resistance. Framing the observation from the standpoint of the contract will keep the therapist's observations on firm ground.

If Necessary Draw any Aggression to the Leader

It is assumed that once the therapist confronts the group directly with its resistance, which in this case was due to the indirect expression of aggression through lateness, absence, and emotional withdrawal, the members' frustration, which had been induced in me, would come out more forcefully. Because the group is in such a tenuous and frustrated state, risking the attack on a member would only further indicate that the group is a dangerous place to be. As a result of this assessment, it is imperative that the group therapist protects members from attack and scapegoating, and one way this can occur is by directing aggressive responses toward himself or herself.

I basically told the group that I was not surprised that some people wanted to leave, and that I could not blame them. When they asked me to explain my statement, I elaborated, telling them that it was clear to me that the group was bogged down, and that the emotional sharing that had at one time been a fact of life in the group, had all but completely died. Moreover, I pointed out that people had in effect been leaving for some time through absences, lateness, and emotional withdrawal, and that it was a matter of time before they would leave the group altogether. I further suggested that they must have been frustrated with me for not being more of a stickler with the contract, and suggested that without my help they must have felt powerless to stop the withdrawal.

THE GROUP'S RESPONSE

As I explained my observations to the group, several members began nodding their heads in agreement. Two of the members who wanted to leave expressed their anger directly at me for not being a more strict parent in the group. One relayed that his father had never stood up to his mother, leaving him feeling powerless and frightened. The other expressed that her parents had always placed responsibility upon her prematurely for her sister's care, which she felt that I replicated in the group. For both members, these earlier experiences were reignited in the group.

Another member defended me saying that it was not just the leader's responsibility to adhere to the contract, but that they had all agreed to take a role. Before the group could turn on her, however, I suggested that while that is ideally the case, sometimes it feels too threatening for a member to do this. I then asked why she had not confronted some of the contract violations, which she immediately understood was because it has always been dangerous to risk the rivalrous feelings of her siblings when joining with her parents.

Though there was much more to the vignette and subsequent group sharing that followed, the processing of feelings that resulted created new life in the group. There were no longer the stale renderings of events outside of the group, but an in vivo experience of them in the interactions in the group. Moreover, the pent-up frustration and aggression was brought into words and directed to me, where I could contain them. Ensuring that the initial burst of anger and hostility was directed at me, and not at individual members, prevented the group from electing a scapegoat, and helped to protect any individual members from too much emotional stimulation.

CONCLUSIONS AND CONTRAINDICATIONS

The vignette illustrates how directly and forcefully confronting resistance can aid a group in becoming unstuck (Fehr, 2003), and in this case was imperative to deal directly with a treatment-destructive resistance (Rosenthal, 1987). The stepwise delineation of the intervention is meant only as a guide to thinking about how to intervene in such a situation, and in no way is meant to convey that this intervention can work in all situations where a group is stuck. The first step,

examining the induced feelings of the therapist, is a multilayered process, which should involve consultation with supervisors, one's own therapist, and/or a careful self-analysis of one's emotional response to the group. It is not based upon an in-the-moment assessment that leads to a quick and impulsive construction of an intervention when so much is at stake. It is recommended that all group therapists considering such an intervention engage in such a process of self-exploration.

In fact, it is because of the very emotional response this therapist had to the group that some time and care was taken to formulate the intervention (between the session in which the members announced an intention to leave, and the subsequent session). Second, knowledge of the members' individual characteristics, capacities for emotional stimulation, self-awareness, and personal histories is essential in helping the therapist navigate the intense exchange that follows any such confrontation. Finally, it is essential to emphasize that the intervention began with a confrontation that was based in behavioral observation, devoid of interpretation and speculation which can derail examination of resistances (Ormont, 1992), and as the leader I used myself to regulate the emotional excitation of the group, what Rosenthal (1999) refers to as the "thermostatic function" of the group psychotherapist or analyst.

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Chapter 76

A Difficult Session

Marvin Kaphan

The greater the difficulty, the more the glory in surmounting it.

(O'Connor, 1993)

INCLUSION

Virtually every authority will agree on the importance of careful screening and thoughtful selection of the members of a psychotherapy group (Rutan & Stone, 2000; Fehr, 2003). Yalom (1994) further suggests that the fate of a group can be sealed before the group begins due to the inclusion or exclusion of its members. Many years ago, when initiating my six groups, I found this relatively easy, since I drew the group members from my individual practice. I had worked with every participant for a considerable period of time, knew them quite well, and felt very comfortable placing each one in an appropriate group.

GROUP DESCRIPTIONS AND INCLUSION

All of my groups are heterogeneous and psychodynamic. They are made up of private patients, on a continuum from moderate functionality to high functionality, and including diversity in age, gender, and diagnosis. Over the years, each group had developed a somewhat different personality, and I had become quite proud of the technique I

had developed for placing patients in groups. This was a process of "fantasy." I would try to picture how a given patient would affect each of the other members of the group, how each of them would affect the patient, and what effect this patient might have on the functioning of the group as a whole. This method had worked so well that I had never been disappointed in the result, and the only surprises had been that patients would achieve more, progress more quickly, or reach more meaningful insights than I had expected.

As time went on, some of my groups' patients came from referrals from individual therapists who did not have groups, but felt that their patients could benefit from concurrent group therapy. Most group therapists require at least one screening interview before placing a referral into a group, but we still have to depend, to a certain extent, on the individual therapist's evaluation of the patient's readiness for group therapy.

On one particular occasion, I placed a referred patient into a rather high-functioning psychodynamic group after a single screening interview. Since the patient appeared to have trouble in social relationships, the therapist hoped that a group experience would give this individual some insight into how he was contributing to his problems. In rare instances, I have found that new patients, on entering a group, will begin to provoke the other members of the group. This becomes grist for the mill of group therapy, and with only minimal help from the group therapist, the group can explore the motivations and unconscious forces that drive such behavior. Usually, as a result of the "magic" of group process, everybody gains.

In this particular instance, it took a very different course. The new participant's attacks were particularly vicious, striking at each member's vulnerabilities, stimulating forceful retaliation from the group members. The provocateur's response to the retaliation seemed to be a rapid decompensation. His wild, frantic, and paranoid utterances seemed to be adding to the outrage of the group. I felt I was seeing a psychotic process in the making, and decided to direct the focus of the group away from the psychologically deteriorating new member.

THE INTERVENTIONS

When group therapists feel the need to direct the attention of the group, they have a choice of only four directions in which to go. They

can either incorporate all four directions, a combination of three directions, or utilize one direction as the intervention of choice. These four directions are as follows:

1. Draw the attention to the member making a comment.
2. Focus on the person responding to the comment.
3. Elicit the responses of another member of the group to the comment.
4. Involve the group as a whole in examining their feelings about the comment.

These four interventions are accomplished with therapist-posed questions. It is essential when such an intervention is used, that the group has been educated to the fact that the therapist will never use rhetorical questions. Most people in our society have been acculturated to expect that many questions are really commands. "Why did you do that?" often can be interpreted as "You should not do that." The therapist must emphasize repeatedly that his or her questions are real questions, aimed at exploring "reasons for behavior."

In this case, in order to protect the new patient, my interventions were meant to direct the group in only three of the four directions for the entire session:

1. Toward a group member subjected to an attack.
2. Toward another group member.
3. Toward the group as a whole.

When the target of an attack retaliated against the attacker, I turned the attention to the retaliator by asking, "If someone had used the words that you used to retaliate, what effect would it have had on you?" This question must be asked very carefully, because in spite of careful preparation for the meaning of questions, it is easy for the patient to experience the question as reproof thus the patient experiences a narcissistic injury. The patient's established trusting relationship with the therapist and the therapist's tone of voice forestalled that misinterpretation. That allowed the therapist to proceed to: "What do you think your purpose was?" and "How would the rest of you have experienced that remark?" This again has completely removed the focus from the new patient.

In directing or eliciting a response from a group member toward the victim of an attack, I used questions like, "How did that make you feel?" If I had wanted to direct attention toward the attacker, I could have asked if producing that emotion was his or her goal, but in this case, since I wanted to direct away from the attacker, I would follow this with, "When have you felt a feeling like this before?" From there it was easy to go to "How have you handled situations like this in the past?" which has completely removed the focus from the new patient. After that, I was able to involve other patients with questions like, "You have talked of similar experiences, how does the one just described compare to yours?" By this point, the group had once more been directed away from the attacker.

Finally, to direct the spotlight onto the group as a whole, I would ask such questions as: "What seems to be happening here?" and "How do you feel about it?" Gradually, as the center of attention was kept away from the deeply troubled patient, he could calm down somewhat. I needed only a brief session with him following the group to satisfy myself that he was sufficiently composed to return home safely. In a subsequent discussion with his individual therapist, it was decided that this kind of group experience was too dangerous for this patient, and no effort would be made to encourage him to return.

TYPICAL RESPONSES

The interventions that were used in this session are common devices to direct the focus of a group, although they are rarely repeated with this frequency and consistency. With moderate use of these techniques, even the most rebellious group members tend to react with benign compliance. Occasionally, a group member will protest with a comment like, "Wait, I want to hear more about . . . ," but the delay in the transition does no harm, as a rule.

CONCLUSION AND CONTRAINDICATIONS

All the patients who enter my groups make a commitment to give a month's notice before leaving, but this patient left without notice. One of my concerns was that the group members might fear that other patients could be driven out of the group if they aroused disapproval,

but after a lengthy discussion of the incident in the next session, I was convinced that they all accepted that this patient's decision to leave abruptly was in his best interest as well as the group's.

I cannot see any contraindications to the use of these interventions, except if they were regularly used with the demonstrated frequency and intensity during a single group session as they might strike some group members as overly authoritarian and overbearing on the part of the group therapist.

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Chapter 77

The Nine Basic Steps for a Successful Group

Joshua M. Gross

CHECKLIST FOR STARTING A GROUP

The literature is ripe with information about how to conduct group psychotherapy. There are many approaches to this work and the interested reader has many choices for basic instruction of how to do this work (Berg, Landreth, & Fall, 2006; Bernard & MacKenzie, 1994; Fehr, 2003; Price, Hescheles, & Price 1999; Rutan & Stone, 1993; Trotzer, 2006). This intervention uses a checklist as a tool to determine if you are ready to have the first meeting of your new group. So often, therapy groups do not thrive and the literature is clear in describing a series of specific steps that are necessary to ensure that the group is ready to start. This intervention is for the leader(s) and is designed to assist them in determining if they have addressed the nine basic steps necessary for the initiation of a successful group.

DESCRIPTION

This is a generic intervention for group leaders and as such has application for many forms of group intervention including homogeneous or heterogeneous groups, a process or theme-based group, a time-limited or open-ended group, or any other category or theoretical approach to the work. The main point here is to ensure that the intervention is well planned, structured, prepared, and initiated.

Often, the beginning group therapist puts more emphasis on the procedures of leadership that take place in the first and subsequent meetings of the group. The main point of this intervention is the idea that the group work begins from the moment that the therapist has the idea that a therapeutic group is needed, which allows for a focus on the many details that require attention before the first group meeting. This checklist was designed with the idea that the beginning group therapist can benefit from having a tool which assures that all appropriate due diligence has been covered and that the group is in fact ready for the first meeting.

CHECKLIST FOR STARTING A GROUP

_____ Clear statement of purpose for the group must include goals, objectives, membership criteria, time frame, and fee structure if appropriate.
_____ Well-reasoned plan for location, schedule, and clinical operations necessary to initiate the group.
_____ Distribution of a written announcement addressed to both referring colleagues and potential group members.
_____ Active development of referrals through presentations, outreach, discussion, posting of flyers, and direct solicitation.
_____ Discussion of prospective cases with colleagues to evaluate the goodness of fit for membership in the group.
_____ Scheduling of consultation session with prospective members to personally evaluate their readiness and to prepare them for their experience in the group.
_____ Orientation to group membership includes discussion of:

1. When the group will meet and start.
2. What to expect in the first meeting and those that follow.
3. Regular attendance.
4. Confidentiality.
5. Resolution of differences between members and leaders.
6. Acknowledgment all contacts with members outside the group.
7. Clear description of fees if appropriate.

_____ Contact group members weekly to remind them of when and where the group will initiate as you are preparing the intervention.

_____ Initiate the first session with a review of the rules and some suggestions as to how the new group members can best start talking with one another productively.

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Chapter 78

An Effective Precipice Toward Recovery

T. Wing Lo

THE GAMBLING TABLE

"Gambling table" is a group therapeutic exercise invented by the author to facilitate clients to face their problems and concerns in a dramatic form. It must be used in the cohesive stage of a group when members have trust in one another and established positive working relationships with the therapist. It assists clients to express feelings that underlie their problems through the use of action and enactment (Blatner, 2000; Karp, Holmes, & Tauvon, 1998; Kellermann, 1992; Leveton, 2001). The intervention is applied with one key client at a time, with other group members acting as helpers and supporters during the role-play. The intervention aims to confront clients with the negative effects of their beliefs and behaviors, handle uninhibited emotion, and gain insight into the clients' own problems.

CLIENT POPULATION

This intervention has been used in gamblers' support groups, extramarital affairs groups, and groups handling love/relationship issues among youths and adults, although it can be generalized to groups of other natures with slight modifications to suit the unique situations of group members. The intervention is applied to situations where the clients experience the "win" and "lose" sensations in the

course of gambling with money or gambling with love. It is particularly powerful for female members who are single but become a third party in someone's extramarital affair.

GUIDELINES FOR THE INTERVENTION

Prepare a table with 2-3 meters in length and 1 meter in width. The table should be strong enough to let one adult stand and walk on it.

Step 1

Help the client to share his or her gambling or extramarital affair experiences in the group. Then blindfold and ask the client to stand on the table. Tell the client the length and width of the table and the rule of the exercise: listen carefully to the scenarios presented by the therapist or the group, then walk one step forward when he or she is happy with the scenarios and one step backward when unhappy.

Step 2

The therapist asks the client, of a gamblers' support group, the first question: "You won $1,000 in gambling. What did you feel?" Normally, the client responds by moving one step forward because he or she feels happy. The step is usually very small because the client is very cautious of the risk of falling down from the table. Then comes the second and third scenarios: "You won $2,000 and bought yourself a nice watch. What did you feel?" "You lost $5,000 and you did not have money to pay for your son's tuition fee. What did you feel?" The client moves forward or backward according to his or her feelings toward the scenarios.

For female clients in extramarital affair group, the happy scenarios can be "dining with your loved one" and "you accompanied him while he was on a business trip." Unhappy scenarios can be: "he had to stay at home with his wife on Valentine's Day" and "you could not hold his hand in public."

Step 3

To involve the participation of the whole group, the therapist invites members to disclose happy and unhappy scenarios for the client.

Normally the group is serious and silent when the client is getting close to the edge of the table. The therapist invites two group members to stand by the table to safeguard the client from falling without letting the client know.

Step 4

After a while, the client begins to feel he or she may have reached the edge of the table. The therapist asks the client's feeling each time the client is close to the edge.

Step 5

The exercise would reach a point where the client feels confused in the gambling journey (for money or for love) because he or she is blindfolded and loses the sense of direction after walking for a while. The client becomes nervous and stressful at this moment. The therapist then confronts the client why he or she has to walk on the gambling table, knowing that the only ending is to fall down and get hurt.

Step 6

The therapist invites group members to give feedback and support to the client, and then helps members debrief the intervention and unfold the myth that no matter how much money or love the client won previously, there will not be a happy ending.

Step 7

If the client is still resistant to change, the therapist can move the intervention further by involving the client's significant others in a role-play. Suppose the client has a son. The therapist invites a group member to stand on the table and play the role of the son. Tell the client that his or her son grew up and became a gambler; he faced the same problem as the client does now.

Step 8

This time group members are invited to give commands (raise scenarios) to the "son" based on the rule outlined in Step 3. The therapist

sets a "mirror" for the client who is standing aside and watching the son's movement. Normally when the son is close to the edge, the client would shout out: "Stop, son. Don't walk any further." Then the therapist asks the client why he or she says so.

Step 9

At this point, if the therapist considers the client has not gained sufficient insight from the intervention, the therapist can adopt the "Gambling Chair" exercise (see Chapter 8) to further confront the client.

Step 10

Based on these experiences, the therapist leads the group to share feelings and discuss the negative consequences of gambling. They are helped to reflect upon what happened in their past gambling experiences, recognize what exists in the present, set goals for the future and, if possible, develop a series of tasks that they can complete so as to strengthen their conviction in the fight against this destructive habit.

CLIENT RESPONSES

Walking on the table and listening to happy and unhappy scenarios have different effects on clients with different problems. For gamblers, their feelings center around the "risk of falling," signifying the risk of losing everything in gambling. But for groups for those in extramarital affairs, and love relations, the clients could be very emotional.

CONCLUSION AND CONTRAINDICATIONS

When a client is experiencing a personal problem in a dramatic form, he or she is likely to be confronted with the issue without any defense. Being the audience, group members are vicariously going through the same psychological journey as the key client. Thus, the postexercise group exchange is meaningful for members to experi-

ence not only their own but other members' successes and failures before they work out solutions together (Lo, 2005).

In relation to contraindications, the therapist should be aware of the different stages of the client's problem. The reactions of a client who is at the initial stage of gambling or extramarital affair would be very different from one who is "addicted" to it. In the latter case, the client may have gotten used to the ups and downs and might have become detached from his or her feelings when the happy or unhappy moments are recalled.

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Chapter 79

Inoculation Training for Trauma and Stress-Related Disorders

Justin A. D'Arienzo

STRESS INOCULATION TRAINING (SIT)

In 2004, Hurricane Ivan left its destructive wake through Florida's panhandle and the coastal regions of Alabama and Mississippi. Furthermore, due to the Global War on Terrorism operations and the storm's destruction of several military treatment facilities, I became the sole military psychologist providing psychosocial interventions for the region at Naval Hospital, Pensacola, Florida. To address the burgeoning and heterogeneous myriad of patients suffering from various anxiety disorders, I formed a closed process- oriented group utilizing Meichenbaum's Stress Inoculation Training (SIT) model (Meichenbaum, 1993, 1996, 2005).

SIT is a cognitive behavioral therapy (CBT), which enhances one's ability to cope with past, current, and future stressors through three phases of treatment. Patients first learn about the stress response. They are then exposed to anxiety-provoking experiences while acquiring the skills to mange their responses. Finally, patients learn to generalize their newly acquired skill sets to cope with increasingly demanding situations and return to the therapist for "tune ups" as needed. In this model, inoculation is similar to the physical immunity generated by exposure to less virulent forms of diseases. During SIT, exposure to minor stressors in therapy fosters psychological preparedness and promotes resilience.

CLIENT POPULATION

This particular group met weekly for twenty weeks and consisted of five women and three men. All were navy servicemen and servicewomen with the exception of one civilian. Ages ranged from twenty-one to fifty-three. Individual members suffered from combat-related post-traumatic stress disorder, hurricane-related acute stress disorder, sexual-assault-related post-traumatic stress disorder, panic disorder, and general adjustment problems with anxiety.

INTERVENTION GUIDELINES

SIT is a flexible and individually tailored alliance-based intervention used with individuals, couples, and groups. Sessions are as short as twenty minutes and range in frequency from eight to forty sessions. SIT has been utilized successfully to prepare patients undergoing medical procedures (Meichenbaum, 2005) and with patients suffering from anxiety (Suinn, 1990), stress disorders, addictions (Meichenbaum, 2005), and anger control problems (Deffenbacher & McKay, 2000). The Joint Department of Defense and Veteran's Administration Clinical Practice Guidelines (2003) designates SIT as a "Class A" treatment for post-traumatic stress disorder (PTSD). Additionally, Meichenbaum (1993) found SIT to be useful for individuals adjusting to the military.

The objective of SIT is to strengthen the patients' coping repertoire (intrapersonal and interpersonal skills) and build their confidence to overcome the perceived demands of stressful situations. Moreover, the SIT model embraces the transactional view of stress described by Lazarus and Folkman (1984) where stress occurs because the perceived demands of a situation exceed the perceived resources to cope. In this view, stress is viewed as a dynamic relationship between the person and the environment. Similarly, SIT was influenced by the constructive narrative perspective (CNP) (Meichenbaum, 2005). In this view, individuals and groups are seen as "storytelling entities." Their stories are both personal and cultural. The nature and content of the stories that they tell themselves and others play a critical role in influencing the coping process (Meichenbaum, 2005; Brewin & Holmes, 2003; Ehlers & Clark, 2000).

The Three-Phase Stress Inoculation Training

1. Conceptual Education

Through Socratic discovery-based interviewing, the therapist assists the patients in identifying and then conceptualizing their symptoms and triggers. With greater knowledge and an understanding of the biopsychosocial underpinning of their responses, the group and therapist work collaboratively toward reconceptualizating each individual's presenting problem. The group then explores each member's established personal strengths, resources, and resiliencies to enhance personal control and mastery.

2. Skills Acquisition and Consolidation

In this phase each patient develops an action plan tailored to overcome his or her stressor. Interventions are problem focused and emotionally focused. Problem solving, rehearsal, in vivo exposure (in and out of group), and cognitive reframing may be used. Take advantage of the interpersonal interactions inherent in group therapy.

3. Application and Follow-through

During this final phase, patients are encouraged to practice their newly acquired coping skills across increasingly demanding levels of stressors utilizing the interventions described during the second phase. The objective is to achieve generalization and maintenance of changes. Use the group to develop individual relapse prevention plans especially targeting risky situations such as anniversaries, social pressures, or high and low emotional states. Reframe relapse as an opportunity for learning rather than a catastrophe destined to lead to further relapses. Lead patients to assume a consultative role for someone in the group or for a friend, and if appropriate, encourage group members to support one another beyond therapy sessions. Finally, provide a plan for future individual follow-up or booster sessions as needed.

CLIENT RESPONSES

The civilian in the group, a fifty-three-year-old woman, who had hurricane-related acute stress disorder, made significant progress. She entered group attributing her significant anxiety symptoms to fears and memories of dying during the storm. She had married later in life to a much older man, who during the storm, simply turned off his hearing aid and went to sleep, while his wife remained awake fearing for her life. During the course of therapy, she was transformed from a dependent and passive person to an action-oriented self-starter. The experience of the storm created a sense that she was alone and that her husband was unable to protect her. Over time and with the assistance of the group in reconceptualizing the meaning of the traumatic event, she transformed this memory of fear and vulnerability into motivation to become self-sufficient. By the end of therapy she had taken on the role of a consultant to her much younger counterparts, enrolled in college for the first time, and was producing a play in the local theater. It became evident that her passivity had diminished when she threatened to leave her job of ten years and demanded a substantial raise—she received the raise. Also, she no longer blamed her avoidance of social activities on her husband's laziness or obesity. With a new sense of confidence and a little persistence she persuaded her once-sedentary husband to break his symbiotic relationship with his La-Z-Boy chair, and assist his industrious wife with her theater production.

A combat veteran was referred to group after a domestic violence dispute. He benefited most from the psychoeducational component of SIT in understanding his hyperarousal and impulsive reactions to his wife's reactions during even the most benign arguments. The SIT group also assisted him in generating a strategy to evoke "more normal" reactions to stressors involving his wife. Another active duty service member, who had been sexually assaulted by a co-worker, acquired the anxiety management skills to cope with frequent interactions with the perpetrator and his friends during the investigation. The vulnerability experienced while discussing the event, several times in a group setting, desensitized her and promoted a healthier integration of her traumatic memory.

CONCLUSION AND CONTRAINDICATIONS

The goal of SIT is consistent with my objective of returning patients to optimal functioning in an expeditious manner with the aim of bolstering their coping skills and self-reliance.

There is, however, a general contraindication to this intervention. When dealing with anxiety and stress-related disorders, the resurfacing of traumatic memories is the rule rather than the exception. One can expect patients to react strongly to these memories and trauma-related fears and projections about the future. Therefore, it is imperative that those with significant personality dysfunction and poor affect regulatory abilities, be excluded from this type of group modality and be treated on an individual basis until they are more suitable for SIT.

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Chapter 80

Using Metaphors and Stories to Resolve Impasses and Bridge Resistance

Jerrold Lee Shapiro

AN INTERVENTION FOR ELICITING GREATER EMOTIONAL DEPTH AND CREATIVE PROBLEM SOLVING

As an existential therapist, my own internal process informs much of my work during sessions. Often this "primary process" occurs in images, auditory memories, and fantasy. At certain times in group treatment, I am prone to expressing these images to clients: sometimes relatively unfiltered feelings and more commonly in story or metaphor.

Therapist storytelling has been used in a variety of theoretical approaches. Erickson (1980) and Erickson, Rossi, and Rossi, 1976 for example, used stories to induce "informal" hypnotic states in clients. Techniques involved instigating a novel form of communication within therapy sessions. In the midst of the session, they altered their tone, word pacing, and often told a story that presumably had within it some clues for patient insight and/or behavior change.

Similarly, Honos-Webb, Sunwolf and Shapiro (2001; 2003) have indicated the salience of storytelling in therapy sessions in effecting alterations in behavior with or without an altered state on the part of the client. They define this healing power of stories in therapy as a method that may obviate some resistance by diverting clients' attention away from their anxiety and normative defense against any recommendations that promote change. Storytelling by a therapist has also been shown to help clients better handle crises, i.e., (Pennebaker, 1997) increase their connection to unconscious process (Sturm, 2000)

and expand their senses of the allowable. At the very least, therapist storytelling is useful in reducing client anxiety.

For existential therapists, there are two sources of anxiety: existential anxiety, which involves facing fears of the unknown and neurotic anxiety, which emerges from clients' attempts to avoid or defend against existential anxiety. In short, stories may help clients deal with existential anxiety by offering alternative expectations and projected outcomes and avoid neurotic anxiety by refocusing the clients' attention on the real challenge.

DESCRIPTION OF POPULATION

I work almost exclusively with time-limited, closed, clinical, and growth groups. However, this technique should work equally well in an ongoing open-ended group. It is definitely a technique that lends itself well to children, adolescents, and adults.

DESCRIPTION OF INTERVENTION

Unlike most techniques or exercises, this intervention is not distinct in appearance nor does it have a unique stage in group process. Instead, it occurs as if nothing different was occurring. At a critical juncture, the group leader may simply share a reflection that, on the surface, seems to be more there-and-then than here-and-now oriented. The reflection by the leader involves interceding in the discussion with a metaphor or with a *short* story that at some unconscious level is connected to the ongoing group process or as a response to an individual's personal sharing.

Using standard descriptions of a four-phase group trajectory: preparation, transition, working, and termination (Shapiro, Peltz & Bernadett-Shapiro, 1998), this procedure is one that is best suited to the third or working (also known as treatment or therapy) phase. It is designed to increase intrapsychic depth, once the group trust is sufficiently strong to support such enhanced levels of affect. However, it may be employed judiciously in the transition phase, while the group is testing the leadership, or in termination with a focus on transfer of training.

Step 1

Allow the normal group discussion to progress until something gets stuck.

Step 2

Focus on process including reflecting on the lack of movement, etc.

Step 3

Slip into a storytelling mode of speech and tell a short story or metaphor along with "therapeutic amazement" (i.e., *"I don't know why I would be thinking about this at this time"* or *"This reminds me of a fellow I once met"*).

Step 4

Allow the group members time to respond to the story, including any confusion they may experience.

Step 5

Continue as if nothing different or unusual had occurred.

Examples

During the treatment phase of a group of health care professionals, two members (Jake and Sally) were describing their "sandwich generation" dilemma, while other members of the group listened intently. Each of the members described feeling overburdened and trapped by simultaneous responsibilities to aging parents, school-aged children, and to their personal retirement. After sharing their experiences and feelings and hearing empathic feedback from other members, the group seemed to experience a lack of energy, described by Jake as a "sense that my own life is over."

Focusing on his experience of a loss of energy, I responded, to Jake, the forty-five-year-old male in the group. My initial response was empathy for his situation; then I began defocusing into a short

story. *"Jake, your situation seems so difficult and you seem trapped by the very real responsibilities to your family."* Slowing my pace as if reminiscing, I said, *"I don't know why I am thinking of this, but as you were talking, I was hearing that little speech that accompanies every commercial airline flight. You know, the one that tells us if there's a drop in cabin pressure and the oxygen masks drop. If you are traveling with a minor child you are to put on your mask first."*

The client seemed confused by the story. As he began to respond slowly, he asked, "What does that have to do with how demanding my mother is?" I replied, "I am not sure. I was listening to you very closely and that is what came into my mind." At that point, Sally, the female "sandwicher" said, almost as if in a trance. "I think he means that we aren't stopping to breathe and need a break for some oxygen, or else our kids, parents and, yes, we will all fail." Jake said, "I do feel like I am almost out of breath, but I need to care for two aging parents and three children. There is no way out that I can see."

- I responded, *"I am not questioning your commitment or loyalty, I think I am focused on the other end of the equation—to look at how you will be able to care for them long term."*
- This led to a metaphor, *"Jake, Sally, I don't know about this but you both seem like sprinters and you are in a marathon. To run the best race, we need to figure out how you can best train and best conserve your strength. Nobody can sprint for twenty-six miles."*

Later in the same group as termination had begun, another member began to opine that she would "get my time when my children are grown." Other members began to argue with her that she would be close to sixty and that her parents might still need her. Several group members told her that she needed to have some time to herself while she was young enough to enjoy it. She claimed that her husband and kids all felt that she was too overprotective and stifled them. She replied that her husband and children told her that all the time. After about fifteen minutes of struggling with that, my co-leader turned to me and asked, "What are you thinking?" When I responded, *"Kenny's Cubs cap,"* all eyes in the group turned to me. After a pause, I continued,

- *"I knew this guy, who, when he was a young boy wanted nothing as much as a brand new Chicago Cubs baseball cap. When he*

was nine, his older brother bought one for him. It was the greatest gift he could imagine. He held it, touched it, smelled it, put it on his dresser. He looked at it every night before he went to bed. However, he would never wear it for fear of losing it or getting it dirty. Regardless of his personal wish and his brother's encouragement that he wear it to school or to the ballpark, he was too afraid. That went on for five years. When he finally got to the point where he dared to wear it, he was fourteen and sadly it was too small."

A week later in the next session, she told the group that she had asked her husband to do the childcare on Wednesday nights, while she went to a dance class "just for me." She reported that he said yes without a second thought.

CLIENTS' EXPERIENCES AND CONCLUSION

This is a technique that increases for clients their ranges of expression and brings non-linear problem solving to the group. By approaching client issues in story or metaphor form, it suggests and encourages "out-of-the-box" solutions. It also has the great advantage of being somewhat transcultural.

There are at least two *contraindications*. First, the group must have sufficient ego strength to be able to handle the level of abstraction and not to be threatened by such a nonlinear intervention. The stories must be appropriate to the group's level of functioning and are best if they are either true or well-known fables or tales or in the pop culture. (i.e., *Aesop's Fables, Star Wars, Harry Potter,* childrens' stories).

Second, the leader must be able to trust her/his unconscious processing and be willing to share it in metaphor or story form. She or he must also be willing to appear less linear to group members.

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Chapter 81

Using Humor to Advance Group Work

Dave M. Cooperberg

HUMOR IN THEORY

Some therapists perceive humor as primarily a form of acting out; hence, some disapprove of its use, while others find value in it to varying degrees (Fehr, 1999, 2003). Much like all else that comes up in groups, whether humor is useful or not depends on how and when it is expressed, as well as if it is processed.

For purposes of this discussion, humor is loosely defined as the quality of seeing things as amusing, comic, or playful. I am primarily suggesting using the humor that can be found inherently in a group's interactions to help develop a more useful perspective to what is happening in the group and with its members. Klein (1987), in *The Healing Power of Humor,* writes about finding humor in everyday life as well as amidst upsets and trauma. He describes using humor as a way to expand our perspective so we remember that life is more than whatever problem is before us. Although jokes or humorous short stories can bring perspective, I rarely use them. They too easily pull people away from what is happening in the group in the moment.

Humor can be initiated in a group by the members, by the therapist, or simply be a spontaneous reaction to events in the group. When initiated by the therapist, humor is an intervention that involves some level of therapist self-disclosure. What is disclosed are usually not details of the therapist's life, but more how he or she relates with others in the moment. It is also role modeling, in addition to the work being done.

CLIENTS

Although I believe humor can be used appropriately in most situations, this discussion is focused on its use in outpatient, in-depth psychotherapy and support groups. The specific nature of the groups, (e.g., heterogeneous psychotherapy men's, women's, cancer support, lesbian mothers, veterans, teens in a group home, Latina physicians, people in recovery, etc.), will determine the specific things that members find amusing and what humor is appropriate, rather than whether or not it can be used at all.

The following examples of effective use of humor come from small outpatient process groups of six to eight gay-identified men that I have run in San Francisco for almost thirty years. The age range has varied, with men generally in their thirties to sixties. Most are in the normal/neurotic range of diagnosis, but usually there are one or two with borderline personalities, who tend to spice things up.

THE INTERVENTION

Since both humor style and content can differ dramatically between individuals, groups, and cultures, there cannot be any "one size fits all" prescription. As with all interventions in groups, members will not all have the same reactions to what we do or say. With therapist-initiated humor, some useful suggestions are as follows.

Keep It Simple

This is particularly good advice for those not used to engaging humor in their groups or with new groups. Simple forms of humor that I typically use include puns, double entendres (meanings), obvious exaggerations and simply laughing or smiling. When the issue of sex unconsciously comes up for instance, almost any comment will include words that potentially have a double meaning. Sometimes I might repeat the word used or, with the right timing, just smile, eliciting either joined laughter or denial, either of which can be further explored.

In one session I intentionally interpreted the opposite of what was going on, an ironic exaggeration to get the individual—and the group—to connect more directly to their emotions. John, a midlevel manager in a large corporation, was reporting an interaction with his previously beloved boss. His boss had been bypassing John in dealings with his subordinates with work, in effect having them put aside tasks John had assigned them, to do something else. This put John in an untenable position with his own staff. When John kept talking content, I commented, "Not that you have any feelings about this," with an exaggerated tone to the word "feelings." John snorted in response, and the group laughed. John then expressed his rage, also connecting it directly to early childhood experiences. Other members were then able to join him in relating their common experiences when feeling undermined by authorities. The result was both a deeper level of work by the individual, and having it become more of a shared group experience.

Avoid Putdowns

Even if the person you are making fun is able to enjoy your comments without injury, this is a group and someone else is likely to feel threatened by it. One needs to be very cautious with negative humor if it is used at all.

Be Alert to Negative Reactions

When these are up front we can attend to them more easily. Sometimes they can be well hidden and not arise until much later. When a situation elicits laughter in a group, any individual can take offense.

In one group, a large, powerful man went quiet after the group erupted in laughter to his claim that he had been forced to have sex with someone he obviously found very attractive. I could see him closing down. I pushed him to acknowledge his anger. Then the group attempted to get him to see why what he said created such amusement. He heard and agreed with some of what was said, yet maintained his offended stance, since not to do so he would have had to break through his denial of interest in having sex with others. This brought to the surface a central issue that was not being discussed.

TYPICAL RESPONSES TO THE INTERVENTION

Usually groups respond well to this use of humor. Its effects in the moment can be an instant connection, and over time tend to make members feel as if they are understood and belong. Some, who were initially shocked at the laughter in a "serious" therapy group, have later said that it helped the group feel more like an "understanding family." Humor becomes a bonding agent in the group, and members become able to recognize the humor in situations and use it in relating with others. Since as therapist, I initiate some of the humor, members feel freer to challenge me in a similar way, as play becomes a safer way of learning.

CONCLUSION

The potential benefits of using humor include:

- Gaining perspective—with humor one can gain a bit of distance from what is happening, relaxing defensiveness.
- Reducing overall anxiety—at times the tension in any group can become stifling rather than therapeutic.
- Enhancing the group cohesion—the group that laughs together feels together in those moments.
- Enhancing pleasure and joy in being alive—feelings which help members stay with the group in the moment. When the therapist initiates humor, it can have the additional benefits of making us appear more human and personally engaged, hence safer to directly engage.

With more highly functional groups, as long as we maintain a therapeutic perspective, humor can be highly effective in furthering the processes of the group and the growth of its members. It draws members into the present moment. They experience that even in the midst of facing difficult and painful truths, they can find also find playful and even joyful connections with others. When the therapist actively engages with the group through humor, we become more available for members to engage us and work out any transference. Finally, it makes the group process itself more pleasurable for all.

CONTRAINDICATIONS

As in any intervention, using humor has its potential risks and benefits (Bloch, 1987). Some general ways that humor can be unskillful in therapy groups include:

- A masked expression of hostility.
- A distracting frivolousness which draws away from the therapeutic work.
- Avoidance of whatever specific issue is emerging in the group. In addition, when the therapist initiates the humor, there is the risk that rather than serve the therapeutic process, it can simply be a form of personal self-aggrandizement.

Although humor can be useful in most situations, using it with clients who show paranoia, and those with other more rigid personalities require special care. Of course that is true with such personalities in any case. With such a population, when humor does arise—and it will—it becomes even more important to "check in" with them when others laugh.

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Chapter 82

Directed Eye Contact: Nonverbal Communication

Shari Baron

> Remembrance of past shames and fear of future shame become a straightjacket against spontaneity and knowledge of self-worth.
>
> (Goulding & Goulding, 1979)

NONVERBAL COMMUNICATION

Nonverbal communication includes the use of body posture (movement and position), tone and volume of voice, eye contact or avoidance and facial expression; we usually express our feelings about others through these nonverbal communications (Fehr, 2003). The way group members experience the nonverbal communications of one another is an important aspect of the group process that may be more powerful than the verbal (Perls, Hefferline, & Goodman, 1951; Fehr, 2003). The therapist can choose to direct a particular nonverbal structured exercise that strengthens the connections group members feel with one another. This intervention must be used judiciously–if it is used too frequently, it loses its potency and can become trite. However, when used on rare infrequent occasions, it can be a powerful tool that helps a depressed or shamed member feel safer in group and more joined with the other members.

CLIENT POPULATION

Yalom (1985) suggests that, in general, structured exercises are of more value in brief specialized groups than in long-term outpatient groups. However, this particular intervention has been used in the "working phase" of insight-oriented groups that focus on long-term relationship building and learning from the responses of and interactions with others. I have found it most useful when working with a client who has doubts about his or her membership in group, particularly when that doubt has grown out of a sense of shame or concern about rejection following "misbehavior" (in or outside of group) or revelation of what the client perceives as shameful historical material.

GUIDELINES FOR INTERVENTION

Although this intervention requires an intuitive sense by the therapist of when it will be most beneficial, the technique is quite simple. The therapist asks a client, who has, in some way, been expressing doubt about his or her right to be included as a member of this group, to stop talking for a few minutes and sit quietly. The therapist directs him or her to "check out" what other group members think by silently looking around the room. All are requested to remain silent. The doubtful member looks from one person to the next, making eye contact. Without direct coaching by the therapist, the other members of the group gaze back with acceptance and reassurance. The doubtful member experiences the needed support of the group without the potential contamination that the addition of words might bring.

Examples

This intervention can be used when the shame or doubt originates with out-of -group behavior. Clara reported to group that she had spent the last few days in bed rather than going to work. She is angry with herself, feels worthless, and doubts that she will ever get better. She says that she is thinking about leaving group because "you must all be totally angry at me and disgusted with me." The therapist wonders aloud if the others in group actually do feel this way and suggests doubt that the group would reject her for her behavior (this plants the suggestion in the minds of the other members that they demonstrate

acceptance of Clara despite her out-of-group behavior). The therapist directs Clara to stop for a few moments, close her eyes, and then open them and look silently around the room at her fellow members. As she moves her eyes around the room, each member in turn looks back at Clara with acceptance and compassion.

The intervention may also be used related to in-group behavior that leads to doubt and alienation. Jim had, for several weeks, been quite depressed and struggling with urges to cut or burn himself. He admits to the group that he has, just within the last few weeks, talked with his therapist about something that he had never discussed before; however, he is not ready to talk about this issue in group because it is too difficult and painful. Some group members express frustration because they cannot seem to reach Jim and want to help him. They feel he is distant and not participating fully in group. Jim withdraws further and says that maybe he should leave group if his participation is not good enough. The therapist wonders aloud if that is what the group is suggesting to him or if they might just be attempting to express their concern for Jim. The therapist directs Jim to sit with this thought for a few moments. She then asks him to look silently around the room at his fellow members. As he moves his eyes around the room, each member in turn looks back at Jim with reassurance and caring.

TYPICAL RESPONSES TO THIS INTERVENTION

Frequently, the results of this intervention are dramatic and emotional. The doubtful group member, who is usually feeling shame, isolation, and disconnection from the group, experiences the unconditional acceptance of the group as a whole and is able to believe that his or her membership in the group is valued. The other members also benefit from the sense of closeness and trust that lingers in the group following this exercise. There is rarely any interpretation or discussion about this reaction. I have found it more valuable to allow the insecure member and the group as a whole to experience the resulting sense of closeness nonverbally and without the contamination of analysis. The doubtful member is then encouraged to sit with his or her experience while someone else in the group works.

CONCLUSION AND CONTRAINDICATION

This tool is most useful in a group that is solidly in the working phase and whose members have the ability and experience to trust the responses of their fellow group members.

It would be contraindicated in a group where there are many new members or when there has been significant recent disruption in the group. Such disruption would undermine group trust and safety and this intervention could, in these circumstances, backfire and lead to further alienation.

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Chapter 83

"Remember Be Here Now"

Ellen J. Fehr
Gary L. Sandelier

IMMEDIACY: HERE AND NOW—BEING IN THE MOMENT

The title of this contribution comes from Dr. Richard Alpert, a.k.a. Baba Ram Dass, author of the classic cult book of the early 1970s, *Remember Be Here Now.* The title encapsulates the essence of the following chapter in which different words are interchangeably used to identify a concept but the concept remains the same. That concept: the "present," which in psychology can be termed "immediacy, the here and now or being in the moment." They all represent the same thing and what they represent is an effective tool of intervention in interpersonal learning for clients in group therapy (Vinogradov & Yalom, 1989).

The need to keep the group and group members in the "present" can be a difficult undertaking for the group therapist as there often is a pull from the individual group members and the group-as-a-whole to verbally leave the room and return to anachronistic events in their lives. It would appear that most people exist in the past and future and due to this try to remain as such in group therapy (Fehr, 2003).

Obviously the past and future have their importance in psychotherapy but are best left to individual psychotherapy where individual time allows for their exploration. In group therapy, the "here and now" intervention is an effective opportunity for providing interpersonal learning that ultimately can reinforce personality change and restructuring.

CLIENT POPULATION AND TYPES OF GROUPS

This intervention is suggested for short- and long-term process groups that are designed for interpersonal learning. The underlying concept of interpersonal growth groups is focused on self-awareness or the self-search. This concept is simply stated as "How do others perceive me and how do I perceive myself in relation to others?" thus providing the opportunity for alterations in one's behavior and personality.

INTERVENTIONAL GOAL AND TECHNIQUE

The goal of this intervention is quite simple in theory. The group therapist wants to keep the group members actively in the "present" disclosing their relationships to one another, their relationship to the person of the group therapist, and the relationship they are having with themselves in a particular moment in time–the "present" (Bernard & MacKenzie, 1994; Carroll & Wiggins, 1997; Fehr, 2003; Rutan & Stone, 1993). The group therapist does this by theoretically altering time. He or she brings the client from existing in either the past or the future into the "now" by creating interpersonal relationships thus providing opportunities for clients to become aware of their interpersonal style and relatedness, which is often the source of their interpersonal difficulties.

Although keeping the group in the "present," sounds rather simple, in actuality it is not. As previously stated, keeping the group-as-a-whole and group members in the moment can be, at times, a daunting task. Ormont (1992) suggested a rather simple tool, a question, labeled "bridging." This technique creates a bridge between the clients in group by asking them direct questions such as:

- "How do you feel about what John has said or John how do you feel about what Mary had said to you concerning your disclosure?"
- "Steve, how do you feel when Sally appears disgusted whenever one of the men speaks about his relationship with women?"

All of these questions are in the "present" and will bring the client, to whom they are directed, into the present with his or her response.

These are direct questions to the client and the goal is for the client to be equally direct, at that moment, in his or her response.

Group-as-a-whole questions can be asked, such as:

- "How does the group feel each time Nico walks in late?"
- "Nico how do you feel toward the group each time you walk in late?"

There is no end to the many questions that can be directly asked to the individual group members or to the group-as-a-whole. It is very important that the client(s) do not answer you directly unless the question is about yourself. The meaning of this is that you feel there is something unspoken from the client to you and you inquire into what that may be.

If the question is not in relation to you, you want the client to directly express his or her answer to the object of the question such as:

- "Steve how do you feel about Gary?" Gary in this case is the object of the question posed. Very often clients, due to their anxiety, will begin to answer your question directly to you. This type of response will remain as such until they become more comfortable adapting to this focused type of relatedness. They, too, will have the opportunity of experiencing that they will not "fall apart" when speaking directly to another person and neither will the other person "fall apart."

This is a tremendous growth for the majority of clients who have rendered themselves passive to others throughout most of their lives and never truly expressed what they felt and thought about another individual.

Until the client becomes more comfortable speaking directly to others, you will probably repeat this phrase many times over and that is "please tell the other person." In the above case the other person is Gary and you would, of course, use the person's name.

CLIENTS' RESPONSES

In a newly formed group and, at times, in ongoing groups, it is quite common for members to express annoyance in attitude when

they cannot turn group therapy into individual therapy and talk about their life experiences outside of the room. Spontaneously disclosing oneself in a room of other people or disclosing how one feels about another person is uncomfortable, especially if it is a relatedness style foreign to one's usual manner of self-expression. It is not uncommon to hear clients say that they do not want to hurt another person's feelings by telling him or her how they feel about what was said or how it was said. Nor is it unusual for clients to feel overwhelmed, rejected, and criticized when they hear others directly tell them how the others feel about what the client has disclosed and the manner in which the disclosure was presented.

This is not to suggest that all the client responses are negative to this intervention. The majority of the time, clients are grateful for the insight given them by the other group members. It provides them the opportunity to change how they relate to others and experience their lives and interpersonal relationships more effectively and with greater satisfaction. It, too, sends a very clear message and that is finally someone has listened when he or she has spoken.

CONCLUSION AND CONTRAINDICATIONS

This intervention attempts to create interpersonal relationships in an attenuated time span between people where an interpersonal relationship had not previously existed. There is a reality, which is everyone will move at his or her own pace but we can provide opportunities that clients had not previously had which could ultimately change a pace style. It is an awesome experience for the clients and the group therapist as both have the opportunity to gain insights into their behaviors with the concomitant opportunity to make behavioral changes in their personalities.

Perhaps, the most salient contraindication is to be found in the therapist's selection of the clients in the group. This group requires the client to have the ability to be introspective and to have the ego strength to allow direct interpersonal communications. These communications, at times, can be emotionally intense and not flattering. A fragile client would not be a good candidate for this type of group. This client would best be served and seen in a support group. After the support group, he or she could eventually be moved into a more interpersonal interactive group after developing the necessary ego

strength. This particular ego strength is the buffer to hearing things about himself or herself that are not flattering at times, are not continuously experienced as a narcissistic injury by the client, but rather as observations that can be of tremendous help in resolving interpersonal difficulties.

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Chapter 84

Highs and Lows: Expressing Gratitude or Grief in Group

Arnold W. Hammari

NAME ONE THING

Expression of "highs and lows" is a simple, nonthreatening group exercise, and often overlooked for its capacity to elicit deep self-awareness at a very existential level. The therapist may instruct the group, saying, "Name one thing that makes you happy right now, and one thing that's making you sad." This is more than just an ice breaker; it is a pathway to deep and potentially troubling issues. It is built upon the principle that people sense that their own vitality and efficacy rest on whether they have purpose, relationships, or freedoms (Yalom 1980; Arkoff 1995).

CLIENT POPULATION

Teenagers are open to this type of introspection. Teens may desperately need to explore the sources of their angst and insecurities. By labeling their subjective "highs" and "lows" as meaningful existential issues, they can better accept their feelings and beliefs as valuable and necessary. Older adults may also learn from this exercise and compare past experiences to the matrix of existential principles to obtain meaning from them.

GUIDELINES FOR INTERVENTION

The group therapist at the beginning of a session asks group members to take turns expressing their highs and lows. Define highs in simple terms such as something relatively current that one is glad about, and lows as something recent that is causing disappointment. Listen carefully and link each response to an existential issue such as success or delays in accomplishing one's purpose in life, losses or gains in relationships, or increases/decreases in freedom. Once you have identified the type of existential issue expressed, it will serve as a springboard to further self-exploration and awareness. You can comment on the uncovered issues either in between the group members' individual turns, or afterward, processing similarities, and who was sympathetic, indifferent, or hostile to whom.

TYPICAL RESPONSES

In a recent group of juveniles in corrective custody, typical answers included highs of "I got a letter from my mom," or lows of "My dad didn't call last night." These seemed to relate to relationships and the dilemma of intimacy versus isolation (Erickson, 1968).

Other answers such as, "I didn't sleep well," "It's my birthday and I'm locked up," or, "I'm being bullied by another kid," may have to do with consequences of loss of freedom (choosing where or when one sleeps, how one celebrates one's birthday, and choosing one's own companions). Yet, other answers such as, "I passed a GED test," "My fiancée had a healthy baby," or, "I will be going home in thirty days," suggest one may be sensing progress in achieving meaningful goals. If you challenge the group to join you in recognizing existential material in their brags and complaints, then alert group members can add additional perspective.

CONCLUSION

Group sharing of individual highs, lows, and connected existential values, helps the group mature. Shared values contribute to the intimacy of the group. Intimacy contributes to the meaning of the group and to the group's perception of freedom to achieve desired group goals.

Maturity helps the group become effective and not absurd. Openness and insight found within the group is transferable to each client's larger world.

CONTRAINDICATIONS

It has been my experience that there are no contraindications to this intervention. If your clients are too young or too cognitively underdeveloped to appreciate existential issues, their moods will still benefit from expressing gratitude and grief and feeling support in the group (assuming the group is supportive).

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Chapter 85

En Mi Viejo San Juan (In My Old San Juan)

Richard Beck

AT WHAT LEVEL DO WE INTERVENE?

When leading a group, we listen at many levels and have the option of making interventions at (1) the level of the individual, (2) a dyad in the group, or (3) the group as a whole (Lindenman, 1993, personal communication).

Those are the only choices we have in terms of where we chose to intervene. When a group members speak, they might be speaking for themselves or they might be unconsciously speaking for the entire group. We just need to listen more closely.

INNER-CITY DAY TREATMENT POPULATION

The group leader worked in an inner city, day treatment program for adult chronically mentally ill substance abusers. He had been leading a psychoeducational group for monolingual and bilingual Spanish-speaking members, with the focus on current events.

One morning, the administrator of the clinic spoke with the group leader and informed him that a decision had been made to shift the name and focus of the group to "Enhanced Communication Skills." This was told to the group leader without warning or discussion.

The leader felt perplexed as he entered the group room, where the usual ten to fifteen members sat seated around a table in the room. One floridly psychotic group member kept his chair away from the

others and against the wall, as he had for the previous three years that this group had been in existence and led by this leader.

Feeling a need to say something which would stimulate communication among the group members, the leader thought for a moment as to how best to intervene and came up with the following: "Como communicar un bebe antes que el quido usar palabras" (how does a baby communicate before it can use words?"). For the next two months, the group, which met once a week, tackles this question, with a variety of responses from the group members. The leader felt a sense of satisfaction that some communication was occurring in the group, but was also filled with a sense of boredom and frustration. The members of this group were compliant in answering a question posed to them and responded in ways that they felt were meaningful. These communications were primarily from the client to the person of the group leader but in this particular group, rarely, was there any interpersonal dialogue among the members during the entire group session.

THE INTERVENTION: "HUM LOUDER"

The intervention described is based upon the group leader listening to the "words and music," which one particular group member uttered. Both the member's utterance and the leader's attunement to it and subsequent intervention dramatically shifted the meaning of and depth to which this group worked.

In one session, a moment occurred that forever altered the life of the group and its members. As the group members were answering "the question" posed to them, one group member was humming something barely audible to the members and the leader. The group leader encouraged the member who was humming to hum even louder, to amplify the feelings that they were expressing.

The member, as it turned out, was not humming, but was singing quietly to herself. "En mi Viejo San Juan" was the name of the song, and soon, she was joined by a few other members of the group who were also from Puerto Rico.

At the next group meeting, rather than continuing with the question about how babies communicate, the group leader asked if there were other songs that the group members knew and wished to sing.

Another song was sung, only this time it was a religious song, and now a few more members of the group joined in. Gradually, members began to sing songs from their countries: Cuba, the Dominican Republic, Puerto Rico, and soon the entire group began to sing together, alternating songs from their countries with songs from their churches.

RESPONSE TO THE INTERVENTION

As the members of the group were encouraged by the leader to sing whatever songs they wanted to, the members began to relate in greater depth to one another. The affective level within the group increased exponentially. People were smiling as they sang or listened to others sing, resonating with the powerful connection to their homeland and with the powerful spiritual and religious beliefs that each of them held.

In one group, the floridly psychotic group member, who for three years had sat with his chair against the wall, moved his chair to the table, smiled at the members in the group and began to sing with his group members. The group leader had waited patiently for three years for this group member to join everyone else at the table.

Everyone in the group clapped as this member joined the group, deeply moved by the songs which the members had now been singing each week for several months.

I told one group member, who had attempted suicide three years prior, that the group needed him, since he was our only baritone, and that he needed to agree never to attempt to kill himself again. He agreed to this contract and you could hear his powerful voice resonate with feeling as he sang all the songs that the group sang, "En Mi Viejo San Juan" was his favorite, since he was born in a small town near San Juan.

CONCLUSION AND CONTRAINDICATIONS

Group members often speak for the entire group. In the case of this group, the leader was in tune with one group member's humming. Rather than view this as a resistance to the work of the group, the group leader enhanced the volume of the humming, believing that this group member was deeply in touch with a very meaningful and

underexamined aspect of each group members' life, namely, missing their country of origin and their strong religious faith.

The contraindication to this type of intervention would be if a member, when asked to amplify his or her "words and music" felt shamed by the leader in this intervention. By listening to both how the member as well as the group responded to the leader's encouragement of the amplification of the humming indicated that indeed the group member was speaking for the group with the song, and that the group leader was in tune with this process.

When we listen to the words and music of each group member, and attempt to find meaning in it, the group will benefit tremendously, as was the case for the members in this "Spanish Communication Group."

Chapter 86

Changing Chairs: Experiential Exercise for Exploration of Interpersonal Boundaries

Patricia Kyle Dennis

WHOSE CHAIR IS THIS?

Soon after the formation of a new therapy group, the alert leader will hear members make references to chairs as they enter the group room. "Where am I supposed to sit?" "We always sit in the same places . . . guess we're in a rut!" "Maybe I'll sit in the leader's chair tonight!" (nervous laughter). People quickly choose places and the topic of discussion is dismissed as settled. However, a group event has already taken place that is rich with meaning and learning potential. This intervention is designed to tap that potential.

Although it is clear that there is a need to set and maintain appropriate boundaries in group therapy (Schoener & Luepker, 1996), it may not be immediately evident that there is therapeutic value to the struggle around boundaries in the group. This struggle may represent similar conflicts and difficulties outside the group room, past and present. The therapist can use this replication to help members learn more about their internal and interpersonal conflicts related to boundary issues.

Taking it one step further, the therapist may create a conflict through a group experiential exercise as a vehicle for learning. According to Hornyak and Baker (1989, p. 3) experiential treatment techniques are based on psychological principles, and are used for "increasing clients' present awareness of feelings, perceptions, cognitions, and sen-

sations; that is, their in-the-moment experience. The method usually involves some degree of action on the clients' part, either physical or imagined."

In this intervention, the therapist asks group members to change chairs, and then discuss their reactions. The focus of the exercise is on interpersonal boundaries.

DESCRIPTION OF THE GROUP

A short-term psychoeducational group of six to eight members is the ideal setting for this activity. Since boundary issues are related to many presenting problems, the exercise may be included in various types of groups, such as those meant to address addictions, abuse, codependency, women's issues, men's issues, etc.

The exercise is quite stimulating and will require plenty of time to process. The length of the group should be eight to ten sessions or more. One entire group session should be dedicated to the intervention, and the therapist should expect that members will refer back to the experience in subsequent sessions.

This intervention requires a group with closed membership, which facilitates the establishment of relationships and familiar patterns of interaction.

THE INTERVENTION

Some time in the middle of the group, after members have had some time to establish their "place" in the group, but well before the group ends, to leave time for discussion, a session should be dedicated to the experiential exercise of changing chairs. It is important not to give clues about the activity in advance, or its effectiveness will be destroyed. The session title may include a reference to boundaries or limit setting, but the content of the session should be left up to the imagination.

- Listen closely to comments about seating and chairs as members enter the room, during all sessions leading up to this exer-

cise. These will be useful for discussion. Take extra time allowing people to get seated, with their drinks, coats, etc., stashed in their favorite places. Be sure that latecomers have had time to arrive. Promote small talk and settling in.

- Carefully note where each person is sitting. Form a plan to reseat each individual in a chair that is most unlike the one he or she chose. Those who sit close to you, will be moved far away. Those who like to sit on the couch, will be moved to individual chairs. Plan to fill the couch completely with people who chose individual chairs.
- Once everyone is settled in, announce that the activity planned for this session will require a new seating arrangement. This matter-of-fact approach makes it seem as if the rearrangement is an insignificant detail. This will prevent members from trying to second guess your intent, which would keep the experience from being spontaneous and characteristic of their usual behaviors.
- Ask each member by name to move to his or her new chair. Take note of the many comments, questions, and reactions that your intervention will engender for later discussion, but encourage everyone to postpone discussion until later. After group members have taken their reassigned places, ask the group to close their eyes, relax, and think about their answers to the following questions, leaving time in between for members to reflect.
- Ask: How do you feel about your new chair? Do you prefer having someone next to you, or do you like having your own space? How did you feel when I moved you? Where would you most like to sit? What would you need to do now to get the chair that you want? How hard would it be for you to do that?
- Ask the group members to open their eyes. Before they have a chance to talk, say "Now I would like you to go and get the chair that you want, without touching anybody." Again, pay close attention to all the ensuing interactions, verbal and nonverbal.
- As soon as it appears that there will be no more change, ask the group members to report on their experience of the exercise, drawing on the questions that you asked while their eyes were closed. Use the rest of the group time to process their thoughts, feelings, and nonverbal experiences, taking the opportunity to use what they say to teach what you want them to know about

interpersonal boundaries. It is likely that they will learn as much or more from one another than from you in this process, so encourage discussion and feedback among the group members. It can be particularly helpful to ask members if they have similar experiences outside of the group or in their families of origin.

INTERVENTION RESPONSES

After conducting this exercise more than seventy-five times, the author has found that there is a very wide range of responses to the experience. Hundreds of meanings and insights have been uncovered in this way. Group members almost always report a heightened understanding of their experience with personal boundaries, intrusiveness, abandonment, competition, and conflict resolution. Connections may be made to family experiences of unwanted touching, interrupting, projective processes, competition, over-control, lack of privacy, difficulty saying "no," not being taught to negotiate, and many others.

Often group members will not realize that although it is not OK to touch while they go after their desired chairs, *talking* has not been prohibited. The healthier members may try to negotiate. Many will make a run for their new spot, or stay put in order to avoid conflict. Sometimes there is a great deal of laughter and good-humored self-consciousness. Other times, the anxiety level goes up to a point where people become confused, flustered, or confrontational.

The therapist should take care to be sure that each individual group member has the chance to debrief, learn from his or her experience, ask questions, and get suggestions. It will take active listening and questioning to help people talk about any conflicts that arose, how they dealt with them, and what makes it difficult to get the chair, or anything else, that they need or want. Those who avoided conflict must not be lost in the process, as they may have the most difficulty of all.

CONCLUSION AND CONTRAINDICATION

There are some contraindications to conducting this intervention. It may be very challenging for people who were not allowed to say *no* as children. People with borderline personality disorder or those with other severe interpersonal deficits may have a great deal of difficulty

managing their feelings and interactions during the event. The therapist should increase supportive comments when this occurs. It is important to have an alternate agenda if the exercise appears to be too challenging for one or more group members.

Empathic, nonjudgmental, and supportive processing of this experiential exercise is usually beneficial to the group members and can be a highlight of the group experience, clearly remembered and referred to often when a group member continues in therapy. Generally, people take their new places and are able to engage in a rich exploration of the event, learning about their difficulties and needs. The event usually results in a deepening of the attachments in the group, the level of self-disclosure, and dedication to the group process. Members almost always try out and discuss new behaviors while finding their seats in subsequent group sessions.

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Chapter 87

Surfing an Unexpected Group's Tide

Uri Amit

DISPEL A BELIEF

Since most adults possess the capacity to anticipate shame, some personal fantasies of psychical significance may remain suppressed and adversely impact the individual's affective agility. The energy spent on containing these fantasies may result not only in emotional rigidity, but also in self-alienation. It may also result in unrewarding interpersonal relationships and stifle creativity. In short, the fear of being discovered robs the scared of the momentary joys life presents.

Group therapy affords participants the opportunities to dispel the belief that one must remain all alone in his or her internal world (Fehr, 1999, 2003) and endure a torturous, lingering process of self-shaming and inadvertently self-deprivation.

SEX OFFENDER CLIENT POPULATION

This particular intervention is appropriate for sex offenders who (1) do not display delusional processes, (2) use language indicative of sex and aggression inextricably intertwined, and (3) have been working together for one or more years in a contained environment.

INTERVENTION

Brief Case Example

"Guy" is a Euro-Asian, lanky man who was assigned to a ten-man therapy group that met twice weekly for a total of three hours. Guy was always the first to arrive for sessions and occupy a chair placed in one of the corners. We were both easily visible to each other. After about a month in group and on occasions outside the hour, Guy used to engage me in chats about sports and movies, inform me of movies to be shown on television on certain evenings, and make it a point to see me on a subsequent day to ask if I saw this or that movie.

During his first month in group, I noticed Guy's propensity to be a silent participant. Consequently, I started to progressively contact him more in each session. So as not to "blow him away," I used to ask him if he concurred with my hunches about the affect reflected in the men's presentations. His replies were terse summaries of the presented and devoid of feelings. I also observed that he writhed in the chair when offenses were described. On one occasion several months down the road, I asked Ben, a group member with an uncanny ability to intuit, to speculate on Guy's seeming discomfort when offenses are described. Ben replied: "He is dying to describe his offenses, but is afraid." Guy nodded his head in agreement and added, "I'm not ready."

Aware of Guy's sexual crimes and appreciating his reluctance to describe his sexual sadism as was reflected in his governing offense, I asked him on this occasion: "Would you agree to go to a movie with me?" He looked at me with surprise written all over his face and said: "You're messing with me, Doc." I said, "No, I shit you not." He then asked: "You mean outa here?" I replied, "No, right in this room, right at this moment."

With that, I got off my chair, asked the group to create three rows of three chairs in each behind the two chairs that I placed next to each other. I sat in one of the chairs and asked Guy to join me. Ben was asked to turn off the light (the large window in the room did not allow for darkness). I invited Guy to project on the wall we faced the movie he created in the mid 1980s and for which he was civilly committed for treatment. He hesitated. I, then, said to him provocatively, "Nothing sexual in this world would be shocking, arousing, perhaps." This

was said in order to lessen Guy's anticipatory shame and fear of being judged by the others.

As Guy proceeded to describe subduing the then eight-year-old boy and anally penetrating him; Ben, seated behind Guy, cried out, "This is how I was raped at summer camp," and proceeded to sob uncontrollably. Thick silence befell the room. I turned my chair around to face Ben and asked Guy to do the same. Placing my hands on their shoulders, I encouraged them to look at each other and give voice to all that emerged between two perpetrators of whom one chose to remind himself of his own victimization.

RESPONSES

After the initial exchange between a perpetrator (Guy) and a victim (Ben), I felt compelled to interrupt and remind Ben that while himself a victim of sexual abuse, he assaulted a prepubescent female in the same manner as Guy. During the remainder of the session and for the two that followed, both Guy and Ben disclosed the nature of their offenses in manners consistent with the victims' statements.

CONCLUSION AND CONTRAINDICATION

What started as an attempt to move one man (Guy) from a silent group participant to a verbally active one resulted in an unexpected outcome. The familiarity of the two involved men's histories prevented the session from turning into a "How could you?" salvo by Ben. At that point, the journey began on the long and bumpy road to understanding the respective psychologies reflected in these men's offenses.

It is strongly recommended, especially with this particular population, that having knowledge of clinical theories is necessary but insufficient to working with a felonious group—one that displays disregard for the personal boundaries of others. Personal contact via the seemingly mundane, e.g., the chats about sports and movies, is important as is the sense of timing, and the readiness to take a clinical risk; the insistence to connect often reflects care that this particular population appreciates. In this respect, these individuals are willing to try out recommendations made by the therapist.

In relation to contraindications with this particular population, a group therapist must be able to free herself or himself from judgment and outrage at the acts committed by these individuals, and keep moral opinions in abeyance. One must feel comfortable with her or his own oddities and, above all, believe that light can be found in darkness' depth.

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Chapter 88

Mindfulness in Group Psychotherapy

Mark A. Cohen
David Cantor

Mindfulness is the awareness of present experience with acceptance.

(Germer, 2005)

A MINDFUL INDIVIDUAL

Most times, when people enter psychotherapy, they are not mindful of themselves or of others. They often enter therapy unaware of what they feel, why they feel as they do, and in what context these feelings are likely to be elicited. There also tends to be an unawareness of the feelings and motivations of others. Many use projection rather than mindful awareness when trying to understand what another person is feeling. This of course leads to difficulties in relationships.

In addition, people tend to use what they have been told about themselves by others instead of being mindful of who they are and instead of being aware of how they feel. People also tend to use the standards of society in trying to figure out how they should be and feel. Instead of looking inward and being aware of what they feel, they replace this introspection with a focus on how society says they should be and feel.

There are negative consequences to living a mindless life. Tart (1994) writes that without mindfulness we live in a state of distorted

perceptions and fantasies, acting inappropriately with reference to our own true nature and the reality of the immediate situation, consequently creating stupid and useless suffering. There are positive consequences to living a mindful life. Surrey (2005) writes that mindfulness is a practice or skill, which opens and deepens our capacity for connection and for relational as well as spiritual renewal.

Group psychotherapy is about building connections between people and building bridges between their self-awareness and those aspects of themselves, which have been disavowed. Group psychotherapy helps the patient do this in a number of ways including providing an arena for interpersonal exploration, a focus on interpersonal interactions, and most importantly a focus or mindfulness on what the patient is experiencing in the moment both with himself or herself and in relation to the other group members. Ormont (1992) writes that the primary task in making our group function effectively is to use any technique which evokes meaningful talk between group members and to develop emotional connections where they did not exist before. He calls this process bridging, and for it to occur the members must use mindfulness.

SHORT- AND LONG-TERM GROUP POPULATIONS

The intervention of using mindfulness in group psychotherapy is effective with most patients both in short-term and longer-term groups. In a short-term group, this intervention is best limited to building mindfulness of feelings and bodily sensations which are already close to awareness. In a long-term group this intervention can be used to teach them to be mindful of feelings and bodily sensations which are less congruent with how they want to perceive themselves.

This intervention is best used with patients who fall within the normal range of intelligence and who have the ability to step back from themselves and observe their feelings and their behaviors. It is also most effective with patients who are able to receive feedback from others without being unduly hurt. It is least effective with those patients who tend to be overly concrete and who lack the ability to suspend projection of their own mental contents onto others.

This intervention can be used by therapists from different theoretical orientations including psychodynamic, cognitive, and behavioral. The psychodynamically oriented therapist can also use this interven-

tion in terms of the patient being mindful of transference issues with the therapist, each group member, and the group as a whole. The cognitively oriented therapist can use this intervention while perhaps focusing more on the patient's thoughts and schemas. The behaviorally oriented therapist would tend to focus more on mindfulness as a behavior rather than as a mental process.

GUIDELINES FOR INTERVENTION

The key to promoting mindfulness in group is based upon helping the individual to become more in touch with what he or she is feeling and thinking in the moment. These interventions can be applied to the group as a whole, such as asking all group members to try the technique. They can also be directed at individual group members who may need assistance with becoming more in touch with the moment. The group therapist can also use this intervention to enhance his or her own personal mindfulness in group.

Identification of Body Language

Using this technique, the individual group member is instructed to become aware of both his or her own body language and that of other group members and also how they feel in regard to the body language. Examples of this include how one is sitting, one's gestures, and one's facial expressions. By looking at one's own body language one can become more in touch with how one is feeling. Likewise, looking at another individual's body language can help put the patient in touch with how he or she may be feeling.

Mindfulness Toward Behavior

Our behavior in group tells us a great deal about how we are feeling and what we are thinking, even at an unconscious level. Examples of things group members can try to be aware of are where one sits (near the therapist, near the door, near the restroom, etc.), whom one sits next to, how one dresses, whether one arrives early, on time, or late for group, whom one chats with before and after group, etc.

Closing Our Eyes

The therapist can ask one group member or the whole group to close their eyes while they listen to the other group members speak. This simple but powerful intervention gets one past the superficial exterior and more in touch with how one feels about the other and how the other speaks. This helps people to focus more on tone of voice and affect, that is, how one is saying things, rather than the actual words. Many group members have been surprised how doing this can help to immediately put them in touch with feelings about the speaker that they were not aware of. This is also an effective intervention for the seasoned clinician to help get in touch with his or her feelings about a specific group member or the group as a whole.

Mindfulness of Physical Sensations

There are many physical sensations therapists and group members have that can help us get in touch with the moment and our feelings. Being aware of one's heart rate, respirations, perspiration level, and level of muscle tension helps one to be more mindful of feelings and even reactions on a subconscious level. For example, because the body reacts so quickly in the fight-or-flight mechanism, one might start to get hot, perspire, or feel his or her heart start to pound before becoming aware of feeling anxious or scared.

Mindfulness of Thoughts in the Moment

Often, a group member might have passing, fleeting thoughts that flash in and out of his or her mind, might have a quick mental or visual association, or may have a verse from a song pop in and out of his or her head. These are all short events that, if one is trying to be mindful, will help an individual become more in touch with what he or she is feeling and thinking in the moment.

CLIENT RESPONSES

When group members apply self-motivated interventions into their personal experiences to help with mindfulness they are surprised at how well and how quickly the intervention works toward becoming

more aware. These are not interventions that require a lot of practice and training, and individuals trying them for the first time can have great success, which ultimately reinforces its continued application. Individuals become astonished sometimes at how much nonverbal communication occurs in a group or at how much of their own thoughts and feelings they were not aware of before practicing mindfulness in their daily living.

CONTRAINDICATION

It has been our experience that there is not any population for which these interventions are contraindicated although individuals must have some introspective ability. If one has the ego strength to be in a process-oriented group therapy setting, then working on mindfulness will enhance the group process. These interventions can be applied to individuals, the group, and the therapist to enhance mindfulness in the group setting.

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Chapter 89

"Zoom"

Barney Straus

A QUICK WAY TO GET A GROUP PLAYING TOGETHER

"Zoom" is a word passing game described by Le Fevre (2002). Its key asset is that it quickly engages all group members in a common task. It is useful in uniting groups of people who may have trouble connecting with one another. It can also help subgroups experience themselves as having a common purpose. The game can be used effectively with almost any group, as it is easy to play and nonthreatening. It is often used toward the beginning of a group's development, or as an ice breaker for a training event.

Essentially, "Zoom" is played by group members. They pass the word "zoom" around a circle in various patterns. The game can be played with increasing complexity and variations. The primary function of the game is to foster a sense of spontaneity and fun within the group. Furthermore, the game can be used as a way to explore dynamics occurring among group members (Gass, 1993).

CLIENT POPULATION

"Zoom" is an effective intervention. Because it is enjoyable and easy to understand, it can be used with many populations. Likewise, it can be played with groups ranging in size from ten to fifty. I have used this game successfully as an ice breaker at professional conferences and I have used it with a wide range of therapeutic groups. Among those that have played "Zoom" profitably are a class of fourth grad-

ers, members of a psychiatric day-treatment program, college students, older adults at a retirement center, and groups in between.

GUIDELINES FOR INTERVENTION

The group leader invites members of a group to participate in a brief game. Depending on the nature of the group, this may require more or less explanation. Some groups are accustomed to trying new physical activities together while many are only accustomed to sitting and talking together. Zoom can be played either sitting or standing, though all group members should be in a circle.

Procedure

- First, the group leader says that he or she is going to pass the word "zoom" around the circle. This is done by turning toward the person to his or her right and saying "zoom." The next person then passes the word to the group member to the right and so on until the word makes its way back to the group leader. Next, the group should try to increase its speed while completing the same task.
- After two or three rounds, the group leader asks the group what zoom spelled backwards is. After someone answers "mooz," the leader then says that he or she is now going to pass the word "mooz" in the opposite direction, that is, going around the circle to the left.
- Next, the group leader explains that there is going to be a race. "Zoom" is going to race "mooz" around the circle. The group leader will start both words simultaneously and see which one gets back to him or her first. It is fair to warn the people just opposite the group leader that they should be on their toes as someone may get hit with both words at just about the same moment. This generally elicits some nervous laughter from the group.

Try the race several times. As you announce which word "won," ask the group members whether they felt affiliated with one word more so than the other. Often those people closest to where a word starts feel like that is "their" word. The group leader should point out that in order for a word to make it all the way around, everyone needs to be

involved in each word. This is a good opportunity to talk about subgroups that may be happening among the whole group.

Variation

- After "zoom" and "mooz" have both been passed around the circle, explain that group members have the option of "putting on the brakes" when a word gets to them. They can do so by making a screeching noise like the sound of car brakes. They then send the other word in the opposite direction. If the same people keep "braking," allow members in different parts of the circle to start. If the group is really feeling ambitious, you can start two or three "zooms" at the same time. This then presents an opportunity to talk about the difficulty of group members perceiving all the information in a group at any given moment.

CLIENT RESPONSES

People generally respond very positively to this activity. There is almost always laughter as the group attempts to complete a new and, what is for many, a novel task. Often a collective sense of delight is felt as the group may be momentarily engaged in an uninhibited, true sense of collective play. All too often, adults lose the sense of play that is such a vital aspect of childhood (LaFevre, 2002). Generally, the opportunity to rediscover this quality, however briefly, is met with a smile.

CONCLUSION AND CONTRAINDICATIONS

As mentioned, this game can be played with just about any group. It is a fun group exercise that brings the group together in a common task.

The group leader needs to be cognizant of the possibility that there might be one member of a group who is so seriously impaired, either cognitively or, have hearing problems, that he or she may not be able to follow the instructions. If that is the case, that person might become the focus of other group members' negative attention. In any

event, it is probably best to offer group members the option of observing if they are uncomfortable participating actively for any reason.

The leader of this activity is in a more directive role than are most group therapists. Keep in mind that group members will experience you differently when you move into the role of activity facilitator. Although they may have feelings about this, their central experience is likely to be one of collective enjoyment.

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Chapter 90

Naughty or Nice: A Technique for Exploring the Mischievous in Us

Lise Motherwell

THOUGHTS ON PLAY AND NAUGHTINESS

Freud attributed healthy adult development to the ability "to work and to love." Terr (2000) argues that the ability to play is an equally important aspect of social, cognitive, and emotional development. Winnicott (1971) writes, "It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and is only in being creative that the individual discovers the self" (p. 54). Play, which involves the capacity to pretend and to shift attention and roles, provides a natural setting in which a therapeutic experience or change may take place.

Naughtiness is a specific form of play: playful misbehavior directed at or against rules, authority figures, or propriety, in which one may get "caught," but which is not likely to hurt anyone else. Naughtiness evokes pleasure, excitement, and delight rather than guilt or shame. The authority's reaction to naughtiness has a big impact on how the subject feels about his/her naughtiness. Thus, naughtiness is a relational interaction, almost always an action in relation to an authority (rule/person/group)—to *them* . . . so it is a topic for group therapy.

DESCRIPTION OF GROUP

This technique can be used in a time-limited group, in ongoing therapy groups that periodically use exercises or techniques to en-

hance treatment, and in workshops. It is particularly useful in groups where clients have been parentified in childhood. Such clients who define themselves as "good children" may have lost touch with the side of them that takes pleasure in being naughty.

DESCRIPTION OF INTERVENTION

Step 1. Address Childhood Naughtiness

I say to clients: *"Share an experience you had as a child when you felt naughty. What was the situation, how did you feel, and what was the response?"*

This exercise raises a lot of affect. Clients recall situations when the parental response was shame, humiliation, or punishment (instead of playful acceptance), which taught them to repress feelings of naughtiness. Children's literature, which contributes to the healthy ownership and integration of difficulty affects, is filled with mischievous acts, which lead children to erupt into laughter. Naughtiness tugs on our wish to thumb our noses at authority and the pleasure of doing so without getting caught. Naughtiness in children's literature helps children both grapple with and integrate their feelings of aggression toward authority.

Step 2. Address Adult Naughtiness

I give clients an index card and say: *"Write down on the card something naughty you would like to do but feel would be hard for you to do."* We put the group's cards in a hat and one at a time a client chooses a card at random to read aloud. The group responds with associations or feelings.

This step is best done anonymously to minimize client shame. Clients are curious to know whose naughty act was whose, so it is important to set and maintain the boundary in the beginning about whether the information will be shared or not. Usually, the group views the naughty act as less bad than the individual who proposed it. This metabolizing by the group allows the individual member to reintegrate that part of himself or herself without the shame and humiliation from the past.

Step 3. Discuss the Difference Between Naughty and Destructive Behavior

As the "Cat in the Hat" says, "It's fun to have fun, but you have to know how!" (p. 18, Seuss, 1957). Some clients do not know the difference between what is naughty and what is destructive. Clients who grow up in families where sadism and abuse were the norm may think that teasing, sarcasm, and malicious mischief are naughty rather than destructive to the self and others, so it is important to discuss how naughtiness is playful and does not really hurt anyone else.

TYPICAL RESPONSES

Clients find this exercise both anxiety-provoking and playful fun. It engages strong affect, so it helps when a group is flat, stuck, or being overly good. Feelings associated with naughtiness include guilt, pleasure, excitement, shame, delight, power, fear, and a sense of "badness." Clients tend to relate to one another's wishes to be naughty as adults, which helps them connect and diminishes shame. Discussion of naughty acts evokes play and humor in a safe environment, and may help clients learn about hidden sides of themselves.

CONCLUSION AND CONTRAINDICATION

If we can encourage our clients to be naughty with us and the group, they may learn to play in other ways, and ultimately find their true selves. While I have not experienced any contraindication to this exercise, one caution is that some clients initially experience shame (i.e., evoked old feelings) when revealing their naughty acts. The leader must be aware of the strong feelings that can arise, and must be able to guide the client through any shame or humiliation he or she may feel. A playful leader can help reduce shame and help the group itself become playful.

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Chapter 91

Look at How I Feel: Art-Assisted Affect Expression

Carol Lark

Several members of your group have been simmering for weeks with unexpressed anger. They seem to be waiting to be invited to express it but, when given an opportunity, they deny they have any feelings and are "just interested" in what the group is talking about. The other members appear unbothered by the palpable emotional energy in the room and fill the interpersonal void with repetitious stories from their admittedly traumatic histories. The group's defenses against experiencing and articulating feelings in the here and now seem impenetrable. It is clear that the group is in a full-scale retreat from the experience of being embodied human beings.

THE EMOTIONALLY DISCONNECTED GROUP

Expressing and working with emotions in the present moment of the group often represent a major challenge to people who are disconnected from their feelings and/or acculturated to presenting a "nice," accommodating stance in the presence of conflict. This reluctance to express so-called negative feelings is often closely associated with a suppression of body awareness and, therefore, little access to emotional awareness that can be stated in words. These disconnections can be bridged by the use of sensory and kinesthetic modes of expression, such as art, movement, and drama (Lark, 2001; Lusebrink, 1990, 2004).

The following intervention is a simple art task that can help a group increase its awareness of the affective-cognitive disconnections between their usual interpersonal patterns of behavior and the way they actually feel. Using art materials activates somatic involvement, which increases awareness of the feeling state and enlarges the amount of the brain used to process this awareness. This intervention can be used in a group that feels emotionally stuck or that expresses inhibitions around expressing unpleasant feelings directly within the group.

GUIDELINES FOR INTERVENTION

Materials: Oil pastels, chalk pastels, markers, 12" × 18" drawing paper, a surface to work on (clipboards, pieces of cardboard to serve as lapboards, or table tops), writing materials (pens, pencils, and writing paper, such as inexpensive copy paper).

Method: A brief warming-up period may be needed to acclimate the group to the use of art materials. Simply suggesting that they "play" with the materials often gives the necessary bridge from making marks to more deliberately creating imagery. Once the group has warmed up with the materials, it is time to move into the more specific intervention. There are several variations on the intervention that can shape and/or extend the experience.

Instructions for the Task

Step 1: Preparing the Group to Focus

The leader comments on the group's "politeness," "unspoken feelings," or other concept that the group can accept as a truthful observation, and suggests that the group might benefit from using other parts of their brains to create a "language" with which to speak about what they are feeling. The drawing paper and boards are passed out, and the supplies are placed in easy reach of the group members.

The warm-up phase begins with the directive, *"Make as many different kinds of marks, shapes, lines, movements as you can in the next five minutes."* This will become a sort of "visual vocabulary" that is often a source of amusement and wonder within the group. Members usually enjoy seeing the variety of imagery within the group.

Once the group has had the experience of using the materials and seeing what's possible, begin the more focused part of the intervention.

Step 2: Basic Directive

Pass out a second piece of drawing paper and say, *"Allow yourself to become aware of how your body feels right now and find the color(s) that come close to matching that feeling. Using your arm and hand, make movements that correspond to the feeling and then make marks on the paper using these movements. As you continue to make marks, allow your body, hand and arm to create an image of your feeling."*

After the group has drawn for a few minutes, ask them to stop and look at what they have created. Ask them to write down their immediate impressions of their own work, what it seems to mean, what it looks like, and freely associated words that come to mind. Tell them that this does not need to make logical sense.

Step 3: Beginning Articulations and Processing in the Group

After the group has freely associated words to the images, ask them to show their work and use the written language to describe how they were feeling while they were creating. A variation is to ask them to say out loud what they have written beginning with the words, *"I am. . ."*

Step 4: Variation and Extension of the Work

Prior to processing in the group, you can ask them now to fold their paper in half. On the front side *"Draw how you would like to be seen right now (or, "How you would like the group to perceive you").* On the back side draw or write *"What I fear will happen if I express my inside feeling directly."*

This variation provides an even more explicit bridge between the internal, nonverbal feeling state and the "rules" the group members have learned about how to be and what the consequences are for being honestly emotional and direct.

CLIENTS' RESPONSES

This set of interventions can increase awareness of embodied feeling states and provide a verbal bridge to express those feelings. This is integrative at a brain-body level, while providing a buffering for the directness of the encounter through the use of produced images. Usually group members feel supported in this activity by witnessing others' work and being witnessed in return. It then becomes possible to assist the group to a more affectively genuine state within the session.

A variation of this intervention can then be used later in the group to encourage more direct encounters with one another. For example, if the group seems unwilling to tackle a conflict within the group, it could be asked to "portray what you think is going on in the group right now" on the inside of the paper, and on the outside to "portray how you would prefer to be seen or experienced at this moment in the group." After a few sessions in which art is used to support these observational and self-reflective skills, the group should be able to speak more directly to the questions.

CONTRAINDICATIONS

This task is relatively benign. However, it can feel overstimulating to some group members if the sudden release of repressed feelings excites them to a more manic state. This would be more likely if only the first set of instructions is used. Conversely, the now physically experienced feeling state may make them feel too exposed or vulnerable, causing a quick return to habitual defenses. If the members appear unable to contain the feelings, or begin to defend against what they have drawn, immediately go to Step 4 to engage their cognitive strengths and to concretize the experience in a less affectively direct way. I have found that interspersing image making and verbal language assists emotional self-regulation that does not deny the experience of feeling.

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Chapter 92

Stress Reduction for Students in Elementary and Middle School

Roberta L. Slavin

LOSS OF MORALE AND MOTIVATION

Many educators, teachers, principals, and superintendents, within school settings, are suffering an overwhelming loss of morale and motivation regarding their ability to make positive change in our educational system. They have become defensive, blaming others for their anger, and adapted a position that there is nothing they can do. Furthermore, they may deny that there are problems or difficulties (Slavin, 1997). These attitudes and feelings also impact on the feelings and attitudes of students (Slavin, 1996; Slavin, 2002).

For example, a kindergarten teacher shrieks at her five-year-old student: "Juan, how dare you yell and scream when I am talking. Go stand at the back of the room!" Juan is crying uncontrollably. The teacher ignores him. Which attitudes and feelings toward education will become fixed due to this kind of treatment? At upper grades, what causes older children to disrupt a lesson? Basically, many of the factors that cause stress in adults also cause stress in children. There is one big difference in that children are at varying degrees of maturation, emotionally, intellectually, or socially. Although schools have taken on the challenge of intellectual maturation, emotional and social maturation have been neglected.

DESCRIPTION OF GROUP POPULATION

Students in the elementary school and middle school where I worked were basically black and Hispanic. The schools were located in an economically deprived area of the Bronx, New York. Many of the children's families were receiving welfare, or parents were receiving less than average wages. A number of the children were being treated for chronic illnesses such as asthma and bronchitis. Many of the students were underachievers, and had moved many times during the school year. A few students were receiving some kind of therapy at mental health clinics.

INTERVENTIONS

I had to keep strict time boundaries such as the length of the school period (fifty minutes) and the period of the day I could work with the children, usually the teachers' break period. I worked to create a safe holding environment by being noncritical, showing interest, and emphasizing the value of each member's contribution (Winnicott, 1965; Yalom, 1995). Other important issues included recognizing the maturational level of the children, emotionally, cognitively, and socially (Flavel, 1963; Mahler, Pine, & Bergman, 1975). Following are some examples of group work in schools.

Example One: The Day the Class Went Silent: Death of a Classmate

I entered my assigned elementary school. The principal was waiting for me at the door. He rushed me to a second grade class explaining that many pupils in this class had witnessed a class member fall from his apartment window. He added that I should help them. I entered the class. The students silently stared at me. I asked if all the children knew the boy. A few nodded. No one spoke. I acknowledged that a terrible thing had happened and told them that I was sad even though I did not know the boy (being with them in feelings). I then told them that we would work together to help one another (instilling a sense of cohesion). I told the class to join hands and close their eyes (giving them a kinesthetic sense of cohesiveness). I started by taking the hands of the children on either side of me. I made sure

that every child was holding hands. Then I closed my eyes. A few minutes later I felt a jolt go through me. I began to feel stronger. I opened my eyes and told the children to do the same. As I looked around, their eyes seemed to have more life in them. There appeared to be less tension in the room. Several said they felt better but an aura of silence was still in the room. I told them that by holding hands we told each other that we were there for each other and that helped us feel stronger. I gave out paper and told them they could write or draw anything they wanted to and that I would collect their work and keep them all together. When they finished, and the papers were collected, I said, "When sad things happen you will know that others are there to help you."

Example Two: Feeling Demeaned

Eight students, in middle school, members of my third period group, came screaming and yelling into my room. I asked, "Kids, what happened?" They continued to scream and yell. Again I asked, "What happened? We cannot have a session if everyone is screaming." They slowly went to their seats mumbling angrily. I gave each of them a chance to talk. One student said the teacher is a rat. They all shook their heads yes. I asked what happened. Pete says he does not have time for breakfast so he buys it on the way to the school bus. He then adds, "The teacher says I make too much noise and will not let me eat it." Another student: "The teacher always says mean things about me." Still another child complains the teacher always criticizes her work but does not explain how to do it. I tell the children that it sounds like the teacher needs a lot of help. The group in unison says "Yeah, yeah." I then ask them how we can help her. Their first reaction is negative. I tell them that if we don't help her she will continue to be mean and unsympathetic. The general reaction is "maybe." I ask them is she really so mean or do they have fun making her angry? They respond, "Well, maybe." I ask if they can try some method of making the teacher feel good. The group should let me know if their methods worked or did not work and we will discuss them.

In this session, the group felt assaulted and demeaned. I focused on the person they were angry at. In another session when they were less enraged, I had them consider their behaviors that might create difficulty for the teacher. By giving the members an opportunity to help

the teacher and view their own behavior, they were in a position that would enable them to make positive changes without anyone saying, "You must!"

CONCLUSION AND CONTRAINDICATIONS

In Example One the children were emotionally isolated from one another and within themselves. The methods I used enabled them to undo the isolation—my empathy for their sadness and fear, as well as sharing our togetherness by joining hands and jointly working on a project that I said I would always keep together. I instilled hope by letting them know that each was important to each other as well as each of them being important to himself or herself (Yalom & Leszcz, 2005).

In Example Two I had a very angry group of children entering my room. If I challenged their anger they would have felt further attacked and their anger would have increased. It was important for them to talk directly about their feelings. Certainly the teacher needs help in how to work with angry children; by deflecting any responsibility from the children and asking them how they could help her, it affords the children time to examine the teacher's feelings, as well as review their own behavior. This must be done in a way that does not belittle or criticize them.

I do not believe there are any contraindications for the interventions that were used. I do believe that the methods I used in working with these children are necessary at all times because they show respect and instill hope, thus helping the children learn to respect themselves as well as others.

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Chapter 93

A Chair Is Not a Chair Is Not a Chair

Joseph Shay

THEORETICAL CONSIDERATIONS

So here you are, standing in a large room with many chairs scattered around. You are about to have your first meeting of a new group. You have told all the members during the screening that the maximum membership of the group will be eight members. Since you do not yet have the eight, you are beginning the group with the five members you do have. One of them calls early in the day to say he is out of town on a two-week business trip so he will not be attending this week or next. For tonight then, you have four members, assuming they all show up. So, it is time to set up the chairs for tonight.

Do you set up eights chairs to reflect the maximum group size? Five chairs because you have five members (you hope)? Or four chairs because four members are expected tonight? Unsure, you turn to the introductory group therapy literature about how to run groups and find either *no advice at all* (Brabender, Fallon, & Smolar, 2004; Friedman, 1994; Pinney, 1970) or *confusing* advice (Rutan & Stone, 2001).

Brabender, et al. (2004), for example, have a separate section on spatial characteristics of the group, and even mention the "configuration of the chairs" (p. 79) so everyone can see everyone else—but not a word about how to decide the *number* of chairs.

Yalom (with Leszcz, 2005) "If members are absent, most therapists prefer to remove the empty chairs and form a tighter circle" (p. 282), implying that the number of chairs *can vary each week* since chairs for any session should match the attendance for that particular

meeting. Rutan and Stone (2001) speak to this issue as well, and present two alternatives. In the first, the therapist sets up chairs for all current and potential members of the group, emphasizing that members are absent, that new members will be coming, and that members who have terminated can be remembered and mourned. In the second, just as Yalom does, as well as Fehr (2003), the therapist sets up chairs only for those expected for a particular meeting. They conclude, "The general principle in either approach is consistency" (p. 180).

It is not until their fourth edition (Rutan, Stone, & Shay, 2007), that they add this approach: "A third approach, and perhaps the most common, is for chairs to be placed for the number of current members of the group, whether expected to be present for a particular session or not" (in press). This setup means that the number of chairs remains the same, week to week, and match the actual number enrolled in the group.

So what is the group therapist to do?

I am going to present a vignette of a group therapist who has selected one approach—placing eight chairs to represent all potential members of the group—but then decides, based on reading the following argument for another approach—to change the arrangement after discussing it with the group members. Among the various models, I will argue for this one:

Model 1: The number of chairs should equal the number of actual members of the group—not the number of maximum members, and not the number of members coming to any particular meeting.

Drawbacks for Models 2 and 3:

Model 2: The number of chairs should equal the number of actual participants in any given meeting. Drawbacks include

- interruption of consistency and predictability of seating arrangement from week to week;
- inability to know until the last moment how many chairs to set up;

- confusion should someone expected to be missing arrive unannounced; and
- less of a sense that missing members are actually still part of the group even when absent.

Model 3: The number of chairs should equal the maximum number of participants, current and anticipated, in the group. Drawbacks include

- weekly reminder of participating in an incomplete experience;
- constant attention directed to the failure of the leader to fill the group;
- diminished sense that *we are the group* since new members have their chairs awaiting them; and
- shame in the group therapist who essentially makes a weekly admission that he or she does not have a complete group.

Assume then, that you are persuaded by Model 1 (knowing it too has drawbacks, primarily occurring when a member terminates the group and the chair is removed, making it seem more like a "death" without a symbolic reminder of this loss). How then do you make this change in your group, midstream?

DESCRIPTION OF THE GROUPS

Generally speaking, the nature of the chair arrangement from week to week—with respect to the number of chairs—has a greater effect on groups that are either ongoing, open-membership, and psychodynamically inclined, or time-limited with a closed membership. For groups in which the membership in its nature varies from week to week, for example, drop-in groups or support groups, or groups larger than, say, twelve, the number of chairs is important in that there be sufficient chairs for all, so that late-comers do not feel embarrassed, uncomfortable, or unwelcome.

THE INTERVENTION

Although I have not used this intervention for precisely this problem, I have used it successfully numerous times for similar situations in which I have felt I have made a structural decision that warrants modification.

1. I arrange the room as I always have before.
2. At the beginning of the session, I say, "I've been thinking a lot about the way I set up the chairs in the room, and I would like to make a change in the arrangement, beginning in three weeks. I currently set up eight chairs to represent the maximum number of group members. In thinking about it, while this seems to have worked for the group, I've come to think there is a better way. I want to set up the chairs to match the actual number of you in the group currently. This will give us all a clearer sense of exactly who comprises the group at this point, so week to week, the group in its entirety equals all of you. Of course, I will add chairs when new members join and remove them when members terminate. I'm glad to hear your thoughts and feeling in reaction to this, and to answer questions you might have."
3. I then create a space for reactions, encouraging verbalization of all of them.

TYPICAL RESPONSES

The therapist can expect a host of responses, the most typical being a wish to retain the status quo. Some members may state that they have never actually felt comfortable with all the empty chairs because it suggested to them that they were not in a well-functioning group. Others may say they are glad because when they miss a meeting, they want their presence represented in the form of a chair. It is highly unlikely that a group member will fight vehemently to keep the status quo.

CONCLUSION AND CONTRAINDICATIONS

It is noteworthy that something as fundamental as setting up the therapy room is given so little direct attention in the literature, presumably because the answer seems obvious. It is not so clear. My primary motivation for arguing for the model I have discussed (chairs

for all enrolled members, no more, no less) is that it helps the group therapist avoid the shame that I think is present in many group therapists when they have to signify, week after week, that they do not have a complete group. Second, using this model, the group members will have a consistent and continuous sense of who is in the group as an active member, whether they are present or not for any particular meeting.

The model is contraindicated if the group therapist is genuinely comfortable with his or her chair arrangement, and if the group is able to profit from exploring this aspect of the group therapeutically. "If the chair is not broke, don't fix it."

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Chapter 94

Nurturing the Community Development Dimension in Groups As a Preemptive Intervention

Avraham Cohen

CREATING THE CONTAINMENT FIELD FOR GROUPS

My family argued a lot and did not know much about encouragement. We were not very emotionally close and saying what mattered to me was not easily done, unless I could be angry at the same time. I have come to appreciate a number of things about my family as an adult, but as a young adult and later as a beginning therapist I only appreciated that my experience had provided me the motivation to look for something more meaningful and alive for my life. I was looking for emotional safety and connection and it occurred to me that perhaps I was not alone in this pursuit. It slowly dawned on me that what created a sense of safety and encouragement for me was being with a group of people that I knew and who accepted and encouraged me. Over time I began to wonder how to create this condition for myself and how to create it in therapy groups, and educational contexts. I discovered that my need was a common one. What follows is a general framework and then some guidelines about how to create this positive and compelling circumstance in groups.

The intervention that I will describe is in the service of creating an environmental atmosphere that is safe enough to encourage and support personal risk-taking on the part of group members. Its inception is based on my own work (Cohen, 2006) and the ideas of Deep Democracy as described by (Mindell, 2002).

It is a preemptive intervention in that it establishes a consistency and structure that can be counted upon and also provides an opportunity for each participant to express, hear, and be heard by the entire group. The content of the sharing is variable but includes where a person is at in the moment, what happened to him or her since the last meeting that is significant, issues related to being in the group, issues with another group member, and issues with the group leader. The group is "taught" that this is an experience to create connection opportunities within the group, to get to know something about the current life experience of the group members, to know their in-the-moment experience, be known, develop the community dimension of the group, and establish an optimal level of safety. This process becomes a predictable and consistent part of the group's process and structure, which meets needs for predictability and security while providing an opportunity to check in.

DESCRIPTION OF GROUP AND CLIENT POPULATION

This preemptive intervention has proven to be effective in both educational contexts and psychotherapy groups. I have rarely found anyone who was a good candidate to be in a classroom or a psychotherapy group who did not fare well and appreciate this approach. Individuals who were not good candidates were those who came from very dysfunctional families and whose initial experiences with family, school, religious institutions, and peers was very abusive and/or neglectful. In fact, I have found in classrooms where I do not have the opportunity to screen for suitability for group context, for some who came from such extreme backgrounds the classroom experience was actually healing as it provided an alternative view to the early experience.

DESCRIPTION OF INTERVENTION

Case Example

This particular example involves a man who was deathly afraid of speaking in groups. For many weeks he said as little as possible and concealed his fear. He eventually shared with me that he had this fear. We discussed the

possibilities for addressing this. I suggested that he could say something about it, tell someone else and have that person share his fear, I could say something, or continue as he had been doing with an emphasis on self-reflection to learn more about the process. He decided that he would share this fear himself in the next group during the opening group process. The group was very interested and supportive. Others with similar fears shared their experience. Most importantly, there was a shift. His dilemma became the group's dilemma. His silence was seen as a loss for the group—whatever he might have to share was not available. Questions arose. What was it about our group that fed the fear? What could we do about it? How could we track the process? This man became a representative of the silent and fearful part of everyone. His response was quite emotional. This process unfolded over a couple of months, became part of the group's oral history, and culminated with him coming to the group one evening dressed up in a costume and performing a piece of theater that involved the group as audience and participants. Essentially, the identified problem, fear of speaking out, became a seed experience for individual growth, community development, and an example of a deeply democratic process (Cohen, 2004, pp. 158-159).

Format for Issue Resolution

Each group or class begins with an invitation to check in and to participate in a personal and community process experience.

A time frame is established and closely adhered to. This adherence helps to establish a sense of safety and the frame for whatever form of psychotherapy is being utilized. Expectations that everyone will have an opportunity are stated.

The content that fits and does not fit is described. In educational environments what does not fit in this initial process time is course content, questions about assignments, grading issues, and any other content that might be construed as informational. In psychotherapy groups what does not fit are questions about administrative issues or processing of issues that are raised.

Develop a group culture that is safe with an opportunity for everyone to do whatever he or she needs to become more fully present in the moment. Build trust and a "containment field" by eliciting the opportunity for process and facilitated inner work. The containment field is the psychological environment within which the major work of the group will take place. Encourage content that is personal and inclusive of in-the-moment experience, recent significant life events, personal responses to any and all aspects of the course, memories, dreams, and reflections.

TYPICAL RESPONSE TO THE INTERVENTION

Group participants have invariably reported very positive responses to this pre-emptive intervention in groups and educational settings. The sense of belonging is a profound counterpoint to the experience of most in group, family, and organizational environments. The experience of being an agent in creating this experience is transformative for many.

Most members describe learning important things about themselves both individually and relationally. As well, participants report that the initial time in the group helped them feel more relaxed and secure in the time period in the group that is devoted to the central focus of the group whether personal therapy or the study of curriculum material.

CONTRAINDICATIONS

A concern and possible contraindication, for group leaders and educators, is that the personal process time will take over and that the identified focus of the group/class will be lost. This may not seem like a problem when it comes to a psychotherapy group, but in fact it is. The frame will be securely established by allowing opportunity for everyone, including the group leader, to check in and holding to the time frame. In educational environments the concern is that the curriculum material will not be addressed. In either context, the art and skill of the leader are crucial. Holding the boundaries, sticking to the content of this initial process for each meeting, reminding members of the limits when they seem to be going outside the boundaries, and attending to an artful and minimalist facilitation during the process and during the ending of this time in the group are important and central foci for the leader/facilitator. If a leader is not skilled in facilitating group process this is the most major contraindication for this intervention.

CONCLUSION

In a typical process time you might hear that someone is tired, another is excited about her child's success, someone else has lost a par-

ent, another person is animated about what he has been learning about himself in response to the group's process, and so on. The task of the leader is to hold the environment in a place of acceptance and containment. Occasionally, issues will arise, usually between people that require facilitation. These interactions provide an opportunity for a deepening sense of the group's meaning and sense of community.

This intervention depends on the ability of the group leader to facilitate, move fluidly between primary and secondary process, hold the boundaries, make connections with participants, facilitate connections between participants, and notice when the group has taken over an "executive" function. This allows the leader to step back and "let the group do it," which models for the group that they can, indeed, hold the energy and participate substantially in the process.

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Chapter 95

Humor As a Defense Mechanism in War Veterans

Vivien Henderson

SELF-HUMOR AND GALLOWS HUMOR

In a doctoral dissertation titled "Humor as a Defense Mechanism in the Holocaust" Ostrower (2000) found four subtypes of self-humor and gallows humor provided the main forms of humor as a defense. With Australian Vietnam veterans there appears to be a similar percentage of humor used as a defense.

Group psychotherapy has been regarded as the most effective intervention in the treatment of Vietnam veterans with post-traumatic stress disorder, (PTSD) (Brende, 1981; Walter & Nash, 1981; Koller, Marmar, & Kanas, 1992; Howard 2000). It has been proposed by Howard (2000) and other theorists that one of the central tenets of trauma theory is the need for getting in touch with the feelings associated with the traumatic memories. Once the feelings have been accessed, then words need to be found in order to work through the trauma (Herman 1992; Parson, 1993; Goodwin & Weiss, 1998; Howard, 2000).

DESCRIPTION OF THE GROUP

In the earlier years, the groups were residential (in the hospital) for the first four weeks. The program was intense, providing psychoeducational groups, individual therapy, and group psychotherapy. Attendance was daily with home visitations for the weekends. After the

four-week intensive phase, the men then came one day weekly for eight weeks.

Although the program has changed over time, with the shift being toward non-residential programs, it still remains a time-limited program of twelve weeks with a maximum number of eight members in each group.

THE INTERVENTION

Humor is considered to be one of the more adaptive defense mechanisms. Gallows humor and self-humor have helped many people to survive exposure to very traumatic experiences.

However, when humor is allowed to continue within a therapy group, it prevents the patient from accessing the feelings behind the humor and prevents the working through of the trauma. This is specifically salient in an all-male group where humor is mostly used as a defense against the cultural stereotype of "being a man." A man does not express vulnerable feelings.

Stages of Intervention

Stage 1

Develop cohesiveness within the group. This will enable the therapist to make the forthcoming intervention so that it does not seem persecutory to a specific group member or the group-as-a-whole.

Stage 2

When a patient seems close to being emotional and the members of the group distract the whole group away from this man due to their personal discomfort, the psychological flight from affect and feelings of vulnerability becomes manifested in gallows humor. At this time, the therapist can draw the group's attention to how they are engaging in this behavior and an exploration of the underlying feelings, which are pushing them into avoidance.

Stage 3

There is an educational component to this intervention and it is important to engage the men in discussing the stereotype of "being a man" in their culture and what their beliefs are about men expressing emotions. Suppressing feelings in war was useful and helpful at that time but now this behavior conflicts with their recovery. It necessitates their getting in touch with their feelings and finding words to put to those feelings, which go with the images of the trauma in their minds.

TYPICAL RESPONSES TO THE INTERVENTION

Initially, such an intervention is likely to draw a response of surprise from the men, as if they have been caught off guard. They may ignore or deny the initial interpretation by the therapist or respond with embarrassment that their "ploy" has been "seen through" by the therapist. Veterans as a rule, tend to hold a belief that civilians do not understand how they think, feel, and behave.

Usually, if denial is the first response, then the therapist usually does not have long to wait before the behavior occurs again. The therapist just keeps *gently* drawing the group member's attention to how he is using humor to avoid feelings.

It is important to remember that avoidance is one of the many symptoms of PTSD and it is important for the therapist to gently keep bringing the men back to these difficult feelings.

CONCLUSION AND CONTRAINDICATIONS

It has been shown that gallows and self-humor tend to be used by individuals as an important defense mechanism when exposed to extremely stressful traumatic situations.

This intervention is not recommended if the group is not cohesive or if the therapist is uncomfortable with strong affect as the ultimate goal is to elicit strong suppressed affect that has been correlated with a traumatic experience.

It, too, is contraindicated if there is a preponderance of paranoia and or persecutory anxieties among group members. Conversely, gal-

lows and self-humor, if colluded with by the therapist in group psychotherapy, prevents access to deeper feelings enabling the "working through" process and the subsequent healing to take place.

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Chapter 96

Trauma Therapy As a Community Enterprise

Norman Claringbull

THE MOST TRAUMATIZED ARE THE VICTIMS OF MINOR EVENTS

Although the major disasters hit the headlines, the fact remains that most traumatized persons are the victims of *"minor"* events, (least in terms of their newsworthiness). Put simply, there are far more armed-robbery victims, assault victims, car crash survivors or people encountering random/unexpected, violent, or otherwise traumatic, events than there are victims of tsunamis, war, or terrorism. Most people's everyday experiences of trauma happen on the street corner, in the workplace, in the home, as part of everyday life and usually involve a very small number of participants, often less than three or four, including the perpetrator.

Nevertheless, whether the traumatic event is affecting large groups or small, it has traditionally been the case that responding to the needs of the potentially traumatized is the province of the specialist, the "Expert Trauma Therapist." However, the U.K. National Institute for Health and Clinical Excellence (2005) warns us that trauma therapy *"should only be offered if it is actually necessary"* and argues that there are many cases when clinical inaction is the treatment of choice. This proposition raises the possibility that trauma therapists may not necessarily be best deployed if they are primarily seen as *"frontline troops."*

A recent literature review (Rutter, 2007), strongly suggests that many, if not most, victims much prefer the help of friends and col-

leagues to the services of the allegedly expert therapist. These observations are powerfully reinforced by Orner et al. (2003), who found that employees in high-risk occupations responded best to the flexible and informal help routinely offered to them by their workmates. It seems that trauma victims often prefer to turn for help to their own local communities, (workplace, social, familial, etc.), than to therapists. Therefore, is trauma therapy best delivered when it is embedded as part of a community enterprise?

DESCRIPTION OF THE CLIENT POPULATION

The client population is, literally, anybody, anywhere, any place, any time, any circumstances. It really is *"a small world"!*

THE INTERVENTIONS

Example

Christmas 2004 simply did not happen for me. I spent it as a member of a dedicated "Reception Team" helping the survivors of the Indian Ocean tsunami who were arriving at London Gatwick. A special receiving area had been set up at the airport where, as they got off the plane, the returnees passed through an organized and orderly reception process that involved medical teams, social welfare teams, clothing and refreshment providers, showers, rest areas, access to phones/e-mail and the help of transport specialists who organized their onward journeys. Of course, as this was the United Kingdom, at all stages there were copious amounts of tea available!

The interesting thing about working with these people was this: There were probably about thirty to forty experienced "service providers" present, including doctors, nurses, paramedics, social workers, police, NGO "experts" and so on. However, as soon as any of the "customers" showed any form of overt emotion whatsoever, the cry went up, "get the therapists"! Why? What was everyone scared of? In the immediate aftermath of the disaster, before any proper organization got going, these victims had been simply scooped up off the beaches and from the wrecked resorts, packed into the first available plane to anywhere and sent off. It was not uncommon to see peo-

ple arriving still wearing their swimsuits and with no other luggage. One woman turned up wearing only her bikini bottom! Naturally, as soon as they got home to the United Kingdom, and could at last feel safe, these people immediately began to react emotionally in very overt and initially inconsolable ways.

My deliberate response to this obvious psychological discomfort amongst the team was to take my co-workers to one side and quietly explain this very normal emotional healing process to them. I wanted to get it established and accepted that it was more than just okay to weep, but actually quite a common human event and even a desirable one. Therefore the most helpful thing that they could do was simply to allow this natural healing progress to occur without pathologizing either the returnees or their psychological reactions. What was I doing? Was I giving my co-workers "therapy," "psycho-education," "normalization/permission" or whatever? I don't know, but I do know that it worked and it was probably the most effective therapeutic intervention that I offered over the entire ten days that we spent meeting the survivors. I know this because I could see the obvious benefits to the survivors and the positive changes in the team's attitudes. Would I do it again? I have no idea–it just seemed right at the time!

Example

In the Gulf War, a well-known, international petrochemical company who was concerned about terrorist activity, briefed me to run coping-strategy training courses for their European staff whose colleagues might suffer psychologically from terrorism-generated trauma. The plan was to help the workers to help themselves. Most employees were keen to get involved but they mostly shared a general feeling of potential incompetence and impotence when faced with, what to them was, the apparently impossible, or even overwhelming, task of dealing with overt human emotion. They were scared of being scared! The following two exchanges show how I tried to respond to their problems and you can judge if, (and perhaps how), you might have done things differently:

Employee A

> I was involved in a bad traffic accident. Although not hurt myself, several people were and the paramedics asked me to sit with one young

> chap who was quite badly injured and awaiting transfer to hospital. I suppose that I was with him at the roadside for about twenty minutes–it seemed like hours at the time. We chatted idly and then he asked me to ride in the ambulance with him. Altogether I was with him for about an hour. I've never felt so useless in my life! He needed urgent medical help and there was just nothing that I could do for him. I keep having nightmares about all this.

In technical terms, my intervention could be described as psychoeducational. In reality, all I did was to explain that the victim was simply asking for the immediate comfort of human contact. Therefore their "idle chatter" was exactly the sort of emotional help that he needed at that time. Far from being "useless," what Employee A was doing was essential and skillful work in helping the victim cope with his fears and make some sense of his shattered world. My input apparently helped because at a subsequent meeting Employee A told me that the nightmares had stopped.

Employee B

> My neighbor was robbed at gunpoint and afterwards she became a changed woman. She was a different person; someone I didn't know. She had huge mood swings; she lost all of her sparkiness and was quite aggressive to everybody. One day she told me that she was terrified that that she might be going crazy and I just didn't know what to say to her because I didn't want to make her worse.

This fear of insanity seems to be quite common in trauma victims who, at least in the short-term, find that their lives and their emotions have been distorted by their psychologically disruptive experiences. My usual intervention is to simply tell them that they are actually quite okay and that it is normal to react abnormally to an abnormal situation. I explained to Employee B that we all get crazy in crazy circumstances and that it usually helps trauma victims if we all openly acknowledge this. There was an immediate alteration in his body language. I could see the changes take place. It seems that learning this simple fact made him feel much better about himself and he later told me that he now felt more confident about dealing with similar situations in the future if he had to.

In both the first and the second examples, at no time was I presenting as an expert trauma therapist. I was just doing a bit of psychological handholding and I was not doing anything that any reasonably

informed, concerned, person could not do. All that I was doing was helping, or encouraging, the members of the community to respond more confidently and more effectively to the needs of trauma survivors. In effect, I was helping to promote the concept of trauma therapy as being a community enterprise. So, if this means that sometimes I find myself making the sandwiches just to show that the response team cares enough about the survivors to worry about feeding them, then so be it. It is often claimed, although unfortunately never substantiated, that Freud once told a group of students that, "sometimes a cigar is just a cigar." True or not, it is a great story, so if our traumatized clients tell us that they only "need a smoke" then perhaps we should leave worrying about transferential analyses, core conditions, object relations, or any of our therapeutic whatevers until another time. Or, better still, perhaps–sometimes even forget about therapy altogether!

A REDEFINING CONCLUSION

There are already a number of community-based approaches to trauma relief in current use. Here are two popular examples:

The first example can be found in a process commonly known as "Critical Incident Defusing" (Mitchell & Everly, 2001). This is basically an emotional recovery process, which is usually most effective if those involved in a traumatic incident carry it out for themselves. This is because defusing is essentially a peer-supported normative process and so bringing in outside "experts" might unnecessarily exacerbate the situation. Defusing is a method of focusing post-incident conversation and social interactions so as to ensure that everybody who was involved, or is otherwise affected, feels able to acknowledge and, if necessary, express their thoughts and feelings. In other words, defusing is a process that acts as an emotional, pressure-relief valve that reduces immediate psychological tensions and prevents accumulative stresses from building up.

The second example of trauma intervention as a client-led, community-centered, process can be found in the Psychological First Aid, (PFA), protocols, developed jointly by the U.S. National Child Traumatic Stress Network & National Center for PTSD (2006).

- Contacting and engaging the victims
- Helping the victims find safety and comfort
- Emotional stabilization
- Finding out just what the victims really need (*everything and anything*)
- Organizing practical assistance
- Connecting victims with own/local social support systems
- Providing the victims with information about what has happened to them, how it might affect them, (including psychological/emotional affects), and how to cope
- Developing links with welfare and health services in case of subsequent need

In sum, it should be noted that most, possibly all, of the components of both defusing and PFA are not essentially psychotherapeutic in nature but focus on meeting basic needs, (e.g., physical safety, interpersonal connectedness, support, normalization, encouraging postevent functioning, etc.). These services must be flexibly delivered, using strategies that meet the specific needs of the victims. As McNally, Bryant, and Ehlers (2003, p. 68), note, "the bottom line is that in the immediate aftermath of trauma, professionals should take their lead from the survivors and provide the help they want, rather than tell survivors how they will get better." So, given that there is a strong case for taking the supposedly expert trauma therapist out of the posttrauma scenario, does psychotherapy still have a part to play in the general care of the traumatized? Can therapists still be of use? Perhaps we might have to retarget our professional intentions and remodel our therapeutic activities. The sample interventions, which I have described in this chapter, suggest that this very task-focused therapeutic evolution might well be achievable and possibly even desirable.

CONTRAINDICATIONS

A major weakness of the community-based approach to trauma therapy lies in ensuring that the needs of the genuinely emotionally pathologized survivor are identified. Relying on laypersons to normalize the abnormal is fine providing that the needs of the seriously disturbed are not overlooked. This is why I argue that is essential that

therapists form part of immediate response teams. I do not suggest that they have to be there to overtly therapize but, as they generally help out in any capacity, they can be watching what is going on and sometimes, quietly, unobtrusively and, above all, respectfully they might identify someone who appears to be a more acutely affected victim, (this includes team members as well as the trauma survivors). In such cases the watchers can become overt therapists once again, even if only temporarily, and use their professional skills to start to address the needs of the more deeply troubled people at a different level, perhaps even at a psychotherapeutic one.

The question we have to ask ourselves as therapists, is, can we find the humility in ourselves to believe that sweeping up at the reception center is as vital a therapeutic task as is being an expert trauma therapist? What is more important–making deeply insightful psychotherapeutic comments or making the tea?

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Chapter 97

Trouble to Resource

Miriam Iosupovici

Where there is much light, the shadow is deep.

Johann Wolfgang von Goethe (1749-1832)

RECOGNIZING DUALITIES AND RESILIENCE

From literature and nonfiction, "good luck/bad luck" tales, and proverbs of many cultures, the reality that problems can directly or indirectly lead to paradoxically positive outcomes, self-knowledge, and resiliencies has long been part of human awareness. The concept of "reframing," originally developed in family therapy contexts, has been broadened and utilized in other therapies, including resiliency interventions (Wolin, S.J. & Wolin, S., 1993). With longitudinal developmental research such as that reported by Valliant (1995) and the Kauai studies (Werner & Smith, 2002), reporting unexpectedly positive life trajectories for multiply stressed subjects, and further stimulated by the influence of positive psychology, the realities of adaptive lifelong functioning are being incorporated into theoretical perspectives (see Fredrickson, Mancuso, Branigan, & Tugade, 2000; Fredrickson, 2001). As Hemingway, in his semi-autobiographical novel, *A Farewell to Arms* (1929) wrote: "The world breaks everyone, and afterward, some are strong at the broken places" (p. 226).

I wish to thank Erv and Miriam Polster for introducing me to this question during a Gestalt Community meeting in La Jolla, California.

POPULATION

Interventions focusing on dualities of experience can be utilized in many types of groups, depending on the comfort of the therapist with the suggested process within their preferred style of group work, group stage, and population (see "Contraindications").

INTERVENTION: FOUR PATHWAYS

Clients are asked to talk about a behavior or event(s) in the past that resulted in any kind of outcome they define as "trouble" (could be one-time event or continuing, major or minor), an experience that has been filtered through their thoughts and actions, becoming a resource in their current lives. Therapists can model the intervention utilizing an example (or more) from other client experiences while encouraging disclosures far different from the ones used as models.

Pathways

1. Introduction

> In dyads, group members utilize this question as part of talking about their life experience as an initial level of self-disclosure in group. This avoids stereotyped methods of self-presentation and can be combined with other beginning introductory questions. When utilizing this question at the beginning of a group, it is likely that the examples will be less powerful than later on, yet it can still be very useful.

Example: Client reports that he was shy in high school, less so now, and this has taught him that shy people are waiting to be discovered so he tries to reach out to them.

2. Organic Manifestation

> Client discloses experience in life that was problematic for him or her, ended in censure or punishment, and the client talks about self-awareness that includes this event (or repeated events) as a resource that is positive in his or her life and/or how they

have used the event as a source now. If client does not notice this capacity in life currently, either you and/or another member can report your knowledge of this skill, awareness, resource. Polster (1992) notes that when heroism is exercised by women, it is often under conditions of daily life or in the collective, and thus may not be seen either by the client or others because our narratives privilege the "lone hero." This may also be true for different cultural populations, as well. After there is sufficient support regarding the original trouble (which can range from acknowledgment to much fuller exploration), therapists can underline this important awareness of "benefit" as one of the inherent dualities of life, and ask the client to respond more if she or he wishes to. Then, bridge to other members of group and ask if they had similar awarenesses.

Example: In the working phase of group for survivors of abuse and molestation, a client talks about her fierce determination to play piano at age five even though her brother would hit her on the head when he would walk by, abuse of sufficient severity to cause partial deafness. The client describes her drive to succeed despite the brutality in the family and notices that she uses that skill in the dynamics of her very competitive graduate school. Group expresses rage at brother and anger at lack of parental protection, with high level of affect including tears. This is followed by statements of respect for client, noticing numerous behaviorally specific examples of her ability to focus and persevere in the midst of adversity and her support of others in the group. Other members, with some leader support, find parallel events in their own lives.

3. Go-Round

Many groups utilize a go-round as a way of beginning each group. This exercise can be utilized as an alternative, evocative way to start a group process, including after a break in the group due to vacation or holiday. When used at the first meeting of a group, the question tends to interrupt stereotyped styles of self-presentation, and may allow parts of self perhaps not yet visible to group to emerge.

Example: Client returns from visit home and reports that a sibling had thanked her for the care she had given him/her when they were growing up. Client acknowledges sacrifice and stress, and talks about what she had learned from making this choice.

4. Psychoeducational Format

> Within a group that combines content and process, clients may be taught a "vocabulary of resiliencies" or be presented with a model like the "Resiliency Mandala" before they explore how they fit into this schema (see Wolin, S.J.& Wolin, S., 1993 and/or Web site for Project Resilience)

Example: After presentation of the model, a client in ACA (Adult Children of Alcoholics) group recognizes resiliencies developed in childhood that were useful growing up in a home with alcoholic parents who were episodically neglectful and deficient role models. He realizes that he was not only "parentified" but acted with planning and initiative on principles of moral choice. He is able to identify how he continues to do so in his new family, while expressing sadness that he was unable to receive what he gives his children. He discusses how he has created positive rituals for holidays, which were often ruined by alcoholism in his childhood home, that are now sources of joy and pleasure for himself and his family.

CONTRAINDICATIONS

Some life experiences may not have this duality and the client's frame is to be honored. This intervention is not a simplistic generality, nor a "If life gives you lemons, make lemonade" cliché. As reflected in the Japanese proverb "The other side has another side," all sides of the narrative are to be honored. Therapists need to be aware of their countertransference to narratives of abuse or other difficulties and only utilize such an exercise for sound clinical reasons: i.e., supporting clients' awareness of both sides of life experience to enhance their functioning. For this reason, some therapists may feel that this structured intervention is more appropriate to a working phase of group, when both members and leader(s) have sufficient experience with one another to create depth in processing.

However, the timing of the intervention would vary depending on the severity of trauma experienced by clients. With traumatized clients, this intervention is recommended only within a longer-term framework and in the working phase of group when the pain of the experience has been acknowledged sufficiently that clients have been validated. The intervention also requires a level of intellectual and emotional functioning allowing for a conceptual holding of duality in human life.

In order to fully utilize the strengths of this intervention, a theoretical schema including resiliency must be integrated by the therapist. In some instances, therapists fluent in asking questions about difficulty may not be as skilled at exploring resiliencies. Clinicians may find useful models for exploring the behaviorally specific aspects of resiliencies through the lifespan in Wolin, S.J. and Wolin, S. (1993) and online at their Web site Project Resilience.

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Chapter 98

Dealing with Anger in Two Different Phases of Group Development

Michael P. Frank

ENCOURAGE A WIN/WIN OUTCOME

Dealing with conflict is an important aspect of life. Dealing with it in a way that encourages a win/win, positive outcome is important to good relationships. A therapy group provides an environment in which conflict can naturally occur and, if properly handled, can have a positive outcome for everyone in the group (Fehr, 2003; Rutan & Stone, 2001).

Since groups change and develop over time, the best ways to intervene can also be different depending on the phase of development the group is in. There are times in a group's life in which conflict can be well tolerated, and times in which it has greater potential for adverse outcomes for individual group members or for the group as a whole. Once a group is well under way, either of these conditions can occur at any time. Typically, however, the group is less able to deal with conflict early on in its life (Fehr, 2003; Rutan, Stone, & Shay (2007), or when there are significant changes in its state (turnover, environmental changes, etc.). It is better able to deal with conflict after it has achieved a good measure of cohesion.

DESCRIPTION OF GROUP AND CLIENT POPULATION

I work mainly with long-term, mid- to high-functioning outpatient groups. These groups are interpersonal/psychodynamic with goals of

increased insight, relief of symptoms, improved relationship skills, and general personal growth. Just because someone functions well in general, however, does not automatically mean the person will do well with any particular issue. Conflict, in particular, is something that many people have difficulty experiencing. The difficulty can manifest in many ways, from overaggressiveness, to avoidance, to passive-aggressiveness. The interventions in this chapter can be useful in a wide variety of clinical situations, with various populations.

EARLY IN THE GROUP'S LIFE

When a group is forming there is a lot of anxiety about whether the group is a safe place (Tuchman, 1965). Among the fears each member brings with him or her are those that have to do with what could happen if there is conflict. Will I be damaged? Will I damage someone else? Will it just be too scary or uncomfortable? Will the group fall apart? The therapist will share in this experience.

Since we each learn about conflict early in our lives, mostly in our original families, that is the experience we bring into the group. If we grew up in a painfully conflictual environment, this is what we will anticipate when conflict arises in the group. If we grew up in a conflict-avoidant environment we received two messages: conflict is scary and/or useless, and we are better off not dealing with it. Often, in the family of origin, when there was conflict there was always a "winner" and a "loser" with no experience of a mutually beneficial result. Regardless of the dysfunctional style, when these families were in conflict they were incapable of being nurturing and secure.

Major questions then arise about the group itself. When there is conflict, how durable is the group–will it survive? How safe is the group–can I survive? How durable is the leader–will he or she be okay enough to take care of me?

The first step in establishing the safety, security, and efficacy of a group is the experience of the therapist as being durable and safe. In dealing with a confrontation will he or she retaliate? Punish? Fall apart? Avoid the issue? Or will he or she deal with the conflict nondefensively and in a way that leads to understanding and growth?

So at this stage, the therapist must be ready to hold each member individually as needed. When there is conflict, one way to do this is

to redirect the anger away from the group member and onto the therapist.

DESCRIPTION OF INTERVENTION

Example 1

Jane becomes angry with Andrew for coming late and "forcing" her to repeat her story. Andrew responds with increasingly uncomfortable mumbled apologies and excuses. Jane only becomes angrier. Neither seems able to effectively engage with each other. There is a real risk of either or both of them becoming an early group casualty.

- At this point, the therapist can intervene by redirecting both of them to himself/herself. To Jane, the therapist may say, "I can understand how you might feel about Andrew's lateness, but I think you also have some feelings about whether I'm doing a good job of establishing the group's boundaries." To Andrew, he/she may say, "I can see this is difficult for you. Maybe you are somewhat angry at me for allowing you to be criticized."

JEFF: "Yeah, Doc, how can you allow this? You have no idea how irritating this is for me. If you can't get *your* act together how are the rest of us supposed to?"

TH: "You're angry at me for not making sure you can get your needs met in here?"

JEFF: "That's right."

TH: "So what is this like for you?"

Example 2

ANDREW: "I thought this was supposed to be a safe place. I guess I was wrong."

TH: "You feel you were unfairly criticized for something that wasn't your fault and I didn't do anything to prevent it."

ANDREW: "You just sat there and let it happen. You didn't do a damned thing about it!"

TH: "What's it like for you to be angry at me about this?"

TYPICAL RESPONSE

There will be a sense of relief on the part of both principals, as well as the rest of the group. The confrontation did not escalate out of control (nobody "died"). Both of them were able to express some anger at a safe and receptive target (the therapist). In addition, the therapist provided a model for nondefensively handling negative feelings. Both principals were also invited to explore and express their own experience of the encounters, thus helping to establish an important therapeutic norm. Other members of the group should also be invited to share what it was like for them. This will open up further disclosures about their outside current and past relationships, fostering more sharing and greater cohesiveness.

LATER IN THE GROUP'S LIFE: THE WORKING PHASE

As the group develops over time, the individual members are more able to tolerate and respond to one another's feelings. There is a greater sense of safety and common purpose: whatever happens, we are here to help one another. The therapist can allow exchanges to play themselves out for longer periods of time intervening later on with questions, observations, or interpretations that foster further insight and growth.

Now, when a confrontation occurs, the therapist can sit back and observe, knowing that the group has experienced this before and knows that he or she will intervene if the therapist thinks it's necessary. Otherwise, as uncomfortable as it may get, it feels safe enough. After a time, the therapist has a choice of interventions, depending on the therapist's theoretical orientation.

DESCRIPTION OF INTERVENTIONS

Once again, Jane confronts Andrew with his lateness to group. Andrew makes excuses and Jane gets angrier. This time, however, the therapist allows it to continue. After a time, Andrew starts to fight back.

ANDREW: "I'm not the only one who's ever late, you know. How come you always get mad at me?"

JANE: "I don't know. There's just something about how you're always so apologetic but you never really take responsibility."

ANDREW: "And you always look to blame first and understand later. Or never."

THERAPIST: "I know that you two have had this issue before, but this time it feels a little different."

The therapist can address the interchange with the principals and the rest of the group in many ways:

The here and now: "What are you each feeling right now?" "What was it like for you all to witness this?"

Family-of-origin or transference work: "Did this experience feel familiar to you?" "How did something like this play out in your own family?" "Jane, how you are feeling about Andrew right now sounds an awful lot like what you've told us your relationship with your mother was like."

Relationship work: "How did you participate in creating this conflict? In resolving it?" "Is there something you would want to do differently?" "Andrew, when you and your partner get into an argument, is this how it goes?"

Each of these interventions opens a door for further work for everyone in the group, turning a "negative" group event into something richly therapeutic.

CONCLUSION AND CONTRAINDICATION

Anger and conflict in the group can threaten therapeutic outcomes and even the existence of the group itself. If well handled by the therapist, however, these emotions can also be openings of great therapeutic power and effectiveness. Knowing how, and when, to intervene is part of the art of group therapy.

The contraindication of this intervention often lies with the therapist's lack of skill and experience. It too depends on the therapist's ability to comfortably experience anger in his or her groups, and the

therapist's psychological sophistication. It is important to know where your group is in its development. Early on in the life of the group, and at times later on, interventions in conflictual situations must protect the integrity and safety of the group first, with the goal being the establishment of cohesion and therapeutic group norms. After the group has become more established the therapist has a much greater range of possible interventions, including the most powerful intervention of all: sitting back and allowing the group to work it out for themselves.

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Chapter 99

The Fee: A Clinical Tool in Group Therapy

Shoshana Ben-Noam

MONEY: A TABOO TOPIC

Money is transactional, interpersonal, and symbolic. It is a taboo topic in many cultures. Talking about it often evokes powerful feelings and impacts our significant relationships. Its symbolic meanings, often unconscious, are shaped by cultural, religious, and familial attitudes and beliefs.

In therapy groups, setting and collecting fees may trigger, among other feelings, anger, shame, jealousy, and greed both in the members and leaders. To gain insight into these feelings and understand their interpersonal meanings, the money taboo has to be lifted.

To this end, money matters need to be normalized and openly discussed in the group. A clear fee and billing policy has to be presented so that members know what to expect, and policy violations can be therapeutically explored (Gans, 1992; Fehr, 2003; Rutan & Stone, 2001). To effectively do so, therapists need to work through any discomfort about discussing money matters, and resolve conflicting feelings about a therapy practice being a "business" (Ben-Noam, 2004).

A SELF-REFLECTIVE GROUP POPULATION

Psychodynamic groups in private practice are most suitable for acquiring insight into negative feelings and/or conflicts triggered by fee payments. To explore the money transaction between therapist and

patient, members need to be adults who self pay or use third-party payments. Adolescent and children's groups need to be excluded. Members need to be self-reflective and insightful. The more insightful patients will gain the most out of these explorations. The less insightful ones may also obtain some understanding regarding money exchanges/matters.

INTERVENTIONS

There are two prerequisites to using fee as a clinical tool in group therapy: First, the leader needs to feel "entitled" to his or her earnings and free to lift the money taboo in the group. Second, a fee and billing policy has to be presented to and accepted by prospective members in the pregroup interviews: members are responsible for paying the bill. Those using third-party payments should pay the therapist directly, if possible, and get reimbursed by the insurance company.

Bills will be handed out in the first session of the month and members are expected to pay in full prior to the end of the month (or any other consistent agreement).All financial matters will be discussed in the group, including overdue payments.

Members missing sessions will be charged. Some therapists agree to a number of missed sessions per year (it has to be clarified that third-party payers do not reimburse for missed sessions).

The policy needs to be revisited in the initial sessions or when a new member joins the group. Contract violations, however, are inevitable.

Clinical interventions when the contract is violated: Mike stayed in the group room until all the other members left. He seemed nervous as he told me he could not pay the bill that month because he lost his job. I responded: "it is important we discuss it next week in the group." The following session, I announced in the beginning of the session that some members were late with their payments. Mike was quiet until Joe said to him: "You look distracted." He then shared: "I lost my job two months ago. I can't pay my bills." Joe turned to me and asked if I can postpone Mike's payment this month. Mike's voice broke as he said: "I was ashamed to share it with the group, I feel like a failure. My brothers have high-powered positions. I couldn't tell them I lost my job." I asked the group how I should handle Mike's fee

for that month. Several members asked me to postpone the payment and I agreed.

Following this session, Mike reported feeling more confident in his job search and told his brothers he lost his job. To his surprise, they offered him a loan. By initially not sharing his job loss with the group, he enacted his fear of being humiliated by his brothers (this was later discussed in the group). My adhering to the policy that financial matters will be discussed in the group, and the group's supportive and nonjudgemental responses, empowered Mike to discuss the job loss with his brothers and pursue the job search assertively.

David announces in one of the group meetings he will miss one of the group sessions the following month since he will be on his honeymoon. He then turned to me and said: "I am giving you five weeks' notice so you won't charge me for the session." The whole group was looking at me. I had mixed feelings. On one hand, I felt happy for David who was getting married after searching for a mate for a long time and wanted to do something special for him. On the other, I wanted to enforce the agreement that I charge for missed sessions. I kept quiet. David then asked me: "Is this okay with you?" I then responded: "Our contract is that all members pay for missed sessions." David and two other members were enraged with me. Mark said: "That's his honeymoon, how can you do it?" Sara then said: "So since I am not married I can't get special privileges?" David then shouted: "My brother was always special. He got the awards at school, he played the violin, the girls loved him, my mother loved him. I always thought I was adopted. I never did anything right!" Sara responded: "I love you. I am happy for you that you are getting married, but I think you need to pay for the session."

This was the first time David expressed the transferential wish to be special and the intense anger toward his mother. In following sessions he expressed warm feelings toward Sara, apologized for shouting at me, and paid for the missed session.

CONCLUSION

Fee-related interventions open up a host of interpersonal learning opportunities. In reaction to these interventions, pent-up feelings of rage, pain, or humiliation toward significant others may be released, discussed, and better or differently understood.

Conflicts regarding money matters in the group or in life may be resolved.

CONTRAINDICATIONS

These interventions are contraindicated for highly narcissistic and borderline patients who will not be able to tolerate and metabolize the intense feelings evoked. Also, leaders who have difficulties in addressing money matters freely and containing negative feelings may not be successful in using the fee as a clinical tool.

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Chapter 100

Remembering When: Therapist As a Historian

Mary Jago Krueger

If we possess our *why* of life we can put up with almost any *how*.

Nietzsche

MAKING THE UNCONSCIOUS CONSCIOUS

Listening intently to the language of others offers us the opportunity to create images that stimulate the senses (Barlow, Fine, Pollio, & Pollio, 1977). Telling stories of lived moments is a creative opportunity to verbally image a moment in time that can provide a perspective from which a shared experience can elicit visceral responses in the group process. Words have an energy that can ignite the listener; it is the awareness of the storyteller that dictates the power of the words. Words weave into stories. Sharing these stories with the group allows for authentic and meaningful connections among the members (Brunner, 1986; Moustakas, 1994).

As a psychodynamic group psychotherapist with humanistic and existential psychological leanings my role as a facilitator is to work with the group and its members to make conscious material that may not yet be fully conscious, conscious. Conscious awareness allows the clients to take personal responsibility and to make conscious choices. In service of tracking the development of the group as a whole and its members as well as offering gentle process interpretations, I use "group produced" historical material. I will recount a

story shared earlier in the life of the group by a group member. This approach not only provides mirroring to the participants, it aids in the grounding of the group and acclimating newer members.

THE GROUP PROFILE

The groups are primarily open-ended, long-term psychodynamic groups. The groups are limited in number with new members entering when a space becomes available and the timing is appropriate for the group and the potential new member. Each group operates under an agreed-upon set of rules which include how a member announces his or her leave-taking. The groups are both homogenous in gender and/or issue or heterogeneous. The groups are all outpatient. Even though the structure of each group begins in a similar fashion, each group develops in a unique and persistent manner. The personality of each group remains intact even when the participants change.

THE INTERVENTION

The overriding goal for my psychotherapy groups is for the participants to view themselves less as targets of others' "ill will," a result of poor parenting, or as individuals who are innately "bad" in a world of good people. By working toward conscious awareness, each participant has the opportunity to rewrite his or her own view of their world. It is in this rewrite that he or she is able to take responsibility when needed and forgive when necessary. The work for the therapist in this intervention is to avoid blame, whether toward client or others while delicately reminiscing.

The first example is the retelling of an individual's story to a group participant. The reason for the sharing of this story was to identify a recurring pattern in this client's mode of relating to immediate family members and to open up the client and the group to the exploration of how she has changed that pattern of behaving. The secondary reason for the intervention at this juncture was to intentionally and gently alter the material the group was empathically reinforcing.

A woman in group was sad and angry. She was feeling as though she had not "moved much" and was "still where she was ten years ago . . . without anything real or of her own." She had lost faith in her abil-

ity to continue to follow her dream to finish her education in the medical profession.

As the group joined her sadness "over her lost dream," I intervene with the individual rather than the group as a whole.

TH: "Yes, I remember when you decided to go back to school. It was during the time you volunteered to have your mom convalesce at your home. I still have the picture in my mind of the two of you lying in bed every morning talking while she waited for her meds to take effect."

GROUP MEMBER: "Wow, I had totally forgotten that. Yeah, that time was something else, we became so close . . . finally, and I realized I was good, really good at this stuff!"

This type of intervention promotes self-reflection among the group members and the group as a whole. It also opens the discussion for group members to process what was happening in the room as prior to this intervention.

The second example is the retelling of a group member's "entrance into group." The reason for sharing this story was to gently interpret the difficult process for a newer member to join an ongoing group. This intervention could be made at a time that the group may be stuck due to a newer client's apprehension.

As material keeps emerging during the group that speaks to trust issues, and "how to enter the group" I turn to a group member and ask her "What do you think may be going on (with the other newer group member) tonight? As I listen, it sounds as if in this group session you have decided to 'let us all have it' as you said."

Newer Group Member: "What did she say?" The group chuckles, and I ask the group member for permission to recount that evening. She affirms my request. I quickly recount that night "she told us all [that] she would never want to know us, could never trust us." At this point the group member whose story I began jumps in and talks about that evening and how she had to feel angry to join. That anger was how she lived in the world. The rest of the group begins to share their entry points.

This particular intervention, recalling events and recounting stories, offers the group and its members the opportunity to observe changes in development and meaning of the events. Group members

also discover that their own affective response changes with each retelling of a story, allowing for new, consciously scripted meaning to emerge.

The process brings cohesiveness to the group by retaining the history of the group as a whole, thus new members feel they are part of something solid and established.

CONCLUSION AND CONTRAINDICATIONS

Recalling historical stories for group members is a simple intervention. When recounting a previously shared account back to the group, the facilitator will most likely find that other group members will also be able to add details or corroboration.

The primary contraindications are not to recount a story in a hurtful or shaming manner. It is important to be very clear that the intent of recounting the historical tale is in service of supporting or reinforcing a current situation that is being addressed with different choices. Of course one other contraindication would be to recount a story to a group member either incorrectly or attribute the story to the wrong group member.

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Chapter 101

Therapist Self-Disclosure As an Intervention Toward Normalizing and Eliciting Hope

Scott Simon Fehr

> Intervention: n. from (inter) between and (venire) to come, to come between. Interventionist: n. one who advocates or practices intervention.
>
> (McKechinie, 1963).

TO FEEL ALONE

One of the profound benefits of group therapy is for clients to hear other clients speak about their particular problem and not feel so alone in their own intrapsychic world (Fehr, 1999, 2003). Yet at times, a client may present something that no one in the group can or is willing to identify as an issue salient to them. Thus the disclosure, of the client, is met with group silence strengthening the possibility of future inhibitions where there is less probability that personal information will be divulged.

The concept of "therapist self-disclosure" is one that often elicits some form of professional discomfort for most of us (Fehr, 2003). Throughout our academics and training, self-disclosure is reinforced as a factor that creates boundary and ethical issues and needs to be avoided (Gutheil & Gabbard, 1993).

Specifically, there is the polarization of the orthodox Freudian stance of never disclosing as it demystifies the therapist and inhibits projections and transferential opportunities, whereas in the more humanistic, especially relational therapies, therapist self-disclosure is not as structurally implemented, (Jourard, 1964, 1971). Often, the catch phrase my colleagues use is "for whose benefit is the disclosure?" Obviously, the client has not come to us in group or individual therapy to hear about us nor are they here to help us with our interpersonal difficulties and conflicts (Corey, Corey & Callahan, 1998; Fehr, 2003; Weiner, 1983). But it is here, in fact, that therapist self-disclosure might be the intervention of choice for normalizing and giving hope to a client or clients in group therapy. This is especially true when the disclosure of the client reinforces existential aloneness. If no one in group identifies with the disclosure, the client may perceive his or her difficulty, as unique or bizarre.

GROUP MATRIX

This particular intervention is effective with both time-limited and ongoing process groups. It is recommended solely for those clients who do not have difficulty with abstract thinking, as it requires the ability to be introspective. It is not recommended for those clients who fall at the lower end of the normal curve in intelligence or those clients who are so sadly disturbed that they cannot go beyond only seeing themselves and cannot make connections or identifications with other individuals.

AN INTERVENTION OF THE THERAPIST SELF-SEARCH

Therapist self-disclosure, if and only if it is in the interest of the client, may be the prescribed intervention. Over many years of running groups, I have found that there are very few interpersonal conflicts or experiences presented by clients with which I myself could not identify in varying degrees. In fact, I use the totality of my being in order to understand what a client is trying to relate in the hope of feeling what the client is feeling. This is similar to two tuning forks resonating on the same pitch (Fehr, 2003). In my mind, I run through my personal history and only disclose those factors that are salient to the

issue at hand specifically if no one in the group identifies with the group member's disclosure. This self-disclosure is only presented if I have personally and successfully resolved the issue presented by the client as an intervention to help him or her not feel alone and to elicit hope that there can be a resolution although it might not be identical to mine.

The person of the therapist is the intervention as is the self-disclosure. Two very simple examples of the efficacy of this intervention are put forth: Example one is of a mixed-gendered group, which I run. One client strongly confronted another berating him on the fact that he bites his nails. The client went on and on about how she would never date a person who bites his nails, that it looked disgusting. No one in the group either came to this man's aid with any form of identification, as he was truly embarrassed, nor did they come to his defense concerning her diatribe. Throughout my adolescence and early twenties, I too was a nail biter. I was not about to leave this client "hanging out to dry" and feel public humiliation and shame without aiding him. In order, for me, to normalize his behavior so he would not feel alone, and to give him hope that his compulsive behavior, nail biting, could be resolved, I disclosed an aspect of my history specifically related to his problem.

Analyzing the root of the symptomotology of the nail biting, I felt, would be of little help or value, at that moment. Normalizing and eliciting hope would be the most effective intervention. I disclosed that I had been a nail biter years before and found that becoming consciously aware of each time I brought my fingers to my mouth eventually helped me overcome this compulsive behavior. The relief seen in this man's face was quite remarkable. He thanked me profusely as he related that he felt so alone and so embarrassed throughout his life. His family and practically everyone in his interpersonal sphere had focused, at some point, on this behavior, which he felt was completely out of his control. Interestingly, two other group members disclosed, after my disclosure, that they too had been nail biters but were not about to disclose it after hearing the diatribe from the other group member. After helping to normalize the situation, other related issues came forth from the group-as-a-whole, which probably would not have taken place or may have taken place much further down the road in this group's history.

The second example is the case of a man who is about ten years younger than I am in. He was in his fifties. He had related that basically everything was going rather well in his life. His relationships with family and friends were good. Economically he was doing well but he felt lost and directionless and was not sure from where these feelings were coming.

The group worked effectively with him and he worked effectively with the group but could not find what might be the underlying issue that was stimulating this sense of loss of direction. I remembered how he would talk about the many times throughout his life that there were people he looked up to as guides in helping him navigate the capriciousness of life. I, personally, had heroes throughout my life but now for a number of years I had none. I thought about the opening line in the book, *David Copperfield,* "Whether I shall turn out to be the hero of my own life or whether that station will be held by anyone else, these pages must show" (Dickens, 1991, p. 1). I disclosed, to this client and to the group, that I no longer had heroes in my own life to look up to for direction or to emulate their achievements and goals. I explained that upon this realization, which was about ten years earlier, I felt sad and lacked direction but realized that it was now my time to forge ahead on my own.

The client, upon hearing this disclosure, immediately said, "I think that's it." He related that over the past few months he had been feeling somewhat lost and directionless because there was no one whose footsteps he had wished to follow. He further disclosed that somewhere inside of himself he knew that a new direction of being was coming but could not figure it out. He smiled and said, "I guess it is time for me to be my own person and find my own direction" and like David Copperfield he became the hero in his own life. I wondered, at that time, after this man's insight if he would remain in therapy or leave but he stayed for another two years pursuing the self-search.

TYPICAL RESPONSE

The typical response to this type of intervention has always been positive for me with respect to a client. It appears to normalize what he or she is experiencing and gives hope that another person, whom they theoretically respect, had a similar issue and worked it through. I

also disclose to my clients that I am not Superman and feel, in many cases, that if I can do something I truly feel others can do it as well.

CONTRAINDICATIONS

This intervention can be loaded with contraindications as boundary and ethical violations could easily be manifested. Because of this, keep in mind that the self-disclosure is for the client. Due to countertransference issues, many therapists are unaware of what they are doing and of the consequences of their self-disclosures. This often can take the form of competitiveness. The client discloses some issue and the therapist discloses a similar issue but with greater intensity, i.e., "if you think your divorce was difficult you should have seen mine." For whose purpose is that type of disclosure as it is a complete negation of the client's feelings? That type of therapist self-disclosure is related to unresolved issues in the therapist's life that have been "set off" by the client's self-disclosure. To again reiterate, if you are considering disclosing personal information about your history, as an intervention, it must be an intervention and you must always remember, **"FOR WHOM IS THE DISCLOSURE DESIGNED?"** and what could be the possible consequences of demystifying your person in the eyes of your clients.

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