The Group Psychologist

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GROUP PSYCHOLOGY & GROUP PSYCHOTHERAPY
A Newsletter of Division 49 of the American Psychological Association

Convention Issue

President's Column

Lynn Rapin, PhD

Lynn Rapin, PhD

One of the wonderful things that happens at APA is that all of the living elements of Division 49 get to coalesce. I love this ambrosia-like mix—with governance leaders, committee members, division members and friends interested in group work having an opportunity to talk. We have a number of opportunities to do so.

Saturday, August 18 is Group Day in San Francisco. I have just learned, as I write to you in mid-May, that our Division Suite will be in the Hilton Hotel. APA Division Services will have our suite number on Friday, August 17th. Two main activities will take place in the suite on August 18th. The Division 49 Board will meet from 8:30 a.m. until noon. If you want to join us, please feel welcome to do so. If you have an item that you think the Board should consider, please let me know in advance (lynn.rapin@uc.edu) and I will put it on our working agenda. Since our meeting time is limited during the very busy conference, many action items generated may be delegated for disposition at our longer meeting in mid winter. We very much want to have member involvement and welcome your suggestions and participation.

Second, the annual Division 49 Party will take place in the Suite from 6 to 9 p.m. on Saturday, August 18th. Please come, take the time to visit with Board members and fellow group enthusiasts and share refreshments in the Suite that is dedicated to ALL members of the Division.

On Saturday morning in the Marriott Pacific Conference Suite E, the Division Fellows Breakfast will honor new inductees. All Division Fellows are welcome and encouraged to attend.

On Saturday afternoon, three Division 49 activities will occur in the Hilton Imperial Ballroom A. My Presidential address will take place from 1:00–1:50 p.m., the Division Business Meeting from 2:00–2:50 p.m., and the Arthur Teicher Group Psychologist of the Year Award and talk by Dr. Phil Zimbardo from 3:00–3:50 p.m. We are very excited that Dr. Zimbardo is the recipient of the yearly award and we look forward to his stimulating talk. Please join us for all of these events.

If you are interested in attending Division 49 programs, you can use the section of this newsletter identifying all of the accepted programs and their times and locations. Jennifer Harp and her committee have volunteered many hours in reviewing, scheduling and publicizing our program offerings. Jennifer and her committee members deserve a raucous round of applause. To locate all group related programs, look in the program catalogue for the Index Term 8.10.1 (Group).

On other fronts, the Division Board is proceeding on its agenda for the year. I am now getting input from the governance members of the Association for Specialists in Group Work and the American Group Psychotherapy Association for the scheduling of a Group Summit, to be held in January or February, 2008. The Past Presidents, Presidents, and Presidents-Elect of each organization will meet to discuss shared issues and collaboration possibilities. I am proud to say that

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You are invited to the Division 49 party at the APA Convention, Saturday, August 18, 6–9 p.m., in President Lynn Rapin's Suite, Hilton San Francisco Hotel.

Division 49 APA Convention Program: pp. 8–9

Bylaws Revision (please vote!): pp. 10–11

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Submission Deadlines:

March 1, June 1, October 1

All material for publication should be submitted to the Editor as an email attachment (Microsoft Word or Word Perfect format).

Contents

From Your Editor

Allan B. Elfant, PhD, ABPP

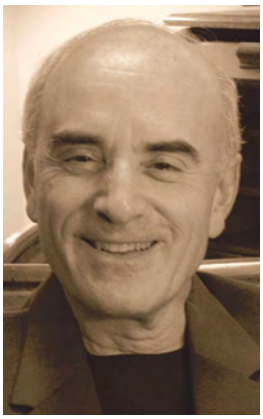
Group Psychotherapy in the Home Office Setting

(Husband) *"Home is the place where, when you have to go there,*
They have to take you in."

(Wife) *"I should have called it*
Something you haven't to deserve."

—Robert Frost, *The Death of the Hired Hand*, 1915

Establishing a home office psychotherapy practice is a significant professional and personal decision for the psychologist. The home office milieu impacts the psychotherapeutic process in so many complex ways. This article will touch on the impact of the home office setting on our clients, on our psychotherapy groups as well as on the therapist's own life. I am writing this piece for those of you that are or were practicing out of your homes as well as those that might be considering such a change, in order to consider and reflect on the many edges of the impact of home office settings. Also, any reader who is or has been in individual or group psychotherapy with a therapist whose setting is or was their home may have pause to consider the many facets for the client or group member in such a milieu.



Allan B. Elfant, PhD, ABPP

My own journey involving the location of where I practice is of course quite telling. I began practice within a large group medical practice in central Texas for twelve years, then for about a year I practiced in a small room, without a bathroom or waiting room (no direct complaints, also no groups), in our new home in State College, Pennsylvania when our daughters were in the sixth and eighth grades. This was followed by five years in a small group practice in a small office building in State College. I then went into solo practice and had a spacious apartment for twelve years as my office that was situated across from Penn State University. For the past five years I have been practicing in an addition to my home, an addition specifically built to my specifications based on previous years of what I believed was best for me as well as my clients in practicing psychotherapy. I continue to learn of the varied effects of being in my home on my clients, my groups and on myself.

About six months ago, a member in a weekly psychotherapy group of four women and two men, dreamt that she was in a group session in my apartment where I lived alone. It was freezing in the room where the group was and I bring in coats and blankets for everyone. Then I leave and return with a frozen cherry pie and the pie is only for me. She sees that the pie is frozen, and knows that she could make me something so much better.

This rich dream led the dreamer to speak of her worries about my health, her fantasies of my wife being absent, and her painful perplexity of being without a male partner when her own home is one that men love to be in. The dreamer also spoke to her wish to be safely closer to me and have the opportunity to take care of my needs instead of having such an imbalanced relationship. The group members each associated to their own struggles and experiences of what was and what was not occurring in and out of their own "homes." In subsequent groups, issues of exclusion and inclusion from my life and/or my family led to painful and eventually healing examinations of being in and/or out of where one desires or longs to be. I am sure the reader can speculate about the many other potential meanings of the dream for the dreamer and the group, and perhaps even the group therapist.

Home office settings blur and push against traditional clinical boundaries. The home office clinical context involves therapist self-disclosure in ways that are more powerful than in other office locations. This self-disclosure may be inadvertent (e.g., the sounds of one's spouse and children, the visiting of grandchildren, the barking and bodily functioning of dogs and cats) or intentional (e.g., how one decorates the home office since it is part of one's home and an office, what one puts out in the recycle bin or garbage, political signs, flags). These revelations might be to clients as well as those connected to clients. Home office settings usually involve rendering manifest or visible multiple roles of the therapist, including being a spouse, parent, grandparent, homeowner, neighbor, customer of services, and member of the community.

The home office setting is always for the benefit and convenience of the therapist. The financial advantages include saving rent, tax incentives and commuting costs. And, the therapist has access to all the amenities of the home living space, and breaks in the clinical schedule due to cancellations or openings can be enjoyed in the security and comfort of the practitioner's living space. In addition to avoiding the distasteful possibility of renting affordable but cold or impersonal office space, the stresses of commuting involving dealing with weather, traffic, noise, and other people are avoided. Being at home may also allow the therapist more time with family (e.g., with children and spouse, being there for meals, tending to an ill family member). By practicing at home we are more in control, including more in control than our clients and groups.

Possible concerns for the therapist in a home office setting may include: the stressful impact on the therapist's marriage and family (e.g., anger, guilt, competition and envy by family members because of all the time and energy devoted to others; the therapist's own guilt as to where priorities are placed at home), possible isolation from colleagues, feeling confined to the home/office, a merger of home and office boundaries for the clinician, and safety and privacy issues.

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President's Column

(Continued from p. 1)

our Division is taking the leadership role in planning this Summit. I will have more information for our membership about the Summit in our November *Group Psychologist*.

Please note the article in this issue by Elaine Clanton-Harpine on using group work in schools. Elaine has volunteered to spearhead the Division's efforts to reach school-based group psychologists and engage them in dialogue. Please join her in conversation and invite friends and colleagues interested in group work to our activities and to join our Division.

Graduate students are encouraged to join us in all of our activities. Please feel free to converse in advance with Billy Yarbrough, our Graduate Student Committee Chair at billyarbro@aol.com prior to coming to San Francisco. He is fun and welcoming and has many ideas to increase possibilities for students in the Division. I would be thrilled if each of you could think of a student or colleague who could join you in attending any of the programs or ancillary selections of the Division in San Francisco.

Our member and board listserves are in transition to a new service provider. Steve Sobelman has generously provided our listserve support for several years. You will notice, perhaps by the time you receive this newsletter, that listserve postings have an APA source. We hope to continue to contact you seamlessly during this transition. The move will provide the Board with more timely and accurate listings of member information.

As a reminder, please take a couple of minutes and go to the Division 49 web site and complete your member information (http://www.apa.org/about/division/div49.html). This will help us to talk with each other more effectively and efficiently.

Jean Marie Keim has agreed to serve as our 2008 Program Committee Chair. Jean has served on the Program Committee and has already begun her program duties for next year. It is quite impressive to know how much back room work is required to produce the yearly products of the Division. This newsletter is a great example. Allan Elfant has been successful in wrangling us all into meeting the deadlines required to provide the members with timely, beautifully presented, and thoughtful newsletters. He makes his complicated volunteer responsibilities look easy.

We welcome you to all of the Division 49 activities in San Francisco. I'll be looking forward to greeting and chatting with each of you!

Help Us With Our Membership! Please encourage your colleagues to join Division 49. An application form is in every issue. Our Membership Chair, Joshua Gross, PhD will be pleased to help. He can be reached at JGross@admin.fsu.edu.

From Your Editor

(Continued from p. 3)

There are many possible unconscious motives for the therapist practicing at home (Maroda, 2007). These may include: a hunger to be known by clients, a need to have clients involved in the therapist's own life, and past and present separation and individuation issues for the therapist. Also, the therapist's narcissistic and power needs, healthy and pathological, may be enacted through a home office. The narcissistic meanings of one's house or dwelling place as well as the power implications of a home versus an office building or other location have enormous significance. Also, does the therapist need to arouse admiration and/or envy through showing social rank and status? Home offices are seldom grungy or dumpy. A home office may represent for the practitioner a private space, one that is all "mine." This may be an attempt to recreate a childhood space or to finally find one's own "better" room as an adult within the family milieu. These and other unconscious possibilities need to be examined with the principle that more awareness will assist the optimal use of the home office for client and practitioner.

A personal illustration involves my currently having a very spacious, comfortable home office space, one that mirrors the homes I have lived in since adulthood. In addition, my home and office are on an acre of wooded land, where deer and other wildlife are in abundance. My early childhood home was cramped and confined, a claustrophobic, thick urban space. I have had to be introspective and aware of my needs for ongoing private reparation as these may impact on my clients who come into my home office and its surroundings.

Most clients really like the home environment, it conjures up feelings of hominess, safety, being soothed and held. The home environment might make for more openness. The home office may help create a more emotional environment. The home office often demystifies the therapist who becomes more of a person, more fallible and human. Being in the therapist's home, the therapist's literal home, will touch on so many implicit and unconscious issues, memories, and wounds from the client's original family system. These can be then worked with in a sensitive, respectful manner with the therapist's acknowledgment that the home office setting adds to the already very arousing and exciting context of psychotherapy.

On the other hand, the home office may not feel sufficiently private for the client (e.g., sounds and aromas intrude). There may be a concern about confidentiality and safety (e.g., aroused by the sudden visits of family, neighbors, friends, trick-or-treaters, the mailman and UPS). If the therapist views the optimal therapeutic environment as constant, private, quiet, and professional, then home office practice does impinge on this type of desired space. Home office compromises neutrality far more than an office in an office building. There are so many personal stimuli that are quite difficult for the therapist to control, and these may be expose the therapist's personal life in ways that are uncomfortable for the therapist, client, and group members..

The client may be over-stimulated by large amounts of personal information that the client has not sought out and cannot manage.

I am reminded of the time I was working out in my home gym and the doorbell to my office rang, I thought it was a UPS or special mail delivery since they sometimes erroneously come to my office door which is near the house entrance, and I was surprised to be greeting a new client who had come an hour early, she dressed quite formally and I appearing in shorts and a sweaty top, quite a start for the two of us! While she seemed nonplussed when we did meet and discussed what had occurred, I never had a second session with her. Then, there was the time my group was interrupted by the sudden appearance of my gentle giant Newfoundland, who leaned his large head and face against the sliding door window of the group room, having wandered over from where my wife had let him out to do what came naturally. He peered into the room, clearly curious about his master, the people, the sounds. Once spotted by the group, the group action ground to a halt, our beloved dog got quickly bored and moved on, and a kaleidoscope of reactions ensued, some with displeasure and irritation. Of course, all was grist for the mill, but none of it was the group's making.

The client may be faced with personal information about the therapist prior to being ready for that information (e.g., who lives with the therapist). While self-disclosure occurs in office building settings, there it's about the therapist's personality, here the setting itself discloses! This reality makes the context all the more influential. Finally, the home office gives a mixed message about the professional relationship. The client is being 'told" you cannot be in my personal life, but we are to meet in my personal space. This personal and professional merging may be a way to tantalize or seduce and can be experienced as a cruel bait and switch.

Bringing these issues up may be very hard for the client or a therapy group (Pepper, 2003). Since it is the therapist's home where the therapist is king or queen, the client or group may have further inhibitions to express power and dominance reactions, and may be submissive as a result. For example, my clients and groups and I are now far more aware of tracking in snow, ice, dirt than in my non-home office settings. After all, the client or group member is in the therapist's castle, and has a limited visa. Wear and tear in the therapist's abode may have a different impact than on a non-home office for all involved. While it is true that the therapist has home court advantage, and can turn that advantage into benefit for the client or group, it is still always the clinician's or group therapist's advantage.

As therapists, the deleterious effects of home office practice on certain clients or in their groups may be hard to see since it is our precious home space. However, home office practice requires us to be vigilant to all the influences of this charged environment on our clients. And, we need to be welcoming to the full range of reactions to being in our personally valued home space, no matter the valence of those reactions. Otherwise, we will not know and the therapeutic process will be diminished.

I believe that the potential anxieties and concerns that arise from the home office context can be opportunities for rich, transformative work for therapist, client, and group alike. However, for these positive results to be possible, the darker possible consequences for our clients, our groups, and ourselves need to be illuminated as well. In terms of literal physical considerations, many tensions can be taken care of by having a clear separation of the home office from the living quarters by having an addition or a carriage house. That said, a home office is never completely separate. Whether the home context for an office is therapeutically helpful will have so much to do with the therapist's own realization of the self-serving reasons for a home office and the therapist's own working through of personal, unconscious motives for an office at home.

As for our groups, the Frost poem dialogue cited at the beginning of this piece between husband and wife goes to the core of what homes and home offices mean to all of us. Is it a masculine or feminine space? Is it a place where justice and what is proper prevails? Is it a generous, charitable crucible that just is? Can it be all of these and more? The home office setting intensifies the group therapeutic space, as group therapists we must find out how it does so and what can be learned and known.

References

Maroda, K. J. (2007). Ethical considerations of the home office. *Psychoanalytic Psychology, 24*, 173–179.

Pepper, R. (2003). Be it ever so humble…:The controversial issue of psychotherapy in the home office setting. *Group, 27*, 41–52.

Note: Your Editor welcomes commentaries for TGP on the issue of home office practice.

Change of Address?

Do you have a change of address? Question about your membership status? Please call the Division Services Office of the American Psychological Association at 202-336-6013 or e-mail division@apa.org.

Listserv

Are you participating in Division 49's e-mail listserv? If not, then you've missed out on many interesting and potentially valuable messages about job opportunities (academic and nonacademic), calls for papers in special journal issues, conference announcements, and so on. The listserv has also allowed members to consult with one another on issues of mutual concern, such as evaluations of various therapy techniques. Several hundred Division members are already on the listserv—if you want to join them, contact Don Forsythe at dforsyth@richmond.edu.

President-Elect's Column

Seeing Groups

Don Forsyth PhD

Don Forsyth PhD

Sometimes I think that only a select few of us—members of Division 49, for example—really understand groups and group approaches to treatment. Last week in class a student, and a particularly bright one at that, looked puzzled when I spoke about group psychotherapy: Is that a method used to treat crazy groups, he asked? Later that same week I was meeting with a professor in the school of business and I mentioned group psychotherapy. He was equally bewildered. Is that a team-building intervention for poorly functioning groups, he suggested? Then, while reading the brand-new APA *Dictionary of Psychology* (2007) I ran across this definition of psychotherapy (p. 757): "any psychological service provided by a trained professional" used to treat "an individual, family, or group (see Group Psychotherapy)." I was pleased to see that groups were listed, but the definition was not quite right. Group therapists are mindful of the interpersonal processes that operate within the group, but rarely are they focused on treating the group per se; they seek to promote the adjustment of the individuals but not the group itself.

These misunderstandings reminded me: Didn't I say something about "improving the public understanding of group psychology" in my bid for the presidency of Division 49? So, I dug out my statement from when I ran for the office, to see what I said I would do if I was actually elected. Since the possibility seemed remote to me at the time, I feared that I had promised, like most politicians, things I could not deliver; an open bar at the Presidential address at the APA convention, a listserv-based email system that delivers timely information about groups and group psychotherapy without distracting spam-like side-effects, and a happy balance between hard-science articles about groups and clinically useful papers in the division journal were all possibilities. I was relieved to find that I had shown an uncharacteristic semblance of self-restraint, for the campaign promises of last year do, in fact, provide a foundation for the presidential initiatives of next year. As president of Division 49, I pledged to promote the shared goals of all members, including (a) disseminating of information about groups and their uses; (b) building networks of alliances among group researchers and practitioners; and (c) enhancing the resources at members' disposal in their studies of and work with groups.

As goals go, these seem to be a reasonable place to start. First, I hope we can redouble our efforts to reeducate the public about groups and group psychotherapy. I find that my colleagues and students do not *see* groups. They focus, instead, on specific individuals, and only if pressed do they recognize the influence of multiple and overlapping social groups. If asked to explain the actions of the individuals they know and work with they readily invoke such concepts as personality, needs, or learned responses, but more rarely do they recognize that group-level processes are actively shaping responses. When group-level concepts are mentioned, such as norms, leadership, social identity, or internalization, these concepts are viewed as vague mysticism in comparison to favored individualistic explanations. This group myopia is complicated by popular introductory psychology textbooks that sequester group approaches near the end of the therapy chapter, sandwiched between sections with such titles as "alternative approaches," "sociocultural perspectives," "family therapy," or "couples counseling." Nearly all therapists can lament the way practitioners are depicted in film and television, but group sessions are mercilessly lampooned (remember Bob Newhart's painful sessions with his odd assortment of clients?). And Wikipedia—which is quickly becoming the first place people look for information about anything—offers a tidy 406 word explanation of group psychotherapy that is largely inaccurate. We need to the set the record straight about the essentials and uses of groups.

Second, the pledge to build networks is consistent both with the initiatives of APA president Sharon Brehm, as well as the work of current Division 49 President Lynn Rapin. Lynn has taken the steps to organize a summit with representatives from organizations and associations that focus on group-level interventions. I hope to carry on this important work, and possibly increase the number of interconnected organizations, to include groups that focus on research on groups and international organizations. Oddly, those who are interested in groups tend to be less likely to want to actually organize them effectively, and make sure they are interconnected so that their impact and stability is maximized.

Third, and perhaps most uncertain as initiatives go, is the pledge to enhance the resources we provide to our members. This initiative builds, again, on the work of past presidents of the Division, including our most immediate presidents, George Gazda and Lynn Rapin. George and Lynn worked diligently to improve the organization's infrastructure, and the results show in improved efficiency and consistency in procedures. The wisdom of their leadership choices became all too apparent to me when I attended, in January of this year, the Division Leadership Conference organized by APA. This meeting, in addition to reminding me that APA is a huge bureaucracy, reiterated the importance of fiscal management and membership recruitment. As past presidents of 49 have noted, membership is the key to the health of the organization, and we must continue to search for creative, and effective, ways to increase our ranks. Our division is one of the grayer groups, and in the coming year we must find ways to make membership in the division so valuable to members that no one who studies groups or who conducts group psychotherapy would consider not joining the association.

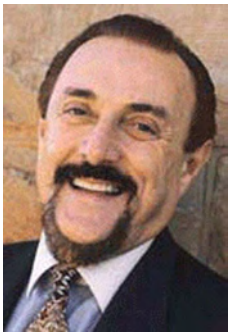
These ideas are, however, just a foundation for my year of leadership, and they will undoubtedly be revised with input from members. If you have any suggestions related to these initiatives, or ideas for other ways that the Division can be of service to you, please get in touch with me at dforsyth@richmond.edu. I look forward to working with the division and its members in 2008, as we take steps to move the study of groups and the use of groups to meet therapeutic goals from the shadows into the limelight.

Group Psychologist of the Year for 2007: Dr. Phillip Zimbardo

Don Forsyth, PhD

Dr. Philip Zimbardo, in recognition of his long and distinguished work in the field of groups, has been named the *Group Psychologist of the Year* for 2007 by Division 49 of the American Psychological Association. The award ceremony, and a presentation by Dr. Zimbardo, will take place on Saturday, August 18, at 3 p.m. in the Imperial Ballroom A of the Hilton San Francisco Hotel.

Dr. Zimbardo completed his undergraduate studies at Brooklyn College and received his MS (1955) and PhD (1959) in psychology from Yale University. He has taught psychology for 50 years, at Yale University, NYU, Columbia University, Stanford University, the Naval Post Graduate School, and the Pacific Graduate School of Psychology. He is currently an emeritus professor of Stanford, and on the staff at Pacific. He has written 50 books and more than 300 articles and book chapters on topics ranging from learning, conditioning, shyness, affiliation, cognitive dissonance, deindividuation, cults, persuasion, and teaching. His introductory psychology textbook, *Psychology and Life*, is in its 18th edition, and he is internationally recognized for his strong, consistent voice of enthusiasm and objectivity as the narrator of the widely seen PBS-TV series, *Discovering Psychology***.** Dr. Zimbardo has been President of the Western Psychological Association (twice), Chair of the Council of Scientific Society Presidents (CSSP), and President of the American Psychological Association. He has appeared on CNN, NPR, the BBC, and the Daily Show.



Dr. Phillip Zimbardo

Throughout his long and productive career Dr. Zimbardo has returned, again and again, to a consistent focus on the behavior of people in powerful group situations. His earliest studies examined intergroup processes and attitude change, as well as processes that prompted individuals to affiliate with others. His provocative theory of deindividuation, published as a chapter in the Nebraska Symposium on Motivation in 1970, reported elegant field and experimental studies of negative actions stimulated by anonymity, negative situational cues, and depersonalization. That work provided the theoretical basis for his best known empirical study: the Stanford Prison Experiment. Seeking to examine how individuals react when confined and when they are given authority over others, Zimbardo and his colleagues created a simulated prison in the basement of the Stanford psychology building. The study was scheduled to run for 2 weeks, but was terminated after only 6 days when the groups contaminated the individual members. The inmates seemed literally to become prisoners; although some rebelled, the majority became withdrawn and depressed. Several were released for medical reasons—they suffered severe hysterical reactions such as uncontrollable crying, disordered thought, and psychosomatic reactions. The guards also changed as the study progressed; many became increasingly tyrannical and arbitrary in their control of the prisoners. They woke the prisoners in the middle of the night and forced them to stand at attention for hours, locked them in a closet, required them to clean toilets with their bare hands, strictly enforced pointless rules, and censored prisoners' mail. Dr. Zimbardo himself sank deeply into the role of warden, worrying over possible prison breaks and autocratically controlling visiting procedures.

The Stanford Prison Experiment provided Dr. Zimbardo with the empirical evidence he needed to confirm his belief in the *power of the situation*. He has consistently maintained that explanations that stress the causal influence of personal, individual factors too frequently underestimate the impact of group-level factors on action. Just as Milgram's classic study of obedience suggests that most individuals, if placed in a powerful situation, would yield to the demands of that situation, Dr. Zimbardo's prison study confirmed the discontinuity between a person isolated from others and a person immersed in a group. His work challenge the methods used in most correctional system, and also provided an explanation for the abuses committed by Army reservists at Iraq's Abu Ghraib prison. Rather than explaining away those abuses as the sadistic actions of rogue soldiers, Zimbardo maintained that the military policies, but creating a malevolent system, were more to blame that the individual soldiers. They were not a few "bad apples," but rather basically good apples trapped in a corrupting barrel.

In his new book, *The Lucifer Effect*, Dr. Zimbardo summarizes more than 30 years of research on factors that combine to create the conditions that can bring the evil out in most individuals. The book, in addition to revealing previously undisclosed details about the Stanford Prison Experiment, offers compelling confirmation of the power of social groups on the individual members, and insights into how people can learn to resist the pull of evil-inducing groups.

Division 49 Website

www.apa49.org

Letters to the Editor are strongly desired. If there are any newsletter pieces you wish to comment on or debate or add to, please do so. This is your newsletter, let's make it lively for our group. And, contributing a 750-word to 1500-word piece would be most welcome. If you wish to run an idea by your editor I am reachable at abelfant@mac.com.

Division 49 2007 Convention Program

The final program for the Division 49 2007 APA San Francisco Convention is listed below. This program reflects the efforts of the many who submitted proposals and the hard work of the 2007 Program Committee.

Many thanks to the 2007 Division 49 Program Committee: Jennifer Harp, PhD (Program Chair); Jeanmarie Keim, PhD (Program Co-Chair); Janice DeLucia-Waack, PhD; Allan B. Elfant, PhD; and Joshua Gross, PhD.

(Please note: The specific room location of the Division 49 Hospitality Suite will be posted at the Division Services booth in Moscone Center).

Friday, August 17

9:00 AM–10:50 AM
Using Group Processes in Retirement Transition Workshops (Workshop)
Moscone Center, Room 2009
Co-Chairs: **Robert K. Conyne, PhD,** University of Cincinnati; **Lynn S. Rapin,** Independent Practice, Cincinnati, OH

11:00 AM–12:50 AM
Power of Group Psychotherapy—An Experiential Demonstration (Workshop)
Moscone Center, Room 2011
Co-chairs: **Allan B. Elfant, PhD**, Independent Practice, State College, PA; **Michael P. Andronico, PhD,** Independent Practice, Somerset, NJ

1:00 PM–1:50 PM

Sensuality and Sexuality in Women's Psychotherapy Groups (Workshop)
Moscone Center, Room 202/204/206
Chair: **Jennifer S. Harp, PhD**, Independent Practice, State College, PA

2:00 PM–2:50 PM
Multicultural Training for Group Therapists—Trainees' Perspectives (Conversation Hour)
Moscone Center, Room 2006
Chair: **Eric C. Chen, PhD**, Fordham University

Participants:
Bethany D. Aronson, BS, Fordham University; **Ryan J. Androsiglio, BA**, Fordham University; **Tonisha Hamilton, MA**, Seton Hall University; **Lauren M. Luttinger, MSE**, Fordham University

3:00 PM–3:50 PM
Training Future Group Leaders—How are Counseling Center Internships Meeting the Need? (Discussion)
Moscone Center, Room 2002
Co-Chairs: **Joshua M. Gross, PhD**, Florida State University; **Nikki J. Pritchett, PhD**, Florida State University

Saturday, August 18

8:30 AM–12:00 PM
Board Meeting
Division 49 Hospitality Suite
Hilton San Francisco Hotel

1:00 PM–1:50 PM
Presidential Address:
Opening the Doors of Division 49: Considerations for Our Future
Hilton San Francisco Hotel
Imperial Ballroom A
President: **Lynn S. Rapin, PhD,** Independent Practice, Cincinnati, OH

2:00 PM–2:50 PM
Business Meeting
(*Open to all Division 49 Members*)
Hilton San Francisco Hotel
Imperial Ballroom A

3:00 PM–3:50 PM
Arthur Teicher Group Psychologist of the Year Award (Invited Address)
Hilton San Francisco Hotel
Imperial Ballroom A

Recipient: **Philip G. Zimbardo, PhD,** Stanford University
People in Groups in Situations in Systems: For Good or Evil

Co-Chairs: **Lynn S. Rapin, PhD,** President, Division 49; **Don Forsyth, PhD,** President-elect, Division 49

4:00 PM–4:50 PM
Poster Session
Moscone Center, Halls A,B,C

Participants:
Eman Fallah, MA, University of Missouri—Columbia
Brief Tibetan-Style Meditation With Partially Hospitalized Psychiatric Patients

Diana J. Semmelhack, PsyD, Midwestern University
Innovations in Group Psychotherapy: The Utility of the Tavistock Model in Establishing Cohesiveness and Reducing Anxiety and Depression in Severely Mentally Ill Institutionalized Populations

Co-authors: **Clive G. Hazell, PhD**, DeVry University; **Diana Michalczuk, BA**, Midwestern University

Joseph R. Miles, MEd, University of Maryland
Team Cognition in Group Co-Leadership
Co-author: **Dennis M. Kivlighan, PhD**, University of Maryland

Samantha L. Haudenschield, MA, University of Indianapolis
Group Therapy for Trichotillomania and Other Body-Focused Repetitive Behaviors: A Preliminary Investigation
Co-author: **Ari D. Gleckman, PhD**, Meridian Health Group, Carmel, IN

Cheri L. Marmarosh, PhD, George Washington University
Patient Attachment Styles and Their Attitudes About Group Therapy
Co-authors: **Rachel Whipple, BA**, GWU; **Sandra Pinhas, BA**, GWU; **Melanie Schettler, BA**, GWU; **Jami Wolf, MA**, GWU; **Sinnan Sayit, MA**, GWU; **Roi Wohl, BS**, GWU

Jennifer L. Stoddard, PhD, Walton Rehabilitation Health System, Augusta, GA
State of Group-Based Bullying Interventions
Co-authors: **Christopher D. Bell, MS**, University of Georgia; **Katherine A. Raczynski, BA**, University of Georgia; **Arthur M. Horne, PhD**, University of Georgia

Christopher D. Bell, MS, University of Georgia
Bully Busters Program: An Abbreviated Version
Co-authors: **Katherine A. Raczynski, BA**, University of Georgia; **Jennifer L. Stoddard, PhD**, Walton Rehabilitation Health System, Augusta, GA; **Arthur M. Horne, PhD**, University of Georgia

Benjamin S. Stillman, PsyD, Georgia State University
Group Psychotherapy for GLB Clients: General versus Population-Specific Treatment
Co-authors: **Rachel Anne Keiran, PsyD**, Georgia State University; **Alaycia D. Reid, PhD**, Georgia State University; **Michelle K. Lyn, PhD**, Georgia State University

Alaycia D. Reid, PhD, Georgia State University
Use of Self in an African American Women's Support Group
Co-authors: **Michelle K. Lyn, PhD**, Georgia State University; **Lisa Ferdinand, MS**, Georgia State University.

Martyn S. Whittingham, PhD, Wright State University
Empirical Examination of Status Satisfaction, Anxiety, Conflict, and Personality in Groups
Co authors: **Rex Stockton, EdD**, Indiana University at Bloomington; **Keith Morran, PhD**, Indiana University—Purdue University Indianapolis; **Rose Ward, PhD**, Miami University of Ohio

6:00 PM–9:00 PM
Division 49 Social/Party (Please join us!)
Division 49 Hospitality Suite
Hilton San Francisco Hotel
(Specific room location will be posted at the Division Services booth and various locations at the Convention).

Sunday, August 19

9:00 PM–9:50 PM
Theory, Research, and Practice of Child Group Psychotherapy (Workshop)
Moscone Center, Room 2011
Chair: Zipora Shechtman, PhD, Haifa University, Haifa, Israel

10:00 AM–11:50 AM
Integrating Spiritual Issues in Group Psychotherapy—An Experiential Approach (Workshop)
Moscone Center, Room 236
Chair: **Kathleen Y. Ritter, PhD,** California State University—Bakersfield

12:00 PM–1:50 PM
Small Group Process—Current Vistas and Future Prospects (Symposium)
Moscone Center, Room 236
Chair: **Fred Massarik, PhD,** Anderson School of Management, UCLA

Participants:
Vivian Gold, PhD, Independent Practice, Los Angeles, CA
Small Group Process as Evolving in the Tavistock Tradition

Robert Legris, PhD, Public Service HR Management Agency, Wakefield, QC, Canada
NTL Institute: Toward Globality in Group Development

Bill Roller, MA, Berkeley Group Education Foundation, California
Promise of Group Therapy and the Reality

Monday, August 20

10:00 AM–10:50 AM
Therapeutic Interventions in Schools—After-School Group Prevention Programs (Workshop)
Moscone Center, Room 224
Chair: **Elaine Clanton Harpine, PhD,** University of South Carolina—Aiken

11:00 AM–11:50 AM
Calculation and Interpretation of Effect Sizes for Group Designs (Discussion)
Moscone Center, Room 274
Co-Chairs**: Scott C. Marley, PhD, MPH**, University of New Mexico; **Jeanmarie Keim, PhD,** University of New Mexico

12:00 PM–12:50 PM
Interpersonal Systems Theory—Using Systems with Relationships and Groups (Workshop)
Moscone Center, Room 226
Chair: **Joanie V. Connors, PhD,** Western New Mexico University

Proposed Division 49 Bylaws Revisions

At the January 2005 Winter Board Meeting in Washington, DC, it was determined that the Bylaws of Division 49 were in need of updating and revision in several areas. Then-President Steve Sobelman appointed the ad hoc Bylaws Revision Committee: (Jennifer Harp, PhD (Chair); Allan B. Elfant, PhD, ABPP; George M. Gazda, EdD; Gloria B. Gottsegen, PhD; and Joseph C. Kobos, PhD, ABPP).

The Committee reviewed and recommended various updates and changes to better fit the workings and needs of the Division. The proposed changes were presented to the Board at discussions and working sessions that occurred at Board meetings in 2005, 2006, and early 2007.

The following is presented for Membership approval. **Please note: Bold, underlined print indicates a proposed revision or wording change.** (Parentheses indicate areas for deletion).

Article I (Name and Purpose), Section 2:

The purpose of this Division shall be to promote the development and advancement of the field of group psychology and the modalities of group psychotherapy **and group intervention** through research, teaching and education, and clinical practice and to further the general objectives of the American Psychological Association.

Article II (Membership), Section 1

A. 2. To qualify for the status of Member, an individual shall be a member of the APA and shall have an interest in the scientific advancement (and) **and/or** the professional practice of group psychotherapy.

B. A member nominated for Fellow status in the Division must:

1. Meet the minimum standards for Fellow status established under the APA bylaws;

2. Have been a Member of the Division for at least one year;

3. Have made an outstanding and documented contribution to the science, teaching and/or research of group psychology and**/or** the practice of group psychotherapy.

D. To qualify as an Affiliate of the Division, an individual shall have an interest in the scientific advancement of group psychology **and/or** the professional practice of group psychotherapy. **An affiliate member need not be a member of APA.**

E. 2. Student Affiliates shall…not be entitled to hold office, serve as voting members of the Committees of the Division, nor vote in elections, **but designated Student Representative(s) may serve as ex-officio member(s) of the Board.**

Article III: (Resignation from the Division) Entire Article is Omitted

Article IV: Officers

Officers **shall assume office on January 1, following the most recent election.**
(Omitted is the start of term at the APA Convention meeting)

(Also omitted are Officers as various Committee Chair descriptions description provided in Article VI)

5. The Secretary shall…maintain coordination between the Division, **the membership,** and the central office of APA.

6. The Treasurer shall…**oversee**/prepare the annual budget in consultation with the President, **President-elect, Finance Committee,** and Board of Directors.

Article V: Board of Directors

2. Members-at-large…shall assume office **on January 1, following the most recent election…**

5. The Board of Directors **shall meet two times each year (at the APA and Winter meeting)…Electronic communication may also be used to inform or transact other business.** (The initial meeting of the incoming Board of Directors shall be held before or after the Division's Membership Business Meeting at the APA Annual Convention following their election. The winter meeting shall be held **approximately** six months after the APA Annual Convention. (The final meeting of the outgoing Board of Directors shall be held prior to the Division's Membership Business Meeting at the following year's APA Annual Convention).

7. …During the interval between meetings, and should the Executive Committee declare there to be an emergency requiring immediate action, a mail or telephone ballot, **or vote via electronic communication** may be taken on the emergency matter from the full Board of Directors.

8. Any officer may be removed from office before the expiration of her/his term by a public two-thirds (2/3) vote of those present at a meeting of the Board of Directors. Such removal can only be effected…

A. A finding of unsatisfactory performance of her/his duties of office—i.e. Ineffective or incomplete performance of role; the missing of two consecutive meetings without presidential approval. All absences must be approved by the president. (Dereliction shall be defined as missing two consecutive called meetings including face to face or telephone conference calls).

Article IV: Committees

2. In the conduct of committee business, the Chair of the committee, who serves as liaison to the Board, shall be responsible for notifying the members of the call for the meeting, its mode of transaction—meetings may occur in person; or through conference calls or electronic mail.

3. **Except as otherwise noted in these bylaws, the members of the Division's Committees shall be appointed by the President, upon nomination of the Chairs of such Committees, depending upon the needs of the Committee and the Division.**

4. The President-elect shall review, with the advice and consent of the Board of Directors, and in consultation with the current Chair, **the functioning and composition of each Standing Committee. The President-elect may then recommend appointments and changes in preparation for her/his presidential term.**

6. The Standing Committees shall be:

B. The Membership Committee, **which shall be represented by its Chair, recruits** Members or Associate Members, Affiliates and Student Members and evaluates…

C. The Program Committee, which shall consist of a Chair, a Chair-designate, and the immediate Past Chair, **and others, as determined by the President, in consultation with the Chair…**

F. The Education and Training Committee, **which shall be represented by its Chair, serves as liaison between the Board, Division, and other educational bodies within APA such as: ABPP, CRSPP, CoA, etc.**

G. The Publications Committee, which shall consist of **the Secretary and the editors of the Journal, Newsletter, and other publications…**

H. The Diversity Committee—to be developed

7. **The President may recommend…**and the Board of Directors may authorize the formation of ad hoc committees to help accomplish the aims and purposes of the Division.

On occasion, a request may be made on the part of members for the formation of Special Interest Groups or Committees…said interested parties shall present…**a minimum of three individuals committed to membership…**

10. It shall be the responsibility of the Chair…to submit a report… **at the Convention and Winter Meetings…**

Article VII: Nominations and Elections

1. The Committee on Nominations and Elections shall consist of the President, who serves as an ex-officio member, **and three Past Presidents willing to serve. If three Past Presidents are not able to serve, the President shall select from the previous Executive Committee members…**in the case of the death, resignation, or incapacity of the **Chair, another committee member shall assume the duties of the Chair.**

2. The Committee on Nominations and Elections **will issue a call for nominations to all members by the appropriate deadline…**(Nominations will be sent to the Chair of the Committee by the appropriate deadline. Signatures are to be checked against a membership list). **A validating procedure shall be used to assure that nominations are made by appropriate voting members of the Division.**

3. **The Nominations and Elections Committee shall seek advice on nominations from the Board of Directors and other members of the Division currently or recently in leadership. Any eligible member recommended by the Nominating Committee, a Board Member, or receiving at least 10 or more nominations from the general membership shall appear on the ballot as a nominee after ascertaining that the nominee is** qualified and willing to serve **if elected.** At least two names should be placed in nomination for each office. (The nominations shall be tallied by the Committee)

4. The Committee on Nominations and Elections shall be responsible for the notification to the board of Directors of the results of the election, the notification to the members whose names appeared on the ballot, and the reporting of the election at the annual business meeting of the **Division and in the Division's official communications to the membership.**

Article X: Amendments

An amendment to these Bylaws may be proposed by a majority of the Board of Directors **OR** (and) by petition of three percent (3%) of the voting Members of the Division and presented to the Board of Directors. The proposed amendment shall be either inserted into the next issue of the Division newsletter, and mailed, **or posted on the Division website/listserv. Returned ballots (including membership number) shall be counted by the Secretary sixty days after the mailing, or email posting,** and the voting period shall then be considered closed.

Please copy and clip the ballot below. Return by **September 15, 2007**

Division 49—American Psychological Association
Bylaws Revision Proposal Ballot

Bylaws revisions as proposed:
_____In favor _____Opposed

If opposed, please list specific item(s) by Article and Section and reason(s)—please use additional pages, if needed:

Division Status: _____Fellow _____Member _____Associate

APA Membership Number_____

Please mail this ballot to Jennifer Harp, PhD, 141 East Fairmount Avenue, State College, PA 16801. Ballots to be tallied by Division Secretary.

Thank you for your participation. If approved, our proposed bylaws will allow us to do this type of voting electronically in the future.

A Multiple Family Psychoeducational Prevention Group for Adolescent Disordered Eating

Colleen E. Clemency, MEd
Arizona State University


Colleen E. Clemency, MEd

Initially conceptualized by Laqueur and colleagues (Laqueur, 1972; Laqueur, Burt, & Morong, 1964), multiple family group counseling (MFGC) was established as a means for working with schizophrenic clients and their families in hospital settings (Asen, 2002). From its inception, MFGC blended traditional group and family counseling techniques, as well as attachment and psychodynamic theory and practice (Laqueur). From its outset, this form of group work involved four to five families and was effective for promoting positive communication and understanding among family members. The power behind the MFGC technique appears to be in its allowance of family members to "learn by seeing parts of themselves in others, including their own dysfunctions" (Asen, p. 5). Like other group counseling formats, the MFGC approach provides a context for immediacy among members and encourages members to expect changes in themselves and other family members. Such practices aid in the improvement of intra-family communication, promote larger systemic changes, and allow family members to identify with members of other families (Asen).

MFGC has been progressively used as a counseling intervention with both in- and out-patient adolescents with disordered eating concerns (Scholz & Asen, 2001). Despite the success of these MFGC *intervention* programs with eating disordered adolescents (Asen, 2002), based on a review of the literature, I found a paucity of research examining MFGC as a *psychoeducational prevention* tool with families who include adolescents at risk for disordered eating.

A review of prevention literature for disordered eating revealed limited successful prevention programs; however, the most successful are those which utilize an interactional format and do not specifically address the diagnostic criteria of eating disorders (Varnado-Sullivan & Zucker, 2004). Recent programs have included a critique of sociocultural norms, teaching young females how to advocate against conforming to the unhealthy ideals depicted in the media (LeCroy, 2004).Given the limited group *prevention* efforts that currently exist for female and male adolescents at risk for disordered eating, the need for the development of prevention efforts aimed at promoting familial systemic change, and the proven efficaciousness of MFGC interventions, I designed this psychoeducational MFPPG model for the prevention of disordered eating in female adolescents.

The main goals of the proposed group are to provide participating families with a safe, therapeutic environment to: (a) promote the enhancement of self-esteem and body esteem among adolescent girls and their families; (b) offer a forum for participants to challenge sociocultural norms of attractiveness; (c) educate participants regarding healthy living, focusing primarily on eating and exercise practices; (d) teach and develop coping skills to deal with teasing and sexual harassment; and (e) enhance familial cohesion and communication.

Theoretical foundation, inclusion criteria, screening/recruitment processes, and a full discussion of each session of the group are beyond the scope of this article (see Clemency & Dixon Rayle, in press); however, presented below is an outline of the suggested 90-minute sessions, to be conducted with four to five families with approximately the same number of leaders as there are families. Group leaders should be of multidisciplinary backgrounds, allowing them greater flexibility to work with families with diverse needs.

Session 1: Introduction and Goal Setting

It is suggested that the first session of the group primarily be dedicated to introducing group members to each other and the group process. Leaders should focus efforts on breaking up family cliques in order to promote between-family group cohesion. The first session should also be focused on establishing group norms and rules. Creating these rules should be dictated primarily through group discussion, but mediated by group leaders and keeping in mind the overall goals of the group. Members should create a supplemental list of goals, specific to each family. These goals should be unique to the circumstances and needs of each family. Finally, each member will be given the opportunity to develop a set of goals as appropriate for them as an individual.

Sessions 2 and 3: Understanding Body Image in a Sociocultural Context

Understanding body image and promoting positive body esteem is a pivotal aspect of this group. As a result, the second and third sessions should be devoted to (a) defining body image; (b) promoting individual member's understanding of their own body image and how it plays a role in their everyday life; (c) recognizing how an individual's body esteem may be linked to sociocultural ideals; (d) understanding and appreciating the natural diversity of bodies; and (e) enhancing the individual's ability to challenge sociocultural norms of attractiveness.

Sessions 4 and 5: Tools for a Healthy Life

The goal of sessions four and five is to educate group members regarding healthy eating, as put forth by U. S. Department of Agriculture Food Pyramid Guidelines. Group leaders should be familiar with current guidelines, which call for the utilization of one of twelve pyramids based on age, gender, and exercise habits (USDA, 2005). Families should be encouraged to complete a general outline of food consumption over the course of the week and work as a group to analyze how the family can develop healthier patterns in the future.

In addition to imparting information regarding healthy food intake, these sessions aim to promote incorporating exercise into daily living. The primary group leaders might invite community professionals to provide information and group activities regarding appropriate

nutrition needs and anaerobic and aerobic exercise as well as strength training, and their benefits.

Sessions 6 and 7: Facilitating Family Communication

Sessions six and seven are dedicated to examining how familial communication patterns may be serving to amplify negative body esteem and maladaptive eating patterns. Many eating disorder treatment facilities utilize mealtime within the MFG sessions as a means of exploring family interactions in the presence of food (Scholz & Asen, 2001). The sixth session should therefore allow group leaders to observe familial interactions in a mealtime setting. The final thirty minutes of this session should be allotted to allow group leaders to provide the families with feedback, as well as process the experience.

In the following session, a primary responsibility of the leaders is to model and facilitate direct member-to-member contact both within and across families. Leaders should additionally facilitate the process of linking common experiences of members and families, allowing members further insight into their own experiences understanding others' concerns (Colahan & Robinson, 2002).

Overall, these sessions aim to develop family understanding of their current communication styles and how these means of interaction may have maladaptive effects on adolescent body esteem and/or dietary habits. These sessions provide the foundation for making positive changes within the family and laying the groundwork for the subsequent sessions regarding teasing and negative evaluation of body shape and size within the family.

Session 8: Dealing with Teasing and Harassment

The goal of the eighth session is to enhance individual coping skills to combat against teasing, decrease negative evaluations regarding weight and shape by the family, and also educate members regarding the detrimental effects of these comments. Because family members, specifically siblings, are often perpetrators of teasing about body shape and size, active engagement of the entire family in this session is of utmost importance.

Session 9: Saying Goodbye

The final session should be dedicated to addressing any last minute anxieties regarding the ending of the group, as well as encouraging members to continue to understand, explore, and develop the gains they experienced over the course of the nine weeks. This session should provide group members with an opportunity to say goodbye to each other. It is imperative to process group termination in a full-group setting in order for members to experience closure (Corey & Corey, 2002).

Discussion

While this MFPPG approach is designed to target at-risk adolescent females' family contexts, larger systemic changes are still necessary for enhanced prevention of disordered eating. Empirical evaluation of this prevention group's efficacy is still necessary; however, its potential is promising by providing adolescent females and their families with consistent messages regarding healthy body image, eating, exercise, and communication styles. The inclusion of the family in this program is intended for support and to allow for the maintenance of gains at follow up, and as such, booster sessions at six-month and one-year intervals are recommended. Successful programming on the school level needs to be developed in order to continue to promote systemic change and increase awareness of the prevalence and severity of disordered eating among America's youth. Indeed, the counseling profession as a whole has an interest in the organizational and societal systemic changes that need to occur to combat all adolescents' propensities toward disorder eating.

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Department of Corrections

In the 2007 Election Issue interview with Yvonne Agazarian, page 17, the third paragraph from the end should read (the corrected word is in ***bold italics***):

"I was ten years behind my family, so my family is now my three nieces and my nephew—they are very loving and very important to me, and I see them each year when I go back to England. My ***other***, who is very significant, is consistently supportive, and when we are together, we have a close and meaningful time. My best friends and I all share an office, have done so for thirty years, and we all have dinner together on Tuesday nights. The community of SCT is as rewarding to me as I could wish for (and I believe it is as rewarding because we all practice the SCT we preach!). We work together and play together well. I am also very gratified at how they have taken over and are running the Systems-centered Training and Research Institute that I developed."

Group Process and Practice in the Forensic Setting

Anthony J. Scuderi, PsyD, DMin
Clinical Psychologist
San Quentin State Prison

Anthony J. Scuderi, PsyD, DMin

January 8, 2007 opened a new door in my career as a Psychologist. For more than 16 years I have been involved in running diverse psychotherapy groups and teaching group process and practice on the university level for both the undergraduate and graduate populations. As most psychotherapists are aware, group psychotherapy usually occurs in a private practice office, a mental health clinic, or community mental health center. Text books will discuss a plethora of approaches to assist the clinician in performing his or her duties as a group therapist within ethical boundaries, and using diverse tools from familiar theorists such as Yalom, Pearls, Rogers, Minuchin and others. The therapist chooses to utilize the tools taught in the classroom to assist the patient deal with the addicted patient, the depressed patient, and even the psychotic patient. Ideal group size is maxed out at about ten-patients, and with the ever present managed care mandates, group therapy has become shorter and shorter over the years. The therapist always hopes of a captive audience, and an audience that will benefit from the psychotherapeutic process. At the end of treatment, the patient goes home, hopefully more in touch with feelings that have been repressed or suppressed and with stronger ego boundaries than he or she entered therapy. However, when a psychotherapist enters the Forensic setting, the therapeutic field drastically changes.

As a Clinical Psychologist working at San Quentin State Prison, an all male prison, in California, my patient population is extremely diverse. Patients are evaluated during a very intense intake process, and a determination is made as to the mental status and placement of the inmate. Mental illness in the Forensic setting is growing. I get the sense that prisons are becoming an extension to the State Mental Hospitals. My patients run the gamut of diagnosis from the *DSM-IV-TR*. I treat everything from adjustment disorders to the most heinous psychopath. Group therapy, in this setting, takes a totally different face than that in the office or clinic.

Inmates are brought to a rather small room in handcuffs by Corrections Officers (COs). Once in the room, the inmate is placed in a steel cage. The cage is approximately three feet by three feet square and about 7 feet tall. On the outside of the cage, attached to the door, is a small, triangular door approximately, 6 inches by 12 inches with a lock and two welded hinges. Once in the cage, the CO locks the main door and the inmate, with his back toward the door, sticks his hands through the small door and his handcuffs are removed. The same thing occurs when it's time for the inmate to leave. The inside of the cage has a small metal stool bolted to the floor, as is the cage. There is no soft seat on the stool, it is just a circle of cold steel attached to a two foot steel pole which the inmate is to sit on during the duration of the group. In the event that an inmate does not show up for group (because they do have the option to refuse group), the clinician must go on the cell tier, and do a brief mental status examination of the inmate at the cell front. The clinician must wear a face mask and a protective vest in the event that the inmate either "gasses" (throws something out of his cell, either liquid or solid), or attempts to knife the therapist.

For those who do attend group, the therapist's job is to perform his or her duties as if it were in a private practice or clinic setting. The function of the groups in the Forensic setting is to give the inmate-patient the opportunity to express feelings, take a look at the crime he has committed and the lives his crime has affected. The key issue is for the therapist to understand that the inmate-prisoner is in prison for his punishment and is not to be punished by the therapist, regardless of the crime. This can be difficult especially when the therapist is dealing with child molesters, sociopathic serial killers, and those who are condemned to death. The therapist must always remember that the safety of the patient, regardless of the crime, comes first. We must keep the inmate-patient safe and alive. In the event a patient is suicidal and on death row (a very common occurrence), he is immediately evaluated by a psychologist, and sent to the psychiatric hospital in the prison until he is safe.

The patients are in different functioning levels and include those with IQs below 70 to IQ's above 130. Some of the inmate-prisoners are from notorious gangs; still others are in prison for minor parole violations. Psychotherapist's treating these patients must understand who they are dealing with in the therapeutic milieu. Even though the inmate-patient must be treated with what Rogers called, "Unconditional Positive Regard," the therapist can never forget who is in front of him or her. At any time, the inmate-patient can strike out or manipulate the clinician, causing grave injury, or attempt to cultivate over-familiarity which can lead to the dismissal of the clinician.

Groups are divided based on functioning level and the clinicians' areas of expertise. Groups run from 7:15 am through 3:00 pm., and are 90 minutes per group. The inmate patient is scheduled by a process called, "Ducuting" (Duck-it-ing). The inmate-patient is assigned to a case manager who is either a psychologist or LCSW, who then assesses the individual. If the case manager feels the inmate-patient's mental status indicates a higher level of care, he is placed in the Extended Outpatient Program (EOP), which qualifies him for group psycho-education. Generally, groups are seven-days a week. However, some of the inmate-patients cannot tolerate that many groups, so the case manager modifies the program through a process called, "Individual Development Treatment Team (IDTT) meeting. The meeting consists of the Correctional Officer, an attorney, the staff psychiatrist assigned to the inmate-prisoner, and several psychologists and psych-techs, and of course the inmate-patient. The team discusses the case, the inmate-patient is given the opportunity to discuss his treatment and level of care, and a decision is made as to the inmate-patient's level of care. If the inmate-patient meets criteria, he is placed in the EOP and assigned to one of the groups.

If the inmate-patient needs to be segregated from other inmates due to possible harm from other inmates or chronicity of illness,

he is placed in the "Administrative Segregation (Ad Seg)" group and assigned to a group facilitator depending on the functioning level of the inmate-patient. In the event the inmate-patient is in the Reception Center (RC), (still being evaluated for transfer to another prison), he is placed in the RC-EOP. If the inmate is on death row, he is placed in my group (The Condemned Group). In this group I deal with death and dying issues, spirituality, medication monitoring and general psycho-education on diverse topics.

The key to being a successful therapist at San Quentin State Prison, for me, is to first understand the rules of the prison. Next, without looking at the patient- inmates file for the first two weeks, I get a feel of the patient. After that, I read the patient-inmate's medical file and Criminal Record File (C-File). Following, the review of all this material I indicate to the patient-inmate that I have read the C-File. This, I have found, stops the inmate from trying to present himself as a nice guy that got a bad break. Within the limits of confidentiality, and if given permission by the inmate, group process sometimes is centered on the crime and punishment, and the remorse, denial or psychopathology of the inmate.

One of my methods to help with the success of groups is to directly ask the inmate-patient what he would like me to focus on in the groups. I then gather the topics of interest from the inmate-patient, and prepare a group from the topic list. Another group technique is to ask the inmate-patient what he would like to present to the group. A topic is given to me, I go online and gather some articles and other research and the inmate-patient prepares the group. The inmate-patient and I have an individual session before he does the presentation to make sure the presentation is appropriate and accurate. The patient does the presentation and the remainder of the group members process the material either the same or the next session. Other groups include therapeutic yard (recreation therapy), stress management (yoga), or, movie day (the movies must by PG or G rated).

In conclusion, it must be remembered that regardless of the nature of the crime, the therapist's job is not to judge, persecute, or hate. Countertransference must always be checked, and appropriate supervision either in the prison or outside is a must. Even the criminal has the dignity of a human person that needs to be respected and treated until paroled, or death.

Somber Reflections on Being an Inpatient Group Therapist

Ann Gassaway, PsyD

Ann Gassaway, PsyD

My work as a group therapist on a mental crisis unit in a large acute hospital often includes patients under the influence and on probation or parole. In California we passed Proposition 36, in 2000, as a treatment strategy for non-violent drug offenders instead of jail. Recently a study by UCLA indicated that, in fact, this proposition did reduce the burden on prisons. At the same time many offenders are not doing the time or the treatment.

This is but one of many strategies and treatment programs I've witnessed in the last 30 years to "get them clean and sober." As a family member I've personally experienced the hope many of these programs promised. Working in the field of hospital mental crisis intervention, coupled with substance abuse, I regret to say that we continue to be overzealous in our language when describing a treatment plan. Misleading, at least, when we stress the power of medical and psychological intervention, as though it were an outside force, and use catchy words such as "treatment works."

My father was considered a "drunk," and "crazy." His "treatment" included jail or Camarillo State Hospital. Both were state-of-the-art strategies and treatment to "help him get clean and sober," and help his "craziness." My sister found him dead, following his last release from county jail. He was surrounded with empty bottles of whisky and "bennies." He was 52.

My siblings followed in his footsteps. Treatment for them consisted of in-patient rehabilitation, 30-90 days and then discharged good-to-go. One died in his late 30's following a month long drinking binge, in the company of two drinking buddies. My sister survived due to a liver bypass, multiple medications and kidney dialysis. She is 68.

Her only son diagnosed as a poly-drug abuser, with a mental illness called bipolar, died an even earlier death at 30. The strategy and treatment for him was hospitalization, followed by sober living homes. He was hospitalized several times, lived in sober living homes when not in jail. A potent mix of alcohol and medications, followed by a seizure killed him during a party with some friends.

Families want a promise that their loved one will get clean and sober; often the one who seeks our counsel wants that too. At best we serve as an educated, trained and experienced professional, listening, guiding and hoping. At worst our psychological theories, strategies and techniques cannot match the insurmountable problems they face.

Why do I continue my work as a group therapist where pain and suffering is so visible, where drugs, alcohol and attempted suicide have been the answer? I stay because on occasion I am witness to a few who find healing, or recovery if you will. It may, or may not include my efforts as a therapist, medical intervention at the hospital, or even jail time. It always includes the power and willingness of the human being to live rather than die. Some who have followed this path tell me it has been a moment of clarity, combined with fleeting memories of all those who have tried to help—an epiphany, and most importantly a fellowship of like minded folk committed to helping each other.

My work as a group therapist, under the direst human conditions, has strengthened my belief in hope; one of Yalom's curative factors, and softened the hopelessness experienced in my youth; noted by Franz Alexander as a "corrective emotional experience." I am grateful.

Multiple Minority Identities in Group Psychotherapy: Ethnic Minorities, Same-Gender Sexual Orientation, and People with Disabilities

Reginald Nettles, PhD

"Multiple minority" refers to the presence of more than one minority identity in an individual or group. Most if not all individuals identify with more than one culturally distinct group and therefore hold more than one identity. Many individuals also identify with more than one minority group. "Minority" as used in this article refers to culturally distinct groups that have been stigmatized, disenfranchised, and subjected to prejudice and discrimination. Members of ethno/racial minority groups, gay men, lesbians, bisexual women, bisexual men and transgendered men and women, and persons with physical disabilities, have historically epitomized the meaning of stigma in our culture (Goffman, 1963). Membership in any one of these groups generally ascribed inferior status carries with it particular emotional burdens, i.e., "minority stress" (Brooks, 1981, as cited in DiPlacido, 1998). Simultaneous membership in more than one can compound these effects (DiPlacido, 1998; Greene, 1997). A Latina or Latino with physical disabilities, for example, would be seen as having two minority identities. An African American gay man with physical disability would be seen as having three minority identities (Nettles, 1998).

Reginald Nettles, PhD

An understanding of multiple minority identities is vitally important to effective psychotherapy, and even more so to effective group psychotherapy. My focus on these multiple-minority identities (racial and ethnic, physical disability, and sexual orientation minorities), in this article reflects that awareness, and is due in part to personal life experiences as a person who identifies with each of these groups. It is also a reflection of my view that group psychotherapy in the absence of diversity, and ability to attend to these within group differences in a multicultural world, is both limited and limiting in its ability to bring about therapeutic change in minority and multiple minority as well as majority individuals.

The early multicultural literature sensitized psychotherapy and mental health to the importance of ethnic, racial, and cultural differences, particularly in relation to the majority culture. The focus was largely on differences between groups. Little guidance or training has been available for working with the within group differences of minority group members. The challenge to clinicians in beginning to understand the interactive effects of these combined group memberships or identities, and their effects on psychological functioning and service delivery, is infinitely more complex when within and between group differences are considered simultaneously (Greene, 2007). A multiple minority focus, of necessity, examines within group as well as between group differences.

Group therapy in particular, distinct from other modalities, is unique in its capacity to foster this integration as it utilizes the "between" as agent of the "within" in groups. Ethno/racial and cultural diversity in group psychotherapy enhances this capacity and challenges the group psychotherapist to discern the relative importance of social identity and clinical issues (Green & Stiers, 2002).

In one of the groups I have lead in my practice, the membership included African American as well as Euro American men and women. All of the members had achieved solid middle class status. This factor came into the group dialogue early in the life of the group as one member commented on the kinds of cars parked in my driveway by group members. My exploration of this comment opened the door to talking about money and social class similarities and differences, which are often, taboo in groups. Later in the life of this group, when a new African American man joined, the group began to split along ethno/racial lines. African American members began to share common experiences of poverty, childhood deprivations, and losses associated with growing up in crime-invested neighborhoods, following the new members lead. African American members seemed to develop a bond based on shared experiences while Euro-American members felt excluded and uncomfortable. My work was to assist the group in talking about the socio-cultural factors leading to these differences in life experiences, as well as to assist individual members in exploring the clinical issues that developed as a result. Assisting the Euro-American members to explore their discomforts and to assist all group members in finding the commonalities across ethno/racial lines was important to the cohesiveness of the group as a whole, as well as to the clinical work of each member.

Shared painful experiences fostered a seemingly solid bond among African American members of this group. Later, one of the African American member became quite anxious because of the conflict he experienced as a result of allowing this bonding to occur for him, without having disclosed his same gender sexual orientation to this new member, who he experienced as possibly homophobic. Anxieties around loss and associated history became salient for this member along with unresolved conflicts in relation to sexual orientation. Here again my task involved integrating socio cultural and clinical issues, within and between group members. In this instance differences in sexual orientation and perceived homophobia conflicted with a shared sense of commonality based on similar socio-culturally determined life experiences of the ethno/racial minority members of this group.

Clinicians often struggle with how to work therapeutically with individuals of cultural minority backgrounds. Traditionally, psychotherapists are trained to interpret and work through the intrapsychic and psychological dimensions of the problems that people bring to therapy. The culturally informed group psychotherapist is also attuned to the cultural. In group psychotherapy and supervision, the ability to interpret cultural issues as they surface in the group, and to balance focus on psychological and cultural facets is an important aspect of cultural competence (Green & Stiers, 2002).

Diversity in cultural and minority group memberships, within and between group members and leaders, was the central focus of the recent Mid-Atlantic Group Psychotherapy Society Spring 2007 Conference (Nettles, 2007a). Attention was focused on multiple minority identities including multiples of racial and ethnic minority, sexual orientation minority, and people with physical disabilities as a minority group, through didactic material presented and distributed (Nettles, 2007b) at the conference. Known and unknown differences among group leaders and members were examined in demonstration groups, plenary sessions, and small groups. Unknown minority identities, beyond those that were the focus of the conference, were also shared by many conference participants. Emergent themes suggested that conference participants increased in their capacities to recognize counter transferences in relation to cultural minorities as well as transferences that might impact therapeutic work across cultures.

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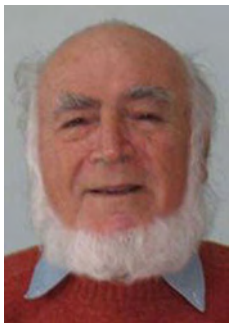
Crisis in Returning War Veterans Continued Health Care

Bernard Frankel PhD ABPP

We have more than 3,000 soldiers killed in Iraq and Afghanistan and more than 25,000 wounded. This is a ratio of six to one. In prior wars, the ratio of wounded to those killed was three to one. Due to the advances of medicine, technology and transportation, the severely wounded can be flown to a model medical facility within 24 hours. It is also estimated that the survival rate from severe wounds has risen from 70% to 90%. Such are the benefits due to the advances of medicine, equipment and science since the war in Viet Nam.



Bernard Frankel PhD ABPP

All other things being equal, this means that an unprecedented number of severely injured veterans require continued hospital care and face long term disability. The consequent cost in dollars, individual and familial dislocation, social maladjustment and human misery has placed an unplanned burden on our veteran care facilities. In addition, while a physical injury is more visible, there are countless numbers of veterans who suffer from emotional disorders, particularly Post-traumatic Stress Syndrome (PTSD). This type of injury is less apparent and less often recognized. It is sometimes difficult for the veteran suffering from PTSD to recognize this condition and to seek help.

The ordinary procedure for discharge from military service for reason of disability is to have a Department of Defense (DOD) examination. If you score a rating of 30 or more, you are eligible for a disability pension, lifetime rehabilitation and health care for self, as well as health care for family. If you score less than 30, you receive severance pay only, but like all former veterans, you can use the VA for health needs but not your family.

At discharge, the DOD transitions you to the VA. You can apply to the VA for disability benefits. Often, VA ratings are consistently over 30 and thus qualify most veterans for disability benefits. In a recent Congressional hearing of the combined Armed Services Committee and the Veterans Affairs Committee, the rating discrepancies between the VA and the DOD covered thousands of cases. The DOD criteria were to determine whether the veteran could return to duty. The VA criteria were to determine whether the veteran could return to civilian life. One Senator at the recent hearings was prompted to ask whether the DOD was attempting to follow a policy of budgetary restraint. I believe there are some grounds for investigation of an implicit policy of denial of benefits.

One particular mishandling of the situation comes to mind as reported in the *Nation* magazine, April 4 edition. At a VA facility, there was an obvious mis-diagnosis of PTSD as a pre-existing personality disorder. If a veteran receives a pre-existing personality diagnosis rating, there are no benefits allowed except for severance pay.

We may currently have a two-pronged attack on veteran's benefits. There is a tendency for the DOD to rate veterans at a rate of 30 or below and a tendency for the VA to assign a designation of a pre-existing condition. This is in addition to a scandalous expose of Walter Reed Hospital and it's OPD care. Other VA facilities are

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flooded with the wounded and thus may also have compromised care. Donald Rumsfeld was known for "War on the Cheap." Veteran's care might become known as "Care on the Cheap."

I recommend that as health care professionals we need to intervene in these systems of veterans care. We have valuable know how in regard to making accurate diagnoses of PTSD, a condition that can sometimes emerge years later if not recognized early on. 9/11 taught us a lot about PTSD and how to enter an organization that may at first be resistant to help and unwilling to acknowledge any signs of vulnerability or dysfunction. Just after 9/11 many of us were able to get footholds into organizations and we worked pro bono with groups, using training and direct service for crisis intervention and trauma work.

The American Group Psychotherapy Association, from the 9/11 work, foundation research grants, training and mentoring of others, developed extensive protocols and ongoing development of techniques. I believe we can play a part in the current crisis by helping that 20% or higher PTSD vets through our skills to diagnose, provide training and use groups as an effective modality. We can help to lessen the logjam and hopefully ameliorate the agony of extensive war trauma. We need entry and resources. It is essential to offer our help as group therapists.

Teaching Group Leadership Skills for Groups for Children and Adolescents

Janice DeLucia-Waack, PhD, and Deborah Gerrity, PhD

"There are many advantages to groups for adolescents: they are a natural way for adolescents to relate to each other, they emphasize the learning of life skills, they focus on generalizing behaviors practiced in the group to real-life situations, and they provide multiple feedback and increase self-esteem that comes about through helping others" (Shechtman, Bar-El, & Hadar, 1997, p. 203–204). Groups for children and adolescents are different from groups for adults and training for these groups must take this into consideration. Many of the groups, particularly those in the schools, are psychoeducational/guidance groups that utilize "group-based educational and developmental strategies" (ASGW, 2000, p. 330) particularly roleplaying, problem solving, decision making, and communication skills training. Psychoeducational/guidance groups teach specific skills and coping strategies in an effort to prevent problems; i.e., anger management, social skills, self-esteem, assertiveness, making friends.

Janice L. DeLucia-Waack, PhD

Structure and Interventions in Psychoeducational Groups for Children and Adolescents

Groups for children and adolescents tend to be shorter in length (30 to 45 minutes), have less sessions (usually 6 to 10), and with a range of members (4 to 12). Group leaders need to provide structure for the session and within specific activities. A suggested structure for a Session is:

- An Opening that reviews material from a previous session, discusses homework efforts, and/or introduces the topic for this session.
- Working Activities focus on the goals of the group allowing discussion and interaction around a specific topic or skill to identify, learn, and/or practice potentially effective behaviors.
- Processing Activities focus on making sense of the working activities and applying them to life outside of group.
- Closing Activities help group members to prepare to leave group.
- Activities need to be focused on the overall goals of the group and the specific goal of each session and emphasize cognitive, behavioral and affective skill development. Processing questions should ascertain that group members understood the goal of the activity and the application of the skills to outside of the group.

Deborah Gerrity, PhD

Strategies for Teaching/Supervising

Our group training classes are arranged around ASGW Best Practice Guidelines (1998), which emphasize 3 areas:

- Planning
- Performing
- Processing.

All assignment includes these 3 areas and includes self-evaluation and integration of science and practice.

Examples of Assignments

The major assignment of the class is a group paper with a partner as co-leader for a specific type of psychoeducational group with in-class activities focusing on the practice of skills. Out of class activities focus on the integration of current research and theory with counseling practice so that group leaders use what has shown to be effective in planning for their groups, based in terms of the topic of the group and also related to group facilitation skills for groups for children and adolescents.

Create a *guide* for others leading this kind of group. It will contain the following topics based on a review of the literature (including theory, practice, and research):

- Statistics and theory to support the need for this type of group
- A Grid that identifies sessions that need to be designed to meet goals identified in the literature. Specific goals for your group based on the current literature and your population
- Procedural decisions
- Co-leadership planning and processing: what do co-leaders need to discuss, plan, and do before they lead together and this kind of group in particular?
- Leadership gathering of materials and resources
- Recruitment procedures
- Selection criteria
- Screening interview outline
- Preparation outline and model
- Outline of 10 group sessions.
- Evaluation: Process and Outcome
- Resource Materials
- References

Implement and plan for future sessions with group member feedback:

- pre-screening interviews
- a 1st session, 2 middle sessions, and a last session
- conduct one in-class activity as a practice session
- review videotapes based on Group Sessions Rating Scale and Therapeutic Factors.
- analysis of leadership and co-leadership skills: Group Counseling Survey, Self-Assessment of Group Leadership Skills, Group Counselor Behavior Rating Form, and Attitudes Towards Group; the Co-Facilitating Inventory, Therapist Self-Description Questionnaire, and Group Leadership Questionnaire.
- Write *Planning and Processing Notes for each Session* with your co-leader and revise plans based on instructor feedback.
- Using the model of Reporting, Reflection, Integration, Planning, and Evaluation (DeLucia-Waack, 2001a, p. 17-18), the Group Counseling Self-Critique, and the CLINICKING section of the Co-Facilitating Inventory, discuss the effectiveness of the session with your co-leader in preparation for the next section.

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Therapeutic Interventions in Schools: After-School Group Prevention Programs

Elaine Clanton Harpine, PhD

Six weeks later, his teacher came rushing up to greet me, "I can hardly believe my eyes; he sits at his desk, completes his work, and actually tries to avoid getting in trouble so that he doesn't get a detention after school and miss your program." What made the difference? A group-centered after-school program called the *Reading Orienteering Club*.

Elaine Clanton Harpine, PhD

On Monday, August 20th from 10:00 to 10:50, Division 49 will sponsor an interactive workshop at the APA Convention in San Francisco that will outline how psychologists can develop and implement group-centered interventions in school-based settings. Group-centered interventions do not follow the constraints of a traditional counseling or play therapy group. Group-centered interventions are evidence-based programs that integrate therapeutic group process with intrinsic motivation in an atmosphere of play. Children learn to grow and change in a positive, safe environment.

My own work targets at-risk readers, but group-centered interventions can help with many school-based problems. Cohesion and group process are the key ingredients of change, and the focus is on working in a group.

Group-centered interventions create a positive play environment where children learn how to work together in a classroom-like setting. Group-centered interventions stress interaction and group cohesion. The idea is to develop a working laboratory, a miniature society where children learn to solve problems and overcome failure in a supportive environment. Group-centered interventions use hands-on activities, not symbolic toys as in play therapy, with intrinsic motivation as an essential component.

In San Francisco, this workshop will introduce group-centered interventions by describing two programs, *Camp Sharigan* and the *Reading Orienteering Club*, presently being tested in school-based settings. We will discuss several school-based issues and illustrate how group-centered interventions can be used to correct classroom problems before they become mental health problems. In this interactive workshop, we will discuss selected case study situations in small

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Therapeutic Interventions...

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groups to illustrate how to implement group-centered interventions in different settings.

When children's emotional problems are linked to classroom failure, children must learn the necessary skills to return to the classroom and perform the desired task successfully as well as learn how to erase the perception of failure (Bandura, 1997). Traditional counseling groups typically tackle only the emotional problems, not the learning deficits that caused the emotional problem to arise; children in the classroom need both (Greenberg, Domitrovich, & Bumbarger, 2001; Ryan & Deci, 2000). Skill training combined with counseling becomes essential. With reading, for example, we cannot divide the inability to read from perceived failure; they are intertwined and must be treated at the same time in order to be truly successfully corrected (Cleary & Zimmerman, 2004).

School-based mental health is a nationwide concern. After-school prevention programs are growing in popularity. Group-centered interventions can help children overcome failure, solve conflicts, and build confidence. This workshop will provide insight into and skills for using group-centered interventions in school-based settings. Groups can be especially therapeutic because they help re-create an environment in which children can learn interpersonal skills.

As group specialists, we need to take the benefits and the therapeutic power of groups into the schools. After-school programming is a perfect avenue for group-centered interventions. We can no longer wait for children to be sent to the counselor's office; the need is too great. We need to step outside the office and take help to the children where they struggle.

In Division 49, a School-Based Mental Health Group Intervention Committee is investigating school-based needs. We welcome questions, problems, and new committee members. If you work in a school-based setting, we hope you will join us.

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Dr. Elaine Clanton Harpine teaches at the University of South Carolina Aiken. She is continuing her research on motivational reading clinics with at-risk children and completing a book on school-based mental health. She may be reached at clantonharpine@hotmail.com.

Using Group Processes in Retirement Transition Workshops

Robert K. Conyne, PhD, and Lynn S. Rapin, PhD

Introduction

Retirement is a complex life transition, rife with issues to be identified, experienced and managed. Some 79 million "baby boomers" alone will be entering this phase of life in the next 18 years. Psychological services have not yet been sufficiently made available to assist potential and early retirees with the variety of psychological and social challenges they will face.

Robert K. Conyne, PhD

Although financial considerations are fundamentally important to a successful retirement, they cover but a part of the overall variance to be considered. Equally important are issues surrounding the replacement of the functions that work once performed in the retirees' life with new and invigorating options.

In our work as group psychologists, we have begun offering group workshops in which we invite participants to become actively engaged in thinking about and planning for their retirement, with a focus on personal-social dimensions. We have found it is important to help participants to reflect about their life, to dream about their future, to plan how their dream can be implemented, and then to engage in living out that plan—subject, of course, to modification and open to new experience. This sequence of steps, all of which influence each other, is central to the operation of Charting Your Personal Future, our company devoted to helping people cope successfully with the psychological and emotional aspects of the life transition called "retirement."

Lynn Rapin, PhD

Therefore, we help people to prepare for the psychological and emotional aspects of retirement by helping them to:

- **Review** their lives
- **Dream** about their future,
- **Plan** how to get there, and then develop ways to
- **Engage** their plans.

These steps are depicted in Figure 1 below.

Retirement Transition Group Work

General Orientation

Deangelis (2007) wonders if America is toxic. She reviewed some recent studies on social connectedness, suggesting that American workers are like "nomads on a treadmill." That is, too many workers are over-invested with putting in long hours and with wealth creation. Too little time and energy are left over for setting down our roots and engaging with one another. One result is that we are becoming an "isolation nation," where social relationships are disappearing and we no longer know most of the people we meet. We lack the equivalent of the British pub, she said, a local place frequented by neighbors just to spend time together and talk. Instead, we tend to live in communities out of which residents drive and to which they return only to vanish quickly into their houses at night to lock themselves in, largely unaware of their neighbors.

Creating Opportunity To Share ("COTS") Groups

When planning for retirement one of the best strategies to employ is to talk with others who are at a similar point in their lives, as well as those who are retired. They often have nobody with whom they feel able to talk about these matters. Becoming a member of a professionally facilitated small group discussion with others anticipating retirement is one of the single best steps a person can take.

Therefore, in our experience with potential retirees we have found incorporating group work to be extremely useful. There is absolutely nothing mystical about it in our approach, no elaborate techniques are needed, nothing beyond what well-trained group leaders already possess. For instance, a general group development model still applies and, similar to other homogeneous groups, cohesion is experienced quickly in retirement transition groups. The strategy, though, is to apply one's existing group skills with knowledge of developmental issues being faced by those about to experience the life transition of retirement, PLUS: sponsoring everyday conversation within a group context.

The latter is very important. What most prospective retirees can benefit from is an opportunity to connect with others who are at a similar transition point. They need to be brought together and invited to share. This is not therapy or counseling. It is a form of intentionally facilitated everyday social interaction, not exactly like what may occur in a British pub (see Deangelis, above), yet still emphasizing informal conversation.

Figure 1

The goal is to create a small group community were people learn from each other. The group leader's role, then, is to initiate the group context and to create with the new members a safe opportunity to talk in everyday conversation about their lives, their dreams, their plans, and how they will engage them. Interconnection is critically important (Conyne, Crowell, & Newmeyer, 2008).

We like to think of these kinds of group opportunities as simply "*C*reating *O*pportunity *T*o *S*hare" groups ("COTS" groups). We have been amazed at the rapid progress to be attained through creating these social opportunities which, as we all know, are unique in American life. The American predilection to independent, competitive functioning inhibits natural opportunities for connecting with others about our lives. As group psychologists, we are very concerned about this national deficiency. In relation to pre-retirement, triggering opportunities for like-minded people to come together and "chat," facilitated by a professional, is a powerful antidote to anomie and important for anticipating psychological and social issues to come in retirement.

Steps Involved in COTS Groups

Review: A first step is help people to review their lives and some of the life challenges they may face in their impending retirement. These challenge come in two forms: (a) concrete ones, such as finances, health, and family; and (b) psychological and social forms, such as replacing the functions work once provided, creating new roles, new responsibilities, new routines, new relationships, and finding a sense of purpose in life (Schlossberg, 2004).

Plan: The second step is to plan for how to best manage the changes and adaptations that will be necessary in later years so that work can be replaced by a meaningful and enjoyable existence. A sense of efficacy, the sense that "I can do this" that is so important for a successful retirement, can blossom with such a good plan.

Dream: The third step is to imagine the kind of future desired. People far too seldom allow themselves to dream in relation to their life course. After all, in popular culture, dreams are "bad things." They are fanciful, meant for sleep time, and linked with non-productiveness. By contrast, the best planning models always include creativity within them in addition to sequential, hard-headed detailing of next steps. The creative process can be dream-like and pull from the right side of the brain that governs innovation and spontaneity.

When we work with future retirees we ask them to identify their dreams for the future. What is their passion? What inspires them? What wild and crazy things might they like to do? Asking these kinds of questions can unlock the creative potential within all of us.

Engage: Finally, we help people to convert their plans and dreams into action steps. We all know from group therapy that thinking or

(Continued on page 22)

Using Group Processes...

(Continued from p. 21)

feeling about something is not the same as acting on one's thoughts or feelings. It is important in these kinds of retirement groups, too, to help participants to create action steps for the future.

Some Guiding Questions for COTS Groups. We conclude with some good "starter" questions we use to work with people who are considering retirement, or in its early phase:

Review

- What have you liked doing all your life?
- What have you been good at?
- What about any family responsibilities?
- How do you feel about your life so far?

Dream

- Are there dreams you have for yourself?
- What is your passion?
- Do you listen to your "inner guidance system" when making life decisions?
- What do you think and how do you feel about your life now?
- What is your attitude about your upcoming retirement?
- What options do you think are open to you in retirement?
- Do you anticipate staying or moving from your present location?

Plan

- Do what degree have you been planning to replace the functions of working:
  a) earning money?
  b) managing your time?
  c) developing a sense of purpose?
  d) knowing where you may fit in?
  e) connecting with others?
- How well are you physically? Psychologically?
- How will you meet your health care needs?
- What will go into your plan? Short-term? Long-term?

Engage

- How fully do you think you are you living each day?
- How can you put your ideas into action?

Sometimes there can be no substitute for sharing thoughts and feelings with trusted others. Doing so can be great "medicine." Creating opportunities to share through group work provides the group psychologist with a natural avenue for being of help to many who are anticipating the life transition of retirement.

References

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Deangelis, T. (2007). America: A toxic lifestyle? *Monitor on Psychology, 38,* 50-52.

Schlossberg, N. (2004). *Retire smart retire happy: Finding your true path in life.* Washington, DC: American Psychological Association.

Robert K. Conyne is Professor Emeritus from the University of Cincinnati. Lynn S. Rapin is President of Division 49.

This paper is drawn from the program to be presented at the 115th Convention of the American Psychological Association, San Francisco, California: August 17, 2007

Personal Narratives of The ABPP Specialty Diploma in Group Psychology

Joshua M. Gross, PhD, ABPP
Examination Coordinator, ABPP Specialty Diploma in Group Psychology

An Interview with David A. Kipper, PhD, ABPP

Joshua M. Gross, PhD, ABPP

The tradition of the ABPP Specialty Diploma dates back to 1947 and involves a process of peer review by specialists in your area of practice. With the development of the ABPP Specialty Diploma in Group Psychology we have a growing number of psychologists who have taken the time and expended the necessary efforts to complete the process of ABPP Specialty Certification. It is my goal to use this column over then the next series of editions to describe some individual narratives about this process with the hope of better describing this process to the membership of APA Division 49.

David A. Kipper, PhD, ABPP

This edition we are talking with David A. Kipper, Ph.D., ABPP. who was a participant in the first round of ABPP examinations for the then fledgling Specialty Diploma in Group Psychology. Those psychologists who participated in this first round of examinations in Group Psychology had to examine each other as we had not yet developed the formalized

structure of the American Board of Group Psychology which now administers the examinations in Group Psychology. Here is another view of those original examinations and what is was like for those seminal participants.

DAK: When Josh Gross asked me to participate in the series of interviews he conducts, I reflected on the above questions and was reminded of an old English proverb, which I paraphrased as follows "A specialty in need is a specialty indeed." So, naturally I accepted the invitation and, actually, was ready to start writing a narrative of my own history with ABPP and how did I become a group psychology diplomate. Then I noticed that this is a semi-structured interview and I am expected to adhere to the boundaries of the interview by responding to 11 questions some that take me many years back 10. Looking back into the past always reminds me of the story of the meeting between two elderly gentlemen, where one turned to the other and said: "Excuse me Sir, you look very familiar to me. What is your name?" The other gentleman pondered for a minute and than asked "How soon do you need to know?" I am one of the small cadres of group psychologists who were the first to go through the ABPP Group Psychology examination. We spent two days examining each other and thereby creating the examination format that is used nowadays. So, ready to go down into 'memory lane' I sat to tackle the first question:

JMG: Do you recall the specific point in your training or practice as a psychologist when you first came to know of the American Board of Professional Psychology?

DAK: That's an interesting question because it takes me back 30 years. When I was a graduate psychology student in Bar Ilan University, Israel I remember that at one point we had two visiting American psychology professors who spent their Sabbatical year in our department. One of them hung his various diplomas on a wall of his office, which included an ABPP Diplomate in Clinical Psychology. I thought that this was kind of a strange thing to do, that is, to display one's diplomas in the office, because Israelis would not do this. At that point I thought that this was a self-propagating behavior that fit my, then, erroneous stereotype of Americans. Of course, now I do the same with my certificates and diplomas and I look at this is as proper behavior. This definitely proves that growing older does mean getting wiser. The next time I became aware of ABPP was 25 years later.

JMG: What did the ABPP mean to you at that time?

DAK: Back to the professor's room at Bar Ilan University, when I looked at the ABPP diploma it meant nothing to me. Of course, I knew of the APA, but this thing about ABPP… never heard of it before. I over-heard the two American professors chat about their reasons for becoming ABPP Diplomates (which later, when I asked about it, they explained to me what it meant). They also said that they went through it because it was the right thing to do, not because they needed it. At that time I was living in Israel and the notion of the ABPP Diploma was not relevant to me, However, I remember thinking that, here again, the structure of American psychology, that is, accrediting different specialty in psychology, serves as a model for other countries to follow. And I liked that type of a leadership

JMG: What then did you think of the idea of psychologist as specialist practitioner?

DAK: At this point we need to move the clock forward 25 years. Now, I am an American psychologist. I became involved in group psychology both here and on the international arena. I served as president of three group psychology organizations in the USA including our APA Division 49. In today's world, psychology *is* a specialized profession. This is not a matter of preference but rather a matter of fact. Like other highly complex professions, e.g., law, medicine, computer science, knowledge becomes vast and mastering it requires specialization. Universities train psychologists to become specialists a trend that is further reinforced in the work environment. Whether we like it or not we *are* specialists. It makes sense to me that we institutionalize that trend and make it part of our professional raison d'etre. It might help our consumers, it might help us in making referrals, and it might make us better service providers.

JMG: How did the development of the new Specialty Diploma in Group Psychology in 1998 influence your decision to apply for your first or subsequent ABPP Diploma?

DAK: Yes, of course because I was one of the group of people who pushed for the creation of such a specialty.

JMG: Was there any significant event that brought you to the point of submitting the first application in the series of materials required for the ABPP examination process?

DAK: Well, again, the decision of the ABPP Board of Trustees to create the Group Psychology specialty was the 'go ahead' signal for me. When it became available I wanted to be on board.

JMG: What was the most daunting aspect of it all for you?

DAK: The fear that I might not end up to be as good as my colleagues, and that I might fail the examination. Our circumstance was different from that which is now the standard examination situation. We were about 25 group psychologists, gathered together, testing each other. Although all of us were experienced group psychologists and leaders in the field, we found ourselves in a peculiar situation of being evaluated (examined) by our peers. Many of us were not in an examination situation in decades. Feeling test anxiety, like students, was a very eerie experience. It was for me, and I know it was also for others.

JMG: Did any of it surprise you?

DAK: You bet.

JMG: Upon being notified that you passed your diplomate examinations, what then were your thoughts about the many procedures you went through in the course of the examination process?

DAK: In our situation, we were notified at the end of the two examination days. We all sat in a lecture room, like students in a class, and Joe Kobos announced the outcomes (we all passed!).

(Continued on page 24)

Reflecting on the examination process I thought that this was a fantastic experience. It was an important challenge. It required me to show what I know. It was an educational, and a terrific sell-affirmation experience.

JMG: Over time, has having the ABPP Specialty Diploma changed your perception of yourself as a professional and/or the way that you think about your practice?

DAK: Not really. I would think that it changed the way students and colleagues view my expertise.

JMG: What advice would you give a candidate?

DAK: Do it. Perhaps, you do not *need* it. But you will feel better about yourself having done it.

JMG: From your current perspective what are the most important benefits you have received for your investment in obtaining and maintaining your ABBP Specialty Diploma in Group Psychology?

DAK: The most important benefit for me is internal rather than external. It feels good to know that I have achieved that which I thought I ought to achieve.

Newsletter Deadlines

March 1
June 1
October 1

All material for publication must be submitted to the Editor as an e-mail attachment (in Microsoft Word or Word Perfect format).

From the *TGP* Editor:

Our Journal Editors, Dennis Kivlighan and Craig Parks (Incoming Editor), have added a Group Case Studies Section to our Journal, *Group Dynamics: Theory, Research, and Practice*. These case studies can be clinical or non-clinical (organizational, sports, naturally occurring groups). I would especially encourage group psychotherapists to contribute to this section as our Journal would be enhanced by more clinical articles. E-mail Dennis at dennisk@umd.edu and/or Craig at parkscd@wsu.edu, or feel free to contact me at abelfant@mac.com for any ideas or suggestions you might have.

Member News

Scott Conkright, PsyD, presented a three hour workshop on April 28, 2007, for the Atlanta Group Psychotherapy Society entitled "Love, Desire and Danger in Group Psychotherapy" held in Atlanta, GA.

Allan B. Elfant, PhD, ABPP, presented a full-day workshop entitled "The Intimate Circle: Love and the Erotic in Group Psychotherapy" at Widener University in Philadelphia on April 27, 2007. The workshop was cosponsored by Widener University and the Philadelphia Area Group Psychotherapy Society.

David A, Kipper, PhD, ABPP, gave a lecture, "The meaning of spontaneity: Empirical investigations." and a workshop, "Happy psychodrama: Psychodrama of wishful thinking," at the 65th Annual Meeting of the American Society of Group Psychotherapy and Psychodrama, Marriott at Brooklyn Bridge Hotel, Brooklyn, NY, April 27–28, 2007.

Robert M. Lipgar, PhD, ABPP, presented a paper titled "*Experiences in the First On-line Group Relations Conference: Lessons Learned"* at this year's Annual Meeting of the International Society for the Psychoanalytic Study of Organizations (ISPSO), June 25–July 1 in Stockholm.

Lorraine Mangione, PhD, was the Chairperson of a New England regional training conference sponsored by the Massachusetts Psychological Association's Training Committee on March 30, 2007, in Randolph, MA, that brought together representatives from all levels of training (academic programs, internship sites, practica, and state boards) to discuss changes occurring on the national level in competency evaluation, accreditation, and licensing laws with educators from APA's Education Directorate, Committee on Accreditation, the Benchmarks group, and the Competencies Conference. The conference was called "New Training, Competency and Accreditation Initiatives: Enhancing Collaboration between Academic and Clinical Training."

John D. Robinson, EdD, ABPP, made a presentation on "Creating Operational Definitions of Cultural Competence in Medical Environments and Implementing Them" at the 3rd National Conference of the Association of Psychologists in Academic Health Centers (APAHC) in Minneapolis, MN, May 3–5, 2007. Dr. Robinson also received an APA Presidential Citation, given by Gerald B. Koocher, PhD, in December, 2006.

Zippi Shechtman, PhD, was promoted to full professor, last May; her book entitled "Group Counseling and Psychotherapy with Children and Adolescents" has been recently published; she achieved Fellow status at AGPA in March 2007; and she led a 3-day workshop on "Working with Traumatized Children in Groups" in Eugene, Oregon in March 2007.

Ann Steiner, PhD, published "The Empty Chair: Making Therapist Absences Less Traumatic for Everyone." in the March/ April issue of *The New Therapist*, a South African journal distributed in South Africa, New Zealand and Australia. Since October, Dr. Steiner presented law and ethics workshops about the "Therapist's

Professional Will": for the International Human Learning Resource Network and the San Antonio Group Psychotherapy Association. She has also produced a CD entitled: "Therapist's Professional Will: The Complete Guide."

Judith S. Tellerman, PhD, ABPP, gave a presentation on the Role of Women in Judaism at a Symposium on the Role of Women in Religion at the Hellenic Museum and Cultural Center of Chicago on May 5, 2007

Thomas Treadwell, EdD, on April 27, 2007 presented a workshop at The American Society of Group Psychotherapy & Psychodrama Annual Meeting, in Brooklyn, New York entitled: "Enriching Psychodrama Through the Use of Cognitive Behavioral Therapy Techniques." He also co-presented a workshop at the same meeting with L. Carlson-Sabelli, P. Remer, & T. Dayton entitled:" TEACHING, WRITING AND COMMUNITY: A Workshop Focused on Integrating Writing Skills for our Professional Journal."

Call for Division 49 Fellow Nominations

The Fellows Committee invites you to apply for initial Fellow status if you:

1. have held a doctoral degree in psychology for at least five years,
2. have been a member of the Division for at least one year,
3. have made an outstanding and documented contribution to the science, teaching and/or research of group psychology and/or the practice of group psychotherapy,
4. are endorsed by three APA Fellows, including two Fellows within the Division if possible.

Current Fellows, who are already Fellows in other divisions, and who seek Fellow status in Division 49 should
submit a statement outlining their involvement in group psychology and/or group psychotherapy.

Please send for your application forms early since the process is a lengthy one. The deadline for final submission of materials for 2007–2008 is December 1, 2007.

Requests for application forms should be sent to Gloria B. Gottsegen, PhD,
Chair, Fellows Committee, Division 49
22701 Meridiana Drive
Boca Raton, FL 33433
Phone: 561-393-1266
Fax: 561-393-2823
E-mail: GGottsegen@aol.com

Federal Advocacy Coordinator Report

Gloria B. Gottsegen, PhD
Div. 49 Federal Advocacy Coordinator

Each year Division and State Federal Advocacy Coordinators join together at their annual March meeting to visit their respective congressional representatives to lobby for legislation important to the science and practice of psychology. In addition, they are responsible for organizing division members to be more active in federal advocacy.

Lynn Rapin, Division 49 President and Gloria Gottsegen, Division 49 Federal Advocacy Coordinator attended the March 2–6, 2007 State Leadership Conference in Washington, DC.

Among the keynote speakers to the Conference were Congressman Frank Pallone, Jr.; Pat Morrison, Director of the International Association of Fire Fighters; Senator Gordon Smith; Newt Gingrich, of the Center for Health Transformation; and Mark Shields, Washington Journalist.

Delegates attended workshops on such diverse topics as: "Psychological and Behavioral Factors in Preparing for and Responding to Pandemic Influenza," "No Child Left Behind at Five Years: Examining Its Past and Psychology's Influence On the Future," "Raising Psychology's Profile in Advocacy," "Mental Health Parity: New Congress, New Opportunity," "Maintaining the Value of Psychological Services in Managed Care," and "Understanding and Influencing Federal Health Care Policy."

Among the actions in which APA Federal Advocacy Coordinators were helpful last year were:

1. Securing congressional funding for the Mentally Ill Offender Treatment and Crime Reduction Act

2. Defeating the Health Insurance Modernization and Affordability Act

3. Protecting benefits in Medicaid's Early and Periodic Screening and Diagnostic Treatment Programs

4. Reversing cuts to the Medicare provider reimbursement rates

Call For Group Humor

Your newsletter Editor is inviting submissions of any jokes or humor relating to group therapy, group leadership, or group process. Be spontaneous, daring, creative, and funny in your contributions. Irreverence and absurdity are encouraged. Submit to: abelfant@aol.com.

Consultation Corner

Tender Longings, Powerful Reactions: Sexuality and Group Psychotherapy (Part II)

Jennifer Harp, PhD

Jennifer Harp, PhD

Issues and questions related to sexuality generate many feelings and reactions for group members and group leaders. Our last column, Part I in a series dedicated to the exploration of clinical issues related to sexuality in groups, raised questions for many readers. One curious reader asked us to delve more deeply into the particular challenges that arise when therapists attempt to address matters of sexuality both sensitively and competently. Dr. Erinn Tozer and Dr. Scott Conkright generously share more of their experience and wisdom with these charged and often complicated matters.

EDITORIAL QUESTION POSED:

Dear Consultation Column,

I was very interested in the last column. Often, issues related to sexuality and sexual curiosity emerge in the groups that I lead and, for the most part, I feel able to provide my groups and group members with a therapeutic approach that allows for deeper engagement and exploration of these issues.

However, in the last column, I was struck by how little thought I'd given to the specific challenges associated with gay, lesbian, or bisexual concerns that emerge in group (not to mention, transgender concerns).

Could you please elaborate upon the kinds of knowledge, awareness, and training/consultation necessary for the effective and sensitive engagement of LGBT issues in groups?

Signed,

Curious

RESPONSE #1:

Dear Curious:

Erinn Tozer, PhD

You seem to be aware that with any multicultural competency issue, it is essential for therapists to possess the awareness, knowledge, and skills that enable us to interact effectively and respectfully with individuals whose backgrounds, viewpoints, and values differ from our own. However, when applying this definition to non-ethnic and non-racial cultural groups, the definition of competency changes slightly. "Sexual orientation counselor competency" is defined as the attitudes, knowledge, and skill competencies that we need to provide ethical, affirmative, and competent services to the LGBT community (Fassinger & Richie, 1997).

First, given the continued prejudice and bias against LGBT people within our current sociopolitical environment, it is essential for you to be aware of your own biases. What do you really think about sexual orientation? Do you support gay marriage? Do you support LGBT individuals adopting children? Are you willing to say so publicly to a group of heterosexual colleagues or friends? Where does your own church stand on these issues? Are you willing to voice your dissent if your church or workplace is not affirming? And, depending on your answers to these questions, do you believe that you are prepared to support and understand your LGBT clients' struggles and dilemmas?

Second, it is important for you to gain actual knowledge on the current sociopolitical realities that LGBT people face. For instance, did you know that while some companies offer domestic partner benefits to their employees, the federal government taxes these benefits? The same benefits are provided tax-free to heterosexual married couples. Did you know that Florida currently prohibits LGBT people from adopting children? Did you know that while Massachusetts is the only state that provides same-sex couples the state-level benefits, protections, and obligations of marriage, this omits the federal benefits provided to opposite sex married couples? For example, same-sex couples are not entitled to social security if their partner dies. For a quick review of the sociopolitical reality of same-sex couples, visit the Human Rights Campaign at www.hrc.org.

Third, it is important to obtain additional clinical training to develop the skills needed to effectively work with LGBT individuals. At the annual APA convention, consider attending workshops or symposium sponsored by Division 44 (Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues). Look for CE courses that focus on the LGBT population. Grab a book on the topic. A good one to begin with is the Handbook of Counseling and Psychotherapy with Lesbian, Gay, Bisexual, and Transgender Clients (Bieschke, Perez, & Dubord, 2006). There is a chapter specifically related to group therapy within this book. Negotiating these competencies (attitudes, knowledge, and skills) within a group therapy setting may be even more complex because you may not be able to predict the attitudes, knowledge or reactions of members within the group. However, safety can be reasonably provided if you have emphasized group boundaries and fundamental ground rules for communication; specifically, that respectful, honest communication is essential. Of course, it is expected that group members will disagree and have reactions to one another. However, it must be clear to the group that it is not acceptable for members to treat each other with disrespect. The safety of the group (and its members) is at stake. It is your job to be aware of communications that may feel unsafe or disrespectful of someone with an LGBT orientation. Such communications must be explored carefully and respectfully.

Finally, you noted that you felt able to explore issues of sexuality and sexual curiosity in your groups. Do you tend to dig for sexual tension between opposite sex members and ignore that as a possibility for same-sex members? If so, it is important to acknowledge that same-sex attractions may exist within the group, even with heterosexually identified clients. Indeed, opposite sex attractions may exist even with same-sex oriented clients. But if you've attended to your attitudes, your knowledge, and your training, and you've nurtured a safe space for your groups, you should be able to handle most sexual orientation issues with comfort and effectiveness.

Erinn Tozer, PhD
Senior Staff Psychologist,
University of San Diego Counseling Center
Private Practice, San Diego, CA

Reference

Fassinger, R. E., & Richie, B. S. (1997). Sex matter: Gender and sexual orientation training for multicultural counseling competency. In D. B. Pope-Davis & H. L. K. Coleman (Eds.), *Multicultural counseling competencies: Assessment, education and training, and supervision* (pp. 83–110). Thousand Oaks, CA: Sage.

RESPONSE #2:

Dear Curious:

I am currently running groups that are mixed male/female and mixed sexual orientation as well as groups that are exclusively for gay and bisexual men. I am often struck by both the commonalities and differences between both types of groups. There are certainly unique issues facing LGBT group members and being knowledgeable about these is part of conducting ethically informed therapy. This is true for whether you are conducting homogeneous groups for any minority population or if you have particular minorities as part of a mixed group. Without the specific knowledge about the unique developmental and cultural factors at play within a minority population the therapist can unwittingly cause more harm than good.

Scott Conkright, PsyD

That said, the majority of issues in groups for LGBT populations are the same as those faced by any other group. I agree with Sullivan that, "we are all more human than otherwise" and for this reason the general functioning and dynamics of a group will stay the same no matter what the sexual orientation is of the group members. What I do find to be pronounced among my LGBT group members is a pervasive sense of shame about their sexual identity. The messages received throughout childhood, communicated directly and indirectly from family, religion and the community at large, that one's attraction is "perverted" or "sick" is immensely wounding. Though general awareness and sensitivity are improving somewhat regarding this, the negative messages are still powerful.

The research to date has found no correlation between psychopathology and sexual orientation. Despite this, both with the field of psychotherapy, as well as within the larger culture, there is still both direct and indirect stigmatization. This means that the majority of the GLBT population that enters our groups has suffered from some sort of humiliation due to their sexual orientation and, as a consequence, carries with them varying degrees of shame. This shame is often manifested in what is called "internalized homophobia." This refers to the negative prejudicial feelings and attitudes from the culture at large which have been taken in by the GLBT individual. In short, this is a form of unconscious self-hatred about being GLBT. In groups, internalized homophobia often gets played out in various scapegoating behaviors and in group members distancing themselves (sometimes knowingly, sometimes not) from those group members who seem "more" gay than themselves.

Internalized homophobia is also seen in the pervasive negative feeling GLBT individuals carry within themselves. For this reason, it is helpful to think of "coming out" as more of a process than a single event. Group members will be in various stages of coming out, ranging from self-acceptance about same sex feelings, to sharing their identity with family and colleagues. Each individual has to make unique choices about these matters, as each has a different potential outcome. For many, the coming out in rural Alabama to a family of conservative Christians is generally not the same experience as that of a liberal urbanite

Issues of sexuality, I have found, generally make themselves known a lot earlier on in the development of a homogeneous GLBT group. For these group members, sexuality has a particular meaning in so far as their sexual orientation has played a central role in their development. A lack of role models and readily identifiable gay figures in mainstream media, and a lack of socially available venues for associating (proms, cafes, etc), have all contributed to a sense of being marginalized and unwanted for LGBT persons. For this reason, therapists working with GLBT individuals often provide homogeneous groups for their treatment. The likelihood of shaming and stigmatization is thus reduced as all members share a unifying identity.

Another important consideration in conducting therapy with the LGBT individual is the therapist's own feeling about same-sex attraction. It is important that the therapist, especially if he or she does not identify as being gay, to not only be well informed about same-sex attraction from current literature in the field, but from self-exploration regarding all manner of feelings, including possible prejudices or anxieties that same-sex attraction evokes. Like our group members, the therapist also struggles with various forms of internalized homophobia, which can be perniciously played out in the group in subtle ways.

Scott Conkright, PsyD
Clinical Psychologist
Private Practice
Atlanta, GA

The Self Nomination Form for Standing Committees is not in this issue of *TGP*. It can be found in the last issue of *TGP* and will be in the next one.

GROUP PSYCHOLOGY AND GROUP PSYCHOTHERAPY (49)
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