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A Newsletter of Division 49 of the American Psychological Association

Contents

Presidents Column

Noelle Lefforge Ph.D. ABPP

Leadership

Public Statements. I've been in several spaces recently where public statements have been a point of discussion; more importantly, a topic of inner tension. As I begin this Presidency, I am thinking about how to transform my positionality into a significant, positive impact. Public statements are a voice of leadership. Lately, I've been asking myself what I should do with my voice.

Are public statements helpful?

Yes, I hope. Public statements help us express our awareness of what is happening in the world around us and highlight the inequitable impact that specific events carry. The statements provide us with the opportunity to stand against identity-based hatred and violence. They call attention to ongoing issues that need to be addressed Most importantly, they shine a light on solidarity. The statements are an opportunity to see and be seen. However, I worry that too many, or repeated calls of attention to one issue, may lose their impact over time.

Are public statements harmful?

Yes, sometimes. When issuing a public statement, the statement alone shouldn't make us feel like we have resolved an issue because there is so much more yet to do. When we issue a statement about one issue or group, we may miss another, thereby reinforcing feelings of being unseen. When we center our perspective from an outsider's point of view, we lose the voice of those who should be most heard. The public statement (in itself) should not be our 'pat on the back'.

So, what should I do?

Despite the risks of getting it 'wrong', **I want to use my platform to promote solidarity**. I feel compelled to recognize the work that needs to be done to address police brutality and other forms of systemic oppression that led to the murder of Tyre Nichols. I want to recognize the unacceptability of ongoing anti-Asian hate and rhetoric, recently amplified by mass shootings in predominantly Asian communities. We need to say something about ongoing efforts to dismantle the rights of LGBTQ+ folx, a context compounding fear in the wake of the Club Q shooting. We need to rally against the rise in anti-Semitism, (including events that, unfortunately, were enacted on my own campus in recent weeks). There is so much more to acknowledge. The bottom line is this: that we, as Division 49, need to stand in solidarity against all forms of identity-based hate and violence. I'm using my voice to say it with confidence that you'll join with me. It begins with all of us.

From Saying it to Doing it - Division Highlights:

The Division met for our midwinter meeting at the end of January 2023. The highlights of the meeting (for me) were the various ways we tackled issues of diversity, equity, inclusion, and belongingness. I am so appreciative of the work our DEIB committee has done, particularly under the leadership of Eric Chen. DEIB work is the responsibility of the entire Division. There are several moments of progress from the meeting that are worth highlighting:

- We continued to fully fund and advance The Institute which raises attention to the cultural, social, and political contexts that are a part of group psychology and group psychotherapy. Many thanks to Shala Cole and the Membership Committee for leading this noteworthy initiative.
- With an aim toward increasing equity, and decreasing reliance on pro bono work, we increased funding for Continuing Education in hopes that competitive pay will communicate our that we value our presenters.
- We looked inward and began some difficult conversations related to decolonizing our own ways of working.

We recognize that we still have a long way to go before we reach our overarching goals. Soon, there will be a call for candidates for our open slates. I hope you will consider participating in leadership, particularly if your voice has been missing. We need your voice to continue this process.

President-Elect's Column

Francis Kaklauskas, PsyD

Connection and Collaboration

I am humbled and excited to serve in the role as President of The Society for Group Psychology and Group Psychotherapy. Like many of us, my life has revolved around groups of all sizes, types, and membership. I hope to support inclusiveness, curiosity, passion, and satisfying relationships within our division, our work, and ourselves.

For many of our membership, these last several years have been personally challenging with the trauma and isolation of COVID, unexpected changes in our finances, and important relationships interrupted. In addition, numerous concerning threats confront our embedding system of the United States, including increased polarization, stereotyping, segregation, and racial, gender, and ethnic violence. The mass media echo chambers have decreased our ability to discuss, think critically, disagree respectfully, and collaboratively problem solve. The many destructive group dynamics that we all know have taken center stage. As we examine our social and political sphere, many of us identify dynamics such as group think, obedience to authority, conformity pressures, idealization, scapegoating, and onwards. The knowledge and wisdom of our membership is urgently needed.

While each of us try in our own ways and as a division to address these concerns, my hope and request is that we also begin to focus on our connections and teamwork within the division. While attending the mid-winter meetings, the board members shared many moments of connection, intimacy, support, and kindness; however, I also witnessed how a small number of division members are working with great effort in solitude and potentially with limited recognition. We all can be grateful for the many younger, early career professionals and students, many from marginalized identity positions, who give of their time, energy, and expertise towards our continued survival and growth.

Moving forward I want to offer an invitation to all to reconnect with one another and contribute to the other division members in any manner that fits with your current situation. For early career members, there are many opportunities to be involved, learn new skills, network, and establish and broaden one's own expertise. While many of us have given to the division and the field, I wonder if now, we can find time and energy for each other. The many

personal benefits that come from forging new relationships include new learnings, increased hope, and mutual emotional nourishment. This is a call of encouragement to extend beyond our current circles.

For mid and later career professionals, there are opportunities to share your experience and scholarship through our expanding educational and scholarship programs, but also to grow through connections with our new generation. The division's institute program that pairs members from different career stages has been wonderful for all who have participated and provides significant benefit beyond just the hour or so each side gives each month. As group people, can we not only talk about constructive group functioning, but live towards these ideals with one another. I believe we can create an inclusive diverse division where beyond the sharing of labor, we share, more importantly, ourselves.

The current board and I are available to support and help you find a meaningful place that fits with your interests. Please do not hesitate to reach out to the board and myself. I hope to see many of you during op discussions and meetings in our future. My desire is that you will be able to feel sustained and affirmed, while we move towards our personal and professional goals together.

From your editors:

Although we are a relatively small Division according to APA standards (Membership Statistics can be found at: https://www.apa.org/about/division/officers/services/profiles), the work of our Board and Committees gives credence to the idea of being "small but mighty". When you utilize the power of the group, much is possible. We especially want to highlight some changes, ongoing progress, and upcoming programming that our Society is engaging in.

First, we are pleased to be sharing future editorials on our new website for ***The Group Psychologist*** scheduled for **fall 2023**. Limitations were being posed by our previous method of publication, so we applaud the Board in supporting the recommendation to create our own website. The plethora of valuable articles and resources are going to be more widely available to members and non-members alike.

We want to highlight some ongoing work by members of our Board, including our YouTube channel, with a range of valuable videos: https://www.youtube.com/channel/UC95OCevsSnx3Zg4FJMAcJ2A. We applaud the ongoing work of the Group Specialty Council and look forward to the upcoming Evidenced Based Group website Fascinating article on the impact of group therapy published in the Group Circle:

New Data on the Impact of Group Therapy on Solving the Mental Health Crisis
Martyn Whittingham, PhD, CGP, FAPA, AGPA-F

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Finally, we are pleased to share the second in a series of essays on **Navigating Academic Departments**. Dr. Nina Brown focuses this one on the climate and culture of departments. The descriptors of a collegial, toxic, and even cult like department offer valuable insights and metrics for reflection to faculty and academics. Please share it widely, especially with department chairs and Deans who are in positions of power to make a difference.

Tom & Leann

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Navigating Academic Departments-Series-2

Nina W. Brown, EdD, LPC, NCC,

Departmental Culture and Climate

This second essay in the series of six on "Navigating the Academic Department" will focus on the culture and climate in an academic department. Many if not most faculty enter a department that has already established a culture and climate most of which is not openly acknowledged. Agazarian (1997) termed this as social convention for therapy groups that include social defenses, communication patterns and ingrained social norms that also seem to apply to an academic department.

Just as in group therapy, the culture and climate in a department play majors roles in the effect and impact on the group members, that is the faculty. Culture is defined here as the "knowledge, beliefs, art, morals, behavioral practices and customs and habits that are the group's traditional ideas and values" (Sue et al., 1987). Climate is defined as the prevailing conditions affecting morale, satisfaction and productivity. Usually, faculty enter a department's culture which has been established over time and can be mainly on the nonconscious level, while climate can be how the culture is acted on at the current time.

In group therapy, the group collectively established its norms on both the conscious level with rules to guide interactions and behaviors, and on the nonconscious level with an unconscious group decision for expected behaviors, taboo topics, and other group matters. Departments and groups have formal and informal rules, expectations, and desires that are seldom verbalized but are the basis for the climate encountered by faculty. This essay will focus on some of the components for an ideal department culture and climate, and descriptions of some behaviors that can signal a toxic culture and climate.

An Ideal Academic Department

Following are some components for an ideal department that are categorized as either mainly under the department chair's control, and those mainly under the individual faculty's control.

Department Chair's Control and Responsibility

Trust exists between faculty and department chair and faculty has evidence that the chair acts in their behalf.

The goals and tasks set for faculty are consistent with their personal performance expectations and with the department's goals and objectives.

There is sufficient evidence that there are equitable distribution of resources.

Performance expectations and evaluations for each faculty member are fair, applied equitably and are communicated to them early in the academic year.

There is an absence of significant university produced stress caused by unannounced changes and other transitions.

The department chair ensures that matters affecting faculty are made transparent.

Faculty Control and Responsibility

Faculty accept, appreciate, and respect each other.

Dissent thoughts and ideas are listened to, tolerated, and carefully considered.

Communications are clear, open, direct, and truthful.

Faculty freely seek out ways to interact with each other.

There is an absence of subgroups, cliques and secrets that affect faculty's welfare in the department.

Conflicts are not avoided, ignored or suppressed, they are addressed for constructive resolution

Collaboration and competition among faculty are constructive.

Collegiality is encouraged and fostered.

Creative tensions are managed and controlled.

Take a moment to reflect on your department at the current time and note how many of the descriptors are present either for the chair or for the faculty.

A Collegial and Constructive Department Culture and Climate

While you may not have an ideal department culture and climate, you may have a collegial and constructive one. Following are some indicators for positive feelings that faculty can have when there is a collegial and constructive department culture and climate.

High morale – Johnsrud (1996)

Feeling mentored – Plata (1996)

Sense of community – Johnsrud & Rosser (2002)

Autonomy - Tack & Patitu (1992)

Intellectual challenge- Magner (1999)

Institutional support is clear – Mellow, van Slyck & Eynon (2003)

Broad definition of scholarship – Antonio (2002)

Having a voice and being heard- Turner (2000)

It's not that everything has to be perfect for faculty to feel appreciated, connected and productive, it just that there needs to be an absence of toxicity as presented in the next section, and the presence of intangibles that are valued by faculty.

Reflect on how many of these describe how you feel in your current department.

A Toxic Department Climate

Following are some descriptors for a toxic department climate. Many of these descriptors will not be verbalized, and some may not be in faculty awareness, but they nevertheless can have a negative effect on faculty.

Ambiguity and uncertainty about performance expectations that cause anxiety because of the unknown nature of how the performance will be evaluated.

Many faculty perceive that they are treated unfairly. While not all faculty feel that they are treated unfairly if many do feel this way it can be unsettling for them.

Policies and procedures are changed or implemented or initiated capriciously without faculty input or sufficient notice.

Faculty and the department chair failure to abide by or follow established and approved policies and procedures without negative consequences.

Communications are lacking, unclear or inaccurate.

Meetings and other interactions reflect a lack of flexibility, or room for differences of perceptions or opinions by other faculty and/or the department chair.

The department chair seems to easily tolerate incompetence tolerated.

There are several faculty that demonstrate that they feel alienation and disengaged.

Faculty are reluctant to provide input even when offered an opportunity to do so.

There are secrets about matters that affect faculty and/or the department but are hidden from most or all faculty.

There is considerable complaining, carping, and whining by faculty, or there are disengaged faculty.

Faculty describe the department has having low morale.

Reflect on your current department culture and climate and note if or how many of these descriptors apply. If there are 5 or more, you may want to consider the level of toxicity present in the department.

Stressors

There are also some stressors that are not under the individual's control that can contribute to faculty's dissatisfaction with the department. Examples follow but are not limited to these.

Isolation and/or exclusion from department and other faculty discussions, projects and/or

assignments.

Some faculty are assigned extra department service which erodes the time left for scholarship or professional service on the national/international levels.

Some faculty frequently encounter sexist, racist and/or homophobic language and behaviors from other faculty, administrators and/or students.

Although prohibited by most universities' policies faculty can encounter harassment, bullying and/or sexual harassment which may be ignored or minimized by the chair or other administrators.

There are many intentional or unintentional microaggressions where it may not seem to the receiver that it is in their best interest to speak up about how they are affected.

Ambiguity, uncertainty, and lack of clarity about expectations and about performance evaluation.

Navigating A Toxic Department Climate Tips for Faculty

Focus more on your scholarship and classes.

Find a mentor or confident outside of your department, and don't confide in your department colleagues.

Do not join or participate in a clique.

Separate your personal life from your professional life.

Restricts your comments that are criticizing or blaming.

Document any physical and/or verbal abuse or other bullying or harassing behaviors.

The "Cult" Department Climate

A department climate that is infrequently mentioned is one that is reflective of "cults" that suck you in, make you feel special and involved, but are in fact undermining and promote "Group Think". Their process can be seen in the following indicators. Everything seems positive at first, colleagues get close to you very quickly with oversharing and intimacy, there are rituals almost every day, dissent is discouraged and/or punished, the department seems overly obsessed with how they are perceived by others, the department events start to take a more prominent role in your life with numerous social events and working long hours, there is a push to get faculty on the same page in an ideological way, former employees are disparaged or shunned, and you can feel that colleagues play on your insecurities to get you to do things that you don't want to do and/or that are not in your best interests. This climate usually goes unrecognized by most of the faculty in the department and it is perceived by many as being "harmonious". Any disquiet you may feel is generally attributed to other possibilities. No fixes or tips are available for this situation except to recognize its negative impact on you and to leave.

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Group Therapy Column

Tevya Zukor, Ph.D.

University Counseling Centers: Unaware of prognostic Mental Health Issues in Public Education

One of the things I deeply value about my work in higher education is that I often get the ability to interact with professionals from different realms than my own. A few weeks ago, I had the opportunity to attend a training about mental health issues that are prevalent in the elementary and secondary school systems. The training was conducted by a high school guidance counselor and a Safety Resource Officer – which is “fancy-speak” for a police officer who is stationed inside of a public school.

As a result of the experience, I got to interact with a number of high school teachers, counselors, and safety officials. A few things of note emerged but first I feel it necessary to say: While there are undoubtably and indisputably systemic and individual issues within many law enforcement communities, the majority of police officers that I have met are truly dedicated to making the world a safer place for the communities in which they serve. The officers at the

training were motivated and committed to fostering the best learning environment for the students under their care. There are real issues with the types of work law enforcement is tasked with doing on a daily basis, but it seems important not to lose sight of the care and good-intentions that many, if not most, officers bring to their job every single day. While I will save my soapbox rant about necessary police reforms for another time and place, it was a reminder that sometimes one's group-identity can cloud people's perception of individuals within that group. It is okay to both have strong feelings about the role and values of police organizations, while also respecting the individuals that take an oath to dutifully serve society.

Another "group-theme" that emerged in the training was the overlapping and complimentary efforts between secondary education and higher education. I can admit that in my more shameful moments, I have been guilty of drawing a clearer and more distinct line than necessary between traditional "guidance counselors" and the psychologists and social workers that make up the majority of collegiate mental health. Because my identity has been tied to University Counseling Centers for almost 20 years, I have a strong affinity for higher education. But the training highlighted; sometimes in ways that likely speak more about me specifically than any generalized statement that would be applicable to the larger population, that, regardless of setting and specific training, all people in the helping professions tend to share a set of common values. I listened intently and with genuine interest as school counselors talked about struggling to assist children with acute mental health issues, such as anxiety, depression, and trauma. I commiserated with those who shared stories about needing to be the primary positive support for a student, especially when the child's parents either chose or were forced by circumstance to be unavailable in the child's life. I empathized with stories about helping a student who had been recently diagnosed with a serious mental health condition that was clearly interfering with both their academic and personal goals. Most of it is the same set of challenges that we confront regularly in higher education, just tailored to the high school level. The titles are different, as is the work environment; but we are all in the group of professionals assisting in the lives of students as best we can.

The final takeaway that was impactful to me, and hopefully to many others who proudly ply their trade of collegiate mental health, is that the problems currently emerging in the elementary, middle, and high school levels are a direct preview, and possibly the best prognostic indicator, of the challenges about the emerge at the higher education level. It was a reminder that while we may not all be in the same boat, we certainly share the same water and anything that can help children at an early age will likely make for a better college experience for those same students. In essence, we're all in the same group, even if our work rarely directly overlaps. The community is larger than we know…and it's nice to have a cohort, even if you don't always see them.

Action Group Therapy Column

Thomas Treadwell E.D., TEP, CGP

Cognitive Experiential (Action) Group Therapy

A model for clinical and college counseling settings.

Thomas Treadwell Ed.D., TEP, CGP

Cognitive Behavioral Therapy (CBT) was established by Aaron T. Beck (1967, 1979), and involves several techniques to challenge negative thought patterns and increase engagement in positive and success-based experiences. Psychodrama group therapy was created based on work by Jacob. L. Moreno (1953), and involves experiential, interpersonal exercises to raise awareness and reduction of internal conflicts in order to change negative relational patterns. The CBT model is sometimes criticized for being overly structured and intellectually oriented (Young & Klosko, 1994; 1996; Woolfolk, 2000). As a result, some group therapists today use an approach based upon CBT or identify with a less structured approach called *eclectic* (Kellerman, 1992) that typically employs techniques that come from cognitive behavioral therapy and its related research. CBT is a robust, proven, and highly effective treatment approach for many mental disorders, including the big ones like depression and anxiety. Beck reports "My employment of enactive, emotive strategies was influenced, no doubt, by psychodrama and Gestalt therapy" (A. Beck, 1991, p.196). Psychodrama is an *eclectic* tool to enhance the cognitive and behavioral change. Several practitioners have worked to integrate CBT into the Psychodramatic model by highlighting the ways CBT enhances psychodrama exercises (Boury, Treadwell, & Kumar, 2001, Treadwell, Kumar, & Wright 2004), adapting psychodrama to include the exploration of irrational beliefs (Kipper, 2002), and considering the way in which psychodrama could be considered a form of CBT (Baim, 2007; Fisher, 2007; Treadwell, Travaglini, Reisch, & Kumar, 2011; Wilson, 2009). The blending of the two models yields a complementary approach to multiple problem-solving strategies (Treadwell, Kumar, & Wright 2004):

- Both the CBT and Psychodrama models stress the discovery process through Socratic questioning. The use of certain structured CBT techniques (discussed within this manual) within the context of psychodrama provides ways to deepen self-reflection, problem-solving, and mood-regulation skills that can be rehearsed through psychodrama exercises.
- Experiential role playing can provide individuals with opportunities to generate new ways of thinking and behaving. The spontaneity and creativity of individuals can be increased through the use of psychodrama techniques, thus helping to produce alternative thoughts.

Cognitive Experiential Group Therapy (CEGT) is an effective model for working with a variety of clinical and nonclinical populations. The model incorporates cognitive behavioral and psychodrama interventions, allowing group members to identify and modify negative thinking, behavior, and interpersonal patterns while increasing engagement in

positive and success-based experiences (Treadwell, Dartnell, Travaglini, Staats & Devinney, 2016, Treadwell, Dartnell, Travaglini, Abeditehrani, 2021. The CPGT environment creates a safe and supportive climate where clients can practice new thinking and behaviors and share their concerns freely with group members (Treadwell, Kumar, & Wright, 2004). Initially, all members are assessed using various instruments to establish the nature and severity of presenting issues and to uncover other relevant information. The first one or two sessions are devoted to establishing group norms, explaining Cognitive Behavior Therapy (CBT) and schemas, and describing the session format. The initial didactic sessions are intended to explain the group format as a problem-solving approach for working through various interpersonal, occupational, educational, psychological, and health-related conflicts. The sessions include information about the nature of the structured activities so participants have realistic expectations about how the group will run. Each group member signs informed consent and audiovisual recording consent forms. The audiovisual recordings create an ongoing record of group activities and serve as a source for feedback when needed. Here's how the model looks the action model is introduced. In session one, the director/facilitator, introduces the Beck Depression Inventory-II (BDI), Beck Anxiety Inventory (BAI), and Beck Hopelessness Scale (BHS) (Beck, 1988; Beck& Steer, 1993; Beck, Steer, & Brown, 1996), and explains the importance of completing each scale on a weekly basis. The instruments are administered before the start of each session and are stored in personal folders to serve as an ongoing gauge of participants' progress within the group (Treadwell, Kumar, & Wright, 2008).

In the second session, additional data on early maladaptive and dysfunctional schemas/core beliefs are obtained when group members complete Young's (Young, Klosko, & Weishaar, 2003; Young & Klosko, 1994; Young, 1999) schema questionnaire. A list and the definitions of dysfunctional schemas and core beliefs are given to participants during the initial session (Treadwell, Kumar, & Wright, 2008). Additionally, we administer the Therapeutic Factors Inventory (TFI) to identify four dimensions of group progress (Joyce, MacNair-Semands, Tasca, & Ogrodniczuk, (2011) during this week, week 8, and week 16.

Each group session in CEGT is divided into three sections typically found in psychodramatic interventions: ***warm-up*; *action*; and *sharing*** (Moreno, 1934). Many CBT techniques (Beck, 2011) are utilized in the **warm-up**, including: identifying upsetting situations, automatic negative thoughts and triggered moods; writing balanced thoughts to counter negative automatic thoughts; and recognizing distortions in thinking and imprecise interpretations of difficult situations. The second portion, **action**, employs psychodramatic techniques such as role-playing, role-reversal, and mirroring, which

facilitate the examination of various conflicting situations individuals experience within the group context. This enables group members to better understand the nature of negative thoughts triggered by situations and their effects on moods. The last stage, **sharing**, allows auxiliaries and group members to share their experiences with the protagonist. At this stage, the director may provide additional guidance to the protagonist regarding ways to begin resolving the actual situation in real life. Normally, the protagonist will be asked to complete a homework assignment that will be reviewed at the next session.

Warm-up

The Automatic Thought Record (ATR) (Greenberger& Padaskey, 1995/2015) is explained and shown how to complete on a white board during warm-up. A group member volunteers his/her situation and facilitators walk the person through the seven columns. This individual is then referred to as the protagonist.

Action

The protagonist selects a group member, to be her **double**. The double communicates thoughts and feelings the protagonist is having but cannot express. Since the protagonist is rather agitated, one may have some difficulty getting into the psychodrama; in this case, the **soliloquy** technique would be helpful. Implementing soliloquy technique, the protagonist walks around the room, thinking aloud, expressing concerns, discomfort, and hopes, allowing protagonist to relax, focus, and prepare for the psychodrama. This is also useful in helping other group members focus on the upcoming action phase. The double walks with her, expressing thoughts he assumes she is thinking but not expressing. To operationalize these unexpressed thoughts the director/facilitator brings another group member to mirror the protagonist's role and has the protagonist watch the interaction. This technique, called **modeling**, occurs when a group member demonstrates to the protagonist how he or she would handle the situation. **Doubling, modeling**, and **role-training** are crucial in learning how to get unstuck from repeated behavioral patterns. Many protagonists are anxious when learning a new role; therefore, it is important to support them as they try it in session.

Sharing

At the end of the psychodrama, group members share and discuss what occurred, commenting on their experience playing a particular role or on how the situation affected them. Sharing is critical both for the protagonist and for each of the group members as they reflect, share, and learn from each other. Sharing is a fundamental component in enhancing group cohesion. During the sharing stage, assigning homework to the protagonist is essential, as it encourages the continuation of work on the new role explored in the session. Role development needs practice for habituation to take place and to move the protagonist to feel safe in her new role.

Summary

Utilizing principles of CBT and psychodrama created a powerful and effective group process, enabling participants to address problematic situations with the support of group members. Clients find CBT helpful in becoming aware of their habitual dysfunctional thought patterns and belief systems that play an important role in mood regulation; the action component allows them to actually see and feel the dysfunction.

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Evidenced Based Group Therapy (EBGT) Update

Tate Paxton, PhD.

In our last update, we gave updates meant to take us through the end of 2022. We are now into 2023, there are many exciting developments to outline!

As a refresher: APA, Division 49, American Group Psychotherapy Association, and German Health Ministry have provided funding and support for the creation of an evidence-based group treatment website. This website will serve clinicians and the public and will be updated and enhanced on an ongoing basis. Right now, the project is in nearing the end of the creation phase, with Drs. Gary Burlingame and Bernhard Strauss leading, coordinating, and supporting the multi-team effort.

Many more teams have finished their disorder pages (see list below), and several new pages have been undertaken to increase transparency and usability of the website. Furthermore, APA Division 49 approved funding for the permanent website. The host of the website has created a framework that will allow for easy updates and additions as more treatments gain research to merit the evidence-based designation. In this final creation phase, we are nearly ready to launch parts of the new site. **Drs. Gary Burlingame, Bernhard Strauss, and one of Dr. Burlingame's graduate students, Tate Paxton**, will be presenting on the project at the upcoming American Group Psychotherapy Association Connect 2023 conference in March.

The creators of disorder pages have agreed to create a landing page where they outline their work and any unique elements of the research literature for their disorder. On that page, they also outline any potential limitations in the literature to avoid over-interpretation of the evidence. Another additional page includes "Promising Treatments." These group treatments have not yet accrued as much evidence but have sufficient evidence to be listed as promising. Many of these treatments will likely gain more empirical evidence in the coming years and be included as evidence-based treatments on the website.

Below is the update with all collaborators and respective disorders. As a note, the additional pages are still under development, but the main treatment page templates have been completed for many disorders.

- **Gary Burlingame and team – USA**
  - Depression (complete)
  - Schizophrenia (complete)
  - Bipolar Disorder (complete)
- **Bernard Strauss and team – Germany**
  - OCD (complete)
  - Anxiety disorders and PTSD (work ongoing)
- **Stephanie McLaughlin and team – USA**
  - Borderline Personality Disorder (complete)
- **Giorgio Tasca and team – Canada**
  - Eating Disorders (near completion)
- **Gianluca Lo Coco and team – Italy**
  - Substance-use disorders (near completion)
- **Cameron Alldredge – USA**
  - Chronic Pain (complete)

Early Career Psychologist

Katie (Kathryn) White Psy.D.

When I was elected Early Career Professional, I did not know that I would be responsible for a column. Truthfully, I asked very few questions before I agreed to put forth my name to replace the outgoing Early Career Professional and,

coincidentally, my direct supervisor, Dr. Misha Bogomaz. As I sat trying to figure out how I might introduce myself to the Division 49 community, my mind continuously returned to the most meaningful group I could have ever facilitated, one for college students with chronic pain and illness. I am deeply familiar with that experience, as I was diagnosed with Complex Regional Pain Syndrome at the age of 9. There has been no realm of my life that my illness has not touched in the 23 years since my diagnosis. Even in its absence, it has always been there.

On the very first day of my undergraduate studies, I had a spinal cord stimulator implanted, and I suddenly went into remission. I enjoyed the freedom of remission for a couple years, but in the back of my mind I always worried that it was too good to be true. Unfortunately, it was, and the pain returned with a vengeance during my junior year. I felt hopeless and imprisoned within a body that had – once again – betrayed me. The college students I was surrounded by lived life fast, with the short-sighted, spontaneity that only youth can have. My illness never allowed me to live with such reckless abandon, but I so deeply wanted their freedom for my own. While my suffering felt pointless at the time, it paved the way for the acceptance that I will continue to nurture for the rest of my life. It is still painful, however, to think back to how broken I felt at that time, though.

Fast forward a few years, and I asked Misha if I could create a group for students experiencing chronic pain and illness. I saw a younger version of myself in them, with their experiences being so akin to my own: They knew no one their age that looked or lived like them, and no matter where they went or who they were with, they felt profoundly alone. They endured loss, sorrow, fear, all within a body that felt more opponent than teammate. They so deeply wanted respite, which they realized may never come. Their tales of resilience reminded me of my own ability to persevere and overcome with a newfound appreciation.

For 90 minutes every week, they received each other with unbridled compassion, despite the heaviness of their own experiences. In a world that questioned the validity of their illness, they believed in one another without hesitation. They appreciated that their illnesses were separate from their personhoods, and they never, for one second, allowed one another to conflate the shortcomings of their bodies with the quality of their character. Within the space we had created, they were not alone in their suffering – in fact, it was quite the opposite: it was their suffering that brought them to see and care for one another so unconditionally. Through fostering this community, I began to let go of all the times when I had not been received by others with such love, and I developed a newfound commitment to treat myself in the way that they treated one another.

I often say that illness has been my greatest teacher. In this case, my illness brought me to this group, who reminded me of some very valuable lessons that I return to again and again when my life becomes difficult. They reminded me that love and compassion are always available to us, should we seek them out. That light can always be found within the dark. That suffering is inevitable, and if we do it right, so is growth. And that if we find good people and we choose to let them see us, we will never truly be alone.

It is so nice to meet you, Division 49.

DEIB Column DEIB Diversity, Equity, Inclusion, & Belonging Committee Update

eric Chen, Ph.D.

Practice Active Allyship in Groups and in Daily Interactions

As we start the year of 2023 and the Year of the Rabbit, I am delighted to introduce our new DEIB member, Shanique Brown, who is joining the other DEIB members: Josh Gross, Pavani Khera (student representative), Elena Kim, Joe Miles, Aziza A. B. Platt (Vice Chair), and Elizabeth Weiner. Here is a brief introduction of Shanique: Shanique (she/her) is an assistant professor of industrial-organizational psychology at Wayne State University. Her primary area of research relates to cognitive processes and states relevant to work and organizational psychology. As a graduate student, Shanique was able to develop her knowledge of the workgroup and team literature while doing research on team composition for future long-duration space missions. Since then, she has integrated her interest in cognition with the workgroup and team literature. Shanique is currently examining decision making and knowledge integration in teams.

As we welcome Shanique as a new member on the DEIB Committee, I am reminded of the importance of helping a new member to feel a sense of inclusion and belonging quickly through active allyship.

In "How to Be an Ally if You Are a Person with Privilege," Frances E. Kendall describe allyship as "An active practice of using power and privilege through intentional, consistent, and positive efforts to achieve equity and inclusion and end oppressions in solidarity with a group of people who are systemically disempowered."

In celebration of Black History Month, recently in my group counseling class attended by 23 students who are pursuing graduate degrees in counseling and school psychology, I started the class with a quote from Maya Angelou: "Do the best you can until you know better. Then when you know better, do better." I then asked the question, "Think of a marginalized identity you do NOT hold. Which of the following may be a main barrier for you to engage in active allyship on behalf of that identity?

- I don't know how others who share my identity will perceive me.
- I don't feel emotionally compelled to get involved.
- I may be accused of being performative.
- I wouldn't want to say the wrong thing."

Almost 70% of the students identified the main barrier of active allyship as: "I wouldn't want to say the wrong thing," with the next main barrier being "I worry I may be accused of being performative." Underlying both barriers seems to be our fear of judgment from others. My students and I then had a long discussion about how allyship is a lifelong, active, non-performative, imperfect, process of cultivating supportive relationships with marginalized individuals. We then discussed Poornima Luthra's (2022) "7 Ways to Practice Active Allyship":

1. Deep Curiosity: understanding allyship is rooted in interest in our own and others' diverse experiences.
2. Honest Introspection: identifying how our own assumptions and biases shape our behavior and views.
3. Humble Acknowledgement: recognizing that all of us with our privileges and intersectional identities will never fully understand another's life experience just as they will not know our own.
4. Empathetic Engagement: engaging and interacting in a way and with a tone that allows for others to examine their biases without becoming defensive.
5. Authentic Conversations: nurturing a psychologically safe environment for interpersonal risk-taking without fear of repercussions.
6. Vulnerable Interactions: embracing our own vulnerability to model for others in identifying (hidden) biases.
7. Courageous Responsibilities: leveraging our own privilege to support and give voice to the voiceless.

I then introduced the multicultural orientation (MCO) framework within the small group context (Kivlighan & Chapman, 2018). In this framework, group practitioners are called to maintain a sense of cultural humility and a high degree of cultural comfort in order to take advantage of cultural opportunities in the group process – the opportunities for us to become active allies to those with marginalized identities, concealable or otherwise, and the opportunities to optimize the sense of belonging and connections among group members. After all, each small group consists of individuals with intersectional identities that often coexist and interact on multiple, simultaneous levels. And our intersectional identities, with the accompanied experiences of privilege or marginalization, shape our experience of the world (Crenshaw, 1989).

As Luthra simply put it, "We don't experience inclusion through strategies and roadmaps. We experience it through our day-to-day interactions with our colleagues — over lunch, by the coffee machine, during meetings, etc. We can't move the pendulum without each one of us seeing ourselves as key enablers of inclusive workplaces — workplaces where everyone feels valued, respected, appreciated, and enjoys a sense of belonging."

At the end of our class discussion, I invited the students to join me in practicing active allyship in their daily interactions with others by: (a) exercising your (non)ordinary privilege as an ally; (b) finding points of (dis)connection in each relationship; and (c) ELF–engaging others, listening, and following up with questions or comments.

In a year of economic uncertainties, global conflicts and devastating disasters, and recovering from the COVID-19 pandemic, what are your main barriers to engaging in active allyship? What are your strengths as an ally, and where do you want to continue to grow? It is by periodically reflecting on questions like these that we can continue to cultivate active allyship both within and beyond our communities.

Eric C. Chen <echen@fordham.edu>

DEIB Committee Chair

APA Div. 49 Diversity Equity Inclusion Belonging (DEIB) Resources

References

Crenshaw, K. (1993). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. In D. K. Weisbert (Ed.), ***Feminist legal theory: Foundations*** **(pp. 383–395). Philadelphia: Temple University Press. (Original work published 1989).**

Kendall, F. E. (2003). ***How to be an ally if you are a person with privilege.*** **http://www.scn.org/friends/ally.html**

Kivlighan, D. M. III, & Chapman, N. A. (2018). Extending the multicultural orientation (MCO) framework to group psychotherapy: A clinical illustration. ***Psychotherapy, 55(1),*** **39–44. https://doi.org/10.1037/pst0000142**

Luthra, P. (2022, November 8). ***7 ways to practice active allyship.*** **Harvard Business Review. https://hbr.org/2022/11/7-ways-to-practice-active-allyship**

Division 49 professional listserv

Group psychology and psychotherapy General Membership Communication Listserv

Shana Shala Cole Ph.D.

The new listserv was developed for general members to provide a means to communicate with others in Division 49 around professional issues. Subscribers are welcome to pose questions, provide professional resources, and engage in general discussion related to group psychology and psychotherapy. All who subscribe to the listserv may post here. Members, Fellows, Associates, and Affiliates are NOT automatically added to

this listserv. You may request to join this listserv by emailing DIV49-request@LISTS.APA.ORG. Please considering joining to be a part of the group community!

Request to join is : DIV49-request@LISTS.APA.ORG, which ultimately just sends me an email request

Group Dynamics Journal - Editor Search

Group Dynamics The Society of Group Psychology and Group Psychotherapy shortly will announce an Editor search for the journal *Group Dynamics: Theory, Research, and Practice.* The journal publishes research and scholarly papers on group dynamics. The incoming editor will begin receiving manuscripts on January 1, 2024 and fully assume the role as editor on January 1, 2025. Deadline for applications will be June 30, 2023. The search committee will accept nominations and self-nominations of outstanding scholars in the group dynamics field with editorial experience. Look for the upcoming announcement of this search on the Division listserv and the journal website:

https://www.apa.org/pubs/journals/gdn/.

Most Valuable Paper of 2022 in *Group Dynamics: Theory, Research and Practice*

The editors of *Group Dynamics: Theory, Research, and Practice* are pleased to announce that Verlin Hinz and Jay Jackson's paper **The relevance of group dynamics for understanding the U.S. Capitol insurrection** is the Group Dynamics Most Valuable Paper of 2022 as voted by the editorial board. Please let your colleagues know about this achievement by sharing the link to the manuscript below. The manuscript will be available as a free download from the journal website shortly. This paper is an important scholarly contribution to understanding an historic event in the history of the United States from the perspective of group dynamics.

Hinsz, V. B., & Jackson, J. W. (2022). The relevance of group dynamics for understanding the U.S. Capitol insurrection. *Group Dynamics: Theory, Research, and Practice, 26*(3), 288–308. https://doi.org/10.1037/gdn0000191

George Tasca, Editor

2022 Division 49 November Minutes

Friday, November 11 3:00-5:00PM EST

Amy Black PhD CGP

Member	Position	Term
Joshua Gross*	Past President	January 2022 - December 2022
Amy Nitza**	President	January 2022 - December 2022
Noelle Lefforge*	President-Elect	January 2022 - December 2022
Debra O'Connell*	Treasurer	January 2021 - December 2023
Martin Kivlighan*	Secretary	January 2020 - December 2022
Aziza Belcher Platt*	Domain Representative for Education & Training	January 2022 - December 2024??
Misha Bogomaz*	Domain Representative for ECP	January 2020 - December 2022
David Marcus*	Domain Representative for Group Psychology	January 2021 - December 2023
Eric Chen*	Domain Representative for Diversity	January 2021 - December 2023
Nathaniel Wade*	Domain Representative for Group Practice	January 2021 - December 2023
Mary Baggio*	Student Representative	January 2021 - December 2022
Michele Ribeiro*	Council Representative	January 2020 - December 2022
Giorgio Tasca	Editor, *Group Dynamics*	January 2019 - December 2024
Thomas Treadwell	Editor, *The Group Psychologist*	January 2018 - December 2020??
Shala Cole	Chair, Membership Committee	January 2020, Open, serves at their pleasure
Vinny Dehili	Program Chair	August 2021 - August 2023
Leann Diederich	Chair, Foundation Committee	January 2022 - ???
Sean Woodland	APA Services, Inc. Liaison	Open, serves at their pleasure

*Voting member per division bylaws

**Voting member only in the case of a tie per division bylaws
Notes. Quorum >50% of voting members, Passing > 50% of votes.

Members Present:
Martin Kivlighan
Eric Chen
David Marcus
Amy Nitza
Noelle Lefforge
Misha Bogomaz
Vinny Dehili
Shala Cole
Debra O'Connell
David Chirko
Tom Treadwell
Carlos Del Rio
Nathaniel Wade

Members Absent:
Josh Gross
Michele Ribiero
Aziza Belcher Platt
Mary Baggio

Dr. Nitza welcomed everyone to the meeting and members introduced themselves.

President (Dr. Nitza)

- **Follow up on Initiatives**
  - Dr. Nitza followed up on the EBGT project and the recent board approval to allocate $3600 to a webmaster to develop and establish the EBGT webpage on the Division 49 website. Dr. Bogomaz clarified the role and tasks of the webmaster and what they will accomplish with these funds. Dr. Bogomaz noted that he felt the ECP representative would be able to handle the EBGT website updates moving forward. Dr. Nitza noted that the board will need to decide who and how EBGT research will be identified and updated on the website moving forward. Dr. Lefforge noted that the division historically had a research domain representative, and the board may want to consider the possibility of reestablishing this position on the board. Dr. O'Connell suggested that the board discuss the possibility to hire someone to run the website and other initiatives that need to be done on a regular basis. Dr. Lefforge noted that this should be an agenda item for the MWM.
  - The board discussed recent publicity of board members and group work throughout APA and upcoming publicity opportunities. Dr. Nitza revisited the conversation from the convention board meeting about increasing the visibility of the division throughout APA and noted the need to continue this initiative moving forward.

President Elect (Dr. Lefforge)

- **MWM Planning/Logistics**
  - Dr. Lefforge noted that she contacted all current and incoming board members about the MWM. Dr. Lefforge noted that 14 individuals have RSVP and will be in attendance of the MWM with 12 individuals attending in-person. Dr. Lefforge detailed meeting agenda and activities for the board and invited conversation.
  - **ACTION ITEM: Dr. Lefforge will continue to communicate with the board to plan for the upcoming WMW.**
- **Newsletter Issues at APA**
  - Dr. Lefforge noted recent issues with the newsletter related to APA changes to publishing format. Dr. Treadwell reviewed some of these issues for the board and recommended that we make a change to the newsletter and use a webmaster to host our newsletter on our website as opposed to going through APA. Dr. Treadwell suggested that we retain the HTML newsletter and include a link to the newsletter on the division website. The board discussed various ways to fund this work, such as hiring a GA for the current president or paying the EBGT webmaster to create the newsletter template for the division website.
  - **ACTION ITEM: Dr. Treadwell agreed to discuss these possibilities with the EBGT webmaster and to follow up with the board at MWM.**
- **CE credits for existing DIV49 YouTube presentations**
  - Dr. Lefforge discussed the possibility of issuing CE certificates for existing content on the division YouTube channel and walked through the process of executing this project. Dr. Lefforge noted that

we would need to get presenter's permission to use their presentation for issuing CE credits. Dr. Kivlighan and Bogomaz offered support for this idea.

- **DSJ sponsored collaborative symposium**
  - Dr. Lefforge brought the DSJ collaborative symposium proposal to the board and opened this proposal to the board. Drs. Dehili and O'Connell noted that this would take away an hour from our division for programming, but it might not impact programming to much. Dr. Chen expressed interest in this opportunity to increase Division 49 visibility and initiatives around DEIB. Dr. Nitza and Dr. Bogomaz also supported this possibility. Dr. Lefforge motioned to contribute a program hour to support DSJ sponsored collaborative symposium, Dr. Bogomaz seconded the motion, and the motion passed unanimously with 6 yes votes.
  - **ACTION ITEM: Dr. Lefforge will reply to the request and indicate our interest as well as work with Dr. Chen to identify a division representative to work on this collaborative program.**

Membership (Dr. Cole)

- **Update on The Institute**
  - Dr. Cole updated the board about The Institute and noted that some additional members have joined. She also plans to further advertise the program in other APA publications.
- **List serv reminders**
  - Dr. Cole reminded the board that the list serve can only be used to promote and announce APA related events and news. She also encouraged board members to use the list serv to announce their group related work and accomplishments.

Additional time for continued discussion of items (Dr. Nitza)

DEIB Committee Updates (Dr. Chen)

- Dr. Chen reported that the new Group Dynamics Editorial Fellow is interested in joining the DEIB committee and he is currently working to get her connected with the committee.

Treasurer Update (Dr. O'Connell)

- Dr. O'Connell updated the board about the division investment account and indicated that she has been meeting regularly with the account manager. She also reminded the board that we may want to consider moving the APF funds to this investment vendor as well.

Fellows Committee Chair (Dr. Nitza)

- Dr. Nitza noted that Craig Parks is needing to step down as the Fellows Committee Chair and the board will need to identify a new chair and quickly in order to get the fellowship call out this year. Dr. Marcus agreed to serve as the chair for the Fellows Committee and will connect with Dr. Parks to learn about this role and the responsibilities.

Budget-Good Shape

Debra O'Connell, PhD.

I am happy to report that our division continues to be in a solid financial position. The final 2022 spending may change a small amount due to some transactions that are still being processed; however, most of our 2022 spending has been accounted for as of the December 2022 financial report from APA, and we did not exceed our proposed spending. Further, we ended 2022 with a

balance of approximately $141,000 in the bank. As reported during the Fall 2022 treasurer report, the board decided to invest $100,000 to a moderately aggressive investment portfolio and at year end, our portfolio increased in value by a little over $3,000. Given the volatility in the stock market for 2022 this is actually a great outcome.

Our budget for 2023 was approved by the Board at the recent midwinter meeting. We are continuing to invest in several projects with relevance to our division membership, including continuing to grow our CE training offerings, continuing to fund various sub-projects related to Division 49's Institute program, and updating our newsletter and website. As you will note, much of the rest of the annual budget goes to support basic operations of the division and increased costs reflect the return to in-person meetings and adjusting for changes due to inflation.

If you have any questions about this report or anything related to our division finances, feel free to contact me at any time.

Debra O'Connell, Ph.D.
Pronouns: She/They
d.oconnell2@gmail.com

2023Proposed Budget for Presentation at the Mid-Winter Meeting

SUMMARY	2022 Budget	2022 Actual Through Dec. 31	2023 Budget
Total income	$ 41,880.00	$ 200,135.96	$ 183,551.94
Total expenses	$ 49,850.00	$ 27,830.77	$ 63,890.00
Income less expenses:	$ 141,495.00	$ 172,305.19	$ 119,661.94
INCOME DETAILS	**2022 Budget**	**2022 Actual Through Dec. 31**	**2023 Budget**
Journal Royalties	$ 40,000.00	$ 55,758.61	40,000.(
Dues	$ 1,700.00	$ 1,818.00	1,700.(
Interest	$ 180.00	$ 57.60	50.(
Contributions	$ -	$ -	
CE Royalties	$ -	$ -	

	Checking Account Balance		$ 141,801.94	141,801.9
	Merrill Lynch MM account		$ 699.81	
	Income:	***$ 41,880.00***	***$ 200,135.96***	***183,551.9***
	EXPENSE DETAILS	**2022 Budget**	**2022 Actual Through Dec. 31**	**2023 Budget**
100	**Midwinter Meeting**	$ 500.00	$ 500.00	$ 13,000.00
200	**Publications**			
	Newsletter Editor Stipend	$ 2,000.00	$ 2,000.00	$ 2,000.00
	Newsletter Publishing/Website Build	$ -	$ -	$ 1,400.00
	Newsletter Website Maintenance			$ 600.00
	Associate Editor Stipends	$ 2,000.00	$ 2,000.00	$ 4,000.00
	Journal Fellowship Stipend			$ 500.00
	One time honorarium for George			$ 2,050.00
300	**Awards & Grants**		$ 503.58	
	Donation to APF	$ 1,000.00	$ -	$ 1,000.00
	One time donation to APF			$ 5,000.00
	Student Posters	$ 600.00	$ -	$ 600.00
	Student Diversity Posters	$ 600.00		$ 600.00
	Student Diversity Award	$ 500.00	$ 500.00	$ 500.00
	Student Travel Awards	$ 4,000.00	$ 1,000.00	$ 4,000.00
	Journal MVP Award	$ 500.00	$ 500.00	$ 500.00
	Awards & Plaques	$ 1,000.00	$ 910.66	$ 1,000.00
400	**Convention**			
	Suite and Executive Meeting	$ 3,000.00	$ 3,307.86	$ 4,000.00
	Social	$ 2,500.00	$ 2,011.75	$ 7,500.00
	Promotional	$ 1,000.00	$ -	$ 1,000.00
	Conference Coordinator	$ -	$ -	$ -
500	**Committees**			
	ECP	$ -	$ 310.00	$ 500.00
	Membership	$ 500.00	$ -	$ 500.00
	Student Committee	$ -	$ -	$ 500.00
	Specialty Task Force	$ 2,500.00	$ -	$ 2,500.00
	Diversity….	$ 2,000.00	$ -	$ 2,000.00
600	**Liasions/External Committees**			

	COS Dues	$ 550.00	$ 350.00	$ 550.00
	COS Attendance	$ -	$ 980.92	$ -
	CAPP/FAC Attendance	$ -	$ -	$ -
700	**Social Media**	$ -	$ -	$ -
800	**Marketing**	$ 100.00	$ -	$ 100.00
900	**APA Administrative Services**	$ 3,000.00	$ 1,755.00	$ 2,740.00
	APA Member Services			
	CESA App Fees			$ 260.00
	Miscellaneous/Other		$ 35.00	
1000	**Miscellaneous**	$ -	$ 185.18	$ 190.00
	Special Projects	$ 10,000.00		
	Webmaster Fee		$ 1,800.00	$ 1,800.00
	Video Camera		$ 1,049.22	
	Institute funding for mentee and mentor funding	$ 12,000.00	$ 806.60	
	CE presenter honorarium			$ 3,000.00
	Our Contribution to Group Council		$ 7,325.00	
	Expenses:	***$ 49,850.00***	***$ 27,830.77***	***$ 63,890.00***

Professional Group Articles

Brief Article 1 - Professional

The Use of Art in Group Psychotherapy **By David Chirko, A.B., psychological researcher/author and artist (chirkoart.ca) Sudbury, Ontario, Canada**

…art is fantasy, created with a brush roaming in a psychic play world… – David Chirko (1989, December)

Author's Note

In an interview, I explained that, with the gestalt1 approach to art, what enters consciousness is the narration of fantasies, executed with paint and canvas (Dunn, 1985, MCTV). Gestalt is defined as the whole being greater than the sum of its parts, forming a *pragnanz*—where the mental structures and forms are complete, simple, and meaningful (Chaplin, 1975). When balance is achieved I have triumphed, conflict free, at least in the aesthetic sense. This is how I can express my *raison d'etre* through what I think and feel.

Regarding psychoanalysis2 via art, I described how words, through their use in free association, operate (Chirko, 1995). For example, how displacement, identification, narcissism, sublimation, and wish fulfillment are involved in the artistic process. I maintained that art can be therapeutic, but it won't, in and of itself, resolve personal conflict.

My first encounters with applying art to groups was in a series of workshops I conducted with grades 10 to 12 high school art classes (2013), and a children's art segment at a playground association holiday party (2019). However, I was always intrigued with how art could be involved in the therapeutic process, with youth and adults, alike.

Preliminary Influences

Sigmund Freud believed the artistic process was the imagination, filling in nebulous, early memories. In fact, psychiatrists Leland E. Hinsie and Robert J. Campbell (1976), state that art is analyzed similar to the way fantasies and dreams are. They explain that Freud, in his *Collected Papers* Vol. 4 (1924-25), declared that an artist is someone who flees from reality because he cannot accept its rejection of instinctual fulfillment. He therefore seeks complete, unfettered, erotic pleasure in artistic fantasy. The authors also say that Carl Jung, in his *Contributions to Analytical Psychology* (1928), believed current artistic imagery employed by the artist could be traced back to a primordial image in the collective unconscious. Otherwise, the artist would be locked out of the profoundest essences of life. Freud and Jung indicated that art was representative of themes, factors, and motives of the psyche.

Where and How Art Therapy Began

Teacher and artist Elinor Ulman (1980) says "Art Therapy," the term, was inaugurated in 1942 by British pedagogue and artist Adrian Hill. He commenced work in therapy with fellow tuberculosis patients in a sanatorium. In the United States, it was psychologist Margaret Naumburg who expanded the field in the early 1940s, under the helm of psychoanalyst and psychiatrist Nolan D.C. Lewis, at the New York State Psychiatric Institute. Psychoanalytic child art therapist Edith Kramer, and psychiatrist and psychoanalyst Paul Schilder, contributed to theory and the latter's wife, neuropsychiatrist Lauretta Bender, to therapeutics. Ulman explains that art therapy paralleled and partially accompanied the upshoot of psychoanalysis employed in psychiatry, and now complements psychotherapy in general.

In art therapy, being proficient technically is not emphasized, and there is no need for completion of the total picture because the artist's effects are rapidly produced. The spontaneous result of which unconscious material will, optimistically, eschew censorship, whether or not there is interpretation of this directly. However, habits, through attitudes and behavior, are broached. What the artist verbally formalizes and associates is valuable to therapeutic interpretation. The therapist therein, if plausible, encouraging a transference between them and the creator of the art.

Self awareness and the latent and manifest characteristics in the art are discussed, enabling the patient to tolerate the less palatable facets of their personality. Art therapist Natalie Wallace, alluding to the work of Shechtman & Perl-Dekel (2000), states that art therapy "assists with accessing the unconscious" (2014, p. 1).

Group Art Therapy

Psychologist and art therapy professor Shaun A. McNiff (1980), explains that it was as an alternative to communicating verbally in group therapy sessions how "group art therapy" began. This was because revealing feelings for some patients was not feasible and/or they were too arduous to be expressed in words.

Usually, when the group session is underway, the creation of art is enacted by patients and presented to other group members to speak about then at, as well as after, the session. This can last from one to three hours. It can also be undertaken exterior to group and presented later for discussion. The group can be small, intimate and private, or function in a capacious, open atelier setting.

McNiff (1980) further says that developing the pure artistic ability of a client can have a positive influence on their entire personality, so art for its own sake is encouraged. The precluding of distractions emboldens the group therapy flow, with its ensuing healing effect. Variations in the members' work and its experiential dimensions are talked about. Purpose, esteem, trust, sharing, and interpersonal learning amongst the group is ratified in the inchoative stages. Later, motives, visual perceptions, and projection of specific emotions, like fears in presenting their feelings and conflicts that have been repressed, are delved and analyzed.

Current Status and Developments

Clinical psychologist and art therapist Alexia C. Electris presents her 2016 review of a book by art therapist and artist Bruce L. Moon, entitled *Art-Based Group Therapy Theory and Practice*. She states that Moon advocates art therapy group leaders be more intuitive and less formulaic, exhibit an aura of self-confidence and personal power, and become artistic role models, unfazed by creative and personal risks.

Patients in Moon's groups demonstrated how they experienced what was transpiring. For example, with green and blue chalk on mural paper, one woman drew a puffer fish with spines and other members opined about its "cuteness." She retorted, "Well, I may be cute, but you better watch out for those spines. They will hurt you if you get too close" (p. 105). Moon commented on how "puffed up" the fish appeared. The member confessed that this was her response to peril, as she found the class threatening because the proverbial ocean felt inauthentic. She admonished that those in group be vulnerable and realistic toward each other.

Electris extols Moon for his cognizance of resistance being the difficulties in connecting and engaging. Members thus travel deeper in how they give expression to their artwork, bereft of words. He believes group art therapy is more process oriented than traditional group therapy, creatively exacting change. Creation is key here, as members must immerse themselves in this process. They then feel less isolated, thus ratifying a relationship with others via their art being viewed, bereft of anything spoken.

In Moon's epilogue Electris avers that he maintains art therapy is unique, influential, and not a pseudo-science, if you will. This approach should be esteemed by colleagues in other professions, who might not comprehend its validity and be biased in favor of talking cures. Moreover, psychotherapy isn't merely about symptom alleviation, but also about those battling with the spoken aspect, who can now acquire insight, understanding themselves and socializing more effectively with others.

Finally, Electris proclaims that Moon fosters individual development in novice art therapists, as they become accustomed to using their experience and intuition in examining their own art, in lieu of any formulaic involvement.

Criticism

There are disadvantages of group art therapy, that Marian Liebmann, an art therapist working in restorative justice, adumbrates (2004). They are: the compromising of confidentiality, the exorbitant number of members involved, the fact that groups can be arduous to organize effectively, the issue of less focus being placed on an individual, the matter of a group being stigmatized, the possibility members can purposely obscure conflicts, and, that some members could be frightened by others' expertise. Pertaining to the last point, envy is part of the human condition, but whenever I was at, for instance, public group exhibits and workshops, all we artists were, on the whole, supportive of each other.

The Supporters

Wallace3 (2014, pp. 50-53) refers to studies by numerous researchers, attesting to the helpfulness and, in many instances, superiority of group art therapy. Below, are just a few of them.

Korlin, Nyback, and Goldberg (2000), in their study contend that arts groups, after four weeks of scrutiny, are advantageous when other modalities failed. Emotions, memories and experiences that cannot be readily verbalized can be located, formalized and integrated. The mood scale signified that the patients' mood was ameliorated, as well as their emotional and cognitive processes. The hospital thereby augmented the employment of arts therapy in other departments.

Shechtman and Perl-Dekel (2000), who undertook a study that was quantitative, ascertained the differences between a verbal therapy group, which was relegated to attending to the present and personal issues; and an art therapy group, which fostered self-comprehension and interacting via expressing creativity. What they saw was that the arts group exhibited a more communicative and cohesive camaraderie.

Karterud and Pedersen (2004), examined a group of 319 patients who had personality disorders, in a short-term, intensive day treatment hospital program, during a six year period. Reviewed were ten different modalities, with sessions lasting ten hours per week: art therapy group, body awareness group therapy, cognitive-behavioral group for anxiety disorders, cognitive group therapy, "day closing" group, group for eating disorder, larger group psychotherapy, medication group, problem solving group, and psychodynamic group psychotherapy. The patients noted the exploration and application of mental visual symbols. They rated the art therapy group as the most efficacious. As per the researchers' suggestion, the art therapy group should become germane to the treatment regimen.

Conclusion

Psychologists, many of whom are also *practicing artists* or have worked with such, have contributed much to the development and application of the modality called group art therapy, be it gestalt, psychoanalytic, or whatever. They have employed it on themselves, too. As an artist, I can identify with this. Of ultimate significance is that a group therapy patient's emotions, anxieties, conflicts and visual perceptions need not always be totally verbalized to enhance their own insight, and perception of themselves by other members. This all enhances social or group contagion, whereby a member's affects, attitudes and behaviors are spread throughout the group interpersonally. Subsequently, this promotes a more harmonious and universal understanding of whatever issues they are working on. The efficacy of art in therapy has been empirically demonstrated for generations in group art therapy, which is arguably more process oriented and often just as effective as pure talk psychotherapy, which it can complement.

Notes

1, 2 The gestalt and psychoanalytic references are that which comprise my Artist's Statement (2011), where I affirmed that art that is "…meaningful in…everyday consciousness…I call 'Creative Communication.' There, psychology--Gestalt meeting…psychoanalytic, wherein symmetrical technique makes meaning of unconscious impulses--fuses with the aesthetic; attracting the viewer with…harmonious use of color, texture, shape and movement."

3 Wallace (2014) asserts "…the literature shows that…art therapists…have not assembled any…document that reports the complete history of group art therapy with psychiatric patients" (pp. 1-2). Further, that she would be doing such in the thesis for her Master of Art in Art Therapy.

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Brief Article 2 - Professional

Breast cancer patients and their perceptions of and recommendations for group work

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Joyce T. Williams, Keepers of the Flame CEO

Author Note

Joyce Williams is a breast cancer survivor whose passion is helping others who are going through what she experienced.

She is the founder of the *Keepers of the Flame:*

Joyce partnered with Elisabeth Counselman Carpenter, LCSW author of

Working with Grief & Traumatic Loss: Theory, Practice, Personal Reflection, and Self-Care

Abstract

Objective: This mixed methods study, which took place during the COVID-19 pandemic, explored the lived emotional experience and therapy preferences of women diagnosed with breast cancer.

Methods: As part of a mixed methods study of 69 women who have or currently live with breast cancer, twenty-seven participants opted into a Phase II semi-structured interview to further discuss their experiences of emotional coping during the treatment process, beliefs about therapy and groupwork during treatment and the impact of COVID-19 on their emotional experience during cancer treatment. Thematic narrative analysis was used to analyze their interviews and to identify common themes related to groupwork among participants.

Results: Participants shared about their experiences with how various modalities of groupwork positively impacted their experience while coping with breast cancer and shared recommendations for groupwork offerings and group content for breast cancer patients.

Conclusions: Group work with women undergoing breast cancer treatment can provide a multitude of resources and benefits, including improved emotional support, decreased isolation, dissemination of important medical information, and the teaching of coping strategies. Ensuring that there are multiple sources for group support including psychoeducation, mutual aid and clinical groups, flexible scheduling and diverse content offerings will continue to improve the overall holistic care and support provided to those in breast cancer treatment.

Keywords: breast cancer, groupwork, COVID-19, pandemic emotional support, psycho-oncology support

Introduction

Being diagnosed with and fighting breast cancer is a time of great emotional vulnerability. Those fighting breast cancer have been found to have increased rates of depression and anxiety, and that both those in treatment for breast cancer and their family members experience negative psychological challenges (Carlson, Waller, & Mitchell, 2012; Celik, Tuna, Samancioglu, & Korkmaz, 2016; Mitchell et al., 2011, Spiegel & Riva, 2014). In the year following the diagnosis of breast cancer, women report nearly twice the rate of depression, anxiety, or both as compared to the general population (NICE, 2009). However, research on psychosocial emotional support and referrals to individual and group therapy for breast cancer patients remains limited, particularly for women in non-Western countries (Celik et al., 2016; Hung et al., 2022).

Group therapy has been found to reduce isolation, improve social communication, allow for the exchange of information and resources, and help those in treatment learn how to cope with the physical and emotional side effects of the treatment process (Nakamura & Kawase, 2021; Yalom & Vinogradov, 1989). While Burlingame and Jensen (2017) have found that group therapy for breast cancer patients has a moderate impact, they also stated that it can improve a variety of outcomes. Forms of group therapy effective with breast cancer patients that have been found to be effective include group-based Acceptance and Commitment Therapy (ACT) for patients currently receiving chemotherapy (Han et al., 2019) and group psychoeducation (GPE) (Onyedibe & Ifegwazi, 2021). At a time when there is a shortage of services and clinicians, group therapy has been found to benefit behavioral health providers by saving both labor and time (Han et al., 2019).

However, there can be multiple challenges specific to developing and running groups with breast cancer patients: the significant demands on time for breast cancer patients as they juggle multiple medical appointments, cope with devastating side effects from treatment and fulfill multiple roles as caregivers and employees. Many patients have trouble committing to regular group time due to competing treatment demands. This has become particularly complicated during the pandemic for group members that may be concerned about health, well-being, and being in-person with others during a time while they are immunocompromised and who experience increased barriers to accessing groups due to lockdown and other pandemic limitations.

This mixed methods study, which took place during the COVID-19 pandemic, explored the lived emotional experience and therapy preferences of women diagnosed with breast cancer. Most participants had participated in some form of groupwork prior to the pandemic, which included in-person clinical therapy groups, in-person psychoeducation groups and peer-based support groups, both in-person and digitally based, typically held through social media platforms. Nearly all participants reported losing access to in-person groups due to the lockdown and ongoing pandemic.

Methods

Sampling

This study used three sampling methods: availability, snowball, and purposive. Through availability and snowball sampling, participants were recruited in the following ways: in person at a hospital-based breast cancer treatment center through posted flyers and posts on approved social media pages related to breast cancer support throughout the country, which included three breast cancer support groups, three cancer foundations, and one digital support group. Participants indicated they received treatment at diverse f hospitals , including ‘state-of-the-art’ hospitals, teaching and research hospitals, community-based hospitals, and rural hospitals. Respondents who shared their geographic location indicated both national and international residence including Georgia, California, New York, Connecticut, Massachusetts, Tennessee, the Midwest, and the country of Jordan. Purposive sampling was used to include women who had undergone or

were undergoing breast cancer treatment and to exclude women who had been identified as having the BRCA gene, and had undergone prophylactic preventative surgery but had not experienced treatment protocols such as radiation, chemotherapy, and medication maintenance. Participants had had to be at least 21 years old to be included in the study. Sixty-nine women participated in the study.

Participants

Table 1 displays the descriptive characteristics of the participants. About 90 % of the participants (n=61) were between 30 and 59 years old at the time of the interview. Nearly 9 out of 10 participants (n=61) were White or Caucasian and about 80% of the participants (n=54) were married or lived with partners. Over half of the participants (n=35) earned more than $90,000 per year at the time of treatment. About 1 out of 3 participants (n=26) had attended therapy prior to breast cancer diagnosis and approximately 30% of the participants (n=20) were in psychotherapy treatment at the time of the interview.

Insert *Table 1. Demographic information.*

Data Collection and Instruments

In the quantitative phase, a questionnaire gathered demographic information, participants' history with therapy, and beliefs about physician-driven referrals to psychotherapy treatment, including referrals to multiple types of groups. All participants were informed of anonymity procedures, data protection, and the scope of the study. Participants were provided with a written copy of informed consent. This study was approved by [blinded for peer review] University Institutional Review Board [reference number #461]. All data were encoded in a password-protected electronic database .

Mixed Methods and Qualitative Analysis

All 69 breast cancer patients who participated in the survey were offered the opportunity to participate in a semi-structured interview. Twenty-seven of the participants opted to be interviewed. Each interview was transcribed verbatim by hand, and participants were invited to review their transcripts prior to coding. All transcription was completed by the researchers to allow for complete immersion in the data and for the opportunity to engage in memoing while coding (Padgett, 2008). Thematic narrative analysis (TNA), a strategy of narrative inquiry, provided the analytic framework for this phase. In TNA, the emphasis is "on the 'told' - the events and cognitions to which language refers during which "a biographical account emerges from the 'self of the narrator rather than in conversation between a teller and particular listener" (Reissman, 2008, p. 58). A cross-case analysis was utilized to look for common themes. To maintain auditability, notes were carefully documented in a clear and logical manner so that others could follow the analytic steps throughout the study's process.

Findings

Sixty-nine breast cancer patients participated in Phase One which was a survey asking about their treatments, coping strategies, emotions, opinions on psychotherapy, and views on physician-driven referrals to therapy. Each participant was invited to take part in a semi-structured interview (Phase Two), and 27 participants opted-in for that portion of the study. Phase Two participants elaborated on the emotions experienced during treatment, the need for mental health support services particularly related to all forms of group work including clinical group therapy, mutual aid support groups and psychoeducation groups, challenges finding emotional support and made suggestions for multiple modalities group support, including in-person and digital opportunities. Overall, when asked the question "what was the best kind of support given",' 74% (n=20) referenced some type of group work in their answer.

Need for Group Support

Though 100 %(n=27) of our Phase Two participants said that patients should be referred to therapy, the majority indicated further challenges that arose with their ability to gain access to all forms of therapeutic support, including issues with group availability and lack of ability to attend in-person groups during the pandemic. Forty-one % (n=11) expressed concerns arising from the pandemic and 11 % reported general therapist availability and scheduling were a barrier, especially post-lockdown . An additional 11 % of our Phase Two participants indicated that cost was a barrier for therapy; and the majority of participants divulged that they, as the patient, were their own barrier, with 74 % (n=20) saying that they were on 'overload' and 85 % (n=23) expressing their inability to pick up the phone and make arrangements on their own due to feeling overwhelmed. Compounding isolation, feeling like 'the only one' going through emotions, and loss of friends during the breast cancer treatment process were identified by one third of participants, suggesting the need for group-based support.

Suggested Types of Groups

With the growing demand for mental health providers and psychotherapeutic interventions coupled with availability and accessibility challenges, flexibility by providing multiple modalities to group opportunities was discussed by our participants as ways to mitigate these issues. Participants were very clear in naming the types of groups that they felt would be supportive during the breast cancer treatment process.

For in-person support groups, participants suggested the following: non-clinical peer-led support groups, groups that included peer-matching for outside-of-group support, and clinical group therapy. Participants also mentioned the benefit of attending psychoeducational group classes both in person and virtually. Other recommendations for virtual or digitally based groups included the option for dedicated virtual 'hangouts', such as those found in non-clinical social media settings as well as scheduled Zoom and/or GoogleMeets. Other virtually-based recommendations included the option of attending live webinars and pre-recorded digital curriculums to attend asynchronously.

Suggested Group Content

Clinical group therapy can provide patients with coping strategies, processing opportunities, and multiple opportunities for interpersonal connection and healing. A number of participants shared that they benefited from learning coping strategies from their psychoeducational clinically based support groups while others commented on how general breast cancer educational information delivered in a group format helped them feel more empowered, in control and learned information that was helpful in navigating the treatment process.

Identified Challenges and Barriers to Attending Groups

Participants also shared numerous challenges and barriers to attending groups including scheduling challenges, fear of exposure to COVID-19, and exposure to secondary and vicarious trauma.

Scheduling.

Overwhelmingly, participants talked about the challenges of attending groups run at set days and times. Clinical group therapy, support groups, webinars, and Zoom/Google Meet groups all have scheduling restrictions and availability concerns, often resulting in patient non-committal tendencies or behaviors of signing up and not attending. Seventy-four % of all Phase Two participants indicated that due to their lack of

time and feelings of being 'overwhelmed' as contributing to a non-committal feeling related to attending group sessions. However, 25 of the 26 participants felt they would have been more accountable for attending all forms of group work if they had had support and assistance in making appointments for group-oriented services.

Participants shared other techniques that would help them improve group attendance, including physician/nurse navigator follow-up as a form of accountability and off-hours groups offered in the middle of the night. Others shared that asynchronous groups and curriculums would be more helpful due to time restrictions. One participant shared "…here I am, almost 2 years into it, and I'm having all of this stuff…I actually started watching [YouTube] Resilience videos...And that has been super helpful because this childcare thing is really, really hard. So, having that online option, that's been valuable to me right now. And, that's something I can access right now."

Fears related to the emotional aspects of group work.

Participants shared that one barrier to group work is the 'Debbie Downer' fear (fear that a group will pull one's mental health down while trying to process other patients' traumas in addition to their own) was noted as a concern in both non-clinical peer-led support groups and social media groups. Participants noted the anxiety and fear that accompanied hearing other patients' traumas. One shared, "At one of the meetings, one of the women was like, "I had it and now it's come back," and that's scary. That's frightening." Another participant added, "Every time I hear a woman who's had it and she gets re-diagnosed … it terrifies me." Another participant noted that in her network of social media survivors, people "...weren't fully accepting and understanding of other people's decisions. And it wasn't just me…I just didn't feel accepted and safe because I saw the way that other survivors were being reacted to".

COVID-19 and Fear of Exposure.

In-person groups and particularly in-person group therapy was reported to trigger the fear of exposure to COVID-19 and other illnesses as breast cancer patients are considered to be immunocompromised. Overall, COVID-19 had a significant impact on this study's participants as 33 % of Phase Two participants (n=9) referenced limited access to emotional support due to the pandemic. Digital group platforms and non-clinical in-person groups can provide more protection against fear of exposure and one-third of participants (n=9) held beliefs of benefit to virtual groups directly as a result of the pandemic.

Suggestions for group content.

Participants shared multiple themes related to group content that could be helpful in coping with the experience of living with breast cancer including normalizing intense emotions, a place to process fear and anxiety, learning to live with PTSD, and processing grief. Seventy-eight percent of Phase Two participants reported a high desire to normalize intense emotions experienced through the treatment process. Eighty-four percent of Phase One and all Phase Two participants reported experiencing intense fear, 46 % of Phase One participants and 85% of Phase Two participants reported depression, and anxiety was expressed by 80 % of Phase One and 96 % of Phase Two participants. PTSD was also noted by 48%of Phase One and 44 % of Phase Two participants.

Grief and loss were another heavily reported theme, experienced by 68 % (n=47) of Phase One participants and 85 % (n=23) of Phase Two participants. Group content should include the understanding of grief and how it accompanies loss as well as ways to address and work towards acceptance of those losses. Discussing the loss of control, loss of health, loss of sense of self and loss of safety is also a significant aspect to

this grief work. Nearly half (n=31) of Phase One participants and 70 % (n=19) of Phase Two participants shared that they felt the loss of control; and 89 % (n=24) of Phase Two participants said they had lost their sense of safety in the world. One shared, "once you get diagnosed, I don't know if you can go back to just breathing normally. You're constantly on edge, constantly afraid, and constantly…like…the world's not even. It's like you're constantly walking this tightrope". Another participant shared:

> I used to think…I used to picture myself 70, my mother's age, no problem…and now I can't. Not without a caveat like, "well, I hope I make it." And that's just a horrible way to view my future...I think about my mortality all the time…I took it for granted. I thought I was going to be a grandma, and now I'm like…I hope….".

Other concrete topics suggested for group content, outside of individual emotional experiences, included how to handle insensitive people, which was reported as an issue by nearly 40 % of Phase Two participants. These comments included "well, you'll get a free boob job" or "my friend had cancer….she died from it and feeling pressured to be the 'perfect' breast cancer patient. How to improve interpersonal communication skills, such as discussing treatments with medical professionals and how to discuss emotions with friends and family were also suggested as topics for discussion. Two participants were also clear in stating that religious and faith/prayer-based groups should be kept separate from referrals to group therapy or psychoeducation groups.

Implications

The majority of participants in this study reported the importance of group work in their lived experience during breast cancer treatment. This study is unique in highlighting the perspectives of breast cancer patients in their own words and share their experiences related to different types of group work, content of group work and how they are offered. These findings suggest that while breast cancer patients self-identify as benefiting from groups, but also need nuanced attention to group scheduling, types of groups offered and tailored content. Particular attention should be paid to the potential for vicarious trauma and secondary stress that can come from participating in an oncology support group, and group facilitators should be mindful of the bias that comes with presenting as the 'perfect' breast cancer warrior. For psychoeducation groups, content should focus on interpersonal and communication skills, for therapy groups, processing of emotions, and groups specific to grief and loss are recommended.

Limitations

There are multiple limitations to this study which includes a small sample size, and a respondent pool that was primarily white, affluent, and younger than the general population of breast cancer patients. As the researchers were mindful of both the pandemic and the time limits of patients currently in cancer treatment, we chose not to be restrictive of criteria for those who opted into the interview phase. This study was exploratory in nature and thus, the findings may not be generalizable to patients who received breast cancer treatment during COVID-19.

Conclusion

Group work with women undergoing breast cancer treatment can provide a multitude of resources and benefits, including improved emotional support, decreased isolation, dissemination of important medical information, and the teaching of coping strategies. Future research comparing the impact and support of in-person groups versus digitally or virtually based groups is warranted, particularly as the COVID-19 pandemic, and a triple-demic of RSV, influenza, and COVID continues to threaten those who are immunocompromised. Ensuring that there are multiple sources for group support including psychoeducation, mutual aid and clinical groups, flexible scheduling and diverse content offerings will continue to improve the overall holistic care and support provided to those in breast cancer treatment. Finally, the voices of those fighting breast cancer need

to continue to be heard in order to provide inclusive and affirmative services in order to both survive and thrive.

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Brief Article 3 - Professional

Cultural Humility as a Universal Group Norm

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One of the most important initial tasks in group therapy is the creation of group norms, which serves multiple functions. First, the norming process is a part of informed consent, laying out the expectations and rules necessary to participate in group. The norming process is the first step toward creating the group ulture, by identifying and clarifying the values to which all members and facilitators aspire. Finally, the development of norms is ideally collaborative between group facilitators and members, empowering members to take ownership of the group space and experience. While some group norms are open to collaboration, others are universal and non-negotiable, based on ethical guidelines – confidentiality for instance. Cultural humility should also be a universal group norm guiding both facilitators' and members' group interactions.

Owen et al. (2011) describes cultural humility as a "way of being" with clients, in contrast to "doing" multicultural work in therapy with clients (i.e. multicultural competence). Cultural humility consists of intrapersonal (ongoing, in-depth self-reflection and self-critique) and interpersonal components (being other-person focused), both of which are relevant to group therapy (Davis, et al., 2018; Mosher et al., 2017). Much of the literature on cultural humility has focused on the individual therapy setting and, specifically, on the client's judgment of the therapist's level of cultural humility (high or low). Cultural humility is an extension of humility, which is "…an accurate view of self, the ability to restrain self-focused emotions and behaviors in socially acceptable ways, and the ability to cultivate other-oriented emotions and behaviors" (Davis et al., 2013, p. 60). Humility is associated with building relationships, increasing trust and safety while in the relationship, and forgiveness when conflict arises, all of which are crucial group therapy experiences and goals. Thus, orienting oneself toward humility seems to be important to form and maintain strong relationships; and given we are all complex, cultural beings, humility and cultural awareness naturally go hand-in-hand.

A useful framework exists describing various ways cultural humility can show up in therapy. While developed with individual therapist-client relationships in mind, this framework can be adapted to better understand how cultural humility may present in group therapy spaces. One aspect of this cultural humility framework is self-examination and self-awareness (Mosher et al., 2017). Group members and facilitators oriented toward cultural humility will be tuned in to the ways their own cultural identities are intersecting with the cultural identities of the other members, beyond simply recognizing differences and similarities. This may look like self-reflection on how they show up in relationships with people who are similar and different to them, a pattern that will potentially emerge in the here-and-now space of group therapy (e.g. cultural differences/similarities in communication or emotional expression). In addition, cultural humility requires both an awareness of one's own limitations in knowledge, as well as an acknowledgement of another person's expertise in their lived experiences. This requires active listening skills, curiosity, openness, and a desire to more deeply understanding someone else – all important to build group cohesiveness and intimacy amongst members. Based on this, it is clear how cultural humility can enhance relationship building, though all of the research supporting this has focused on the therapeutic alliance (Mosher et al., 2017). Extrapolating to group therapy relationships, expressions of cultural humility can facilitate a sense of connection and trust amongst group members. This could manifest as a group member expressing their desire and intentions to more deeply understand other group members. These intentions can be enacted by communicating awareness of what one

knows and does not know, and, further, expressing curiosity to know or learn more about someone's cultural experiences. These behaviors are also useful when navigating differences in values or beliefs amongst members, something that can also be an important source of interpersonal learning. Another aspect of cultural humility is a willingness to repair relationship ruptures (caused by cultural mistakes) and to navigate differences in values. If a rupture occurs, a culturally humble group member would remain open to feedback from the injured group member, to better understand what happened. This might look like validating the other person's pain, expressing remorse or apologizing for the pain caused, communicating one's own limits in knowledge, and expressing appreciation for the opportunity to learn and repair the rupture (Mosher et al., 2017).

In addition to its relevance to group dynamics, cultural humility is also relevant when considering group therapy ethics. Brabender and MacNair-Semands (2022) describe a number of group therapy ethical paradigms that group facilitators can adopt to guide their behavior. Both components of humility are featured in all of these paradigms: adopting another-orientation (*prioritizing group members' well-being, their rights, equitable treatment) and an accurate view of self (competence and knowledge of one's limitations, awareness of power dynamics*). Culturally-relevant group therapy ethics should be universal for all group therapy experiences, regardless of the type of group or the population being served. Whether or not a group therapy space is intended to serve marginalized communities or not, these spaces will inevitably be rich with cultural diversity. Because of this reality, adopting cultural humility as a group norm and value can serve as an important guide for ethical behavior on the part of group facilitators.

Cultural humility, as an orientation in therapy relationships, has not only been found to enhance the alliance building process, but positively impact therapy outcomes as well (Mosher et al., 2017; Owen et al., 2011). As I have dug into the literature on cultural humility, and humility more generally, it has become clear to me that the benefits transcend the individual therapist-client relationship. Cultural humility, as a group norm, increases the chances of group members obtaining what they are hoping for out of a group therapy experience, such as community, connection, and interpersonal learning opportunities. Additionally, an intentional attunement to cultural humility lays the foundation for group facilitators to engage with group members in ethical and principled ways.

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Student Research Review & Articles

Research Review I

Women's Action for Resilience and Empowerment (AWARE)

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As Noted by Lipson et al. (2018) the unfortunate reality that Asian Americans, especially college-attending Asian American females, are prone to mental health problems, such as depression, anxiety, and PTSD symptoms based on multicultural stress and systemic oppression. Furthermore, due to the fact that culturally-based psychotherapy interventions geared for Asian American women are limited, many Asian American females do not seek mental health services, in general. Recently, Hahm et al. (2017) developed a group psychotherapy intervention program called Asian Women's Action for Resilience and Empowerment (AWARE) to speak to the mental health needs of Asian American women. AWARE was created to specifically target depression, anxiety, and Post Traumatic Stress Disorder (PTSD) symptoms faced by Asian American women. Essentially, the Asian American women in this particular group psychotherapy intervention attend 8 weekly in-person sessions that are approximately 90 minutes long. After their session, these women receive a daily text reinforcing what they learned during the day's session.

Hahm et al. (2022) conducted a two-fold study to examine whether or not AWARE could successfully be utilized in university settings and if AWARE could help reduce group members' depression, anxiety, and PTSD symptoms. Forty-four Asian American females between the ages of 18-35 participated in AWARE sessions across three universities in Massachusetts, led by female Asian American group therapists at their respective universities. The measurements included a modified version of the Seeking Safety rating scale to assess implementation fidelity over the course of therapy, the Center for Epidemiologic Studies Depression Scale (CES-D), Hospital Anxiety and Depression Scale-Anxiety (HADS-A), and the PTSD Checklist-Civilian version (PCL-C) to assess patients' depression, anxiety, and PTSD symptoms, respectively, at the end of the program. It is important to name that the PTSD Checklist is a standardized self-report rating scale for PTSD comprising of 17 items that correspond to the key symptoms of PTSD and is based on the DSM-V criteria for PTSD. That being said, two versions of the PCL exist: the PCL-M, which is specific to PTSD caused by military experiences, and the PCL-C, which is useful to understand any traumatic event (Wilkins, Lang, & Norman, 2011). The PCL-C has been adapted for use in primary care or general medical settings, and has been used extensively with the Asian American women in this study.

Summary of Procedure & Findings

The researchers found that the member attendance rate across all three schools was at the 75% mark, which was statistically higher than most other group session attendance rates. In addition, therapists evaluated on the Seeking Safety modified Likert scale averaged at a score of 2, which is classified as good. Finally, group members' depression, anxiety, and PTSD symptoms significantly decreased by the end of the intervention. As indicated by Table 1, the pre-post intervention comparison showed significant improvements for depression, anxiety, and PTSD symptoms. All clinical measures utilized in this study showcased reductions in depression, anxiety, and PTSD symptoms.

Table 1. Pre-post intervention clinical measures for AWARE participants across three colleges/universities

	School A		School B		School C		All Sites		
Variables	Baseline Mean (SD)	Post-intervention Mean (SD)	Baseline Mean (SD)	Post-intervention Mean (SD)	Baseline Mean (SD)	Post-intervention Mean (SD)	Baseline Mean (SD)	Post-intervention Mean (SD)	Pre/Post Change Mean (SD)

CESD-R (Depression)	35.8 (19.2)	26.8 (20.7)	25.7 (13.3)	6.43 (3.78)	19.2 (11.9)	12.4 (8.17)	26.2 (16.5)	16.3 (15.5)	-9.95 (10.9)
HADS-A (Anxiety)	13.6 (4.48)	11.0 (4.58)	12.0 (2.24)	5.57 (2.88)	11.1 (4.45)	6.35 (2.69)	12.1 (4.20)	7.84 (4.15)	-4.30 (3.36)
PCL-C (PTSD)	43.4 (13.8)	39.2 (15.9)	45.4 (9.50)	26.1 (6.72)	38.2 (10.3)	29.8 (8.75)	41.4 (11.6)	32.4 (12.4)	-8.95 (11.5)

Clinical implications & Limitations

The Hahm et al. (2022) study made contributions to the literature. The study was the first to showcase a group psychotherapy model that is culturally applicable for Asian American females. These findings are important because by utilizing AWARE in mental health service centers, young Asian American females will feel comfortable to seek out group psychotherapy to alleviate their mental health problems and learn new coping mechanisms. However, several limitations also exist. Hahm el al. recognized that this study had a small sample size, was non-randomized, and had no control group. Along with that, because the group members self-reported their symptoms after completing AWARE, there could have been social desirability bias. Finally, because the forty-four group members of this study were from three universities in Massachusetts, there is the issue of low generalizability. Their research inspires additional studies that are needed to explore AWARE and other types of group psychotherapy interventions that are culturally appropriate for Asian American females in broader settings and to evaluate how to prevent lapsing symptoms after the intervention is complete.

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Brief Article 1

A Sameness in Resistance: The Barriers to Leading and Participating in Group Therapy

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Abstract

The present article presents the supportive evidence for the effectiveness of Group Therapy and argues that there is a shared resistance among individual participants and group therapy leaders in participating in group therapy. Psychological resistances such as, social anxiety, fear of anger from other group members, dread of experiencing shame and humiliation, and desire for individual attention are explored and followed by practical and structural resistances, such as, lacking, a scarcity of referrals, financial incentives, and skepticism and lacking awareness of the benefits of group therapy in the field. Given such resistance, further research and innovations in training are necessary to better educate clinicians and potential group participants to ensure that more individuals can benefit from the positive gains and impact of group therapy.

Keywords: group therapy, leading group therapy, resistance to group therapy, shame

There is a growing body of evidence to support the effectiveness of group therapy (Burlingame & Jensen, 2017). In comparing 67 studies of individual and group therapy formats, no differences in rates of acceptance, dropout, remission, or improvement were found (Burlingame et al., 2016). Among many unique benefits, it is posited that group therapy invites individuals into a multitude of here and now relationships, enables members to observe and potentially change their relationship patterns, provides a space to receive feedback on attempted new ways of relating and being, supports the development of accountability for one's actions, and reduces isolation and shame through sharing experiences in the supportive presence of others (Shay, 2021). Further, research consistently indicates that the most important predictor of outcome in therapy is the quality of relationship between the therapist and patient (Norcross, 2002). This relational quality is true of both individual and group therapies; however, group therapy more heavily relies upon the power of relationships due to its relational focus and context (Rutan, 2021). Further, Shechtman and Kiezel (2016) posit that some individuals prefer group therapy because they enjoy listening to others, appreciate not always being the center of therapeutic attention, desire to connect with others through shared experience, and find the format more affordable than other individual therapies.

Though the benefits are evidenced, both clinicians and individuals maintain some hesitance to engage in the work of group therapy, as either leaders or members (Shay, 2021). According to Shay (2021) the obstacles to participation in group therapy are noted to include:

- social anxiety,
- fear of anger from other group members,
- dread of experiencing shame or humiliation, and
- desire for individual attention

Shechtman and Kiezel (2016) add that patients may prefer individual therapy out of desire for a more intimate and individual relationship with the therapist, wherein they are the recipient of the provider's full attention. Further, individuals are more likely to trust the confidentiality and nonjudgement of the therapist (Shechtman & Kiezel, 2016).

As a result, these hurdles impact both individuals who might be referred for group therapy and the clinicians, themselves, who might take on leading such groups. According to Shay's (2021) investigation of these barriers to pursue group therapy seem to suggest a parallel process by which reluctance persists across both potential participants and leaders, reducing the access and uptake of the powerful benefits of group therapy. As a clinician in training, with an interest in taking on the work of leading groups and admittedly with trepidation, I will explore some of these resistances through the lens of my own experience.

Participants may, according to Shay (2021) avoid engaging in group therapy is that they wish to maintain the primary attention of the therapist, what individual therapy offers, and they find it difficult or even painful to share the attention of the therapist with others. Similarly, clinicians may face this very same experience, in which they fear losing their patient to another provider, which may lead them to avoid referring their own patients to group therapy. **As an extern** starting my clinical training, I have found myself at times seduced by the "fantasied blissful relationship of a maternal dyad," (p. 72) that Alonso and Rutan speak of pervading our culture and consider what it might mean to share the lives of my patients with other practitioners (as cited by Shay, 2021). Further, this idea raised my interest in the ways in which early clinicians may also be reluctant to disperse their influence or power, by inviting a whole group of untrained individuals (i.e. the group participants) to speak into issues and challenges raised by the group members by offering shared experience or suggested approaches that have worked or them in the past. Such reluctance may be a result of a novice clinician's desire to establish their own authority or therapeutic voice, or it may also be a result of competency concerns in the clinician's self-perceived ability to navigate ruptures between group members. There is leader humility required in the task of watching other group members make the very interventions, or perhaps sometimes even better interventions, than we ourselves as clinicians might employ. In many ways, the group is an invitation for the disbursement of the therapeutic power from the therapist to the group members. It is important to know boundaries, as Shay (2021) notes, "it can be unsettling or depriving to have to share this position of prestige with others," of sharing the gratification of being the central helpful figure in a patient's life (p. 71). Both novice and seasoned clinicians need to be educated to appreciate the benefits offered by the group in providing a multitude of transferences and dynamic relational opportunities that create a rich environment for learning and growth.

Further, it is suggested that one of the most powerful deterrents to group therapy is the fear of shame and humiliation (Shay, 2021). This appears to be true for potential group participants, but also for potential leaders, who may fear being challenged, particularly in a group environment (Weber & Gans, 2003). As a clinician in training, my skin crawled before even entering my program at the thought of having to record sessions or potentially have live-observation. There is something profoundly vulnerable about the experience of sharing one's clinical work, whether process notes, transcripts, or recording. The group inherently opens a microcosm of life in which the therapist's work is suddenly made visible to many individuals all at once, the group participants and potential leaders & co-leaders, who are likely to display a myriad of different responses to the therapist's approaches and interventions. The fear of judgment, rejection, or attack in front of the group is a shared experience for both leader and participant. Further, members of the group bring with them their own "needs, goals, and levels of attachment and emotional health," that the therapist is tasked to attend to all at once (Shay, 2021, p. 73). The power of shame lies in its propensity towards hiding because in isolation, shame festers and grows. The group space can be an "antidote to shame," (p.72) by providing a shared space for members to speak openly of their shame-embedded experiences and be accepted by others, who may share similar experiences and support them in processing, metabolizing, and integrating their experiences (Shay, 2021). This very opportunity is arguably not present in the same capacity within the confines of individual therapy, wherein clinicians don't often provide self-disclosure of shared experiences of shame with their patients (Shay, 2021). Thus, the group provides a unique opportunity to be met with shared experience of the other that might powerfully reduce one's shame and further, provides group leaders with an invitation to, "use their life experience, self-awareness, and countertransference to deeply attune and resonate with group members' vulnerability" (Shay, 2021, p. 72). Weber and Gans (2003) suggest that patients' resistance to addressing shame may best be overcome by group leaders, who are prepared and willing to acknowledge,

tolerate, and work through their own shame. Such capacity for the group leader to persevere and resist their own fears of shame and humiliation require adequate professional support and training.

Beyond the psychological deterrents, there are also the practical and structural aspects that may prevent clinician's from taking on group work, such as, lacking resources and space to host the group, a scarcity of referral sources, financial incentives, and skepticism or lacking confidence in the modality by colleagues or institutions (Shay, 2021). It is these obstacles that often lead clinicians interested in group therapy to pursue costly memberships and certificate programs within professional networks and organizations that prioritize and promote awareness of the specialty and, as Shay (2021) notes, "not simply [as] an adjunctive therapy to serve more patients at one time or to help patients pass time while waiting to access individual therapy" (p. 70). Given the apparent stigma and psychological and structural obstacles, the field must do a better job at prioritizing educational opportunities, supervision, and training in group therapy to expand access and breakdown misconceptions that group therapy is a secondary treatment. Normalizing and modeling the referral process, training beginning clinicians in how to evaluate the appropriateness of group therapy for individuals and providing a vernacular for how to promote group therapy and share its benefits with prospective and current patients should be a core part of training for new clinicians. I recall only one instance in which our program's clinic proposed discussing groups openly with prospective patients and this happened to occur when our clinic was on a waitlist for individuals and there was a desire to offer something to such clients. This attitude promotes the idea that group therapy might be the appetizer that we offer in lieu of the entre, and I am made to wonder in what ways this impacts the formation of such groups, the amount of resistance patients bring into the group, and the retention of such groups.

Summary

The group therapy process is an important one that might unlock specific dimensions of support and healing for patients. Yalom (2020) posits that the group process begins with the instillation of hope, wherein hope emerges as patients witness change in others in the group with shared challenges and their experiences become more universal and serve as a point of connection rather than isolation. As the group has formed, members begin to test out the safety of the group and begin sharing and expressing emotions, which leads to both individual and group growth (Yalom & Leszcz, 2020). The final stage of the group includes a review of the progress and outcomes, acknowledging what worked and did not, and exploration of feelings related to the ending of the group (Yalom & Leszcz, 2020). Attitudes of skepticism, fear, and anticipated shame prevent many from accessing group therapy and experiencing such gains. It is important that we, as clinicians, maintain an open curiosity about our held biases that might prevent us from referring our patients to group or prevent us from engaging in leading groups, ourselves. We have an opportunity to use our knowledge, clinical judgement, and the research available to demystify the group therapy experience and invite others into it. As we begin to model an openness and curiosity towards group therapy, perhaps our patients too might do so.

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Brief Article 2

Enacting Group Dynamics in Virtual Supervision: Oscillations between the Macro and Micro

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Abstract

This article explores the group dynamics of a 2020 cohort of doctoral students in the field of professional psychology. I will be reflecting on my experience as a member of this cohort and the ways macro-level (e.g., on the societal level) and structural realities of oppression and disempowerment, in addition to disavowed grief and anger, influenced and shaped micro-level (e.g., between individual and peer-level) interactions within the cohort. A case study demonstrating these levels of group interactions will be presented. I will also touch on how it relates to the parallel aspects in the patient and how it could have been used to facilitate clinical training and the personal growth of both students and faculty.

Keywords: *Group Dynamics, Macro Group Processes, Micro Group Process, Graduate Program, Racial Dynamics.*

Context

At the start of the academic year, there was a buzzing sensation in the air within the cohort and outside on the streets. Each student plugged their laptop and attended the first day of graduate school virtually. For some, the comforts of home helped cushion the jitters of first-day meetings, for others, the nagging sounds and intrusions of family members made it ever more difficult to land in the moment; a moment of indulging in the harvest of one's hard work. For the international students, the uncertainty and instability of the geopolitical conditions implicating the pandemic border controls, made a precarious situation, ever more stringent and chaotic.

Beginning in the initial week of classes there was a notable excitement, watered down by an invisible tension. Was this tension competition? Fear? Adult anxiety attachment? The palpable sentiment in the new cohort was different, there was a sharpness and zeal to it, the kind that hovers over immense existential reckoning. One of our first semester courses was a class titled "Diversity." The instructor shared her intention was to provide a space for deeper understanding of ways the structural contours and interacts with the intrapsychic (Layton & Leavy-Sperounis, 2020). This class allowed for the release of socio-political tensions related to the murder of George Floyd, and five months of quarantine life, but it also made us ever so aware of the pressure valve preventing us from unraveling. It provided a space for students to put language to experience that felt raw, unprocessed, and unnamable.

Despite the raging fire on the outside (literally since some of us were located in Washington, D.C. during the 2020 U.S. presidential elections and later January 6th insurrection), we were expected to continue work as usual. We joined with one another, with the scent of tear gas and burnt tires still fresh to some of us, from the Black Lives Matter protests and militarized police response. There was a unison escape into academia and professional training, that simulated a familiar return to a secure attachment. We clung to the familiar as the world felt ever more uncertain and mournful (Marmarosh, Forsyth, Strauss & Burlingame, 2020). In conversations with one another, mainly through messaging applications, we shared memes, jokes, and side comments about the world. Our desire for closeness and belonging was manifested in a multitude of ways. For some students, there was a clear desire for closeness, as they sent out messages and initiated conversations. Others lingered in a distant way sharing emojis and memes; they were able to be in the group while also maintaining a safe distance. The group was not yet cohesive; we were sharing virtual space, as we were carrying with us the embodied burden of a virus that is unseeable causing deaths, and the lingering stench of structural oppression.

Case Study

To explore the impact of group dynamics in this cohort, I will present a vignette from the first semester of our first year. The intention behind this vignette is to reflect the permeability of structural reality and apply group dynamics to understand how a supervision intervention led by white instructors left students of color feeling shamed and unseen. The vignette pertains to a required course titled "Case Conference." The course is garnered through presenting recorded

de-identified clinical material, allowing first year graduate students to reflect over what they are hearing, and they are asked to ascribe theory to moment-to-moment dyadic interactions. The instructors were two white identified clinicians, with over 10 years of clinical experience. Both instructors identified as white Jews, one was a cis-gender female who had been treating the patient for many years in her private practice and was sharing the video for educational purposes. The cohort was 30% international students, 50% students of color of various ethnic backgrounds, and 20% white identified students. The client was a bisexual, non-practicing protestant, cis-woman, who was also middle class. Her presenting problem pertained to depressive symptomology and trauma, and she appeared to function within the borderline level of personality functioning when under duress.

From the very beginning, there was a division amongst the GW cohort, relating to counter transferential feelings. For example, almost all the international students and students of color, shared countertransference of resentment, anger, and disgust that the patient was over-dependent on the therapist. They appeared to see the white patient as having too much privilege and feeling angry about her neediness. Secondly, almost all of the white-identifying students, on the other hand, shared countertransference pertaining to sadness, longing, and helplessness.

During the case discussion, faculty's initial response to students of colors' counter transference was framed as a "lack of empathy toward the patient." At one point, the client shared feelings of entitlement pertaining to her living condition in a rented apartment, to which students reflected associations with a "Karen."[1] The students of color perceived the white patient to be entitled and did not recognize the patient's suffering, and both instructors appeared uncomfortable staying with these negative reactions toward the patient in the class. Rather than explore these students' associations and projections of the patient being privileged, the instructors encouraged them to reflect more *deeply* into their feelings in a separate space outside of the classroom. This was the significant rupture because the white instructors were not open and curious about the legitimate reactions students of color were raising toward white people. The faculty did not see the white patient as a privileged "Karen," so they denied this possibility could exist. For the students of color, the white faculty started to act like white people in society who immediately reject the rage, pain, and hurt associated with people who have suffered from oppression, systemic racism, and intergenerational trauma. Over time, the students who expressed powerful negative feelings towards this client, began to withdraw. They felt judged by their initial reactions and misunderstood.

The conversation was then taken up by majority white students, who thought through the client's traumatic childhood experiences, locating her sense of passive aggression as a byproduct of her trauma history and disavowed aggression. These students were often lauded by faculty for their capacity to demonstrate "compassion" and "attunement" to the client's underlying suffering beneath her angry behaviors in the session. Empathizing with "sadness underlying her entitlement/anger" was rewarded, but expressing anger and frustration was not. Increasingly, the silence of the students of color grew louder. It has been noted by Debiak (2007) that the possibility of utilizing group interventions in culturally competent ways, must be closely examined. Additionally, group dynamics can "easily replicate oppressive conditions in the larger society," adding "therapists must pay special attention to the needs of individuals in the minority in a group" (Debiak, 2007, pp. 5–6). In many ways, the students of color needed the same empathy and attunement that the white students and faculty were generously giving the white patient. The students of color need the faculty to see beneath the surface of their negative perceptions of the patient, to the more painful underlying group dynamics plaguing the students of color all the time, lack of trust and safety they feel in society, in their program, and in this class. It was extremely painful for students of color to not receive the same empathy from the faculty or fellow students who were able to easily see the underlying pain in the white patient.

According to DiAngelo,(2016), white fragility is presented in the inability to tolerate and acknowledge the shame evoked by identifying with the normative hegemonic group. The faculty/leaders struggled to situate the rage and fear expressed by students of color in the group as coming from years of oppression, racism, discrimination, and injustice. White society often avoids reactions to oppression. Instead of welcoming these reactions of rage and anger that were projected onto the white patient and exploring them as legitimate, the faculty shamed students of color by focusing only on their lack of empathy. The faculty focused on the needs of the patient, and they missed an opportunity to address the needs of students of color, especially during a time where racism and hate surround them. From my point of view,

[1] **Karen is a popular term used to connote an entitled and demanding white woman (Lang, 2020).**

rage, anger, grief, and fear that comes from coping daily with social injustice, discrimination, and oppression was influencing the perception of the patient, fellow students, and the faculty.

As the semester progressed, the faculty became aware of students of color withdrawing from participation and asked people to share their honest reactions. However, the group space at this point had become mired for enacting macro-level processes, producing an unhabitable space to pick up this question without worrying of retaliation. As a result, using the private messaging feature on the Zoom application, I was witness to side conversations, in which students of color began to conceptualize the client away from the gaze of the instructors. Consequently, students of color were finding a safer way to express themselves avoiding moving away from the primary medium of discussion. Because the group was not safe and the members could not trust the white leaders, they needed to find a safer way to express themselves. Subsequently the group was having a powerful impact on my own sense of safety.

This experience brought revelations around the growing silence I was seeing on the streets. As I walked the streets of Washington D.C., I ran into Black Lives Matter sign after sign, but I wondered if I could trust them, similar to my uncertainty of trusting the white faculty and students. I wondered about the people behind the walls; were they virtue signaling? Was this a protection of their property? Or was there a shift happening, ever so incrementally in a collective reckoning with the years of enslaved labor and cultural erasure? I was not sure who I could trust.

According to Gitterman (2018) “when members of the larger social group are less secure about aspects of their identity, such as in high school or college settings, certain differences can threaten members’ emerging and fragile self-concept, thus leading to greater exclusion” (pp. 103). In this way, many students of color, insecure in their new role as a doctoral student, attempted to express their laden affect pertaining to the client’s presentation. They were taking a risk by expressing their honest thoughts & feelings about the patient. They were not aware of the underlying group dynamics emerging when they “walked” into the classroom led by two white instructors. The white faculty were not considering the underlying dynamics that could play out when students watched the case presentation and started to discuss it. The group dynamics were influencing everything, but no one was aware of any of it.

Reflecting now, I do not know how much was related to the client directly, and whether my cohort was commenting on the salience of holding space to process white fragility, in a world that felt unstable, uncertain, and fearful. It was a rupture in the group caused by the faculty/leaders, who unbeknownst to them, were ignorant to the fear, rage, and confusion experienced by the students of color when they heard a white woman complaining about her experience to another white woman. Many of the students of color had strong negative reactions that expressed a larger issue in society. How could they not be activated by seeing a white patient complaining and entitled.

The white students, on the other hand, were students who did not experience the same systemic discrimination, hatred, and oppression, and they were not triggered by two white faculty evaluating them or watching two white women engage in psychotherapy. The white faculty and students, with their white privilege, were not aware of the group dynamics influencing the entire group/classroom experience. The faculty filtered students of color as non-empathic, and were focused on protecting the patient from the negative projections. This, maybe, related to the faculty’s own denial and white privilege, to protect the patient with a history of trauma and abuse. But these two group leaders missed an opportunity to be empathic with the students of color. The students of color were shamed when leaders used the term “unempathetic” and asked them to “reflect deeper on your own,” it led to withdrawal, silencing, and a lack of space to talk and engage in repair.

As Marmarosh (2022), Debiak (2007), and Ribeiro (2020) all emphasize: the group space can very much activate and repair structural and systematic wounding. However, the group space must be approached with a cognizance, a curiosity, and a critical pedagogy willing to tolerate fragility, ambiguity, and the righteous rage that has long been disavowed. The group space could have been utilized in a more curious way, by not foreclosing the students’ countertransference as shameful. When students felt embarrassed, they recoiled. Possibly, if the leaders could have opened the space to name and identify the students’ feelings as a reaction and response to white fragility, they may have felt witnessed and understood, expanding space for deeper insight and self-awareness into their countertransference and what was coming up. The alternative space engendered in the “Diversity” class, became a place in which students of color learned the term “white fragility” and the vestiges it holds. In one way, the ruptures in one group space, were repaired in an alternative space. However, this has not given chance for both the instructors/leaders of the original course and the students to repair the confusion, erasures, and hurt feelings.

I am currently completing my third year in this graduate program, and I have noticed how time has healed some of these wounds, while also worked to maintain walls of difference. I write this, with the hope that we create and expand spaces of critical reflection, so we not only encourage but model to students how we can engage in what is happening "out there" by bringing it "in here." I have learned that whether we like to acknowledge it or not, our groups are always in the room.

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COR Corner -APA Council of Representatives

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Well, this quarter's column will be a little different from my usual overview of Council items, as we are still about three weeks away from the midyear Council of Representatives meeting (based on the date I am writing this article). And, as the agenda is still in process, I will also not be reporting on what will be discussed, as reps just received some of the agenda items a few days ago.

So instead, I thought I would take a little time to talk about the importance of helping shape *OUR* APA and division. Earlier today, I resent a call for nominations to our listserv outlining the numerous boards and committees that APA offers including the following:

- Board for the Advancement of Psychology in the Public Interest
- Board of Educational Affairs
- Board of Professional Affairs
- Board of Scientific Affairs
- Committee for Global Psychology
- Commission for the Recognition of Specialties and Subspecialties in Professional Psychology
- Committee on Rural Health
- Ethics Committee
- Finance Committee
- Membership Board
- Policy and Planning Board
- Publications and Communications Board
- Committee on Animal Research and Ethics
- Committee on Human Research
- Committee for Postdoctoral Education and Training Programs in Psychopharmacology for Prescriptive Authority
- Committee on Aging
- Committee on Associate and Baccalaureate Education
- Committee on Children, Youth, and Families
- Committee on Disability Issues in Psychology
- Committee on Division/APA Relations
- Committee on Early Career Psychologists
- Committee on Ethnic Minority Affairs
- Committee on Professional Practice and Standards
- Committee on Sexual Orientation and Gender Diversity
- Committee on Socioeconomic Status
- Committee on Women in Psychology
- Continuing Education Committee
- Fellows Committee

- Health Equity Committee

Each time I see this list, I am reminded what a diverse and fantastic organization we are all a part of. I also realize that there are amazing members in our division and within the larger APA that may never volunteer to join any of these boards/committees during their tenure in the organization. In fact, I have never served on any of these either and only in the past seven years reinstated my membership with APA after about a ten year hiatus. Looking back, I regret that I didn't have the mentoring to encourage my earlier involvement and engagement. Fortunately, I did find my way into Division 49 by running for the board and having colleagues that encouraged me and believed I could make a difference. Thus, I implore you today to take that step forward like I did seven years ago and get more involved whether in leadership, by inviting a student(s) and/or colleague into the organization, and/or telling us what you need/want from our division so we can change and grow with the needs of our membership. Your ideas help us better define and guide who we are and what we do.

With new leadership, comes new ideas. Along these lines, we have some exciting things developing including a new institute that was birthed by Dr. Shala Rae Cole and Dr. Lisa De La Rue, now going on its second year; a new CE program offering the latest in group psychotherapy developments organized by Dr. Aziza Belcher Platt, and tireless work by Dr. Noelle Lefforge and others, with building and maintaining group as a specialty within APA. Other opportunities to get involved are through the written word, as Dr. Tom Treadwell and Dr. Leann Diederich, our newsletter editors for *The Group Psychologist*, are always inviting article submissions; and Dr. George Tasca leads an exceptional team that directs our journal publication, *Group Dynamics.* Our division has so many opportunities for professional growth and involvement.

Come involve and share your ideas to help us develop in more inclusive and equitable ways. As your council rep feel free to email me at Michele.Ribeiro@oregonstate with your questions, comments, ideas related to the Council of Representatives or the division generally. And as always, thanks for your continued membership in our special division where belonging and community is at our core.

Division 49 Standing Committees

Division 49 Leadership

https://www.apadivisions.org/division-49/leadership/committees/index