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I wish to thank Erv and Miriam Polster for introducing me to this question during a Gestalt Community meeting in La Jolla, California.
WORKING WITH HIDDEN FRAGILITY IN GROUP MEMBERS

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

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

POPULATION AND PROBLEM

In a group that had been meeting for several years, a particular member had become increasingly withdrawn and silent, even though he had been an active participant for several years.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

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

**INTERVENTION AND GROUP RESPONSE**

1. **Assess the permeability of the insulation barrier.** This technique requires understanding how and why a person uses certain defenses, and how he or she reacts to the group’s attempts to penetrate the defenses.

2. **Provide an external insulation barrier.** If, as in this case, the person’s ego is fragile (even if it is transient state of under insulation), we must step in to provide a temporary insulation barrier. I told the group that it seemed as if Dave was “against the ropes awaiting the knockout blow;’ when in fact what he might have craved most was “tenderness and understanding.” The group became immediately defensive. They retorted that Dave is quite capable of hearing their input and integrating it as he had done on many occasions. I did not back down, however, and suggested that perhaps that has normally been the case, but that somehow it was different this time given his withdrawal and nonverbal, emotional reactivity.

3. **Use bridging to someone with similar defenses.** Find someone who is underinsulated, and employ the technique of bridging (Ormont, 1990), which is a method for helping one member establish emotional communication with another, around similarities as well as differences. In this case I consulted with “Daniela,” who was more characterologically underinsulated, and asked if she understood Dave’s withdrawal. I knew that she was experienced with feeling injured in the face of confrontation when all she wanted was “tenderness and understanding.” She immediately empathized, and added that she felt hesitant to say anything because she did not want to be attacked like the group attacked Dave. She said that people in her life never understood how deeply their words and behavior could injure her. As she spoke, Dave welled up with tears, but at the same time nodded as if feeling understood for the first time in months.

4. **Continue to help the group explore the impasse, its resolution, and emerging feelings.** In this case Dave was eventually able to share how Daniela’s empathy helped him rejoin the group. The group was surprised at the depth of Dave’s feelings of being misunderstood and unrecognized. They shared their perception that Dave was quite capable relationally, and were taken aback by Dave’s apparent neediness. What they did not know, until Dave shared it, was that recently in his life, he had been feeling similarly misunderstood by friends and family, who he felt had always underestimated his needs because he was so adept at putting up a front of “being together.”

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

CONCLUSION AND CONTRAINDICATIONS

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

With group members who are under insulated characterologically, this kind of work would
have to be repeated and worked through numerous times before the patient’s insulation barrier
was more firmly established internally. In the case of Dave, the intervention was more reparative
than structure building, which was all that was required to bring him back into the fold of the
group. What can be appreciated from the scenario, the use of the concept of emotional insulation,
can be invaluable in crafting an appropriate intervention; however, its effectiveness depends
upon an accurate assessment of the nature of the insulation flaw.

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

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**The Gambling Chair**

**T. Wing Lo**

**INTRODUCTION**

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

**CLIENT POPULATION**

This intervention was first applied in a gamblers’ support group, but was later used more frequently in groups handling extramarital affairs and love relationship issues among young people. Group therapists may feel free to generalize its use to groups of a relevant nature. The crux is that the clients must experience the “win” and “lose” sensations in the course of gambling with money or gambling with love.

**GUIDELINES FOR THE INTERVENTION**

Prepare a number of chairs that should not be too heavy so that the key client is able to pile them up one by one. The chairs should not be too light or else the dramatic effects would

**Step I**

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

**Step 2**

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

**Step 3**

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

**Step 4**

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

**Step 5**

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

**Step 6**

Now the three group members who acted as family members return to their seats, leaving three empty chairs in the middle of the room. The therapist takes up the fourth chair, saying that this is the husband’s chair. The therapist invites the client to sit on it, facing the three empty chairs and answers the queries of his wife and two children.
Step 7

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

Step 8

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

CLIENT RESPONSES

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

CONCLUSION AND CONTRAINDICATION

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

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The Vicissitudes of Power and Its Relationship to Money

Lise Motherwell

MONEY CAN REPRESENT POWER, LOVE, FREEDOM, OR SECURITY

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

DESCRIPTION OF GROUP

This technique can be used in time-limited group, or in ongoing therapy groups that periodically use exercises or techniques to enhance the treatment. The exercise allows members to know one another at a deeper level as they learn about their own relationships to money. It works in mixed-gender groups, women’s groups, divorce groups, and culturally diverse groups by encouraging members to share differences in how money is perceived and dealt with. Because the method builds group cohesion, it should be used in the early stages of group after the group has developed some trust. I have successfully used these techniques in ongoing psychodynamic therapy groups, and with psychotherapists who want help dealing with fees in their practices or want to work more effectively with their clients about money issues.

DESCRIPTION OF INTERVENTION

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION AND CONTRAINDICATION

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

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

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**INTRODUCTION**

One ongoing group in my private practice consists of 8 women who come together every week for 90 minutes. The indications for the women in this group vary from learning autonomy in intimate relationships, to standing up for one-self in conflicts, working on a more realistic relationship with their mothers and functioning better in work situations.

**PATIENT POPULATION**

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

**The Issue of Boundaries:**

As a female therapist in an all female group there is much emphasis on the special importance of boundaries (Oakley, 1996). This is due to the fact that so many women have experienced inner and outer boundary violations. Trying to prevent boundary violations does not imply that they will never occur but certain precautions maybe implemented to attenuate their occurrence. In order for group members to work on personal issues and feel safe within a group, these members need to know that there are boundaries in the group and this structure often helps to reduce anxiety (Nitsun, 1996).

**The Group Contract:**

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

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

- Always meeting at the same time and at the same place.
- The therapist and the group members telling in advance about vacations, cancellations and payment.
- The profundity of respecting the confidentiality of other group members.
- Arriving on time and coming and verbalizing what they feel and think. Knowing what belongs inside of group and what belongs outside of group.
- Socialization is strongly discouraged outside, of the group, but if it does occur, the patients are encouraged to bring into the group what was discussed during this outside meeting.

THE SITUATION BEFORE THE INTERVENTION

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

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

The group now had 3 pregnant women, which in itself begins to alter the dynamics of the group and, at times, brings in some unforeseen issues.

One evening before the group started a group member called me and said:

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

**Th:** "See what happens, maybe he’ll arrive soon and then you can come later”.

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

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

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

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

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

Three weeks later after getting a phone call that the second pregnant woman had given birth, I decided that I needed to address the boundary crossing, which had taken place – bringing the baby into the group. A boundary needed to be formulated and a change in contract implemented. I experienced the multiple new lives in the protruding bodies as a group within a group although I had never before had subgroup such as this but I did not want three new members, either!

INTERVENTION

Addition to the Contract:

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

In the case related above, an implementation was required to avoid difficulties in the future for both the patients and for the therapist. As the group therapist, I related this new addition to the contract. “A couple of weeks ago when one of our group members came in with her little baby I was touched and somewhat overwhelmed. It was a “special”situation and I was worried and nervous because the heating had broken down and I was concerned how having the baby here might have affected all of you. I, also, felt that I could not be as attentive to your needs as I wanted to be because my attention was distracted. I propose that in the event that someone does not have a babysitter, that this problem will not be taken to the group but will be resolved elsewhere which might include not being able to attend the group on that particular day.”

CLIENTS RESPONSES TO THE INTERVENTION

Pregnant and not pregnant women found a common ground in this discussion about an addition to the contract. The childless woman, in the group, admitted she found it difficult but very helpful being in a group with pregnant women. She felt that she can be around pregnant women now comfortably and she stated that this particular case had been an emergency.

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

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

CONCLUSION AND CONTRAINICATIONS

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

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

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

Haran Wernik

INTRODUCTION

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

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

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

CLIENT POPULATION

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

GUIDELINES FOR INTERVENTION

Materials

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

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

Items to be Ranked

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

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

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

Administration

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

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

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

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

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

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

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

**CLIENT RESPONSES**

When initially presenting the task to the group, the members tended to flood the leaders with questions about how to complete the task. Withholding specific answers caused a certain degree of stress, but after a couple of minutes the group understood the idea and started working. In our
case the task led to a heated debate between a few of the members. Some took very active roles, others seemed not to be able to find their own voice unless asked directly by another group member, and quite a few negotiations took place that allowed the group to reach a final ranking. The fact that the task invoked passionate participation led to a lively discussion and perhaps also increased the motivation to learn about negotiation skills in the following session.

CONCLUSION

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

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

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Haran Wernik, Psy.D. was a post doctoral psychology intern at the Adult Psychiatric Unit at Hadassah University Hospital in Jerusalem, Israel. His formal academic doctorate was in the United States at the Indiana University of Pennsylvania.
Interventions in Groups with Clients Sharing the Same Critical Fact

Cristina Martinez-Taboada Kutz
Ainara Arnoso

WHEN SOCIAL REGARD CLAIMS FOR ADJUSTMENT

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

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

The conceptual guidance is based on Theories of Social Identity (Turner, 1987) as well as the model of Psychosocial Intervention (Martinez, Taboada, et al., 1992, 1996, 2006).

CLIENTS

The clients, in this particular group, are people who have a critical circumstance in their lives. For example, a diagnosis of chronic illness, parents whose child was diagnosed with a particular syndrome, widows, individuals in the early stages of divorce, etc. These groups could be used with any group of people sharing a common bond and psychological task, which makes them, feel vulnerable with uncertainty, or with an identity struggle that maybe in contradiction to the “norm.” The clients should have as a basic premise a wish of overcoming their difficulties and have the cognitive capability to express and share their experiences.

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

INTERVENTION DESCRIPTION

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

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

A THREE PHASE INTERVENTION

Phase One – Unveiling the Steps:
A focused question is posed to the group to spur dialogue and interaction. A question such as, “How would you describe yourself apart from being a divorced individual, parents of a sick child etc.”?

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

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

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

Phase Two – Discovering the Aim:
The next step will be to become aware of the process itself. Every member is encouraged to bring for the next session a second exercise. They are requested to describe and write down briefly a situation, which had made them feel good or bad relating with their actual situation.

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

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

Phase Three – Working together a feedback:
The last step of this intervention will be to put forward a feedback with all the contributions of the group about the same issue.

We ask the members to share the most suitable strategies, they have found, how they plan to use them and also which ones they have been wondering about. Along this process, it has been shown the need of social self-esteem in order to integrate the valueless perceptions into a
positive way.
- Therefore, we have been diminishing their urge toward negative self-talk and to enjoy little daily things and to give importance to what deserves importance.

RESPONSE OF CLIENTS TO THIS INTERVENTION

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

To be able to speak about it together inside the group elicits feelings of not being alone and having the potential of other possibilities and strategies for personal interactions. The sense of elaborating, contrasting and sharing their sensation makes it easier to put into practice these new strategies which they have by now discovered.

CONCLUSION AND CONTRAINDICATION TO THIS INTERVENTION

The purpose of this kind of procedure is to show that when one of our living circumstances becomes a threat, it would affect not only oneself but also our social self-esteem, as we are perceived by others. The outcome of which will be the need to redefine one’s social identity and through the use of group therapy, of this kind, the client has the opportunity to improve his or her relationships with others and with one’s personal self. In other words, this type of group is the opportunity of helping clients become conscious of the interaction between social comparison, social identity and psychosocial well-being.

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

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Hardiness Enhancement: A Pathway to Resilience

Justin A. D’Arienzo

Hardiness as a Concept

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

This hardy attitude was comprised of three perceptual dimensions: commitment, control, and challenge. The resilient individuals remained committed to their circumstances, desired to be involved in the current situation, and found meaning. They believed they had personal control of the outcome in obstacles and shunned passivity and powerlessness. In addition, they perceived change, whether positive or negative, as challenging and as an opportunity to acquire wisdom and growth. The study also found that having hardy attitudes led to hardy coping, hardy health practices, and hardy social support networks. Those with resilient attitudes faced problems and turned potential disasters into opportunities, had positive interactions with significant others comprised of mutual assistance and encouragement, and prioritized physically healthy activities such as exercising, dieting, relaxation, and following their doctor’s recommendations (Maddi, 2002, 2007; Maddi & Kobasa, 1984).

U.S. Military Population

I have utilized this psychosocial group therapy modality in the mental health departments of a U.S. Navy medical clinic and aboard an aircraft carrier. Group sizes have ranged from three to twelve individuals. All members were active duty military members aged eighteen to thirty and diagnosed with adjustment disorders, v-codes, and low-to moderate-grade anxiety and depressive conditions. An initial psychological evaluation indicated that an improvement in adjustment and coping skills was warranted, which could thus be acquired through hardiness training and enhancement. In addition, all individuals were deemed motivated to improve their condition and their ability to cope with their presenting stressor per self-report.
My original goal was to maintain groups as closed; however, flexibility was required due to the high frequency of patients needing this treatment. Groups met for one hour on a weekly basis and individuals participated in approximately eight sessions, but could participate in more sessions upon request.

AN INTERVENTION OF EIGHT STAGES

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

Group 1

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

Groups 2-3

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

Group 4

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

Group 5
Discuss hardy health practices. Teach about the psychological and physiological benefits of exercising, relaxing, and following doctor’s orders. Also instruct the group in relaxation exercises such as guided imagery and diaphragmatic breathing. Suggest that they participate in these hardy health exercises. Review their personal histories and emphasize the powerful benefits they received during physically healthier times in the past. Explore roadblocks to these practices or past failed attempts and develop problem-solving plans to improve those attempts in the future.

**Group 6**

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

**Group 7-8**

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

**TYPICAL RESPONSE**

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

**CONTRAINdications AND conclusions**

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

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

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Some Thoughts on Silence in Group Therapy

Bennett Roth

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

SILENCE IN AN ANALYTIC GROUP POPULATION

After being a group therapist for a number of years I was actively engaged in the technique of not looking at the person speaking in the group, one that was counter-intuitive to my being a group member. In doing this task, watching the nonverbal and verbal responses to the speaker and not being in the thrall of the person speaking, I became aware that the other group members were as silent as I was. Put succinctly, the entire group was silent except for one person. In other words, in group therapy, there was more silence, more people silent than speaking from a phenomenological perspective. What was going on in the silence? What were their responses to what they were hearing? Why were they not responding to the speaker? I had no idea. Silence appeared to be the absence of a visual or verbal response to the words that were being spoken by one group member. If every member of the group spoke at the same time it would have created chaos, a “Babel effect” of everyone speaking at the same moment. So it seemed that in that group of seven, plus one therapist, there was actually more silence than speaking! Since that time I have questioned a number of basic ideas about the nature of verbal group therapy and silence.

THE IDEA OF LISTENING TO SILENCE

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

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

**THERAPIST SELF-INTERVENTION**

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

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

When considering those prolonged silent moments, it also must be considered whether the group is putting pressure on the therapist to intervene, to speak, to take responsibility for the matters being spoken about, or to say something that individual group members cannot articulate because of defensive reasons. In this manner, the silence is like snow to Eskimos in that it has to be understood for its meaning, depth, texture, and (emotional) color.
If the group therapist is compelled to speak and understands the nature of the group silence it is best to make the comments general (Bollas, 1987). Here, we have an additional problem not found in the dyadic situation: discerning the nature of the “cause of the silence” must be determined.

**A Clinical Example**

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

**LISTENING TO ONESELF IN GROUP**

**Pressures for the Group Therapist**

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

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

**CONCLUSION**

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

**CONTRAINDICATION**

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

Finally, when the analyst is speaking, not only must he or she listen to himself or herself and the choice of words and rhythms of speech but he or she needs to be aware that the rest of the group is silently listening. They listen with acuteness and sensitivity to every element of what the therapist says because in their silence they are making sense and confusion of his or her words.

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Bennett Roth, Ph.D. is a clinician in private practice in New York City and a training analyst and on faculty at IPTAR. He is an author, editor and contributor to multiple journals about group therapy and movies.

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**Bridging in Group Therapy Using Movement Improvisation**
Joan Wittig

AUTHENTIC MOVEMENT

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

PROCESS ORIENTED GROUP POPULATION

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

A SEVEN-STAGE INTERVENTION

Step 1

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

Step 2

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

Step 3

Each pair decides who will move first and who will witness first. The witness then tells the mover again what his or her issue is.
**Step 4**

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

**Step 5**

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

**Step 6**

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

**Step 7**

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

**CLIENT RESPONSES**

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

**CONCLUSION**

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

**CONTRAINDICATIONS**

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

**REFERENCES**


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**The Fee Payment As an Aspect of Group Communication**

**Patricia Kyle Dennis**

**THEORETICAL RATIONALE**

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

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

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

GROUP DESCRIPTION

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

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

THE INTERVENTION

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

Sample Statement

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

The policy is a reflection of the agreement by group members to be responsible for fee payment. The therapist avoids unhealthy behaviors such as enabling, coddling, harassing, reminding, and avoiding. Note that the therapist does not calculate or distribute a bill in advance. Doing so is not only unnecessary, but would also deprive the group of the chance to learn from conscious and unconscious decisions by members to deviate from the payment frame.

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

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

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

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

RESPONSES TO INTERVENTION

When this intervention is introduced in an existing group that is not used to discussing the fee payment, the group members are likely to express shock, outrage, and resistance. As in many families and cultures, the discussion of money may have been taboo, so that the status of fee payment, an essential component of the group’s health, has become a group secret. Once the members see the benefits of this discussion, however, they are likely to participate more willingly. New members may be more open to the discussion, since they are given the opportunity to review the payment policy before they choose to participate in the group.

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

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

Deviations from the payment policy can reflect many other meanings, for each member and for the group as a whole. A general wish to avoid anxiety and shame associated with money management may lead to a hasty, inaccurate calculation of the check, or “forgetting” the check at the first session of the month. Since group members are aware that the health and life of the group depends on the therapist being paid, hostile wishes toward the group or individual members as part of unresolved conflict may be enacted by delayed, short, or missing payments.
When nobody pays correctly or on time, the therapist reflects on the general functioning of the group or the possibility that the group has experienced a trauma.

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

CONCLUSIONS AND CONTRAINDICATIONS

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

REFERENCES


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Using Art Therapy Technique in a Psychodynamic-Oriented Group

Haim Weinberg

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

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

**CONDITIONS AND POPULATION**

The following technique can be used in either workshops or continuous therapy groups. When used in a therapy group it needs enough time to both create the drawings and work through their meaning. Therefore it needs more than the common ninety-minute session. It can be spread between several consecutive sessions or applied in a marathon session. It does not matter whether the group is short-term or long-term.

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

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

**DESCRIPTION OF THE INTERVENTION**

**Materials and Preparations**

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

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

**Instructions for Intervention**

*Step 1: Dividing into Twos*

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

*Step 2: Drawing Your Partner’s Body Contour*

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

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* Thanks to Tami Elad for introducing me to this technique.
Step 3: Paint Yourself

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

Step 4: Pictures at an Exhibition

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

Step 5: Associations, Feedback, and Projections

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

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

Step 6: What Did You Learn About Yourself?

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

Step 7: Initiating Interaction

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

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

As previously related, it might take a few hours or sessions to allow all the group members to do the work.
Step 9: Group Process

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

CLIENTS’ RESPONSES

This is a very powerful experience for group members and they usually see it as expanding their awareness of self-images, body perceptions, and how they come across to others. Drawing and painting is fun, and the group members enjoy it. Some participants use their fingers and hands to smear colors. Others are reluctant to get dirty, and their responses can be elaborated in the final stage. Some people choose interesting positions, such as cuddling like an embryo. The work with the partner, drawing the body outline, is felt as very intimate, and should be discussed as well. If led in a nonjudgmental group climate, the associations of other group members are very meaningful. People are surprised how much they learned from an “exercise” that looked so simple and naive.

CONTRAINDICATIONS

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

CONCLUSION

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

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

REFERENCES


Haim Weinberg, Ph.D., Certified Group Psychotherapist, Certified Group Analyst, is an Israeli clinical licensed psychologist, now living in the United States. He is Past President of the Israeli Association of Group Psychotherapy and has published more than a dozen articles about group therapy and co-edited a book on the Large Group. Dr. Weinberg is the list owner of the
very popular group-psychotherapy discussion list on the Internet since 1996

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Therapeutic Play Reading

Barney Straus

THE HIDDEN ASPECT OF ONESELF

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

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

A LITERATE POPULATION

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

INTERVENTION DIALOGUE AND IMPLEMENTATION

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

Selection of Material

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

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

<table>
<thead>
<tr>
<th>Title</th>
<th>Author</th>
<th>Pages</th>
<th># of roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>All The Comforts of Home</td>
<td>Howard Amend</td>
<td>10</td>
<td>2M, 4W</td>
</tr>
<tr>
<td>Hall of Healing</td>
<td>Sean O’Casey</td>
<td>36</td>
<td>3-9 M, 2-8 W</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(11 parts total)</td>
</tr>
<tr>
<td>The Mother</td>
<td>Paddy Chayefsky</td>
<td>33</td>
<td>2M, 8W</td>
</tr>
<tr>
<td>Waiting for Dr. Hamle</td>
<td>Doug Stewart</td>
<td>13</td>
<td>6M, 4W</td>
</tr>
<tr>
<td>A Wedding, or a Joke</td>
<td>Anton Checkhov</td>
<td>12</td>
<td>8M, 4W</td>
</tr>
</tbody>
</table>

Copying

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

Assigning Roles

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

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

Reading

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

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

RESPONSES TO ACTIVITY

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

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

CONTRAINDICATIONS

Therapeutic play reading can be used to great benefit with groups that have ample time to spend together. Although there seem to be very few contraindications to this intervention, the most salient is in its preparation in relation to the group members as a whole. For example, it does require that group members have the ability to read efficiently. Some group members may need enlarged print. If there are one or two illiterate group members, or others who may have trouble reading for any reason, these folks may prefer to listen. If these group members do not mind being prompted by staff, they may wish to take a role in spite of their deficit. The group leader should try to gage whether assigning roles to those who may struggle with the reading will cause them humiliation as this is to be avoided.

REFERENCE


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

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

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

**DESCRIPTION OF GROUP AND PATIENT POPULATION**

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

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

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

**THE INTERVENTION**

The group intervention consists of five steps.
1. The therapist’s self-exploration of his or her own feelings in the moment.
2. The therapist using that self-exploration to provide feedback to the patient on the issue of identification.
3. The therapist inviting the group to share feelings and thoughts about what the patient is saying.
4. The therapist inviting the group to share similar identifications.
5. The therapist inviting the group to confront the patient when he or she hears them speaking from that identification.

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

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

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

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

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

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

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

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

The third step was inviting the group members to express their feelings and thoughts about what they were hearing from the patient. Fortunately, this was a group who was used to thinking in terms of identifications and who was also comfortable giving feedback to one another. They expressed to this woman their own anger at how she was being treated along with their irritation at her for accepting her ex-husband’s assessment of her. The group communicated to the patient that she was identifying with him, but that she did not have to do that anymore. They expressed to her that she could choose differently.

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

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

**TYPICAL RESPONSE TO THE INTERVENTION**

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

**CONCLUSION AND CONTRAINDICATIONS**

Everyone comes into therapy with identifications that do not work for him or her. The group can be a powerful force in countering a patient’s negative and maladaptive identifications. It can be profoundly effective in teaching patients how to find their own “true voice” and also effective in helping them use this voice in their interpersonal interactions outside the group.

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

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-E115-

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

Arnold W. Hammari

**HYPOTHETICAL SITUATIONS**

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

**POPULATION**

These existential fantasy questions have been used with juveniles in a corrections center in the western United States. Usual group membership is limited to eight boys, aged thirteen to eighteen, awaiting assessment before assignment to a long-term residential facility. Members come and go; stays in our custody last from a few weeks to a few months. The boys that reside
here have been committed by a magistrate to receive help with a variety of problems from stealing, lying, drug abuse, rebelling against authority, aggression, gang activity, destruction of property, sex offenses, etc. We have found that even antisocial youths are willing to express themselves in this thought-provoking manner. Examining existential issues is often very interesting to them. Existential issues might go even further with older adults since they have had more time to reflect on the meaning of life and frustrations they have encountered in attempts to make their lives meaningful.

**GUIDELINES FOR INTERVENTION AND EXISTENTIAL QUESTIONS**

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

1. If you live to be seventy, which decade of your life will be the most important to you? (e.g., meaning of life, approach of death)
2. If you were stranded on a desert island, whom would you want as a companion? (intimacy, freedom)
3. If you had thirty days to live how would you spend your remaining time? (anxiety, approach of death, meaning)
4. If you had to lose one of your five senses, which would you choose? Which would you never choose to lose? (degrees of freedom, death)
5. If you were deported from your home country, never to return, which other country would you choose to live in? (isolation, freedom, death)
6. If you could change one thing about your physical appearance, what would you change? (isolation, intimacy, identity)
7. What is one year of your life you’d like to skip; what is one year you’d never have skipped? (responsibility, meaning, intimacy)
8. Who is one famous person, historical or fictional, that you’d like to meet? (meaning, intimacy)
9. What is your greatest strength? Greatest weakness? (degrees of freedom, meaning)
10. What short message would you like written on your gravestone along with your name? (meaning of life, absurdity, death)
11. Given your present situation, what freedoms do you have left? (degrees of freedom, responsibility, meaning, death)
12. How will you know when you have become successful? (meaning, approach of death)
13. The most important relationship in my life will be with whom? (intimacy, meaning)
14. What invention would you like to create to improve the world? (meaning of life)
15. Which friend or family member would you grieve the most for if they died? (intimacy, isolation, death)
16. If you could choose another family to be born into, which family would you choose? (intimacy, isolation, freedom)
17. If you could commandeer the front page of the local or national newspaper, what headlines and story would you write? (meaning, isolation, freedom)
18. If you could control another person’s behaviors completely, whom would you like to control? (responsibility, intimacy, freedom)
19. What would you be willing to give up in order to gain your freedom? (responsibility, meaning, freedom, death)

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

**TYPICAL RESPONSES**

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

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

**CONCLUSION**

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

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

**CONTRAINDICATIONS**

Basic contraindications for this intervention are related to certain requirements inherent in the
client. The client must be of average intelligence, have abstract thinking abilities, and some capacity for insight as the prerequisites for ultimate success. Time constraints, in this type of facility, may also be a contraindication because we cannot get more than thirty minutes each day, of group time, with these particular boys and their time-limited stay here.

REFERENCES


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INTRODUCTION

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

TYPE OF GROUP AND POPULATION

The violence abatement groups I have led typically consisted of 10-12 men who were court mandated into a 14 or 26-week treatment program that combined pro-feminist education and analysis, with cognitive-behavioral methods and conflict resolution skill building. While the groups were structured with each week focusing on a specific topic and/or skill, as the group progressed, and instances of excusing, justifying, and minimizing abuse and violence had been well confronted, we gradually explored the quality of attachments in the members’ relationships, and how those attachments might contribute to feelings of intense vulnerability. It is essential
that in this exploration, there is a balance of empathic understanding for their vulnerability, combined with an understanding of how these feelings are often mitigated through the use of power and abuse as the men abdicate responsibility for their feelings, and externalize blame onto their partners. While empathetically holding them in their vulnerable feelings, we also help them to appreciate that they are solely responsible for managing their feelings and subsequent coping behaviors, and that to externalize blame is to head down the slippery slope of using abuse and violence to control their partners.

**THE INTERVENTION**

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

   Men exhibiting an ambivalent style often present in a confused, uncertain manner. At times their stories are presented without focus or clarity, and there is a quality of self-absorption that makes others in the group seem irrelevant. They attenuate their feelings through long-winded story telling, which keeps them detached from the underlying vulnerability. For these men there is both a desire and fear of establishing intimacy, which can make them unpredictable in their relationships. They vacillate between intense need and intense anger when affect is stimulated, and can also fall into passivity as an attempt to regulate affect.

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

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

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

Men with ambivalent attachment styles describe more inconsistent early parental interactions. While parents could be intensely rejecting and harsh at times, these experiences were mixed with nurturing. As a result, these men tolerate some rejection in order to receive the nurturing. How these experiences led to ambivalently held attachments in their adult relationships are explored and illuminated. Their pattern of relating to others through a vacillation of submitting to the demands of others, while simultaneously resenting the shame this submission brings (Holmes, 2001), is actively explored, especially as their shame and resentment can result in unleashed fury when shame reaches intolerable levels.

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

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

3. Managing the countertransference: Because of the intense affects that can be invoked in us as therapists with this population, a co-therapy team is extremely helpful in managing the inevitable countertransference feelings. Typical but not exhaustive of working with each attachment style, the avoidant group member can elicit resignation in the therapist as (s)he relentlessly attempts to break through the rationalizations and justifications; the ambivalent member can elicit boredom and fatigue as he anesthetizes the therapist and group from their feelings as he does from his own through monotonous story telling; and the disorganized member can elicit intensely disorganizing experiences in the therapist and other group members through powerful projective processes. Group leaders must rely on each other to manage these countertransference feelings, often by bridging to other group members about what they think the member in question might be thinking or feeling. In many cases, we use the bridging technique to have other members make sense of what is going on in the interactions between particular group members and the leader (Ormont, 1990; 1991, 2001). For example, if one leader is caught in an enactment with an avoidant member in the group, relentlessly trying to break through rationalizations, the other leader can turn to another member and ask “Why do you think that Dr.
Van Wagoner won’t let this drop with Carl.” This can lead to further exploration of the interaction, the underlying attachment difficulties fueling the conflict, and how this person impacts others. Soliciting the feedback of others also helps break the impasse between therapist and member, which at times can replicate what happens between the member and his partner when he feels attachment threatened.

**THE GROUP’S RESPONSE**

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

**CONCLUSIONS AND CONTRAINDICATIONS**

Exploring attachment style in men who batter can be a powerful and emotionally provocative technique designed to help men understand triggers from and to the intolerable affects that in the past have led to abuse and other forms of control over their partners. This exploration, while not designed to resolve early traumas in the context of short-term groups, can plant the seeds of understanding for further therapeutic work. More immediately this exploration can provide a framework for understanding how attachment styles affect relating and attempts to regulate emotions and emotional proximity to significant others. One contraindication of this technique is that with this population, great care needs to be taken not to provide the men with another way of excusing their behavior (i.e. “See, it was my past that makes me abusive!”), and so group leaders need to be ready to confront such attempts to externalize responsibility for their abusive behavior. This exercise should only be employed once denial, justification, and minimization have been thoroughly confronted in the group, and the men, not just the therapist, take responsibility for confronting one another.

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

Roberta L. Slavin

INTRODUCTION

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

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

However, despite the challenges, members of all types of groups (therapy, classroom, outpatient, and others) have a need to bond with one another, seek common purposes, and create a safe haven where they can be open and honest without fear of reprisal (Winnicott, 1965; Yalom, 1995).

DESCRIPTION OF GROUP POPULATION

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

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

Case Example One

In the initial stage of the group the members dealt with the setting of group norms, and ambivalent feelings of loyalty and trust toward the members and the leader (Yalom, 1985). One particular meeting during this phase began with awkward silence, furtive glances at the leader, and a reluctance to open the conversation. I silently considered the members’ insecurity in a new, strange situation, and their need to feel protected. Shortly after, a member described the stress caused by the lack of access to supplies locked in the principal’s closet (emotional nourishment). Other members nodded in agreement. Not having this access made them feel like aliens, feeling like they were not given the same consideration as the teachers in regular classes. They felt like supplicants who had to beg. Administrators were experienced as not being on their side. Would they also have to be supplicants for emotional nourishment from the group leader?

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

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

Case Example Two

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

This workshop is an example of the successful use of group dynamic techniques with a teaching staff within a school setting (Slavin, 1997). The participants built a trusting relationship with the leader that enhanced their relationships as teacher and psychologist. They began to feel understood. Other successful workshops have addressed elementary school students (Bany & Johnson, 1964), and high school students (Laquercia, 1977; Slavin, 1997, 2002; Welber, 1977).

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

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Roberta L. Slavin, Ph.D., L.P. is a Licensed Psychoanalyst who has also worked as a teacher, school psychologist, and mentor to new teachers for many years.

Modeling a Non-Defensive and Empathic Acceptance of Group Resistance in a School-
Based Anger Management Group with Urban Adolescents

Ellen Decker

“OTHER PEOPLE’S CHILDREN”

Some call them “other people’s children” (Delpit, 1995, p. 137). They are a unique clinical population not only because they are adolescents, but because many of them come from high-risk environments where extreme emotional reactivity is the norm. Gangs are prevalent in their urban neighborhoods. Some have seen family members shot in the street. When they come to school, some of them are ready and eager to learn, and appear to have made sense of the trauma that is part of their daily existence. Others, however, come laden with firmly set defenses and seem more ready to fight than to learn.

GOALS OF THE GROUP AND GROUP COMPOSITION

The goals of the group are to prevent and reduce the frequency and intensity of angry outbursts and to assist group members in finding alternatives to inappropriate expressions of anger. Critical competencies and skills necessary for a successful mastery of the transition from adolescence to adulthood are incorporated into a supportive and therapeutic environment. A positive peer culture is stressed. Although the group is designed for schools, it can easily be adapted to community settings.

Described as an “anger management” group, and part of a larger school counseling program, the group is comprised of female students who have been referred to the school counselor because of frequent angry outbursts toward staff and peers. Some of the students are self-referred and others are referred by teachers or staff. A few are referred by their parents. Parent/guardian permission is required for group participation.

The school population is comprised primarily of African-American students. Group members are between the ages of twelve and fourteen. The group is gender specific and tailored to the unique issues adolescent girls face. The students themselves have requested that the group be for “girls only” and very clearly stated that they would feel self-conscious if the group included boys. Mixed-gender groups appear to make it difficult for girls to explore intimate and sensitive issues.

GROUP DESIGN

The group meets once a week for one hour. The setting is the school counselor’s office in an environment that is welcoming and relaxed. The group model integrates psychoeducation, cognitive-behavioral therapy techniques, relaxation training, journaling, and the processing of feelings related to normative life transitions. Group can be scheduled during the school day at a specific time or can be conducted after school. Group planning plays a large role in group success and before starting the group, the leader must do a thorough job of group selection. Brigman & Goodman (2001) provide a very helpful pregroup interview outline that can be used when making determinations of group composition.

THE INTERVENTION
Modeling a Nondefensive and Empathic Acceptance of Group Resistance

This section describes a group intervention intended to help members of a school-based anger management group gain skills in understanding and regulating their feelings. The goal of the intervention is to foster the development of empathy among group members and diffuse the anxiety resistance by modeling empathy. The leader’s skill at modeling a nondefensive and empathic response to resistance in the group forms the crux of this intervention. By demonstrating empathy “in vivo” within the group, members may begin to experience the group as a safe and supportive enough environment where the corrective emotional experience can occur. Internalization of the corrective emotional experience by group members can begin to chip away at the nonproductive defenses young people from high-risk backgrounds carry around with them. Although clearly not a technique that lends itself easily to a “how to” format, when using the modeling of empathy as a group intervention it is helpful to keep the following in mind:

1. **Resistance** is always going to be a part of any group, including adolescent groups. It serves a function of regulating group tension and defending against anxiety. It is the task and duty of the group leader to understand this concept and develop a way of being in the group that reframes the resistance.

2. **Therapist self-awareness** is the first step in modeling empathy in groups. It is imperative that the group leader take some time to explore his or her underlying, culturally learned assumptions, as well as identifying the cultural backgrounds of group members.

3. Developing skills in “reading” a group member’s emotional message is an important part of enacting the intervention. Keep in mind that behind the adolescent’s resistance in group is a feeling that is too difficult to confront. Use clinical skills to accurately interpret the emotional trigger and respond empathically. Ask questions based on empathic understanding.

4. The group leader should make a conscious effort to **weave empathy into the group** experience by encouraging and nurturing group members. By modeling a reflective listening style that mirrors an expressed emotion, the leader provides group members with an “in vivo” example of how to acknowledge and support what others have said.

5. When responding to group members’ expression of feelings, **utilize a structured listening approach** such as the one developed by Levine (2005). This technique can also be taught to group members as a means of effectively responding when members self-disclose. Levin suggests asking the following questions:

   - What happened? (identify the event)
   - How is the person feeling? (an understanding of the other person’s feelings leads to empathy)
   - What will I do? (decide on a specific action to respond to the event)

The group leader can teach this structured listening approach and demonstrate how it can be used effectively in group. Group members are more likely to respond to one another with empathy after being encouraged by the group leader to ask these three questions.

6. **Be conscious of physical space in the group.** Empathy can be modeled in group by physically orienting oneself toward the group member who is speaking.

7. **Be consistent in providing a structured, limit-setting yet supportive stance when acting out**
Adolescents can say and do things that may be hurtful to each other and/or to the group leader. Validate feelings without condoning behavior that is harmful to themselves or others. Working with adolescents takes tremendous personal energy and patience. Take the time to reflect with trusted colleagues or a supervisor when countertransference reactions appear to be impeding group growth.

8. **Reinforce empathic responses** given by group members to one another. For example, when a member makes a self-disclosure that displays a parallel experience (“me-too” disclosures) (Fuhriman & Burlingame, p. 501), or in another way verbally confirms an understanding of another group member’s experience, the leader can reinforce the response with an encouraging verbal comment and/or a supportive look or nod.

**CONCLUSION**

Modeling a nondefensive and empathic acceptance of resistance in adolescent groups is an intervention that can enhance adolescents’ empathy and prosocial behavior. In order to effectively carry out this intervention, the group leader must ascribe to the paradigm that resistant behavior in the group is a part of the group’s developmental need, and as such, must be responded to with a positive connotation (Hurley, 1984). Equally important is a stance that incorporates the dynamic of “power and otherness” (Delpit, 1995, p. 134) when communicating across individual and social differences within the group. Power differential, stereotypes, and other barriers can “prevent us from seeing each other” (p. 134). “Seeing” each other forms the core of the empathic response, and when modeled by the leader in group, can be an effective technique when working through the resistance of adolescents.

**CONTRAINDICATIONS**

Contraindications to group membership include combining girls who are of the same chronological age but at different cognitive or social developmental levels. If these differences are not taken into consideration when forming the group, peer rejection and feelings of frustration may impede the growth of the group and the acquisition of critical anger management skills. Consideration of these contraindications leads to a greater probability that the group environment will be one in which members will learn practical and healthy ways of relating to their peers and gain understanding of their own feelings and behaviors.

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Saying Goodbye: A Termination Ritual

Jondra Pennington

CONNECTEDNESS

Group work creates connection. However, many times the group does not encourage maintaining these connections outside the therapy room. Nevertheless, the bonding of members can be intense and they usually want some way to hold on to their group experience once it is over.

In the lives of many patients, endings have not necessarily been positive experiences. They can stir up unresolved issues around loss and separation (Fehr, 2003). Termination rituals give patients a new, different, and corrective emotional experience that they can take out of the group room and into their lives (Shapiro, Peltz, & Bernadett-Shapiro, 1998).

This particular goodbye ritual provides patients a means to not only receive a new goodbye experience, but, also a tangible touchstone, if you will, with their group experience that they can literally carry with them for years to come.

CLIENT POPULATION

I was introduced to this ritual at an inpatient eating disorders facility in groups made up of women aged eighteen and older. The group was process oriented and met every morning for ninety minutes at the beginning of the treatment day. When the facility had a full census the group had eight patients with two therapists facilitating. Although this intervention was used in an inpatient setting, it is just as useful in an outpatient setting where patients move beyond the superficial level of interaction by sharing and processing at deeper levels. This would be a very appropriate intervention with adolescent groups, as well.

DESCRIPTION OF THE INTERVENTION

You will need to create a small collection of interesting rocks to keep in your office. The rocks should not be too small or too large, but of a size that allows them to be carried in a person’s pocket or purse, and it should have some interesting characteristics.

Step One: Selecting a Rock for a Patient
Notice the rock’s characteristics: sparkly, shiny, smooth on one side, rough on the other, perfect except for one small flaw, multicolored, sharp, soft, small yet heavy, larger yet lightweight. Consider in what ways the characteristics of the rock remind you of the patient—the more you can connect the characteristics and “feel” of the rock with the patient, the better.

**Step Two: Beginning the Ritual**

The session opens with the therapist announcing that the group is saying goodbye to a peer that day. The therapist then takes out the rock and is the one who begins the ritual. It might go something like this:

TH: Martha, one characteristic that made me choose this rock (holding it up for others to see) is that it is seemingly perfect, except for this one tiny flaw. Yet, notice that the imperfection does not detract from the rock’s beauty, but actually enhances it. We all know how you struggled with perfectionism and how, during your time in group, you have come to accept yourself, warts and all. When you look at this rock and recall that its beauty is not detracted by the imperfection, but, it is the imperfection that makes it beautiful, I hope you will apply that to yourself and continue to embrace your own beauty and uniqueness.

If you look closely, you will even see that that the rock has a certain sparkly quality. When you first got here, you were quiet, shy, and withdrawn. Now, as you prepare to leave and I reflect on how far you have come, I see a woman who enthusiastically reaches out to her peers by being helpful and supportive. You allow yourself to have fun and as a result, your own sparkly personality shines through. Your effervescence is one of the things that I will always remember about you.

**Step Three: Passing It On**

Once the therapist has spoken, the rock is then passed to the person beside her, who then shares his or her thoughts with the patient, talking about the progress they have made, how their time together has influenced them, or anything else that summarizes what the two have shared while in group together. The rock is further passed around the circle for every member to speak. The “patient of honor” must simply listen to the comments until all have had a turn.

**Step Four: The Departing Patient’s Turn**

The rock will eventually return to the therapist after making its circle around the group. The therapist then places the rock in the departing patient’s hand. It is then the patient’s turn to address each member of the group, including the therapist(s), sharing his or her experiences and what the group and their time in treatment together has meant to the patient.

**Step Five: Ending the Session**

This intervention will probably take up the entire group time. If your group has a regular closing ritual, close the group as you normally would.
VARIATIONS ON A THEME

This same intervention can be used with shells or any other element from nature that is not fragile and will last. In addition to the feedback element of the ritual, each person can also “endow” the item with some characteristic that the patient needs to get by in the world. For example, “In parting, I put into this rock the gift of self-esteem with the hope that you always remember how valuable and worthy you are.”

CLIENT RESPONSES

The emotions in a group are often heightened at termination, even if only one person is leaving. The relationships formed have a deep level of intimacy and this intervention allows the patient to leave the group with a tangible symbol of his or her experience and the healing changes they have made. Typically, the departing patient will be uncomfortable being the center of attention. Often patients are not used to receiving this extent of positive feedback at one time, about how he or she has changed, grown, and the impact the patient’s being has had on other members of the group. Tears are common as the individual begins to experience leaving in a completely new way. After the group ends for the day, it is typical for members to take turns hugging the departing peer and, because of this, leaving the group room usually takes longer on “goodbye days.” Patients’ self-reports indicate that they become quite attached to their memento and carry it around with them, at all times, or give it a place of honor in their home or office.

CONTRAINDICATIONS

This ritual, due to its emotionality, calls for depth of knowledge of the patient by the therapist and the group members. It will not have a profound effect if the group was at a point where intimacy had not yet been attained. Therefore, the most favorable predictor of its outcome will be in clinical settings where personal information is disclosed and trust had been built between the clients. Psychoeducational groups, due to the parameters of their particular paradigm, seem to be the only contraindicated group for this intervention because of the oftentimes superficial level of personal information that is typically shared.

REFERENCES


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Using the Group Power for Interpretation

Dan Raviv

A PERSONAL STYLE OF INTERVENTION

There are many approaches to the art of conducting group therapy (Fehr, 2003). However, interventions by the therapist are used in most of those approaches and are among the most important tools used for affecting change. Over the years I have attempted to use various approaches which probably reflected the way I perceived the world at different periods in my life. Over time I have found myself settling into a more consistent, eclectic approach that seems to express my comfort zone at the present time. Therapists need to find the style of intervention that suits them and are appropriate to the situation in the group at the time they make the intervention (Yalom & Leszcz, 2005; Caligor, Fieldsteel & Brok, 1984). Interventions while conducting group therapy, are very important moments in the process and when done correctly and appropriately, can create the impact that can change a person’s life. The most powerful interventions that seem to typically affect group members are the interventions that draw insight from the here-and-now, group-as-a-whole experience in the room (Agazarian, 1989). Those interventions seem to cut through resistance because they are experienced in a very authentic way when the timing is just right.

CLIENT POPULATION

This type of intervention tends to be effective with clients who possess average and above-average cognition capabilities since it requires some abstract thinking. Clients who tend to be concrete in their perception of the world may become too defensive as they may perceive the intervention as an attack or may not be able to see a connection between their issues and the issues of other group members.

INTERVENTION GUIDELINES

The group therapist needs to listen simultaneously to the individual member as well as the mood in the room. Experienced group therapists are aware that often the silent group members are “carrying” the feelings that are not expressed by a talking member. On many occasions during the group process a person who is expressing certain frustrations are talking from their heads but not necessarily from their emotional base where old pain is lodged. The goal of treatment is to move the focus from the head where the problem is theoretical in nature and therefore not resolvable, to that elusive emotional base where the pain is hidden and needs to be released. By allowing the frustration causing pain to be fully felt there is a chance for resolution.

Example

A forty-year-old single woman who has been in the group for about three years was talking about the recent admission of her alcoholic brother to a rehabilitation facility. She spoke in length about her awareness that the rest of her family will not act honestly when they are called to a family treatment session as is required by the rehabilitation facility. She felt that
she would need to take care of her family members by protecting them from having to face the truth about their own contribution to her brother’s addiction. She was also worried about being attacked and isolated by her family if they felt too threatened by her approach to dealing with her brother’s addiction issues. While she was talking, the rest of the group members were mostly quiet with occasional concrete suggestions as to how to respond to her family members.

**Therapist Intervention: A Four-Stage Process**

**Stage One: Seeking the Core Issue**

It is the role of the therapist to be able to extract the core issue from the many words and feelings that the client(s) in group therapy disclose. In this case, one of the co-leaders asked her if she thought about her own needs and who will take care of her.

**Stage Two: Clients Ponder But Are Often Interrupted by Other Group Members**

She thought for a minute but was interrupted by a group member who wanted to give her advice as to how to deal with her family and she did not respond to the therapist’s question.

**Stage Three: Observation and Analysis of Group-As-a-Whole**

As I observed the process I realized that the entire group was becoming numb and slowly fading away. I realized that the issue in the room was the inability to ask for one’s own needs. The group members were all identified with the unparented child who needs to take care of his or her parents to make sure they will survive and to take care of himself or herself.

**Stage Four: Appropriate Timing and Reframing the Interpretation to a Group-As-a-Whole Issue**

At that point, I said that I am aware that everyone in the room is a caretaker and no one is allowing others to take care of them. That stopped the discussion and changed the process to focus on what makes it so difficult for the members to allow themselves to receive care, etc. The timing of this interpretation was powerful because everyone was so busy focusing on the member who was talking about her family that they dropped their conscious defenses against their own difficulties in accepting support from others. During the rest of the session the members focused on being “trained caretakers” who are not comfortable in receiving care and their need to change this tendency.

**CLIENTS’ RESPONSES TO THE INTERVENTION**

Clients were able to refocus their attention on the reasons many of them enter therapy in the first place. Once their defenses were lowered by the focus being on another group member, they really heard the therapeutic message, which allowed them to reflect on avoiding old behaviors and its consequences while considering new behaviors that may be more in sync with their true needs.
CONCLUSION AND CONTRAINDICATIONS

The group therapist needs to work on at least two levels. She or he needs to listen to the content and at the same time listen to the emotional mood in the room. The content is important since it provides the substance for the verbal interaction, but the emotional mood provides the true unspoken and possibly unconscious issues in the room. A well-timed interpretation may make this unspoken and/or unconscious material available for exploration by the group members and may lead to growth.

A contraindication of this intervention is a poorly timed interpretation, which may create a hardening of the defenses and close off potential openness for growth (Yalom & Leszcz, 2005). If the interpretation happened too early in the session the group members may not have considered themselves to be in the same “camp” with the member who spoke and not connected emotionally to her particular tendency to avoid being nurtured.

REFERENCES


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VIOLATING A CORE VALUE

The chronic and progressive nature of addiction eventually leads the individual to violate one’s core values as a person (Perkins, 1997). Motivation to change increases when there exists a sense of dissonance between one’s ideal self and one’s behavior (Festinger, 1977; Aronson, 1999). Individuals are more likely to make an argument for change when they begin to experience incongruence between their stated goals and their behaviors (Miller & Rollnick, 2002). A confrontation of the individual’s incongruent behaviors may lead to increased defensiveness and discomfort with the change process (DiClemente & Velasquez, 2002).
DESCRIPTION OF THE GROUPS

This group activity can be used with any group whose main focus is to change behaviors. These can be substance abuse groups, anger management groups, batterer groups, and groups for individuals with co-occurring disorders. The author has used this exercise with many of these populations and it has been helpful in assisting the group members to identify the core values that have been violated.

THE INTERVENTIONS

This group activity requires that the group leader take more of a facilitator role. The group facilitator should be willing to be dramatic and convey enthusiasm and energy for the group members in order to be effective.

Activity

The group facilitator tells the group that today we will talk about core values. At this point, the group leader should be standing and writing the group members’ answers on the board. Elicit a definition of what a core value is. The definition is agreed upon by consensus.

The facilitator then requests that the group members take five minutes to think about which values they hold most dearly. After the five minutes have elapsed the group leader will ask each group member to share his or her answers.

The facilitator needs to be skilled to elicit specific core values. For instance, if a group member gives the answer that family is a core value for them the group leader will ask for the details. An acceptable answer would be: Being trusted by my family is a core value. The group facilitator’s task is to elicit and write the responses on the board. By the end of this part of the exercise there should be at least double the amount of core values as there are group members.

At this point the group members are provided with an imaginary $1,000 credit limit with which they will be able to bid on the values on the board. The group members are encouraged to outbid one another in increments of $100 in order to do the math. For instance, the core value of having a sense of integrity could be “bought” for $300. If John Smith buys this value his name is placed next to the core value along with the cost. John Smith would have $700 on his credit limit remaining. This process continues until all of the core values are bid on by the group members. The group facilitator can mimic the speech of an auctioneer and feel free to use the expression, “going once, going twice, going three times . . . sold to Mr. Smith for $300.”

Once all of the values have been bid on, the group facilitator questions each owner of the value on how his or her substance use has violated this core value. Enough time is allowed to process these answers among the group members. At this time the group facilitator should be seated as in a traditional process group. It is important for the group facilitator to provide support and encouragement to the group members as they begin to realize how their behaviors have violated their core values.

TYPICAL RESPONSES

The initial response from group members would be one of reluctance to participate due to a sense of embarrassment. After the second or third core value is bid on, group members begin to
feel more comfortable. Friendly competition among group members may manifest itself. Group members may brag that they were able to buy what they really wanted or they may verbalize disappointment that they were outbid by a peer.

Group members will tend to become more serious as they speak about how they violated their core values. These group members may begin to verbalize feelings of guilt and shame regarding their core values. The skilled group facilitator will be able to help the group members change from a sense of discomfort and guilt into a sense of increased motivation to change his or her behavior by providing support and encouragement. The group facilitator helps to elicit arguments for change from the group members. For example, what would happen in the future if this behavior does not change? What concerns you about your violation of your personal core value? How important is it for you to change this behavior? How confident are you that you will be able to change this behavior? If not, what has to happen in order to make this happen? These are just some of the examples of the type of open-ended questions that can be asked in order to increase motivation.

**CONCLUSION AND CONTRAINDICATIONS**

This group activity can assist in engaging group members into a greater understanding of how their behaviors are ego dystonic, thus producing motivation to change behaviors. It is also a good diversion from the traditional process group.

This group activity can be used with any population that is able to have a minimum level of abstract reasoning. Individuals who are severely impaired in this area may enjoy the auction part of the activity but they may not be able to ultimately make the necessary connection between these abstract core values and their own behaviors.

**REFERENCES**


John Mendez, Ph.D. received his doctorate in social work from Barry University where he is an adjunct professor of Social Work. He currently works for the Department of Veterans Affairs, in their Miami Outpatient Substance Abuse Clinic.
Individual Psychotherapy in the Context of a Group: An Intervention

Joan E. Childs

INTRODUCTION

To better understand the following intervention, it would be necessary for me to explain the format I developed over the thirty years I have been in private practice. I often include individual experiential psychotherapy in the context of the group. This approach is commonly used in inpatient treatment centers where group therapy is the therapeutic modality of choice. When an opportunity presents itself to work with a client within the context of the group, I first ask permission, (e.g., “Would you like to do a piece of work?”) This approach not only provides insight and/or resolution for the participating client, but also promotes processing and feedback for both the individual and other group members. Often, other members are triggered into their own unresolved conflicts while being a benign witness to a working member and can benefit greatly from this process.

I employ an eclectic approach combining many therapeutic modalities, but in this particular intervention I predominantly used the principles of guided imagery. Guided imagery is an effective and simple relaxation technique used for meditation and/or hypnosis that helps to manage stress, reduce tension, and induce regressive and/or repressed memories. I also use neuro-linguistic programming (NLP), a communication technology that utilizes the work of Milton Erikson, MD, founder of the American Society of Clinical Hypnosis and one of the most widely acknowledged and clinically successful psychiatrists of our times (Bandler, Grinder, 1975; Bradshaw, 1988; Zeig, 1985; DeLozier, 1977; Dilts, Ginder, Bandler, & DeLozier, 1980). NLP employs the three most influential components involved in producing human experience: neurology, language, and programming. Used together with Eriksonian hypnosis, these modalities provide experiential processes, rather than “talk therapy,” which impact the amygdala, (where I believe trauma and stuck states are lodged, thus helping individuals to release repressed negative thoughts, feelings, and compulsive behaviors that are preventing them from moving forward in their lives.)

GROUP DESCRIPTION

This particular group is newly formed. It consists of eight participants—five women and three men. The group is time limited and requires a six-month commitment in order to participate. The members have the option of continuing at the termination of the six months, with another six-month commitment. No new members are permitted entry during the six-month period. The focus is primarily an experiential, process group. The members are high functioning, all having the ability to be introspective and open. They are selected from my client population. Each member has been in treatment for at least six months.

PRESENTED ISSUE

A client disclosed sadly that her cat of fourteen years had suddenly passed away. Over the weeks, she had revealed that a new relationship had usurped her time with her pet, as all her available time after work had been dedicated to developing this new romance, leaving little time
and attention for her animal.

This client holds a high professional position. Her job is demanding, quite often she keeps longer hours than her staff. Due to the pressure of the job and her new boyfriend, the cat was left to fend for himself, which was a deviation from the fourteen previous years as her one and only pet.

The client related that her animal had an ingrown nail that went clearly unnoticed until an infection caused her to take him to the vet. The vet assured her that the procedure of removing the nail was not dangerous, stating that she would be called as soon as he was ready to go home.

Hours later, she received the unexpected phone call that her animal had died. The vet was shocked. The client was horrified and felt responsible. She felt she had done to him what her family had done to her: a reenactment of abandonment.

When she shared her loss with the group, her affect was flat as she reported the event and circumstances leading to his death. Her inability to emote prompted an intervention. It occurred to me that she was indeed in a state of grief and remorse, feeling responsible and guilty for her cat’s demise, but her defenses prohibited her from releasing the appropriate emotions. Asked if she wanted to do some work with this loss, she accepted the offer without contemplation.

THE INTERVENTION

I began with the use of guided imagery, (Bandler & Grinder, 1975; Bradshaw; 1988), and asked the client to close her eyes and go to the last time things were well with her cat and her. I had her visualize that moment. In only seconds, the tears flowed. I asked her to tell her pet that this would be the last time they would be together. The group watched in awe as her state transformed into one of deep grief. Her head held in her hand, she began to weep. I prompted her to tell him whatever she needed to say to have the closure she so desperately needed. “Look into your cat’s eyes and tell him how sorry you are that this happened. Tell him that you hope he will forgive you for not being there as much as you used to be. Imagine that you can touch his back, feeling the fur that coats his body; imagine that you can put your face close to his and feel his presence; allow yourself to be present and tell him how important he was to you.”

All this was done in silence through her own neurological system. I prompted her with the words that would provide her with the healing she needed. I had her complete stem sentences such as:

• “What I will miss the most about you will be. . .”
• “I will treasure and cherish. . .”

As she did her internal processing, she was encouraged to say whatever else she needed to say to complete this work. As she processed these moments in silence the tears and sobbing exacerbated. I encouraged her to release her pain.

“Let it come up,” I said, encouraging her to allow her feelings to emerge. Some of the other members encouraged her as well. They identified with their own losses. Soon the sobbing became louder, and her guttural cries resounded in the room. She cried for her cat. She cried for herself as a child. The intervention took about ten minutes. I encouraged her to release the energy that had been frozen in her since childhood.

RESPONSES TO THE INTERVENTION
The response of both the client and the group to this particular intervention was perceived according to each member’s own history. Some shed their own tears; others sat in silence caught up in their own memories and thoughts. I asked the client to look around the room at the faces of all the others. I asked her if she wanted some feedback. She observed their empathy and sensitivity to her pain. I asked her to first state her own feelings about what had just occurred. She described her experience as a release of long pent-up emotions, and felt grateful to the group and me for the time and validation. After she disclosed her feelings, each of the members gave her feedback. At the conclusion, we talked about grief and loss, each member relating his or her own experience: a healing for everyone.

**CONCLUSION**

In conclusion, this particular technique is very effective for providing feeling work, catharsis, (especially for grief work), and the opportunity for the client to realize that the client is not alone, (Yalom, 1975). It allows for feelings to be expressed, acknowledged, and honored. It is part of the healing work or original pain work (Bradshaw, 1988).

**CONTRAINDICATIONS**

Individual experiential psychotherapy must be handled and utilized cautiously. The clients must be high functioning, have good ego strengths, and willing to receive feedback from the other members. It is important to be careful about who is chosen as a member. Certainly anyone with borderline personality features or disorders, antisocial or narcissistic personality disorders would not be a candidate. Severely depressed clients with poor ego boundaries, active substance users or anyone with marginal intellectual functioning would not be appropriate. In addition, no one should be forced to participate if they are not willing to do so. However, when choosing members for this type of group experience, that is already a consideration.

**REFERENCES**


Joan E. Childs, LCSW, is a Clinical Social Worker specializing in Inner Child Work and Second Stage Recovery. Joan is certified in many modalities such as NLP, (neuro-linguistic
programming), EMDR, (eye movement desensitization and reprocessing), Hypnosis, PAIRS, (Practical Applications for Intimate Relationship Skills), and Original Pain Work.

The Rope Exercise to Experience Process in the Group

Edward W.C. McAllister

EXPERIENCING THE VARIOUS STAGES OF GROUP

Groups move through various stages of development. Many theorists have described these stages (see Fehr [2003] Chapter 7 for an overview of some of the theories). In working effectively in a group, it is useful if the group members have some idea about what to expect while in the group. Shultz (1973) has a theory of group development that will help group members to understand some of the phenomena that they will experience in a group. He bases this work on three interpersonal needs of inclusion, control, and affection.

Inclusion refers to my feelings about being important, significant or worthwhile. Control refers to my feelings of competence, including intelligence, appearance, practicality, and ability to cope with the world. Affection revolves around my feelings of being lovable, of feeling that if my personal essence is revealed in its entirety, it will be seen as a lovely thing. (p. 38)

As members of groups learn to look for the manifestations of these needs within the group, it helps them to understand their own behavior in the group and the behavior of their fellow group members. The issue of inclusion generally arises at the first stage of the group and creates the feeling that you are in or out of the group. The second stage develops when the issue of control arises. Each group member tries to establish a position in the group. Are they near the top or the bottom in the group in competence, appearance, and influence? The third stage begins when the issue of affection arises. Do members of the group feel close or distant to others in the group (Schultz, 1973)? The development of these stages is not linear and the stages may continually cycle during group sessions. However, if group members are able to recognize the need behind the behaviors in the group, the process may be expedited.

A creative technique to help group members experience some of these issues and group stages involves the use of a long rope. Jacobs (1992) stated that the reasons for using such techniques are to make concepts more concrete, to heighten awareness, to dramatize a point, to speed up the counseling process, to enhance learning because people are visual learners, to enhance learning because people learn through experience and to focus the session.

DESCRIPTION OF THE GROUPS

For many educational, growth, or short-term outpatient process groups, this intervention might help to provide experiences that demonstrate the issues and stages that are involved in
group work. The group should be high functioning so that members are able to verbally process the physical and psychological experiences that occur during the intervention.

**GUIDELINES FOR THE INTERVENTION**

**Materials**

In order carry out this exercise in a group of about ten, you will need a rope of about fifty feet in length and at least three-quarters of an inch thick. (The operating guideline is about five feet of rope per person.)

**Procedure**

*Step 1: Bring out the rope and explain the exercise*

Bring out the rope and explain to the group that the exercise is designed to create some physical representations of reactions and feelings that they might experience in the group. Tell them that they are going to all work with the rope at the same time and create a group that is simultaneously holding the rope.

*Step 2: Setting the group to hold the rope*

Ask each member of the group to form a line and have everyone face in the direction selected by the therapist. Take the rope behind the line of people and ask each person to hold a section of the rope behind them about belt high. Each person should hold the rope across his or her back at the belt line with each hand facing palm forward. This means that each person will receive the rope with his or her left hand, palm facing forward, run the rope across their back at the belt line and then hold the rope with the right hand, palm facing forward. The rope then extends on to the next person who holds the rope in the same manner. When the initial preparation is complete, everyone should be holding the rope across his or her back at the belt line with two hands and about two feet of space between each person.

*Step 3: The first movement*

Tell the group that you are going to give them some directions to move and that you will tell them what to do. Ask each person in the group to carefully move about the room in any direction that they choose without letting go of the rope for about five seconds and then tell them to STOP. Next tell them to each move again in a different direction for about five seconds and then tell them to STOP. (If the group members had all moved in the same direction on the first move ask them to be sure to go in different directions on the second so that they are NOT all going in the same directions. Also remind them to not let go of the rope.)

*Step 4: The second movement*

Ask the group to keep holding the rope behind themselves at the belt line with both hands and to now form a circle keeping about two feet of space between them. When they do this they
should all be in a circle facing the center of the circle with the rope going around the back of each person in the group. Ask the group to move together in a circle. Do not tell them which way to go. Once the group is moving in a circle smoothly for about five seconds tell them to STOP and remain in place.

**Step 5: The third movement**

Place a chair just inside the group at some point in the circle. Ask the group to continue holding the rope and ask them to resume going in a slow circle. As the group is moving, select a person who has just passed the chair and say, “Mary (use the person’s name) the next time you come to the chair sit down on it.” When Mary comes to the chair and sits, the group will likely stop and Mary may let go of the rope. When Mary is sitting with or without holding the rope, tell the group, “Okay, let’s resume moving in a circle now.” The group will either move on without Mary if she has released the rope or if she is still holding the rope, she will likely get up and move with the group.

**Step 6: End of the exercise**

After the group has made another revolution around the room tell the group to STOP. Ask them to let go of the rope, remove it from the group and ask everyone to find a place and to sit down. Tell the group that you now want to explore what happened during the exercise.

1. First ask the group members what it was like to try to move around the room connected to the rope. Next, ask if they had any feelings about any of the other people or other people’s behavior during the first movement.
2. Ask the same questions about the second movement where they went together in a circle.
3. Ask the same questions about the third movement starting with the person that you asked to sit in the chair.
4. Ask the group member reactions to the overall exercise and to the people along the rope with them.

In working through each of the questions, the therapist is centered on interpreting the responses from the group members using the issues of inclusion, control, and affection. Did group members express feeling in or out of the group in each of the movements? Did they feel that their competence or power was top or bottom in various movements? Did they develop any feelings of close or distant during the movements? After the initial response reports, the therapist should give an overview of the stages of inclusion, control and affection in groups. Discuss how these issues are continually active in a group with the most success occurring when the majority of the group members are in, top and close.

**RESPONSES TO THE INTERVENTION**

The skill of the therapist in identifying the issues of inclusion, control, and affection is key to the success of the exercise. In the first movement many people will describe feeling restricted or inhibited. They are feeling in the group since they are attached to the rope but restricted by the rope so at the bottom in power. Some may say they went along with some other person’s
movements (bottom) or they just moved as they wished and let others follow (top). In the second movement there may be more reports of feeling like they were moving together (in) or that they were dragged along (out and bottom). In the third movement, the person who sits may say they felt they moved out of the group or that they had the power to stop the group (top). Those in the group might report feeling stopped by the one who sat (bottom). Responding to the overall exercise there might be reports that lead to in or out, top or bottom and even close or distant feelings.

**CONTRAINDICATIONS**

The main contraindication to carrying out the exercise is the issue of safety. The therapist must be aware that people need to move with some care and not become too exuberant lest people fall or get injured. In working with adolescent groups or those with individuals who may be easily frustrated the therapist should consider if the intervention would be appropriate or should take extra steps to ensure that no one violently or suddenly pulls on the rope. The rope that is selected should also be of concern to be sure that it is smooth and not rough on the skin.

**REFERENCES**


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Let’s Talk

Susan J. Mendelsohn

**EFFECTIVE COMMUNICATION**

The concept of effective communication between two humans seems so simple; yet communication—or ineffective communication—is at the crux of what tears relationships apart. Furthermore, Markman (1981) identified premarital communication as one of the strongest predictors of future marital distress.

Communication is so healthy, yet we do it so rarely. Between e-mails, memos, text messages, faxes, and Blackberries, we can go an entire day, or even days, without talking to a single person. Effective communication is so much more than merely getting your point across. It’s about listening, empathizing, and allowing ourselves to be open enough to become vulnerable all in the
name of reviving relationships and enhancing self-esteem.

In this sense, self-esteem refers to whether one accepts oneself, respects oneself, and considers oneself a person of worth and assertiveness training (AT) is thought to enhance one’s self-esteem, self-confidence, interpersonal relationships, personal fulfillment, and internal locus of control (Delamater & McNamara, 1986; Mendelson, 2007).

THE GROUP

This particular intervention is effective with both time-limited and ongoing process groups. These skills are recommended for clients with at least average intelligence and those who have the ability to be introspective. These skills are not likely to be used with clients that are psychotic or intellectually challenged. These skills can be practiced within the group setting as well as outside group therapy with a partner or in a mirror for enhanced proficiency.

DESCRIPTION OF INTERVENTION

Before learning the skills of effective communication, I empower my clients with a list of basic human rights. We carefully review this list together and pinpoint those statements that the clients find challenging. Reviewing this list provides insight, which allows the clients to realize that they, too, deserve to be treated with dignity and utmost respect. Most of my clients have the belief that they are selfish if they place their needs before the desires or requests of others, hence, their difficulties and disorders grow worse and worse over time. Learning these interventions will assist them in not only healing themselves, but also provide more assistance to their friends and loved ones with enhanced effectiveness. I often use the example: If the plane is going down and you hand out oxygen masks to everyone else, you have no life left. But, if you give air to yourself first, you can provide subsistence to everyone else and all can thrive.

Working through this in the group setting provides the members with a sense of universality and allows them to work through their personal conflicts together. I teach my clients that if they want respect they must first respect themselves. If they believe they must be “sweet” at all times, they will invite being used. In the same sense, if they behave as if they are incompetent, they will invite others to be critical of them. In the following section are the basic human rights that the group members are armed with and must believe in prior to gaining the skills of effective communication (Mendelsohn, 2007).

I Have the Right to:

- Ask for what I want.
- Say no to requests or demands that I cannot meet.
- Express all of my feelings, positive or negative.
- Change my mind.
- Make mistakes.
- Not have to be perfect.
- Follow my own values and standards.
- Say no to anything when I feel I am not ready, it is unsafe, or it violates my values.
- Determine my own priorities.
- Expect honesty from others.
• Be uniquely myself.
• Be angry at someone I love.
• Feel scared and say I am afraid.
• Say I do not know.
• Not give excuses or reasons for my behavior.
• Make decisions based on my feelings.
• My own personal space and time.
• Be playful and frivolous.
• Be healthier than those around me.
• Be in a non-abusive environment.
• Make friends and be comfortable around people.
• Change and grow.
• Have my needs and wants respected by others.
• Be treated with dignity and respect.
• Be happy.

After the group members have learned and processed their human rights together, they are ready to move on to effective communication skills. At this time, the group leader reviews the following tips for proficient assertiveness communication. They are as follows:

• Agree on a time and place that is convenient for you and the person to whom you are making a request.
• Make sure your requests are clear, direct, and nonjudgmental.
• Speak clearly, audibly, and firmly.
• Keep tone of voice moderate without implying blame or attack.
• Maintain eye contact. Looking up and down and all around is passive behavior. The listener will lose respect for you if you cannot look at him or her directly.
• Make request small enough to avoid major resistance.
• Keep request simple, specific, and understandable.
• Be objective by communicating the facts rather than fighting the personalities involved, providing the opportunity to state your case.
• Be honest, not cruel. This is not about winning, but communicating to be understood and to experience the realities of others.
• Describe your desires in terms of behaviors, not attitudes.
• Keep arms and legs uncrossed so as not to put the person to whom you are talking on the defensive.
• Do not apologize after you have made your request. This only negates your entire request or feelings, keeping you passive and wishy-washy.
• Focus on the results. Mention the benefits of having your request fulfilled rather than the disadvantages. You do not want to appear manipulative.
• Use “I” messages that express your feelings without blaming others. This gives you personal power and does not attack the other person.
• Connect the feeling statement to the behavior of others, rather than to the person. People are not “bad.” It may simply be that their actions dissatisfy you.

Once this list is reviewed, the group breaks into pairs for rehearsal. Later, each pair will role-
play in front of the other group members and all members will constructively critique the group members’ skills. If the clients are timid at first, the group leader can model the assertiveness skills initially with a “courageous” group member.

**TYPICAL RESPONSE TO THE INTERVENTION**

My clients feel a renewed sense of self-esteem in nearly all aspects of their lives as their skills improve. They feel hopeful that they can conquer obstacles that come their way without retreating into a world of fear that has paralyzed them in the past. This is evidenced by observing the group members using their newfound skills appropriately week after week during group sessions with decreased anxiety.

Interestingly, I have noted a secondary benefit to this training not only for the communicator, but for the listener as well. The group members who typically shied away from being confronted are now able to accept being confronted without recoiling back into their fearful and passive stances. In other words, when a group member asserts himself or herself, the former “scardy cat” is no longer personalizing what is being said and rather gaining a better understanding about what is happening. Hence, the previous “scardy cat” has gained the tools to step up to the plate and communicate more effectively as well, allowing for a more healthy exchange.

This type of intervention assists my clients in all aspects of their lives, providing a sense of self-esteem, self-worth, pride, and overall well-being.

**CONTRAINDICATIONS**

This intervention may have contraindications if the client is not fully educated about the purpose of the skills training from the start. The client must understand that assertive communication is for the sake of the client and not for the sake of changing others. Clients must recognize that standing up for their rights and expressing their views will provide them with a greater sense of freedom, enhanced self-esteem and self-worth, and assist him or her in eliminating self-destructive behaviors by uncovering some of those pent-up thoughts, feelings, and desires. They will feel more empowered to overcome obstacles, which in the past they were too fragile to overcome, simply by getting it “off their chest” rather than consciously suppressing their thoughts and feelings.

If the clients irrationally believe they are going to change the response of others simply because they are speaking up, there may be unnecessary frustration that would cause the clients to withdraw, once again, into a world of self-destructive thoughts and behaviors.

Another contraindication to learning this type of skill is a possible loss of a current relationship. It is sad but true. For example, in the case of a marriage or other intimate partner relationship, the more dominating partner may have chosen the more passive partner for obvious reasons: control. Once this passive partner becomes more assertive (hence enhancing his or her sense of self-esteem), the more dominating partner may not appreciate this newfound sense of self-worth on behalf of his or her partner and become frustrated and experience feelings of insecurity due to the loss of control and anxiety over the new direction in which the relationship has begun to develop.

Therefore, both partners should learn this technique together. If both partners are not willing to learn this skill together, this may be the very reason that one partner came in for therapy, in the first place, that is, to learn how to speak up and find a voice. I strongly urge the clinician to
use a disclaimer prior to beginning of this type of skills training by explaining to the client the benefits and consequences of enhancing his or her sense of self-esteem through this method. Obviously, the long-term benefits certainly outweigh the short-term consequences for the client. Living in passive fear will only hinder striving toward one’s greatest potentials, and the loss of a current abusive relationship is hardly a consequence to gaining a skill that will enhance the client’s future in all aspects of his or her life.

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A Transitional Exercise from Didactic to the Experiential in Group Therapy

Daniel S. Schoenwald

INTRODUCTION

Many mental health graduate programs require classes in group psychotherapy. Like all forms of groups, student groups are unique in their specific set of challenges, mainly as a result of its format. Although variation exists among programs and instructors with respect to design, most group psychotherapy classes, in addition to didactic portions, necessitate that the students conduct process psychotherapy on one another over the course of a semester or longer. Learning group psychotherapy and process must be achieved experientially (Fehr, 2003). This task presents as a challenge for many students, as transitioning from the didactic to the experiential format requires that they engage in new roles. In order to aid in this process, I introduce a particular exercise which is also designed to strengthen the bonds among them, fostering a more emotionally based setting.

A GRADUATE STUDENT POPULATION

The intervention is proposed for mental health graduate students (social work, master’s/doctoral in clinical psychology, psychiatry) taking classes in group psychotherapy and process. By definition, these are time-limited groups. However, this particular intervention can be adapted for use in any format of clinical group, depending upon the needs that the leader
views as necessary.

DESCRIPTION OF INTERVENTION

I format my group psychotherapy class to have didactic sessions and chapter presentations during the first half of the semester. These presentations are conducted in a therapeutic circle and are thus, an introduction to the group psychotherapy sessions, which occur during the second half of the semester. This particular intervention, which involves students presenting the chapters in the book as their initial experience with learning how to create dialogue in a group, was taught to me by my professor in graduate school. The initial class meeting usually entails a mixture of both anxiety and excitement, and then proceeds for several class meetings with intellectualization as the prominent feature.

With the intention of introducing more emotion to the class environment, I introduce a “special exercise” at the halfway point of the first half of the semester, toward the end of the didactic portion of that particular class. Previous to this point in the semester, on the first day of class, I mention that the 2002 American Psychological Association’s ethical guidelines outline that students are not required to disclose personal information about themselves (APA, 2002). A developing sense of cohesion at this point typically allows for the exercise to be effective. The instructions, which are adapted from Irvin Yalom’s *Theory and Practice of Group Psychotherapy* (Yalom, 1995, p. 7), are as follows:

**Exercise**

I begin the exercise with these instructions: “Please take out a blank piece of paper. Without showing anyone, I would like you to write down the one thing about yourself that you would be most disinclined to share with the class. When you are finished, fold your paper in half.” Usually one or more students will ask me what I intend to do with the papers or push for an elaboration on the exercise. I respond by simply repeating the instructions. After everyone has indicated that they have completed the task, I collect the papers in an empty coffee can (personal choice). Naturally, the anxiety level is significantly elevated at this point, as the students anticipate the fate of their comments. After mixing the anonymous folded papers, I walk around the classroom and ask each student to remove one from the can, instructing them not to unfold and read them until I tell them to do so. After each student has received one, I ask them to individually read the written portion of his or her paper aloud to the class.

As each student reads this written portion, I mark each response under an adapted category/theme as initially described by Yalom (1995). These categories are written on a board in front of the class (but not until each one is represented), with each additional response fitting of that category marked by adding a number next to the theme. Yalom (1995, p.) initially stated that invariably, the most frequent “revelations” include “basic inadequacy, interpersonal alienation, and sexual secret.” In my adaptation, I have termed the themes as: personal flaw, difficulty with intimacy, and sexual concern. These three themes are indeed the most frequently described. As the initial responses are expressed, I suggest the aforementioned themes that I believe are the most cogent, while requesting input from the students with respect to these categories. I find that most are in agreement with the suggested themes, allowing the students to evaluate subsequent categorizations on their own. When disagreement exists among students to
the specific categorization, I allow for a response to be placed under multiple themes. Following a brief period of silence to allow for absorption, I ask the students for their reactions to and feelings about the exercise.

**TYPICAL RESPONSES TO THE INTERVENTION**

Previous to the exercise, students often ask aloud, “Is this a group, or is this a class?” As the answer is “both,” many members experience anxiety as they attempt to bridge the gap in this blurred boundary. Common statements such as, “After all, we have to see each other outside of class, in the halls, and in other classes this semester and in later semesters” reflect their concerns about possible confrontations among their classmates in the group setting. A discussion/debriefing period following the described exercise is imperative, as strong affects (the desired goal) are likely to have been generated. Appropriate processing of these feelings is necessary. Naturally, different personality structures have different responses to the experience. However, like the themes, a number of typical responses are likely to be expressed.

Many students express feeling relieved. Upon elaboration, they say that their “secret” had always felt shameful or frightening, but hearing it read aloud anonymously by another person seemed to demystify the power. Others acknowledge that the relief is found in knowing that others in the class have similar concerns.

**CONCLUSION**

The intended goal of the exercise is to allow students to experience their connection to their fellow group members as they transition to the experiential from the didactic. When a significant number of students, who are likely to be of varying ethnicities, genders, and ages, express similar fears about themselves, a bond is created and members feel less alone. As stated by Yalom (1995, p. 7), “this method usually proves to be a valuable demonstration of universality, empathy, and the ability of others to understand.”

**CONTRAINDICATION**

Like most interventions in psychotherapy, timing is an important factor in this exercise. An instructor must rely on intuition to feel that the class trusts him or her as this will be the driving force behind students’ ability to trust that the exercise has educational and therapeutic value. As previously noted in the literature, trust is an essential theme in the formative stages of group (Fehr, 2003; Rutan & Stone 1993; Yalom, 1995). If the exercise is pushed upon them too early before trust is developed, they may withdraw from fear of further wounds. Conversely, if the exercise is engaged too late, an overintellectualized norm may be established due to a missed opportunity for interpersonal bonding.

In contrast to privately led therapy groups, instructors of group psychotherapy do not have the luxury of choosing their members. While many students are equipped to succeed academically, some maybe less emotionally fortified and this intervention may represent a threat to their ego integrity. Properly addressing the APA’s guidelines (APA, 2002) regarding student disclosures may aid them in deciding how to proceed with the exercise, as students are no longer required to engage in this practice.

Finally, blurred boundaries in the format of a group psychotherapy class also affect the
instructor. As one navigates between the teacher and therapeutic roles, a dual relationship is created, and the instructor must be aware that student reactions to the class and/or to himself or herself can lead to strong countertransference feelings. Addressing these issues within oneself or with a colleague is recommended when such conditions arise.

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**What and Who Belong in the Group? Managing Early Crises**

David Glyn

Being a respected and effective member of the group, being accepted, being able to share, to participate, belong to the basic constructive experiences in human life. No health is conceivable without this.

(Foulkes & Anthony, 1965)

**A GROUP DEVELOPS**

The group psychotherapist’s interventions reflect her or his assumptions about how a group may best develop a therapeutic process. Often, the therapist’s ideas about this are different from those of other group members. Early interventions may be directed toward providing group members with opportunities to discover what sort of group the therapist has in mind.

In the early phases of a group’s life, everyone is trying to discover how things work, and will work, around here. Inevitably, for some, this is a period of great anxiety and there will be all sorts of challenges and tests to be negotiated during the formation of a working group culture. Such challenges do not generally declare themselves as such, but the group psychotherapist will recognize that they are occurring because she or he will experience pressure.

One way in which the therapist may notice this pressure is when the belief forms that a particular individual’s problems cannot be managed by the group. Often, it is the therapist’s own
belief in the capacity of the group to both contain conflict and to maintain a reflective attitude that is being tested. How the therapist then intervenes will have a significant impact on the future course of group development.

A UNIVERSITY SETTING

These particular groups are comprised of young people in a university setting; in other words, adolescent, or postadolescent groups. Many of the group members have presented with difficulties in dealing with social situations, interacting with their peers, and managing intimate relationships. The struggle to reconcile individual needs and impulses, with the longing to belong can be intense and painful. Most members have only taken a few steps away from families of origin and all the feelings relating to family failures and conflicts are fresh and pressing; they suffice current attempts to establish, and think about, new relationships.

Initially, in these groups, there may be discussion of difficulties at home, in the seminar room, or with a sexual partner. However, before very long the group is likely to find a way to create its own “domestic” crisis.

Example

Around session five of such a group, Ms. A arrives in a manic state; previously depressed, she now reports that she is feeling much better. The reason for this is that she has started to cut herself again. No one else in her life, apart from those of us here in the group, is aware that she harms herself. And she feels great!

Ms. A is wild-eyed and her repeated declaration that she is feeling very, very good, worries the therapist. This feels like a crisis and it is the first that the group has produced, so it is at a sort of crossroads.

Some group members seem to withdraw into themselves; others are ready to respond as though they interpret their task as one of advising and influencing Ms. A. They offer reasons for not cutting herself, strategies for refraining from doing so when the impulse arises, and so on. However, these are not well received by Ms. A, who has become the focus of considerable attention. Indeed, the therapist is aware that she has repeatedly told the group how wonderfully effective is the self-harming behavior; it makes her feel great.

One by one, the group members give up. At the same time, the therapist feels an increasing sense of anxious responsibility: Ms. A is going to need more help than this group is capable of providing. Perhaps she will have to be referred elsewhere. At the very least the therapist will have to see her individually, in order to try to address her dangerous self-harming behavior. He or she feels angry with Ms. A and afraid that the group will disintegrate.

At moments like this, the therapist’s own state of mind may be a good indicator of what issues are being worked out in the group. Generally, when we experience a sense of crisis, it suggests that very basic conflicts and fears are being dramatized; here, it would seem to be the conflict between individual and group needs.

Attention is focused on an individual whose problems seem intractable and “too much” for the group. The therapist feels he or she has made a grave misjudgement and is losing faith in the group’s ability to manage Ms. A’s disturbance. He or she becomes aware of the attention focused on him/her: everyone else is at a loss, so what can the therapist come up with?
A SIMPLE INTERVENTION

A simple intervention is proposed: a type that a group psychotherapist may make in many different circumstances. Here, its significance lies in its being a response to the perception that everything is combining to encourage attention to the individual in crisis. There are any number of ways of saying it, but the essence of the therapist’s contribution is:

“I wonder what others in the group are feeling as they listen to what Ms. A has been telling us?”

There are a number of factors that support this sort of intervention:

• it provides an antidote to the temptation, which the therapist may feel, to try to reassure the group by demonstrating his or her own ability to treat Ms. A—a response that would tend to reinforce doubts about the value of the group;
• it shifts the perspective so as to suggest that, in order to understand Ms. A’s communication, there is a need to see it as part of a larger picture; and
• it introduces group members to unfamiliar ways in which their own responses—negative as well as positive, belong in, and form part of, the group’s life and so begins to extend the general sense of belonging in the group.

What may emerge, in response to the therapist’s enquiry? Initially, group members may respond by returning to the scenes that Ms. A has been describing, renewing their attempts to find ways to correct the perceived problem that she has presented. If this occurs, the therapist may try reiterating the question, in a different form, so as to put emphasis on feelings about the situation in which group members find themselves, in the group. The purpose of the intervention is to make available, to the group, as much information as possible about what has been happening, during this session. Expressions of sympathy, helplessness, anxiety, anger, feeling rejected or ignored will all help to build a picture of the scene that is being played out. Some will undoubtedly contain resonances for Ms. A and it is important to find ways to include these.

CONCLUSION

At any moment, the preferred intervention reflects how the therapist understands prevailing group-developmental tasks. When the group is trying to lead us to the individual, we should be most alert to the needs of the group. From the writer’s perspective, the individual’s problems cannot be made sense of, outside the context in which they manifest themselves. The therapist’s efforts are directed toward creating as effective a demonstration as possible of the group’s ability to function as a ‘working model of the world’.

It is desirable for group members to learn to report supposedly unhelpful and even unsympathetic responses, as well as more obviously helpful ones. In order to understand the meaning of an act or utterance, we need to discover the sorts of responses that it evokes in others. For members of a new group, the fact that “unwanted” feelings can be received as a valuable contribution to the group’s work may be a surprising discovery—one that begins to change the terms of belonging and group membership. Rather than conceiving of the group as a problem-solving instrument, this intervention seeks to foster a sense of the group as somewhere to think
about the context in which a problem has its place, within a nexus of relationships. Ms. A may, initially, be dissatisfied with the shift of focus; in particular she may feel angry, or disappointed, believing that the therapist has taken from her that which she is seeking. However, by shifting the focus away from her, we begin to create a situation where she can find other ways to express the feelings involved in her secret acts. Given time, she may come to feel that there is a place for these feelings, in the world, and thereby extend her own sense of belonging.

**CONTRAINDICATIONS**

During the assessment process, we need to be alert to our own responses: Is this a person with whom you can imagine working, in a group? Do you look forward to it? If you are aware of anxiety or reluctance, what makes you imagine it will be different for others and for whom in particular? One of the great benefits of groups is that they contain more resources than the therapist’s alone, but it’s neglectful to disregard our own feelings. If in doubt, give the assessment process a bit longer.

However, sometimes we find that we have just got it wrong. We have missed something in an assessment or the disturbance that an individual is bringing into a session; is it too much for others to respond to at that particular time? The group is not ready to take it on or becomes overwhelmed with anxiety. In such cases, the therapist will have to look for ways to preserve the group and to attend to the needs of the individual in a different way.

**REFERENCE**


David Glyn, BA, Dip Gr Psy. has been practicing in London for fifteen years, as a Group Analytic Psychotherapist. Part of his working week is spent in the Student Counselling Service at City University.

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**Leaving the Room for the Sake of Connecting**

_uri Amit_

**ALONE IN A PHYSICAL WORLD**

Group therapy affords participants the opportunities to end a protracted process of believing that one is all alone in his or her physical world (Fehr, 1999, 2003). Connecting, among the believers, of being “the strangest” is a mean proposed by Ormont (1992).

**SEX OFFENDER CLIENT POPULATION**
This particular intervention is appropriate for groups of sex offenders who (1) do not display psychotic processes, (2) are preoccupied with atypical sexual fantasies, and (3) have been working together for at least one year with the same therapist(s) in an inpatient treatment facility.

DESCRIPTION OF INTERVENTION

Case Example

Wy is a Caucasian, six feet, two inches, 240 lbs. man who was in a group of ten men that I and Dr. E inherited from two other therapists. For nearly two years, Wy has been mostly a silent group participant occupying the seat by the room’s door. Despite his silence and expressed disinterest in a process that, according to him, was conducted by two of the state’s “hired guns” (Dr. E and myself), I never ceased asking him for his thoughts and feelings about the material presented by others. A common reply to my urgings was that he is repulsed by people and prefers the company of small animals. To add oomph to his common reply, he mentioned on numerous occasions that he tends to entertain fantasies of physically torturing people who affronted him and thoughts of sexually tormenting women. In fact, his offenses include extreme sexual sadism, and one of his fantasies included (and perhaps still includes) penetrating a woman with a mammoth dildo attached to a “f—k machine” turned on to its highest speed. The group respectively was leery and yet interested in Wy. The wish to “get into your [Wy’s] head” was voiced by a few of the men on various occasions. He has also been viewed by them as a “weirdo.”

On several occasions, Wy labeled me as a “weird doctor” and received support for the diagnosis from a few other members. On one such occasion and after having him in group for nearly two years, I asked the group if there are other “weirdoes” in addition to Wy and myself. Zi, a six foot, 200 lb. African-American man with a history of three rapes and a pervasive “I don’t give a f—k” attitude announced that “I am like Wy. I don’t trust people: I don’t trust mental health.”

THE INTERVENTION

• I asked Zi to contact Wy directly rather than talk to me about him. Silence befell the room when Zi told Wy that, “I am also a weirdo.”
• After a few minutes of silence, I informed Wy and Zi that, “us voyeurs would leave the room for few minutes so as not to disturb your date.” I immediately added “a straight date” once I realized the stares I received from some of the heterosexual men.
• I got up and left the room with the rest of the group following me.
• About five minutes later, I knocked on the door and announced the group’s return.
• Once inside, I proceeded to tell the group Hans Christian Andersen’s tale of The Ugly Duckling and concluded, saying: “enjoy the beauty of your shared ugliness.”

RESPONSE TO THE INTERVENTION

I have acted twice in the manner described, once as recent as in early January, 2007 and once in the early 1980s in a different institution for a similar population. In both cases I left people with no option but to speak with each other and find a common ground for connection. The
common ground has evolved from expressing mistrust in the therapeutic process to talking about
the offense committed and engaging in the examination of psychological expressions inherited in
the offending. As was evident over time, a dialogue of two expanded to include others. At
present, group time has been used for “floor taking” by members to speak to the crimes
committed and achieve cogent understanding of the forces that compelled them to sexually
aggress against others.

CONCLUSION AND CONTRAINDICATION

It is strongly suggested, especially with this particular population, that having knowledge of
clinical theories is necessary but not sufficient to working with a population displaying severe
developmental arrests. The natural flow of humor, the readiness to act clinically albeit
uncommonly, yet ethically, and the tenacity to connect and reflect compassion of ten elicits
respects from this particular population. Due to this respect these individual are willing to try out
recommendations made by the therapist.

In relation to contraindications with this particular population, a group therapist must be able
to free herself or himself from judgment and outrage at the acts committed by these individuals,
and suspend personal moral issues. One must feel comfortable with her or his own oddities, trust
her or his intuition and, above all, see the “good in the bad.”

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A Symbolic Meaning of Money in Group Therapy

Gregorio Armañanzas Ros

THE MEANING OF MONEY

Money in group therapy has a lot of connotations and evocations (Fehr, 2003; Gans, 1992;
Motherwell, 2002). This chapter will explore the symbolism of money in private practice groups.
A Dual Perception

The Therapist’s Perception of Money

Therapists are people too. We need to earn money to pay for things, to be compensated for our efforts, our time, our investment, as a symbol of recognition, etc. In this cluster of needs can be included the need from the therapist to have clear compensation for his or her work and dedication. The fees established must be enough for the therapist not to feel a personal demand for gratitude or to place on the patient an emotional debt which must be paid for the therapist’s efforts.

The Patient’s Perception of Money

Money is a symbolic subject in which the patient gives to the therapist many messages within the therapeutic space: resistance to work, aggressiveness, call to attention about the implication of the therapist, need to be fed without feeding, testing the dependence of the therapist, (not paying, delaying the pay, or paying less in a mistake); feeling of debt not resolved, excessive submission (deciding to pay in advance, paying more in a mistake); acknowledgement, gratitude, freedom from the debt, etc.

Because of these two very different perceptual sets, it is necessary for the therapist to have clarity of differences between both areas of money when he or she speaks or thinks about money and its relationship in therapy. We must have this clarity in mind when and if we are speaking about money. Is the money related to perception 1 or is the money related to perception 2?

It would not be uncommon for there to be an overlap for some interventions, which could engulf both areas, for example, the therapist’s approach to confronting the patient’s lack of payment. Due to this possibility, it is of the utmost importance that the therapist have the aforementioned clarity to separate the two perceptions in order for him or her to work effectively when this topic is approached with the patient. Specifically, if the therapist has a strong need for money, he or she will confound the therapeutic dialogue with greater personal needs than professional inquiry.

PATIENT POPULATION:
WHO IS RESPONSIBLE FOR THE BILL?

Initially, it is obvious that the discussion of money would be in relation to who is going to be responsible for the services rendered. If it is in the case of a minor, the discussion would be with the parents or guardian of the child but in this chapter the concept of money is related to adults, specifically who are in group therapy. For a discussion of money to occur, the patients appropriate for this type of group therapy would be intellectually cognizant of actions and reactions and have the ability to understand abstract concepts.

THE INTERVENTION

I always make an arrangement with patients in group therapy about how to pay for services rendered. In this agreement I ask for payment to be made directly to me. I discourage payment being made to my secretary, by bank transfer or credit card, nor will I accept a check. The
reasons I approach this form of payment are as follows:

1. We can clearly explore the therapeutic relationship without external, intervening variables such as, “I did not know my bank did not transfer the funds.” We can explore the patient’s attitude to the actual therapy, which ultimately will bring to light his or her relationship with both the therapist and the group.

2. By paying directly to me, both of us can see the money that comes between the patient/group and myself. This is a part of the relationship that must be present. It constitutes a key element of the work in private practice. It is important also in public practice, but in that environment there is more which is concealed. If, for example, the payment is made by a bank, or indirectly as in public practice, the fantasy of gratuitousness can grow in both therapist and patient with negative consequences in therapy.

3. We can manage easily all the events around the money because it happens between group/individual and the therapist, without other people in between.

It is necessary to establish a clear contract with the patients about the conditions of payment in order to know the limits and not confuse our need for money with the perception of money of the patient, which can be the manifestation of a symptom.

**Case Example: The Context of an Experience**

A new group was started in private practice. The group was comprised of four women of middle age, and me. All of them had previous experience with me in individual therapy. It was determined that we would work in group once a week for an hour and a half. The techniques used would be group analysis and psychodrama. The minimum therapy commitment to the group was a year. After this, people could end the commitment with a month’s notice of termination. It was a “slow open” group: more people could also integrate the group at any time.

I previously informed the group members individually and during the first session about the amount of the payment. I decided to establish a payment based on a fixed amount for each person and session. I doubted whether I could establish a fixed amount per session no matter how many people would be in the group. I felt this kind of contract could increase the feeling of belonging to the group, but that it would put a lot of responsibility on the members if one of them stopped the experience. Also, the incorporation of a new member and the size of the group could be strongly conditioned by the money/fee. I choose for myself the economical consequences by the size of the group and place the payment responsibility on the individual patient thus liberating the patients of the burden of being responsible for the group as a whole.

**The Actual Group Experience**

During the first sessions I asked the group about how they would like to pay, when to pay, and if the group as a whole would assume the responsibility of paying the total amount or if each one would be individually responsible for her bill. Three of the four members answered clearly that they would like to pay at the last session in each month and that each one will take the responsibility of paying her amount. The fourth member did not assume a clear position. In the last session, of this month, one of the members did not bring her part of the money. One patient brought her money in an envelope with her name but added to her part the money previously owed for an individual session. Others put the money envelopes on the table, in front of the group, without their names.
**Therapeutic Concerns**

I was concerned with this contract: should I discuss the payment of the monthly group to each individual separately, or discuss the payment to the group as a whole? I needed a clear system in which I could confront clearly in the group the mistakes, delays, etc. I do not like to make particular communications, out of the group session, by confronting a mistake in payment. This would mean taking out of the group, information that is pertinent to the group as a whole. I too felt that individual dialogue with a group member could possibly give individual relevance and I did not want to reinforce that type of intervention.

My need, after the first month’s payment of the group, was to confront a nonpayment situation in order to achieve the two aforementioned perceptual needs.

- First: my right but also my obligation to claim the money in the established contract.
- Second: the lack of implementation, of the contract, in the group and its meaning.

**Implementing a Direct Intervention**

In the next group session I put the money on the table that was given to me in the previous session. I disclosed that this was not the money that the group owed, because, in this type of intervention, my “patient” was actually the group as a whole and monies were still due to me. I too related that only monies for the actual group would be accepted and monies for individual psychotherapy would not be accepted at the same time.

**Patients’ Responses to Direct Confrontation in This Intervention**

The group felt moved and reacted aggressively, saying that I made just as much as I had wished. The member that had not paid the previous session brought her money and placed it on the table. One of the members stood up and added further monies, which she put in an envelope. This movement split the group between submission (to order and put all the money in an envelope) and rebellion (rejection of this movement). These responses are actually the ones we wish to occur. It is through these defensive reactions that we as therapists come to understand many underlying components in our patients’ personalities and certainly their relationship not only to money but to personal responsibilities.

**CONCLUSION AND CONTRAINDICATIONS**

It is highly suggested that in private practice a clear contract concerning payment for services rendered is established including details about how to pay. In order to do this, the therapist must consider all the different situations and how, if problems emerge, could they be resolved considering the two perceptions of money. If there is a breach of contract, the therapist must:

- Confront in the group all the deviations from the contract and encourage the group as a whole to investigate its meaning.
- Make the money physically present in the group, which gives it a sense of reality. A difficulty could arise in this particular process if the payment is sent indirectly through a
public health service, insurance, or another agency. The money then becomes a ghost. In order to be able to work therapeutically with the ghost in a group therapy situation it is suggested that:
— This invisible payer is made visible by reference to its existence in order to avoid future problems. Refer to it and make it become a conscious entity and a topic for discussion.

Another situation is when the therapist does not receive payment for his or her services and the therapist is working pro bono. In this case, it is suggested that the therapist seek some kind of payment by the group in order for the group members not to feel indebted, which could ultimately alter the way they relate to the therapist and the other group members. This payment would have to be discussed with the group as a whole and a decision would need to be reach which then would become part of the group contract.

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Visualizing Connections and Disconnections: A Social Diagram of the Group

Carol Lark

People nowadays will disclose their sexual fantasies more readily than they will discuss how they feel about each other in terms of preference.

(Gershoni, 2003, p. 110)

THE MOTIVATIONAL FABRIC

“Where do I fit in? How do I find a safe place for myself within or outside this (or any) group and what does it cost me to stay there?” These very human questions form part of the motivational fabric of any group. The answers are complex, weaving together earlier relational experiences, current social concerns, and the present moment of group life. Staying in the moment of group encounter long enough to examine these questions can be difficult, however, requiring the ability to be both aware of one’s feelings and willing to explicate those feelings.

The following exercise is a helpful tool for groups that are either too stimulated by
interpersonal encounters to maintain an optimal self-observational level, or too avoidant to be able to identify their interpersonal connections and disconnections. It is based on sociometry, which is the study of the valences within a group and examines the questions, “To whom am I drawn and from whom am I moving away? Who is drawn to me and who is moving away from me? Under what circumstances do these movements take place?”

**THE GROUP**

This intervention can be used with almost any type of group in which the group members would like to learn about themselves as relational beings. The theoretical orientation of the group leader can range from process-oriented to psychoeducational, but the leader and the group must be open to examining the interpersonal encounters within the group. It is best used within a relatively stable group frame where group members have made a commitment to continue in the group. (See “Contraindications.”)

**GUIDELINES FOR INTERVENTION**

**Materials’**

Materials for this exercise include: pencils with erasers and two sheets of paper per person; a larger sheet of paper (18” × 24” if possible, or a sheet from a flip pad) for the group; a clipboard or something else for each participant to write on if a table is not available; and a box of markers or crayons sufficient that each person will have a unique color for himself or herself.

**Methodology**

The use of a sociometric technique can evoke a mixture of excitement and some anxiety in the group. The strategy makes the more or less covert relationships, desires for connection and the disconnections in the group visible. This exerts pressure on each member to make clear statements about his or her position(s) in the group, and to listen attentively to the statements of the others. It challenges the members to accept both connections and rejections. It is important for the group leader to have a clear set of boundaries, especially regarding desires to rescue or gloss over difficult moments in the process. It is important that the group leader remind the group that these are fluid choices influenced by many factors in the moment in the group, and that these positions can help the members to reflect on their habitual and habituated positions in their personal lives, their family of origin, current intimate and social relationships, and at work.

**Instructions for the Task**

**Step I: Preparing the Group**

Explain to the group that you will help the group figure out “each member’s relationship to the others in the group.” Each member will create a personal sociogram (Blatner & Blatner, 1988; Hale, 1985) of the group. This is a diagram of the relationships within the group as each member experiences them personally. It is important that they be as honest as possible.
Step 2: Directions for Phase One

Pass out the pencils and smaller papers. Tell the group members that the edges of the paper are the boundaries of the group, and that they should write their name somewhere inside that boundary where they feel themselves to be in the group as a whole. They should then write the names of each of the other group members, including the leader, placing each name in a position on the paper in relationship to the other group members including the member whose sociogram it is.

Finally, similar to creating a genogram, they should draw a double line toward those with whom they feel very connected, a dotted line to those from whom they feel distance or disconnection, and a jagged line to those with whom they feel conflict or uneasiness. These lines should end with a directional arrow toward the other. Explain that this must be done as honestly as possible in order to get the most information from the experience.

They should create similar lines from the names of the other toward themselves with a directional arrow at the end. Explain that some of these lines may feel one-directional to them. That is, they may feel warmly toward another group member but experience less warmness or even conflict from that member. Some of their lines may end with a directional arrow both toward the other and from the other. These are the natural valences, or lines of energy within the group as each member perceives them.

Step 3: Directions for the Phase Two

When all group members are finished with their personal sociograms, put the larger piece of paper in the center of the room. Invite them to place their own names on the paper where they experience themselves to be in the group. They should use their personal color (crayon or marker) for this part of the task.

Next the group leader asks each member to draw a line, using his or her color, toward the group member(s) they feel a sense of closeness to, then jagged or broken lines toward the group member(s) toward whom they feel conflict or disconnection. At this point, the group composite sociogram will become a colorful representation of the group’s perception of itself.

Phase Two usually increases the anxiety in the group. This is when members declare themselves very visibly, and there may not be congruence between what they expected and what is actually depicted on the larger group-constructed sociogram.

Step 4: Processing the Work

Where there are lines of closeness, conflict, or disconnection on the group composite, the leader should invite the members to describe their positions relative to the other, and assist them to encounter one another and clarify meaning and relationship. It will be tempting to “solve” the attractions and avoidances or conflicts, however, it is very important simply to let them be seen and stated. There may be a sense of relief or affirmation in knowing clearly where one stands relative to the others.

As in a family genogram, the leader may want to help the participants notice and articulate dynamics such as triangulated relationships, dyadic relationships, and isolates in the group. These dynamic tensions can be viewed as replicating to some degree the family-of-origin dynamics.
It is rare that a group will have a “perfect” sociogram; i.e., one in which all the connections and disconnections have been accurately depicted by every group member. The complexity of the group sociogram and the reactions of the group members to it will be good “grist for the mill” for some time to come.

**THE CLIENTS RESPOND**

This is a highly stimulating exercise that can evoke high levels of feeling, especially feelings of being exposed and vulnerable. The format helps to contain these feelings, and to anchor the experience of being in the group in a concrete way. Usually clients have felt relieved to be able to “confess” their sociometric experiences. They also discover that interpersonal relationships can be fluid and open to change once the underlying dynamics and tensions are exposed and worked through, offering hope to the group members.

The Phase Two task and subsequent processing can be too explicit for some groups and/or group members to tolerate. The group leader should be prepared to discuss the dynamics of direct encounter in general and what holds the group back from explicating their relationships, rather than proceed with Step Two and/or processing of Step Two if the anxiety has become too great. Step One may be all the group can tolerate in the moment. (See additional contraindications.)

**CONTRAINDICATIONS**

Sociometric strategies such as this one can be way too explicit in early-formation stages of a group and/or in a group with vulnerable, traumatized, or very frightened group members. In order for this strategy to be effective, the group must have some level of trust in the leader’s capacity to hold conflict and in their own abilities to hold strong feelings while also processing sometimes difficult feedback.

The group must also have the opportunity to continue processing in subsequent group meetings. Unless this technique is heavily modulated with didactic information, such as in a training workshop, it should not be used in groups that meet only a few times, as it takes time for the impact of the exercise to be metabolized by the participants.

Finally, this is a task that can have adverse effects on work groups if there is little or no follow-up or sustainable process for working through the relational tensions that are revealed in the sociograms and/or insufficient sociometric criteria have been included (meaning that the personal preferences of the group members have not been identified for the group’s work task, such as “who would you most trust to fly with on a dangerous mission,” etc.).

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Shape: A Kinesthetic Approach to Building Healthy Boundaries

Danielle L. Fraenkel

A RELATIONSHIP TO ONE’S BODY

The question of boundaries comes up in many group therapy situations from territorial disputes regarding conversations outside of group, subsystems within the group, and personal space, to ethics, identity development, and the interpersonal challenges precipitated by the vicissitudes of group processes (Agazarian & Peters, 1981; Fehr, 2003; Gans & Counselman, 1999; Minuchin & Fischman, 1961; Ryder & Bartle, 1991; Scott, 1993). The common understanding of boundaries are as limits or borders. How interactions between and among group members evolve depends on both the strength and the flexibility of each group member’s boundaries. Shape, one of the main movement parameters in the LivingDance-LivingMusic approach to group work, provides a kinesthetic sense of the body boundary that lays the foundation for many kinds of sharing—from confrontation to divulging painful or intimate realities (Fraenkel, 2003; Fraenkel & Mehr, 2004). Group psychotherapists who recognize that changes in the relationship to one’s body affect changes in one’s relationship to self and others, will find attention to shape in two dimensions: the horizontal and the vertical; it can have a profound effect on both individual and group processes.

UNLIMITED PATIENT POPULATION PROFILES

I developed this exercise more than twenty years ago while working with men and women who were struggling with eating disorders—anorexia, bulimia, and compulsive overeating (Franks & Fraenkel, 1991). With time, I learned that attending to shape benefited nearly all people—including children, adolescents, and adults faced with the challenges of severe mental illnesses, to normal neurotic individuals seeking to self-actualize. For a particular group I adapt the basic instructions provided to meet the developmental, cognitive, and emotional needs of group members.

A KINESTHETIC INTERVENTION

A Step by Step Approach to Sensing Your Shape (2-D)

Step 1: Use touch to heighten awareness and prepare for kinesthetic sensing.
To prepare for the exercise, center yourself with a simple calming exercise of your choice. Put your nondominant hand on a flat surface. Trace your hand with the index finger of your dominant hand, starting at the wrist on the little finger side of the hand. Concentrate on the skin, your physical boundary, your first line of defense. If you prefer, you can start by using a crayon to outline your hand.

Hold your hand in front of you. Looking at the back of your hand, use your imagination or mind’s eye to outline the hand. Be aware of your wrist, fingertips, and the places where your fingers attach to the palm of your hand.

Look straight ahead and away from your hand, and visualize the complete outline of your hand. Be sure to look straight ahead and not to follow the outlining process with your mind’s eye. Just sense the outline.

Move your hand in any direction or make figures in the air still looking straight ahead. When finished, note how your nondominant hand feels compared to that of your dominant hand.

Follow the same process with your dominant hand (Steps 1-6).

**Step 2: Involve more of your body.**

Outline other parts. (The rate at which you do so depends on client needs, group processes, and time.)

**Step 3: Sense the whole shape:** Make use of the horizontal and vertical planes’ links to trust, autonomy, identity development, and boundaries.

The ultimate goal of this technique is to be able to sense your body as a unified whole. When that happens, your attention will be equally distributed around your body. If you focus only on the moving part, your attention will collect in one spot. You will lose the sense of wholeness that comes with the sense of your shape.

Outline the silhouette of your entire body with touch. Using your hand, start at the top of your head and trace the outline down one side and up the other. Were you a stuffed doll, it would be your seam. *Note: Clients who are uncomfortable with self-touch can use a feather, paintbrush, or equivalent.*

Use your mind’s eye to sense your shape, e.g., imagine tracing your shape with a laser beam, crayon, etc.

Move one body part without watching the movement to see if you can stay aware of your seam, holding onto the sense of your whole self. Using your hand as an imaginary needle, touch the spots where you lose your awareness to “sew up the holes” in your seam.

Move more than one body part. Notice once again where you need to sew up your seam. The task is not to seek perfection, but to identify your vulnerable spots, the holes in your seam. Once you know where they are, you can focus on them, or touch them, to claim or retrieve your shape.

**Step 4: Play with the sense of your shape (make, merge, and reclaim your shape).**

Identify the feelings that emerge as you move in and out of your shape. Notice what happens to you, your role in the group, and the group as a whole when you have the sense of your shape. Share your experiences with others in the group.
CLiENTS’ RESPONSES TO THE INTErVENtIOEn

Case Example

Conversations between people in group change once people understand the concept of shape. Paula and Rita belong to an open group that meets for six hours once a month. It does not have rules about socializing outside of this monthly meeting. After an intensely intimate interaction with Rita in group, Paula could not contain herself. She wanted to pursue the relationship and phoned Rita asking if they could get together. Rita turned her down. When Paula and Rita talked about their interaction at the next meeting, each woman referred to her shape. Paula said she had her shape when she called, and did not fall apart, even though she was disappointed when Rita turned down her invitation. Rita said that being in her shape had helped her say no. The group was thrilled. Everyone knew that Rita believed that hurting anyone’s feelings was an anathema. In addition, it was Rita who suggested that they talk in group about whatever it was that Paula wanted to share. Paula told the group that she had been worrying about doing so, and that she had her shape. She was ready to talk about her attraction for Rita and her fear that it would upset her life as wife and mother.

CONCLUSION AND CONTRAINDICATIONS

As a dance/movement therapist who has applied movement analysis to the creative dance concept of shape, I use shape as an improvisational tool to make concrete the abstract notion of boundaries. However, you do not have to be a dance/movement therapist to introduce this exercise to members of your groups. Even therapists who are uncomfortable dancing can combine kinesthetic sensing and the simple movements described to access their sense of shape. In doing so, they literally embody the seemingly intangible concept of psychological boundaries, which is often so hard to explain. To be sure that you are comfortable with the task, follow the directions yourself before you give them to anyone else. You need to know how you respond to kinesthetic sensing, touch, and simple movement, particularly if you have group members who fear self-touch or have such distorted body images that they cannot separate themselves from their negative self-assessments. Since awareness of shape will help them in the long run, take the time to prepare them for the intervention as it has the potential to counter the somatic distortions that govern their lives.

As long as you attend to the affective, cognitive, behavioral, and developmental needs of group members, there are no obvious contraindications for engaging the shape to foster healthy boundaries. Once group members have identified the vulnerable spots in their boundaries (the holes in their seams), and sensed their shapes, they will be able to take more responsibility for their contributions, or lack thereof, in group. Therapists who can sense their shape will be better able to remain present and congruent.

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**Trauma Therapy:**

**An Integrative Approach**

**Norman Claringbull**

**LIFE-THREATENING TRAUMATIC SITUATIONS**

Since the Twin Towers attack, (9/11), the possibility that large groups of people might be adversely affected psychologically by being somehow involved in life-threatening, traumatic situations is becoming more and more publicly recognized. Unfortunately trauma victimization is nothing like a new phenomenon and 9/11 only served to dramatically highlight the problems that such unfortunates have been facing for many years. Among the better-known dramatic incidents are Hurricanes Katrina and Wilma, the Pakistan Earthquake and many, many similar events such as the tragedy at Virginia Tech in the spring of 2007.

The natural human response to such situations is to try and help. The problem is how? One of the superficially easy ways to do this is to throw resources at the situation and this often includes providing the supposedly “expert” help of the therapist who, it is hoped, will be able to deal with all the awkward bits of the problem, especially those involving any emotional discomfort, that might be discovered in either the victims or the assistance providers. Authors such as Bessel,
Van Der Kolk, McFarlane, and Weisaeth, 1999; Scott and Stradling, 2006; and Warren 2006 and many others give us lots of clues about how therapists might go about such a task. So, how can therapists best help, and given that most of these events inevitably produce large numbers of potential victims, how can we help on a “mass-production” scale? Surely the very being of the therapist, especially that of the group therapist, lays in a supposed ability to multi-task the delivery of therapeutic inputs to multiple-populated client groups? If we can’t help then who can?

DESCRIPTIONS OF THE CLIENT POPULATION

Basically, the traumatized client population includes just about everybody; all ages, all types, all nationalities and all backgrounds. Given this variety of demand, it is not even possible to say, for example, that a U.K. therapist will typically meet a U.K. population, that U.S. therapists have particular issues and clients who need a special “USA twist” or that a therapist from more or less anywhere will have any especially foreseeable problems, (with the possible exception of language difficulties). Bearing in mind the heterogeneity of most national populations and the global village nature of today’s world, trauma therapists need to be prepared to meet the needs of whoever presents, from whatever background, from any origin and under whatever circumstances happen to be predominant at the time.

THE INTERVENTIONS

There are lots of arguments about the best ways to help such client groups. These range from the long-established, but now heavily criticized, technique of debriefing, (Dyregrov, 1997; Mitchell 2004, 1983), to the very modern approaches using such cognitive-behavioral techniques as eye movement desensitization, (Shapiro, 2001), emotional freedom therapy (Hartman 2000), and so on. At the core of all these approaches, at least in the immediate aftermath of a traumatic incident, is the need to address the disabling cognitions, the distorted beliefs, and the maladaptive thinking that the traumatic experience has engendered. Put simply, whatever views therapists might hold about best practice for the long-term approaches to helping traumatized clients, in the short-term, normalization appears to often be the key early need for clients and this usually means focusing the therapeutic interventions at core cognitive levels. Cognitive processing of a traumatic incident means keep on linking the clients thinking processes back to what they perceived as happening as the incident progressed. It is a circular and an iterative process.

In my own psychotherapy consultancy practice I get involved as a “trauma expert,” (if there really is such a calling), in the aftermath of quite a lot of serious and dramatic events. In my experience, even the aid professionals have difficulty in handling the emotional needs of the traumatized victims. Indeed, they are often not much better at handling their own psychological discomforts either! Following is an example.

Background

In October 1999, just on the outskirts of London, thirty-one people died and hundreds were injured when a Thames Trains service went through a red signal and collided with a Great Western InterCity Express. One can only roughly estimate how many people were directly,
(passengers) or indirectly, (relatives, colleagues, friends, etc.) suffered emotional damage. The figures run to at least the low thousands. In addition, major psychological effects were discovered in many of the emergency service workers. I was tasked to facilitate two groups of passenger survivors, none of who had any significant physical injury. However, they all apparently felt sufficiently emotionally pained to prompt them to voluntarily take up the psychological therapy. In Group 1 there were six women and three men, of various ages and in Group 2 there were five men and seven women. In neither case did I ever learn anything striking or of any significance about their backgrounds, origins, or personal circumstances. We met in a small conference room in a hotel that had been requisitioned for the purpose. Their presenting emotional conditions ranged from anger, through deep sadness to ongoing terror.

Group 1

To begin with, I asked each participant to describe their entire day, from when they got up on the morning of the crash to when they got to whatever or wherever represented a safe place for each of them. I wanted each of them to tell me their story. This was not done on a one-by-one basis that started at breakfast time and went through to bedtime but one that was undertaken on a horizontal time-slice basis that took all of the participants in turn through the first segments of their day, then all of them through the second segment and so on. Although we wanted to hear from everybody, the trick was to keep the group focused on the individual task in hand while at the same time not wanting to suppress anybody’s need to urgently express themselves if necessary, whether or not it was their “official” time to tell part of their own story. What became obvious at an early stage was a need in some of the participants to deal with their own feelings by sabotaging the emotional “downloading” of other group members. For example:

Participant A: “As I cowered by the track side, I kept on worrying about getting home in time to pick up my dry cleaning as I was going to a PTA meeting the next day and I didn’t want to look scruffy and let my children down”

Participant B: “My immediate worries were for everybody else. I had already probably saved one guy’s life by dragging him clear and I knew that the most important thing was to care for the injured”

Looking at Participant A, I could see that she was starting to feel ashamed of herself. Possibly she was feeling personally diminished by only having such apparently trivial worries when “Mr. Hero” was rushing round selflessly risking life and limb in the service of his fellow victims. The danger was that A, and possible other group members too, would be silenced by their awe of B’s apparent heroism. The essential element in working in this way with traumatized clients is to keep bringing them back to the “what were you thinking—what did that happening mean to you”? This is because such an approach is consistent with the classic principle of any cognitive therapeutic intervention in that the thinking precedes the action or the feeling. Thinking, including maladaptive thinking, is the cause of perceptions, emotions, and emotional discomfort; it is not the result of inappropriate emotions or perceptions. In the case of the exchange, by asking both A and B what their individual thoughts were, at the time that they each were referring to, we could get their responses into proportion. In addition, and probably most important of all, they could both learn to understand themselves and to normalize their own
cognitions. As it happened, it turned out that A had been thinking about how the crash might affect her immediate family and B had been thinking that he was in immediate danger and so he found that displacing this fear into activity helped him to cope. It is clear from this example that the trauma therapist’s early stages interventions need to be targeted at continually “closing the loop.” This concept is perhaps better illustrated by one of my experiences when I was working with Group 2.

**Group 2**

This group of victims all described a common scene from their experiences:

There was a huge bang; a huge jolt and the train went all over the place. I was thrown around all ways and there were incredible noises—screaming, crunching, banging, explosions and the sound of huge pieces of metal crashing together. It was like hell had opened up. Then it stopped and I found myself outside the train sitting on the track. There was a hush, no noise, and no sound at all. Then from one direction I heard a mobile phone starting to ring, and then from somewhere else another phone joined in, then another and then another and another and another. Gradually the air became full of the sound of phones ringing. It was the sound of life!

This is a hugely dramatic story and, as some of the survivors talked about this experience it became clear that its power was putting all of us, everybody in the room, back at the crash site. It filled our being and we all were there, at the actual event, at the actual time. Now let’s get back to therapeutic reality and see if we can close the loop. Put simply, the story wasn’t true! The crash happened on a busy mainline train junction, under a crowded airport flight path and in a busy, heavily trafficked London suburb. There was no period of silence—and that particular survivor’s story existed only as a perception, albeit an incredibly powerful one. What was the real situation? It had to be one of noise, shock, and fear. Where did the belief come from that all was quiet? After all, this was real life at a major, and still ongoing, disaster. With hindsight, my best professional guess now is that this misperception probably had its origins in some erroneous thinking patterns, (cognitions), that if noise equals danger then silence equals safety. Therefore, in order to save themselves, my storytellers had to create their own reality because the real life situation that surrounded them was far too threatening. So how did I intervene? In this case I didn’t—I was overwhelmed too! Sometime you just can’t avoid going with the flow. Sometime the best intervention that a therapist can make is simply not to make one!

**CONCLUSION AND CONTRAINDICATIONS**

Obviously, there are powerful humanitarian reasons to try to help the traumatized as soon as practicable. This is especially so in the case of the major disasters. Nevertheless, the fact remains that the majority of people who experience traumatic or critical incidents recover within four to six weeks. Therefore, in most cases, early intervention is either uncalled for or is likely to be counter-productive. It is a psychological process that is akin to grief in that it is a normal human reaction to a distressing event and one that simply has to be “gone through.” Emotional pain, like physical pain, is sometimes an unpleasant but a necessary response. Therefore, in many cases the best treatment for the traumatized person is often to do nothing! However, it is very common to
hear on the news that after a particular traumatic event has occurred “counselors were immediately made available.” This might be comforting to the authorities and probably to the rest of us, all of whom want “them to do something.” Whether this is always actually helpful is far from clear!

As psychotherapists, we too will find ourselves under urgent pressure to rush to the aid of the critically traumatized and here I am particularly referring to those affected by immediate, high-impact, high-profile events. The question that we have to ask ourselves, as ethical therapeutic practitioners, is, “Can we find the strength within ourselves to sometimes refuse to respond to a plea for help?” After all, what did the Javanese fishermen who lost their livelihoods in the 2004 tsunami disaster need most—psychotherapy or new boats?

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Painting Verbal Images

Mary Jago Krueger

Her head fell back, her shoulders lifted; her eyes turned to opaque pools of water as she gazed up at the ceiling as if at any moment relief would sweep in and ease her pain. Another member of the group inquired, “Where are you?” She whispered “I don’t know how to explain it. I don’t have the words.”

USING FIGURATIVE LANGUAGE AS A TOOL IN GROUP THERAPY
Figurative language offers us the opportunity to create images that stimulate the senses (Barlow, Fine, Pollio & Pollio, 1977). Creative verbal imaging can provide a perspective from which a shared experience can elicit visceral responses about a moment in the group process. The use of figurative language in psychotherapy is a means of communicating sensitive material aimed at interpreting defenses in a personal manner (Yeomans, Clarkin, Altschul & Hull, 1992). A metaphor is hatched or an analogy is constructed all in the service of translating a defense or demonstrating mutuality between group members.

**GENERAL CLIENT POPULATION**

Figurative language may be used with any type of group to illustrate a point, make an observation, or convey a concept. It can also be a gentle and rich method for interpreting process in a psychotherapy group or addressing points of difficulty without prejudice or judgment. The requirements are that the members of the group share a common understanding of the language or phrases used for the interventions and have the ability to think abstractly, even if it is at a basic level.

**TIMING AND SAMPLES OF INTERVENTIONS**

My orientation to group work is integrative with significant influences from psychoanalytic and existential theories. The groups which I work with are predominantly closed ongoing, long-term adult psychotherapeutic groups. I have found that the use of figurative language can be used strategically as a tool in any stage of group development.

**A Sample Metaphor**

The use of metaphors as an intervention has been highly effective when a member of the group becomes resistant to the immediate process in the group resulting in the group as a whole seizing to a halt. Common metaphors or colloquialisms also have been very effective to gently observe an event in a working group that may need to be addressed, as well as, similes to explain a parallel process in order to avoid jargon.

A sample metaphor that is commonly heard and understood by group members is the observation: “Just now, you look like a deer caught in the headlights.” This metaphor combined with the inquiry “What was happening for you when you heard Judith tell her story?” offers the group insight into what was observed while not diverting attention away from the member.

**A Sample Analogy**

The following analogy has effectively moved the group from an impasse between two members. Two of the group members were in deadlock due to the manner in which they were relating to each other. The intervention at that moment was the simple phrase,

“As I hear Kim talk to Jeannie, I cannot help but picture Jeannie as a scared kitten backed into the corner taking swipes at Kim as she keeps trying to pick her up.”

This indirect, easily identifiable feeling for most people, was highly helpful in providing the opportunity for the two group members to disclose their actual feelings which ultimately moved...
them out of their cognitive dueling into their actual feelings.

**CONTRAINDICATIONS**

Possible contraindications for using figurative language would be with a group in which there are members who are highly concrete or when the primary language being spoken in the group is a second language for some of the members. In these cases, the nuances and abstractions of figurative language may be alienating or distracting to part or all of the group members.

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**Awakening Social Consciousness**

Chad V. Johnson

True peace is not merely the absence of tension: it is the presence of justice.

Martin Luther King Jr.

**INTEGRATING SOCIAL JUSTICE INTO GROUP THERAPY**

Amongst virtually every mental health discipline, the call is going out for integrating social justice into practice. Many fields such as psychology, counseling, and social work are imploring practitioners to take seriously the task of addressing inequalities and injustices faced by their clientele. As Prilleltensky, Dokecki, Frieden and Wang. (2007) eloquently stated, “if we don’t challenge the status quo, we tacitly support it, and if we concentrate exclusively on intrapsychic dynamics, we run the risk of neglecting the social origins of suffering and distress” (p. 20).

Tragically, mental health treatment suggests a trend toward neglecting the social origins of emotional distress and shifting the primary emphasis to brain disease (Albee, 1998). Helping professionals have begun to recognize the need to address both our clients’ pain and the social injustices that help create it. First, as therapists we need to raise our awareness to how counseling theories and practices serve the status quo of oppression and injustice rather than challenge it (Albee, 2000; Katz, 1985). Second, we need to help increase our clients’ awareness of the ways that they are contributing to or being victimized by forces of oppression. Third, we can help our
clients articulate how their suffering results, at least in part, from sociopolitical factors. Finally, we may collaborate with our clients to ameliorate injustices in society and, subsequently, in our own lives.

AN OPPRESSED CLIENT POPULATION

This intervention may be particularly useful with groups consisting of those generally recognized as oppressed—e.g., domestic violence survivors, those in poverty, or racial/ethnic/sexual minorities. However, this intervention is intended for any short- or long-term process-oriented therapy groups including those in private practice, mental health agencies, and college counseling centers. It is not recommended for clients who may be sensitive to retraumatization through the experience of recognizing ongoing oppression in the here-and-now of group.

A 10-STEP INTERVENTION

Step 1

Make a commitment to develop multicultural competencies and social justice awareness in your practice (see Arredondo et al., 1999).

Step 2

Work diligently to recognize sources of oppression, prejudice, and injustice in the theories, practices, and systems of healing and mental health (see Albee, 2000 and Katz, 1985) and in your clients’ lives.

Step 3

If beginning a new group, consider informing potential members that one of the tasks of group will be recognizing and exploring how sociopolitical realities are reflected in group and affect group process and attainment of therapeutic goals. If this is an existing group, consider introducing this idea as something worth exploring together as a group from this point forward.

Step 4

Develop a framework or template for recognizing instances of power, oppression, competition of resources (e.g., the leader’s attention), etc., in the group process. For example, ask yourself the following types of questions: “How is the group process reflecting injustices (or oppression, etc.) in our society?” “How may this conflict between members reflect sociopolitical conflicts and tensions?” “How am I as leader a symbol (or actual source) of oppression and how might this be influencing the process?” “Whose voice is being silenced and who is doing the silencing (e.g., the leader, the group, particular members)?” “Who is being privileged by the group and why?”

Step 5
Recognize and illuminate positive ways the group shares power, gives voice, recognizes oppression, and takes action to eradicate it in their personal and social settings.

**Step 6**

Consider first identifying your own actions as contributing to injustice, unearned privilege, or oppression in group when it occurs. This may help alleviate fears about this process and prevent the group from going on a “witch hunt.” However, if a witch hunt or active censoring ensues it is another instance of how oppression dehumanizes and creates conflict (Freire, 1970/1995). Thus, this kind of experience is grist for the mill of group discussion and exploration.

*Caution: Leaders may become a scapegoat in the group for initiating this type of discourse. Be open to criticism, be willing to hold these types of accusations, and actively explore any reactions members may have. Demonstrate your willingness to engage actively in searching out your own contributions to injustice and oppression. Emphasize for the group that no one is immune and that you are fellow sojourners when it comes to eradicating oppression from our personal lives and society.*

**Step 7**

Identify the various sociopolitical roles that members enact in group and facilitate bringing these roles to the groups’ awareness. For example, if one member continues to “talk over” another member, in addition to addressing the interpersonal issue, use this as an opportunity to explore the phenomenon of silencing or “power over” in our culture. Of course, like with other group interventions do this gently and without judgment recognizing that we all partake in different types of oppressing and being oppressed.

**Step 8**

Invite exploration of the subjective and interpersonal experiences for each sociopolitical role. Examples: “What is it like to be silenced?” “How does it feel to be seen as receiving unearned privilege in group?” “Martha, what are you experiencing as you talk over Cindy and appear to dismiss her contributions to group?”

**Step 9**

Translate these experiences and insights to growth and action through helping members connect their suffering to social and political forces and through being empowered to make changes in their personal lives and in their communities to eradicate these forces.

**Step 10**

Consider making a commitment as a group to a community service project in whatever arena most closely aligns with a particular member’s pain or a group issue.
CLIENT RESPONSES

Expect initial resistance to this type of intervention from some members who may be threatened by language such as “oppression” or “injustice” and/or believe this type of discussion conflicts with their personal and political views. Like discussions of sex, members may perceive dialogue about social and political processes as taboo. Group leaders may avoid much of this resistance through using inclusive language such as “silencing” and “control” rather than “oppression” and “power.” I find that an emphasis on promoting full person-hood and eradicating dehumanization in our personal, relational, and communal lives helps prevent defensiveness. Most have found the experience of exploring personal and social experiences of oppression and injustice illuminating, healing, and empowering. Once a group increases its awareness along these lines, it becomes equipped with another powerful resource of healing, growth, and action to complement other group methods such as psychodynamic, existential, relational, or cognitive-behavioral.

CONTRAINDICATIONS

I have found few contraindications for this intervention and believe it is a powerful adjunct to successful therapy. Occasionally, a member might have experienced severe trauma that becomes activated through intense exploration of oppressive processes in group. This does not preclude utilizing social justice interventions, but may mean postponing this intervention until such time that the member has sufficient resources to effectively work in this way.

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Chad V. Johnson received his PhD from Pennsylvania State University in counseling psychology. He is an Assistant Professor of Human Relations at the University of Oklahoma, as well as a licensed psychologist. His research and clinical interests include the interface of spirituality and psychology, group psychotherapy, body-oriented and experiential psychotherapies, and applications of social justice in counseling practice.
The Empty Chair As a Tool to Promote Self-Awareness and Interaction in Groups
Thomas A. Glass

THE HOT SEAT

Early in my training in Gestalt therapy, I became acquainted with the dual-chair technique, originally introduced by Frederick (Fritz) Perls, founder of Gestalt therapy. I was struck by the versatility and power of this method, not only to increase self-awareness but also to promote interaction among group members (Glass, 2001). As originally practiced by Perls, an individual indicated his or her willingness to engage with the therapist by taking the “hot seat,” a chair facing the therapist. An additional “empty chair” next to the client was used to imagine the presence of a significant other, or a disowned or denied part of self for the purpose of initiating a dialogue.

For example, if the client was in conflict within a part of himself or herself, e.g., one part had expectations for high achievement and another part procrastinated and made excuses, (a particular personality split that Perls labeled “top dog/bottom dog”) the therapist might suggest the client have a dialogue between these two parts. This technique involves the client moving back and forth between the two chairs, speaking alternately from each position. As the interplay between these polar opposites is heightened and thereby more fully experienced, integration through greater self-acceptance becomes possible.

Although Perls originally practiced Gestalt therapy primarily as an individual form of treatment, others subsequently have expanded the approach to working with groups in a way that encourages more interaction among group members (e.g., Glass, 1972; Feder & Ronall, 1980). For example, using the empty-chair technique, invite an individual who has only shown his friendly, “nice guy” persona in his interactions with other group members to put his critical, judgmental side in the empty chair. After giving this side a voice with accompanying affect, the member is then asked to experiment with engaging others in the group from this perspective, expressing criticisms and disagreements as may be appropriate to his relationship with each group member. Group members are then asked to respond, leading to more authentic group interaction. Additional examples can be found in discussions by other authors (Woldt & Toman, 2005; Yontef & Jacobs, 2005).

APPLICABILITY TO A VARIETY OF CLIENTS

The empty-chair technique has broad applicability to a variety of clients and types of groups. It can be successfully implemented in personal growth groups, therapy groups, and training groups. It is probably best to introduce it after the group has developed some familiarity and a degree of trust, since identifying less accepted parts of self may require a measure of risk taking, self-disclosure, and a willingness to explore unfamiliar territory. The method assumes a willingness by participants to work on unfinished relationship issues, past or present, and to seek more authentic interactions with others. Also needed is a willingness to experience strong affect in the presence of others.

GUIDELINES FOR THE INTERACTION

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In working with the group, I watch for comments, behaviors, nonverbal cues, or interactions that suggest hesitation, ambivalence, avoidance, or conflict as members interact. For example, one member sits on the edge of the group, hugging her knees, and seems afraid to get involved. Another member rolls her eyes and challenges everything others say. A third member says he doesn’t feel safe in the group.

**Step 1**

Invite the member to focus on the behavior, posture, or feeling that drew your attention. Ask member to pay close attention to how it feels, e.g., hug your knees; roll your eyes; focus on feeling of not being safe.

**Step 2**

Ask member to repeat, exaggerate, or intensify the experience. For example, the member hugging her knees reports she feels like she’s hanging on for dear life; the one rolling her eyes says she’s disgusted with everyone’s complaints, whining, feeling sorry for themselves; the one who feels unsafe says he’s convinced that if he doesn’t take care of himself others will exploit or take advantage of him.

**Step 3**

Invite member to put a projected, opposite, or disowned part of self in the empty chair. For example the part that is holding her, supporting her, keeping her together, not letting her fall apart; the part of her that is whiney, complaining, and feels sorry for herself; the part of him that’s exploitive and takes advantage of others.

**Step 4**

Once the person has moved to the empty chair, ask him or her to give a voice to that part, speaking in the here-and-now, first-person present tense as that aspect of self. For example, “I am holding you and supporting you; I won’t let you fall apart; I’ll make sure you are okay and will take care of you.;” “Oh, I’ve got so many problems and no one seems to care about me;” “You’re all a bunch of losers; the only way to survive is to take what I need.”

**Step 5**

Ask the person to focus on and report how it feels to take this position, paying attention to thoughts, feelings, posture, and body sensations.

**Step 6**

Ask the person to speak to one, or several group members in turn, from this place. For example, “I am strong, capable, and able to take care of myself;” “Oh, please pay attention to me–unless I make myself out to be pathetic, you won’t even notice me;” “The only way to
survive is for me to look out for myself and take what I need from you.”

**Step 7**

Using two chairs, have member dialogue between the part identified in Step 2 and the opposite or projected part identified in Step 3. For example: the helpless one and the caretaker; the one disgusted with others’ need for attention and the one who wants attention; the one who fears being taken advantage of and the exploiter of others.

**Step 8**

Invite the member to reflect on his or her own experience and to request feedback and reactions from others in the group. Ask others in the group to notice any identification with the issue at hand and to share related experiences with the member who did the dialogue.

**TYPICAL RESPONSES: RECONCILIATION OF CONTRADICTORY ASPECTS**

Almost invariably the exercise enhances empathy, identification, and appreciation for the member’s openness, honesty, and trust in the group to deal with the issue at hand. One person’s work frequently serves as a stimulus for others to open up more themselves, and enhances group interaction. Members frequently report that they feel more accepting and less judgmental of some of the contradictory aspects of self they were dealing with.

**CONCLUSIONS AND CONTRAINDICATIONS**

I have found this technique to be effective if the therapist is willing to trust that meaning and integration will occur if the client is guided to finding his or her own discoveries without feeling the need for either therapist or client to interpret, explain, or theorize about what the work means. Gestalt therapy is grounded in the belief that by attending to present-centered awareness and immediate experience, the clients will discover important understandings that are helpful to them.

If there are any contraindications, they may lie in the fact that Gestalt techniques can release intense affect. Clients who are severely disturbed or who lack impulse control may be overwhelmed by the emotions that emerge from identifying with disowned or unintegrated aspects of self. If there is insufficient ego strength or group support, this technique may generate a level of affect that is hard to contain or integrate.

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A Spiritually Informed Approach for the Group Leader

Robert L. Weber

**THE SPIRITUAL DIMENSION**

In the past four to five years I have encouraged and welcomed a spiritual dimension to enter my groups in more explicit ways; prayer, worship, and spirituality are and always have been vital to my own personal life and psychological growth. Part of me was influenced by the bias of Freudian tradition and a concern about how I would be viewed by professional colleagues if I made this aspect more manifest. Another reason for avoidance was the awareness that, for many group members, spirituality and religion are very problematic issues that seemed extraneous to the presenting psychological concerns. Now, perhaps as a function of my aging, spiritual, existential, and ultimate concerns such as these, including mortality, have become more predominant.

**LONG-TERM OPEN-ENDED GROUPS**

All four of my groups are long-term, open-ended psychodynamic groups (Rutan & Stone, 2001) with a strong emphasis on the “herean-now” interpersonal dimension (Yalom & Leszcz, 2005). All are heterogeneous in gender and age. I view these groups from three theoretical vantage points and base my interventions on them: (1) *group as object* (using whole-group interventions); (2) *group as setting* (applying individually focused interventions); and (3) *group as agent* (using process-oriented group interventions) (Kauff, 1979).

**A FIVE-STEP INTERVENTION FOR ELICITING SPIRITUAL AWARENESS IN THE GROUP LEADER**

**Step One: Be Clear About Your Own Spiritual Orientation and Its Importance**

Before working more explicitly with spiritual concerns in groups, it is essential for the therapist to consider the place of spirituality and religion in his or her own life and to be very clear that the goal is neither to proselytize nor convince anyone of its importance, nor to
emphasize a particular tradition or practice specifically. This requires personal reflection, consultation, supervision, and therapy in order to develop “cultural competence” in the area of spirituality (Abernethy, 2004; Bartoli, 2007).

**Step Two: Be Clear About Your Definition of Spirituality and Religion**

The therapist must next give considerable thought to his or her understanding of the meanings of spirituality and religion that he or she will use to describe these phenomena to group members. I read widely and choose to define terms for my patients in ways that are inclusive without being imprecise.

*Definitions That Meet These Criteria*

Spirituality encompasses a search for meaning, for unity, for connectedness, for transcendence, and for the highest of human potential. Religion is a (more or less) organized search for the spiritual associated with a covenant faith community with narratives that enhance the search for the sacred (Emmons, 1999).

In other words, although there is a strong connection between the two phenomena, the understanding of spirituality and the context of it varies from individual to individual and may or may not connote religion per se. Furthermore, it may denote a theistic or non-theistic orientation. The group leader’s function is neither to prescribe nor proscribe an individual’s specific approach. Rather, it is to foster this dimension on the individual’s own terms.

**Step Three: Be Clear About Your Understanding of the Interrelationship Between the Spiritual and Psychodynamic Dimensions to the Work**

Having set the stage for inclusion of the spiritual aspect, the next step is to work with it as it manifests itself in the dynamics and process of the individual and the group. There are various ways to frame this; however, I will place emphasis on one dimension I find particularly relevant to group members. This is the area of self-development, especially what can be called searching for the “true self” (Winnicott, 1960) in psychodynamic terms, or responding to one’s “vocation” (Merton, 1965), in more spiritual terms.

The chief complaint of many group members is a lack of self-esteem and a profound sense of shame about themselves. Often, in lieu of a real or “true self,” a person develops a “false self” and loses connection with himself or herself in the service of survival and protection of the “true self” (Miller, 1981). For many, this is the great tragedy of their lives underlying the presenting complaints. So, what does this have to do with spirituality?

At the heart of my own approach to life and to therapy is the notion that the individual’s fundamental “vocation” or task in life is to become who he or she truly is (Merton, 1965). If there is a place for the word “holy” here, its implication is “wholeness.” This is not to imply that there is a preestablished mold into which one must fit. Rather, it is a lifelong process of continual efforts at self-understanding, rooted in mind, heart, and spirit, and decision making that actualizes this understanding by good decisions made in freedom.

**Step Four: Make Explicit That You Welcome the Spiritual Dimension into the Group Process**
My own practice is to invite this topic during the first two individual meetings I have with a prospective group member; the goals of these meetings are as follows:

- To get to know the person and his/her hopes and goals for the group work in a preliminary way and to determine whether there is a mutually good match for the work
- To prepare the person for entrance through discussion and written materials that inform and educate him or her about the ways to get the most out of group

Up to this point the content of our meetings has been generic and psychodynamic. My first introduction of spiritual-religious content occurs when I point to a four-legged table in my office. I ask people to consider the four legs of the table and think of them as the “Four Legs” on which all our lives are built and on which we will be working in group. I call the legs: love, work, play, and pray.

After giving some elaboration to the first three legs, I turn to the pray leg. My mention of the pray leg is often surprising to people because many people who come to therapy do not expect a therapist to inquire into this area. This area may also be very problematic for many patients who have had bad and even traumatic experiences during their religious upbringing. For these reasons it is essential to define and describe my inclusion of this dimension in a way that is more far reaching than the traditional confines of religion.

I tell the person that “pray” might be taken in a more literal sense by some individuals, making use of specific prayers or prayer forms, within a specific religious or spiritual tradition. However, it might also be taken in a broader sense as (1) a philosophy of life by which one lives; (2) a particular spiritual practice or path within a tradition such as Buddhism; (3) a meditative practice such as mindfulness; or (4) the values or principles by which one lives and orders one’s life. My point is that we are all searching for some meaning in our lives and this goes to the heart of what spirituality and religion are all about. This is very close to what Yalom (2005) calls “existential factors” in his list of “group therapeutic factors.” It is also reflective of what others call “the psychology of ultimate concern,” which involves “an ultimate vision of what people should be striving for in their lives” and the strategies to reach those ends (Emmons, 1999).

**Step Five: Address Spiritual Issues in the Group**

Now when I lead a group I am very aware that I view the members and the group process with a vision I characterize as psychospiritual. This vision is binocular, engaging a dialectic that oscillates between a spiritual view of the work occurring and a psychodynamic conceptualization of what is happening, each mutually informing and reinforcing the other. Let us consider one such focus that, in psychodynamic terms, can be self-psychologically conceptualized as the establishment of the true self, and, in spiritual terms, can be considered the work of seeking one’s “vocation.” Both involve a full and rich integration of all aspects of our humanity, the good, the bad, and the ugly.

Practically, what occurs in group is that an individual begins to open up about his or her self-worth. Gradually, as trust in the group and leader increases, the individual invites us into his or her life at a deeper level, overcoming the initial reluctance to do so. A spiritually informed response is: it is not because we are perfect that we are worthy of love, but because we are human that we are worthy of love.
CLIENTS’ RESPONSES TO THE INTERVENTION

To give people a better picture of themselves and in order to enhance self-understanding and to correct distortions in self-perception, I encourage individuals to “try to see yourself in our eyes,” mine, and those of other group members. Although the person may object, e.g., saying that I am paid to say things like that or that group members are just trying to be reassuring, gradually, genuine responses and feedback begin to take root in the person. As group members face themselves with others they can face their internal shame, which ultimately elicits changes that will give them richer, fuller lives.

CONCLUSION AND CONTRAINDICATIONS

In summary, the milieu I wish to create in group is one that is psychospiritual in nature without being heavy handed about either side of the polarity. First, I do this by welcoming the spiritual into what is a psychological domain in my preparatory work for group treatment. Second, I use my own understanding and experience of the linkage between the two to foster and encourage that in the group members. I do not proselytize or convert people to my view. Third, I seek for a common language and phenomenology that interconnects the spiritual and the psychological, in this case, I emphasized the notion of self and its development.

My job then is to serve as a psychospiritual guide, assisting the individual to a place of acceptance and integration by first emphasizing the universality of his or her pain and shame, saying for example, “Isn’t that true for all of us?” This statement is more inclusive and reflects the reality of our shared humanity, which is more alike than not. A spiritually informed stance reflects the reality of an underlying belief that God, the transcendent, the sacred one, is kind, compassionate, forgiving, and accepting of the fact that we are sometimes all too human and that we encounter this God through our basic humanity and human experience.

This perception must necessarily involve the full picture of the individuals, their shortcomings, and “bad” aspects. If group members and the leader can bear to be flawed and limited in the presence of one another, change can begin to take place.

In general, there appear to be no contraindications about dealing with religious or spiritual issues. Although addressing such issues with more severely disturbed clients seems contraindicated, there is clinical evidence that addressing spiritual issues with this population can actually be therapeutic (Kehoe, 1999). The one instance when caution must be exercised occurs when such issues arise in groups with members who may have experienced abuse or trauma from religious authorities or due to the organizational structure of their ecclesiastical institutions. In such cases one must wait for indications that the individual is ready to engage such issues productively.

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**Group Cognitive Behavioral Model: Integrating Cognitive Behavioral with Psychodramatic Theory and Techniques**

*Thomas Treadwell*

*V.K. Kumar*

*Joseph H. Wright*

This brief chapter combines psychodrama and cognitive behavioral therapy (CBT) techniques in applied group settings. We illustrate the application of some CBT techniques that were found helpful in the three phases of psychodrama with college students and patients diagnosed with mood, substance abuse, anxiety, and personality disorders. Although both CBT and psychodrama models stress the discovery process through Socratic questioning, the use of certain structured CBT techniques (e.g., the Dysfunctional Thought Record) provides additional ways of stimulating the development of self-reflection and problem-solving skills. The group cognitive behavioral therapy (GCBT) model focuses on identifying upsetting situations, automatic negative thoughts, triggered moods, writing balanced thoughts to counter negative automatic thoughts, and recognizing distortions in thinking and imprecise interpretations of difficult situations. The GCBT environment provides a supportive and safe climate to practice new thinking and behaviors (Treadwell, Kumar, & Wright, 2004).

Although traditional psychodrama is conceptualized in terms of three main techniques—warm up, action and sharing—there is no dearth of techniques that may be applied in those three
phases (see Treadwell, Stein, and Kumar, 1988, Treadwell, Kumar, & Stein, 1990). The versatility of psychodrama stems from the variety of techniques that have been borrowed or adapted from various individual and group psychotherapy modalities. With the increasing popularity of cognitive behavioral therapy (CBT) techniques, especially those developed by Beck and his colleagues (see Beck, 1995; Beck, Rush, Shaw, & Emery, 1979) in the treatment of anxiety and depression in individual psychotherapy, we found incorporating these techniques within a psychodramatic environment produced persuasive results. Thus, the blending of the two models yields a complementary eclectic approach to multiple problem-solving strategies.

**CLIENT/PATIENT POPULATION**

This particular intervention has proven to be effective with college students and patients diagnosed with mood, substance abuse, anxiety, and personality disorders.

**GUIDELINES AND INTERVENTION FOR A GROUP COGNITIVE BEHAVIORAL THERAPY (GCBT) PSYCHODRAMA**

In applying the various CBT techniques within the context of psychodrama, it is important to devote the first one or two sessions (at least three hours each) to educating the participants about the GCBT model (cognitive behavioral and psychodrama) to create a safe and secure environment in which individuals can share their concerns freely with group members.

The initial didactic sessions convey the notion that the group format is, foremost, a problem-solving approach for working through various interpersonal, occupational, educational, psychological, and health-related conflicts. Group members receive instruction about the nature of the structured activities so that they have realistic expectations about how the group will be run. At the outset, the therapist introduces the group members to the significance of completing the Beck Depression Inventory-II, the Beck Anxiety Inventory, and the Beck Hopelessness Scale on a weekly basis. Diagnostic instruments, which are completed before the start of each session, are stored in their personal folders to serve as an ongoing gauge of their progress in the group.

In addition to the Beck inventories, group members complete Young’s (Young, Klosko, & Weishaar, 2003; Young & Klasko, 1994; Young, 1999) schema questionnaire(s), which allows therapists to obtain additional data on early maladaptive and dysfunctional schemas/core beliefs. A list of dysfunctional schemas and core beliefs with definitions are given to participants during the initial session. The Social Network Inventory, similar to a genogram, (Treadwell, Stein, & Leach 1993) is utilized to map and quantify participants’ relationships with family members, significant others, groups, and organizations. Each group member signs an informed consent form and an audiovisual recording consent form. The audiovisual recordings establish an ongoing record of group activities and serve as a source for feedback when needed.

**APPLYING CBT INTERVENTIONS AND TECHNIQUES TO PSYCHODRAMA**

**Dysfunctional Thought Record (DTR) or Automatic Thought Record**

The classic psychodrama techniques of role reversal, doubling, self-presentation, interview in role reversal, mirroring, future projection, surplus reality, empty chair, and other action techniques (Moreno, 1934; Blatner 1996; Kellerman, 1992) can be applied directly to situations
indicated in the DTRs. During the initial didactic sessions, we found that it is extremely helpful to teach the group members how to complete a DTR. It is important to introduce the DTR as a self-reflection strategy for recognition of automatic thoughts that occur within and outside the therapy sessions and for improving problem-solving and mood-regulation skills.

**Automatic Thoughts (ATs)**

Automatic thoughts usually contain one or more *cognitive distortions* (Greenberger & Padaskey, 1995). The auxiliary ego and the therapist may help the protagonist discover the possible cognitive distortion in the protagonist’s stated AT. For example, for an identified “all-or-nothing” cognitive distortion, the therapist develops a scenario to explore the distortion in an action format to get an in-depth, concrete explanation of the protagonist’s thought processes. Additional auxiliary egos or the self-presentation technique are used to represent the many conflicting selves to facilitate working through the cognitive distortion.

**Downward Arrow Technique**

The downward arrow technique consists of challenging the protagonist by repeatedly asking the questions: “If that were true, why would it be so upsetting?” and “Being upset means what to you?” The technique can be used during any stage of psychodrama to explore a deeper understanding of the core beliefs/schemas underlying an AT.

**The Case Conceptualization Technique**

This technique is applied as an ongoing therapeutic tool. After three or four sessions, the therapist explains and teaches the main ideas behind the technique to group members and asks them to complete the case conceptualization form on an ongoing basis as the group progresses. A member discusses his or her completed form with the group on an assigned day.

Case conceptualization may help the group member reflect on their various rules, conditional assumptions, beliefs, and means of coping. It is also a good way of introducing the cognitive triad to group members who characterize their situations to reflect themes of loss, emptiness, and failure. Beck (1995) referred to such bias as the negative triad, viewing oneself (“I am worthless”), one’s world (“Nothing is fair”), and one’s future (“My life will never improve”) in a negative manner. This view is usually distorted and the purpose of designing a case formulation is to challenge the patient’s views of self, the world, and the future.

**CLIENT/PATIENT RESPONSES**

Initially, we found clients/patients to be hesitant of the GCBT model. In contrast, once they are taught the basics of the automatic thought record and understand what an automatic thought is to them, they then realize this technique yields real-life data that are not terribly threatening. They show signs of relief and begin to see that automatic thinking is what “we” all do. In addition, they recognize “their” core beliefs and schemas in relation to “all” people across their life span, that negative situations activate schemas/core beliefs and this now has a calming effect. This knowledge serves to normalize the group cognitive behavioral therapy process allowing group members to feel at ease. Patients/clients have found this model useful in combination with
individual therapy, either at the same time, or in sequence.

**CONCLUSION**

From our experience, integrating CBT with psychodramatic techniques creates a powerful and effective group process enabling participants to address problematic situations with the support of group members. Students and clinical populations respond well to the CBT techniques and find them helpful in becoming aware of their habitual dysfunctional thought patterns and beliefs systems that play an important role in mood regulation. Therapists can use advanced CBT and psychodramatic techniques, not illustrated in this brief chapter, to address intricate problematic situations. The basic and advanced cognitive behavioral coupled with schema-focused techniques merge nicely within the psychodramatic framework. Therapists can expect some resistance from group members, especially with regard to their not completing DTRs on time or their unwillingness to share their DTRs initially with the group. We found, however, that group members quickly begin to see the usefulness of the various structured CBT techniques and adapt accordingly.

One of the most important elements of GCBT is that it is data based—group members keep track of their dysfunctional thoughts, depression, anxiety, and helplessness scores from week to week. They are able to see changes that result from group therapy that make the therapeutic process a tractable one. The GCBT model promotes dynamic group interaction, experiential participation, provides opportunities for catharsis, and facilitates basic group psychotherapeutic techniques. The integration of CBT techniques allied to psychodrama help provide a balance between an exploration of emotionally laden situations and a more concrete, data-based, problem-solving process.

**CONTRAINDICATIONS**

Therapists need to be skilled in both cognitive behavioral and psychodramatic therapies before attempting to implement group cognitive behavioral techniques. We suggest avoiding using psychodramatic techniques during session one and focus on psychoeducation. From our experience, the preferred size of a group is between five and ten members with sessions lasting two to three hours. The duration of treatment can be brief, fifteen weeks or extended. Patients need to be screened before matriculation into the group.

Based on our observations, the following exclusions are recommended: (1) individuals with self-centered and aggressive disorders display strong resistance to group work, especially when assuming auxiliary roles. They tend to lack spontaneity and are rigid in their portrayals of significant others; that is, they either insulate or attempt to dominate others in the group; (2) it is better to rule out individuals with narcissistic, obsessive compulsive (severe), and antisocial personality disorders since individual therapy is more suitable for them; and (3) individuals with Cluster A personality disorders and impulse control disorders, such as intermittent explosive disorders, have difficulty functioning in a group composed of individuals with different diagnoses.

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**Preparing Members to Fully Participate in Group Therapy**

Rebecca MacNair-Semands
CREATING NORMS FOR GROUP MEMBERS

There is strong consensus that pre-group preparation can be profoundly beneficial, not only for prospective members but also for the group as a whole (Rutan & Stone, 2001; Yalom & Leszcz, 2005). Group norms such as confidentiality, attendance, punctuality, socializing with other group members, and contact between group sessions should be repeated often and reinforced frequently throughout the life of the group. Norms for therapy groups can be infused by the leaders at almost every moment, starting with a pre-group meeting between prospective member and group leader(s). The initial meeting also develops member expectations for group, which may help the entire group stay focused on treatment goals.

Group members who are prepared prior to entering group therapy may experience greater group cohesion, deviate less from tasks and goals, be more committed to attend meetings, have less anxiety, better understand their roles and behaviors in the group, and show an increased amount of faith in the group as a whole (Bednar & Kaul, 1994; Piper & Ogrodniczuk, 2004; Yalom & Leszcz, 2005). There are three primary methods used to prepare members for the group experience: cognitive learning, vicarious experiencing, and behavioral practice. It has been found that a combination of modalities (e.g., verbal, written, experiential, audiovisual) is most effective (Piper & Perrault, 1989). This chapter will emphasize the first two methods of pre-group preparation interventions to assist leaders in creating high functioning therapy groups. There are also numerous recent examples of written preparation materials that leaders can access in the CORE Battery-R (Burlingame et al., 2006), the American Group Psychotherapy Association Ethics Curriculum (MacNair-Semands, 2005), and various journal articles (MacKenzie, 1997; Rutan & Alonso, 1999).

DESCRIPTION OF PSYCHOTHERAPY GROUPS

All forms of group treatment, regardless of duration, setting, or theoretical model generally benefit from group preparation for members (Budman, Demby, Soldz, & Merry, 1996; MacKenzie, 2001; Rutan & Stone, 2001). The pre-group preparation interventions presented here are designed to develop individuals to be fully participating members of process-oriented general therapy groups. Such groups emphasize the here-and-now to guide interpersonal learning and are specifically designed to be heterogeneous rather than theme-based or problem-based in nature (Yalom & Leszcz, 2005).

A PRE-GROUP INTERVENTION

The pre-group meeting is an opportunity for group leader and candidate to discuss the benefits and scopes of the group. During this meeting, the candidate should be given the opportunity to interview the group leader and ask questions, allowing the candidate to form a judgment and make an informed decision about the group. A pre-group meeting can also be considered a type of mini-group experience to assess how well the candidate may interact in the group setting. It is recommended that the following information is conveyed in both written and verbal formats to provide repeated reinforcement of norms. Verbal interventions are put forth in the next section, followed by written comments that can be incorporated into a handout adapted for a particular clinical setting.
The following examples of initial introductory comments can be presented by clinicians that describe the group therapy experience to potential members.

- In group, you can go a step further than talking about the way you relate to others; you can actually practice changing the way you relate to others.
- Group has been shown to be an effective treatment of choice for your specific issues—people like you do well in group.
- An individual therapist is often unable to observe your interpersonal style that you feel is not working for you; in group, these dynamics can become clear to you as others observe you.
- One of the nice things about groups is that you may work through a problem merely by listening to another group member struggle with your issue. Without speaking at all, you may gain insight and healing. You do not have to do all the work by yourself.
- Your problems are similar to those of other clients in group counseling; although your situation may be unique, your underlying feelings will be remarkably similar to other group members. People often describe feeling less alone and isolated once beginning group therapy with others who understand difficulty.
- You may feel nervous about the first group session. As you hear others disclose and you begin the process of letting people get to know you by revealing yourself, you may be surprised at how quickly you feel more comfortable. The people who are able to share things in group often get the most benefit.

Written handouts with information specific to therapy groups can greatly benefit clients’ understanding of the group process. Such handouts and can be utilized to clearly communicate group norms and help create a healthy group climate. These handouts may be given prior to the pre-group meeting to help prospective members begin to absorb the concepts.

The following statements are easily incorporated into a written format for handouts:

- You are encouraged to talk about your feelings and experiences, particularly in areas that are emotionally uncomfortable or risky for you. You will make the most progress if you allow yourself to experience and discuss your true feelings and reactions to others.
- It is normal to feel some anxiety as you talk about your personal feelings, thoughts, and experiences with others. Share these difficulties or concerns at a pace that is comfortable for you rather than forcing yourself to disclose too quickly in group.
- You will be challenged to relate to one another without superficial conversation, social amenities, and other forms of social distancing in order to be as direct, frank, and spontaneous with your thoughts as possible. Questions should be rare, but the thoughts and feelings behind your question will be important to explore.
- Confidentiality is mandatory; it is extremely important to help you feel safe in discussing personal issues in group. You may talk about your own feelings and growth experiences with someone outside of the group but you may not discuss other people or reveal the identity of any group members. Please do not use Internet forums such as Facebook or MySpace to discuss your therapy group experience or reveal the identities of other group members.
- When you have reactions to something another member says, it is helpful to share those feelings in group directly with the person. A good way to do this is to use “I” statements,
such as “I can relate to what you are saying because I also feel afraid when. . . ,” etc. Giving advice, labeling someone, or criticizing are generally not productive in group.

• We make every effort to begin and end group on time. Please be on time for the group sessions, and if you have to be late or miss a session due to an emergency, please call and leave a message ahead of time for one of the leaders.

• We ask that you not have social relationships outside the group with other group members. All members are encouraged to let the group know if you have had a significant conversation outside of group. This helps to keep the group relationships therapeutic.

• Attendance is mandatory in order to keep the group feeling cohesive and safe.

• If you decide you need to leave before the ending of the group, please inform the group and give a minimum of two weeks notice.

ANXIETY ABOUT THE UNKNOWN

Group candidates often come to pre-group meetings with a significant deal of anxiety. Typically, clear guidelines reduce this anxiety but may also raise new questions for the members. Questions related to how they will be perceived by the group and whether personal needs will be met often surface during the pre-group session. It is helpful for leaders to communicate a solid sense of hopefulness about meeting treatment goals through group therapy while also assisting the member in voicing concerns and addressing how leader(s) will help protect and serve the client throughout the process. Leaders can ask candidates to identify what barriers or behavioral patterns might impede the group process, and then leaders can gain verbal permission to push or encourage members when such resistances surface.

CONTRAINDICATIONS

Groups are more successful when a clear and thorough orientation is provided to potential group members. There are generally no contraindications to conducting pre-group preparation sessions, but clients who feel easily rejected may need a compassionate and thoughtful explanation of why a particular group is not a good match for a specific candidate. Overall, most leaders find that pre-group meetings build a strong beginning for developing trust in the leader(s) and an understanding of the group process.

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What to Do When the Group Is Falling Apart

Steven L. Van Wagoner

THE IMPORTANCE OF RESISTANCE

The study of resistance in group psychotherapy and what it reveals about the member’s core conflicts and interpersonal difficulties is central to psychodynamic and analytic group psychotherapy (Fehr, 2003; Ormont, 1992; Rutan & Stone, 1993). Because resistances in group can also be thought of as transference resistances, we must be prepared to work through these transferences from the members to the therapist, and to each other (Ormont, 1993). This requires the willingness of the group members to work in the “here and now,” communicating their immediate reactions (thoughts and feelings) to one another and to the therapist, and the ability of the therapist to foster, through whatever interventions at his or her disposal, this kind of group work. Often, transferences in groups generate intensely negative feelings, which members resist communicating verbally. In this instance, it is essential for the group therapist to help members communicate these feelings verbally, before they become entrenched and threaten the very survival of the group (Rosenthal, 1976).

THE GROUP IN CRISIS
A mixed-gender adult psychotherapy group had been meeting for approximately two years. Up until this phase, in the life of the group, members had learned to express both positive and negative feelings toward the therapist and one another, and reflect upon their thoughts and feelings toward one another in the “here and now,” but suddenly this began to change. Communication in the group quickly became devoid of real feeling, almost lifeless. People talked solely about problems in their lives outside of group, but it was as if life outside the group had sucked the life from within the group and between the members. In addition, a couple members were either periodically late, or did not come, often offering seemingly reasonable excuses. It was the pattern, not the absence per se, that was suspect. Attempts by the therapist to explore members’ reactions to one another or to the absences were met with either silence or feigned acceptance. The group-as-whole seemed to thwart any attempts by the therapist to intervene. Finally, one member announced that he was leaving, which led to two others expressing that they felt similarly. Suddenly the group was in serious trouble.

**THE INTERVENTION**

*Examine Induced Countertransference Feelings*

One of the more important things I can do, as a group therapist is to examine the feelings I am having about what is occurring in the group. With this group I was feeling particularly frustrated with the lifelessness of the group, but more with what I thought was a group-as-whole resistance toward me and the contract. Becoming clear about these feelings through consultation with a colleague helped me appreciate the high degree of frustration in the group members that was being induced in me. Could it be that the members were also feeling frustrated with one another’s deviations from the contract? With this understanding I was the intervention.

*Stay Mindful of the Contract*

My group contract not only identifies patterns but is able to decrease the intensity of my own emotional reaction and extract myself from my own counterresistance to breaking the impasse. Thus it proceeds with defining lateness and absence as a form of nonverbal expression of feelings (i.e., “Put all thoughts and feelings into words, not action”), but also encourages other members to confront deviations from the contract as they occur. The contract can be a starting point from which to identity resistance.

*Confront the Group with Behavioral Observations About the Resistance*

Avoiding interpretation and speculation when sharing one’s assessment of a group’s destructive resistance is essential if the members are to be able to look directly at their resistance. Framing the observation from the standpoint of the contract will keep the therapist’s observations on firm ground.

*If Necessary Draw any Aggression to the Leader*

It is assumed that once the therapist confronts the group directly with its resistance, which in
this case was due to the indirect expression of aggression through lateness, absence, and emotional withdrawal, the members’ frustration, which had been induced in me, would come out more forcefully. Because the group is in such a tenuous and frustrated state, risking the attack on a member would only further indicate that the group is a dangerous place to be. As a result of this assessment, it is imperative that the group therapist protects members from attack and scapegoating, and one way this can occur is by directing aggressive responses toward himself or herself.

I basically told the group that I was not surprised that some people wanted to leave, and that I could not blame them. When they asked me to explain my statement, I elaborated, telling them that it was clear to me that the group was bogged down, and that the emotional sharing that had at one time been a fact of life in the group, had all but completely died. Moreover, I pointed out that people had in effect been leaving for some time through absences, lateness, and emotional withdrawal, and that it was a matter of time before they would leave the group altogether. I further suggested that they must have been frustrated with me for not being more of a stickler with the contract, and suggested that without my help they must have felt powerless to stop the withdrawal.

**THE GROUP’S RESPONSE**

As I explained my observations to the group, several members began nodding their heads in agreement. Two of the members who wanted to leave expressed their anger directly at me for not being a more strict parent in the group. One relayed that his father had never stood up to his mother, leaving him feeling powerless and frightened. The other expressed that her parents had always placed responsibility upon her prematurely for her sister’s care, which she felt that I replicated in the group. For both members, these earlier experiences were reignited in the group. Another member defended me saying that it was not just the leader’s responsibility to adhere to the contract, but that they had all agreed to take a role. Before the group could turn on her, however, I suggested that while that is ideally the case, sometimes it feels too threatening for a member to do this. I then asked why she had not confronted some of the contract violations, which she immediately understood was because it has always been dangerous to risk the rivalrous feelings of her siblings when joining with her parents.

Though there was much more to the vignette and subsequent group sharing that followed, the processing of feelings that resulted created new life in the group. There were no longer the stale renderings of events outside of the group, but an in vivo experience of them in the interactions in the group. Moreover, the pent-up frustration and aggression was brought into words and directed to me, where I could contain them. Ensuring that the initial burst of anger and hostility was directed at me, and not at individual members, prevented the group from electing a scapegoat, and helped to protect any individual members from too much emotional stimulation.

**CONCLUSIONS AND CONTRAINDICATIONS**

The vignette illustrates how directly and forcefully confronting resistance can aid a group in becoming unstuck (Fehr, 2003), and in this case was imperative to deal directly with a treatment-destructive resistance (Rosenthal, 1987). The stepwise delineation of the intervention is meant only as a guide to thinking about how to intervene in such a situation, and in no way is meant to convey that this intervention can work in all situations where a group is stuck. The first step,
examining the induced feelings of the therapist, is a multilayered process, which should involve consultation with supervisors, one’s own therapist, and/or a careful self-analysis of one’s emotional response to the group. It is not based upon an in-the-moment assessment that leads to a quick and impulsive construction of an intervention when so much is at stake. It is recommended that all group therapists considering such an intervention engage in such a process of self-exploration.

In fact, it is because of the very emotional response this therapist had to the group that some time and care was taken to formulate the intervention (between the session in which the members announced an intention to leave, and the subsequent session). Second, knowledge of the members’ individual characteristics, capacities for emotional stimulation, self-awareness, and personal histories is essential in helping the therapist navigate the intense exchange that follows any such confrontation. Finally, it is essential to emphasize that the intervention began with a confrontation that was based in behavioral observation, devoid of interpretation and speculation which can derail examination of resistances (Ormont, 1992), and as the leader I used myself to regulate the emotional excitation of the group, what Rosenthal (1999) refers to as the “thermostatic function” of the group psychotherapist or analyst.

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An Effective Precipice Toward Recovery
THE GAMBLING TABLE

“Gambling table” is a group therapeutic exercise invented by the author to facilitate clients to face their problems and concerns in a dramatic form. It must be used in the cohesive stage of a group when members have trust in one another and established positive working relationships with the therapist. It assists clients to express feelings that underlie their problems through the use of action and enactment (Blatner, 2000; Karp, Holmes, & Tavon, 1998; Kellermann, 1992; Leveton, 2001). The intervention is applied with one key client at a time, with other group members acting as helpers and supporters during the role-play. The intervention aims to confront clients with the negative effects of their beliefs and behaviors, handle uninhibited emotion, and gain insight into the clients’ own problems.

CLIENT POPULATION

This intervention has been used in gamblers’ support groups, extramarital affairs groups, and groups handling love/relationship issues among youths and adults, although it can be generalized to groups of other natures with slight modifications to suit the unique situations of group members. The intervention is applied to situations where the clients experience the “win” and “lose” sensations in the course of gambling with money or gambling with love. It is particularly powerful for female members who are single but become a third party in someone’s extramarital affair.

GUIDELINES FOR THE INTERVENTION

Prepare a table with 2-3 meters in length and 1 meter in width. The table should be strong enough to let one adult stand and walk on it.

Step 1

Help the client to share his or her gambling or extramarital affair experiences in the group. Then blindfold and ask the client to stand on the table. Tell the client the length and width of the table and the rule of the exercise: listen carefully to the scenarios presented by the therapist or the group, then walk one step forward when he or she is happy with the scenarios and one step backward when unhappy.

Step 2

The therapist asks the client, of a gamblers’ support group, the first question: “You won $1,000 in gambling. What did you feel?” Normally, the client responds by moving one step forward because he or she feels happy. The step is usually very small because the client is very cautious of the risk of falling down from the table. Then comes the second and third scenarios: “You won $2,000 and bought yourself a nice watch. What did you feel?” “You lost $5,000 and you did not have money to pay for your son’s tuition fee. What did you feel?” The client moves...
forward or backward according to his or her feelings toward the scenarios.

For female clients in extramarital affair group, the happy scenarios can be “dining with your loved one” and “you accompanied him while he was on a business trip.” Unhappy scenarios can be: “he had to stay at home with his wife on Valentine’s Day” and “you could not hold his hand in public.”

**Step 3**

To involve the participation of the whole group, the therapist invites members to disclose happy and unhappy scenarios for the client. Normally the group is serious and silent when the client is getting close to the edge of the table. The therapist invites two group members to stand by the table to safeguard the client from falling without letting the client know.

**Step 4**

After a while, the client begins to feel he or she may have reached the edge of the table. The therapist asks the client’s feeling each time the client is close to the edge.

**Step 5**

The exercise would reach a point where the client feels confused in the gambling journey (for money or for love) because he or she is blindfolded and loses the sense of direction after walking for a while. The client becomes nervous and stressful at this moment. The therapist then confronts the client why he or she has to walk on the gambling table, knowing that the only ending is to fall down and get hurt.

**Step 6**

The therapist invites group members to give feedback and support to the client, and then helps members debrief the intervention and unfold the myth that no matter how much money or love the client won previously, there will not be a happy ending.

**Step 7**

If the client is still resistant to change, the therapist can move the intervention further by involving the client’s significant others in a role-play. Suppose the client has a son. The therapist invites a group member to stand on the table and play the role of the son. Tell the client that his or her son grew up and became a gambler; he faced the same problem as the client does now.

**Step 8**

This time group members are invited to give commands (raise scenarios) to the “son” based on the rule outlined in Step 3. The therapist sets a “mirror” for the client who is standing aside and watching the son’s movement. Normally when the son is close to the edge, the client would shout out: “Stop, son. Don’t walk any further.” Then the therapist asks the client why he or she says so.
Step 9

At this point, if the therapist considers the client has not gained sufficient insight from the intervention, the therapist can adopt the “Gambling Chair” exercise (see Chapter 8) to further confront the client.

Step 10

Based on these experiences, the therapist leads the group to share feelings and discuss the negative consequences of gambling. They are helped to reflect upon what happened in their past gambling experiences, recognize what exists in the present, set goals for the future and, if possible, develop a series of tasks that they can complete so as to strengthen their conviction in the fight against this destructive habit.

CLIENT RESPONSES

Walking on the table and listening to happy and unhappy scenarios have different effects on clients with different problems. For gamblers, their feelings center around the “risk of falling,” signifying the risk of losing everything in gambling. But for groups for those in extramarital affairs, and love relations, the clients could be very emotional.

CONCLUSION AND CONTRAINDICATIONS

When a client is experiencing a personal problem in a dramatic form, he or she is likely to be confronted with the issue without any defense. Being the audience, group members are vicariously going through the same psychological journey as the key client. Thus, the postexercise group exchange is meaningful for members to experience not only their own but other members’ successes and failures before they work out solutions together (Lo, 2005).

In relation to contraindications, the therapist should be aware of the different stages of the client’s problem. The reactions of a client who is at the initial stage of gambling or extramarital affair would be very different from one who is “addicted” to it. In the latter case, the client may have gotten used to the ups and downs and might have become detached from his or her feelings when the happy or unhappy moments are recalled.

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Using Humor to Advance Group Work

Dave M. Cooperberg

HUMOR IN THEORY

Some therapists perceive humor as primarily a form of acting out; hence, some disapprove of its use, while others find value in it to varying degrees (Fehr, 1999, 2003). Much like all else that comes up in groups, whether humor is useful or not depends on how and when it is expressed, as well as if it is processed.

For purposes of this discussion, humor is loosely defined as the quality of seeing things as amusing, comic, or playful. I am primarily suggesting using the humor that can be found inherently in a group’s interactions to help develop a more useful perspective to what is happening in the group and with its members. Klein (1987), in The Healing Power of Humor, writes about finding humor in everyday life as well as amidst upsets and trauma. He describes using humor as a way to expand our perspective so we remember that life is more than whatever problem is before us. Although jokes or humorous short stories can bring perspective, I rarely use them. They too easily pull people away from what is happening in the group in the moment.

Humor can be initiated in a group by the members, by the therapist, or simply be a spontaneous reaction to events in the group. When initiated by the therapist, humor is an intervention that involves some level of therapist self-disclosure. What is disclosed are usually not details of the therapist’s life, but more how he or she relates with others in the moment. It is also role modeling, in addition to the work being done.

CLIENTS

Although I believe humor can be used appropriately in most situations, this discussion is focused on its use in outpatient, in-depth psychotherapy and support groups. The specific nature of the groups, (e.g., heterogeneous psychotherapy men’s, women’s, cancer support, lesbian mothers, veterans, teens in a group home, Latina physicians, people in recovery, etc.), will determine the specific things that members find amusing and what humor is appropriate, rather than whether or not it can be used at all.

The following examples of effective use of humor come from small outpatient process groups of six to eight gay-identified men that I have run in San Francisco for almost thirty years. The age range has varied, with men generally in their thirties to sixties. Most are in the normal/neurotic range of diagnosis, but usually there are one or two with borderline personalities, who tend to spice things up.
THE INTERVENTION

Since both humor style and content can differ dramatically between individuals, groups, and cultures, there cannot be any “one size fits all” prescription. As with all interventions in groups, members will not all have the same reactions to what we do or say. With therapist-initiated humor, some useful suggestions are as follows.

**Keep It Simple**

This is particularly good advice for those not used to engaging humor in their groups or with new groups. Simple forms of humor that I typically use include puns, double entendres (meanings), obvious exaggerations and simply laughing or smiling. When the issue of sex unconsciously comes up for instance, almost any comment will include words that potentially have a double meaning. Sometimes I might repeat the word used or, with the right timing, just smile, eliciting either joined laughter or denial, either of which can be further explored.

In one session I intentionally interpreted the opposite of what was going on, an ironic exaggeration to get the individual—and the group—to connect more directly to their emotions. John, a midlevel manager in a large corporation, was reporting an interaction with his previously beloved boss. His boss had been bypassing John in dealings with his subordinates with work, in effect having them put aside tasks John had assigned them, to do something else. This put John in an untenable position with his own staff. When John kept talking content, I commented, “Not that you have any feelings about this,” with an exaggerated tone to the word “feelings.” John snorted in response, and the group laughed. John then expressed his rage, also connecting it directly to early childhood experiences. Other members were then able to join him in relating their common experiences when feeling undermined by authorities. The result was both a deeper level of work by the individual, and having it become more of a shared group experience.

**Avoid Putdowns**

Even if the person you are making fun is able to enjoy your comments without injury, this is a group and someone else is likely to feel threatened by it. One needs to be very cautious with negative humor if it is used at all.

**Be Alert to Negative Reactions**

When these are up front we can attend to them more easily. Sometimes they can be well hidden and not arise until much later. When a situation elicits laughter in a group, any individual can take offense.

In one group, a large, powerful man went quiet after the group erupted in laughter to his claim that he had been forced to have sex with someone he obviously found very attractive. I could see him closing down. I pushed him to acknowledge his anger. Then the group attempted to get him to see why what he said created such amusement. He heard and agreed with some of what was said, yet maintained his offended stance, since not to do so he would have had to break through his denial of interest in having sex with others. This brought to the surface a central issue that was not being discussed.
**TYPICAL RESPONSES TO THE INTERVENTION**

Usually groups respond well to this use of humor. Its effects in the moment can be an instant connection, and over time tend to make members feel as if they are understood and belong. Some, who were initially shocked at the laughter in a “serious” therapy group, have later said that it helped the group feel more like an “understanding family.” Humor becomes a bonding agent in the group, and members become able to recognize the humor in situations and use it in relating with others. Since as therapist, I initiate some of the humor, members feel freer to challenge me in a similar way, as play becomes a safer way of learning.

**CONCLUSION**

The potential benefits of using humor include:

- Gaining perspective—-with humor one can gain a bit of distance from what is happening, relaxing defensiveness.
- Reducing overall anxiety—at times the tension in any group can become stifling rather than therapeutic.
- Enhancing the group cohesion—the group that laughs together feels together in those moments.
- Enhancing pleasure and joy in being alive—feelings which help members stay with the group in the moment. When the therapist initiates humor, it can have the additional benefits of making us appear more human and personally engaged, hence safer to directly engage.

With more highly functional groups, as long as we maintain a therapeutic perspective, humor can be highly effective in furthering the processes of the group and the growth of its members. It draws members into the present moment. They experience that even in the midst of facing difficult and painful truths, they can find also find playful and even joyful connections with others. When the therapist actively engages with the group through humor, we become more available for members to engage us and work out any transference. Finally, it makes the group process itself more pleasurable for all.

**CONTRAINDICATIONS**

As in any intervention, using humor has its potential risks and benefits (Bloch, 1987). Some general ways that humor can be unskillful in therapy groups include:

- A masked expression of hostility.
- A distracting frivolousness which draws away from the therapeutic work.
- Avoidance of whatever specific issue is emerging in the group. In addition, when the therapist initiates the humor, there is the risk that rather than serve the therapeutic process, it can simply be a form of personal self-aggrandizement.

Although humor can be useful in most situations, using it with clients who show paranoia, and those with other more rigid personalities require special care. Of course that is true with such
personalities in any case. With such a population, when humor does arise—and it will—it becomes even more important to “check in” with them when others laugh.

REFERENCES


Dave Cooperberg, MA, MFT, CGP, has been a member of AGPA since 1989. He has run workshops on the effectiveness of humor in psychotherapy and has been in private practice in San Francisco for the past 30 years. His specialty client population is Gay identified men.

Highs and Lows: Expressing Gratitude or Grief in Group

Arnold W. Hammari

NAME ONE THING

Expression of “highs and lows” is a simple, nontargeting group exercise, and often overlooked for its capacity to elicit deep self-awareness at a very existential level. The therapist may instruct the group, saying, “Name one thing that makes you happy right now, and one thing that’s making you sad.” This is more than just an ice breaker; it is a pathway to deep and potentially troubling issues. It is built upon the principle that people sense that their own vitality and efficacy rest on whether they have purpose, relationships, or freedoms (Yalom 1980; Arkoff 1995).

CLIENT POPULATION

Teenagers are open to this type of introspection. Teens may desperately need to explore the sources of their angst and insecurities. By labeling their subjective “highs” and “lows” as meaningful existential issues, they can better accept their feelings and beliefs as valuable and necessary. Older adults may also learn from this exercise and compare past experiences to the matrix of existential principles to obtain meaning from them.

GUIDELINES FOR INTERVENTION

The group therapist at the beginning of a session asks group members to take turns
expressing their highs and lows. Define highs in simple terms such as something relatively current that one is glad about, and lows as something recent that is causing disappointment. Listen carefully and link each response to an existential issue such as success or delays in accomplishing one’s purpose in life, losses or gains in relationships, or increases/decreases in freedom. Once you have identified the type of existential issue expressed, it will serve as a springboard to further self-exploration and awareness. You can comment on the uncovered issues either in between the group members’ individual turns, or afterward, processing similarities, and who was sympathetic, indifferent, or hostile to whom.

**TYPICAL RESPONSES**

In a recent group of juveniles in corrective custody, typical answers included highs of “I got a letter from my mom,” or lows of “My dad didn’t call last night.” These seemed to relate to relationships and the dilemma of intimacy versus isolation (Erickson, 1968).

Other answers such as, “I didn’t sleep well,” “It’s my birthday and I’m locked up,” or, “I’m being bullied by another kid,” may have to do with consequences of loss of freedom (choosing where or when one sleeps, how one celebrates one’s birthday, and choosing one’s own companions). Yet, other answers such as, “I passed a GED test,” “My fiancée had a healthy baby,” or, “I will be going home in thirty days,” suggest one may be sensing progress in achieving meaningful goals. If you challenge the group to join you in recognizing existential material in their brags and complaints, then alert group members can add additional perspective.

**CONCLUSION**

Group sharing of individual highs, lows, and connected existential values, helps the group mature. Shared values contribute to the intimacy of the group. Intimacy contributes to the meaning of the group and to the group’s perception of freedom to achieve desired group goals. Maturity helps the group become effective and not absurd. Openness and insight found within the group is transferable to each client’s larger world.

**CONTRAINDICATIONS**

It has been my experience that there are no contraindications to this intervention. If your clients are too young or too cognitively underdeveloped to appreciate existential issues, their moods will still benefit from expressing gratitude and grief and feeling support in the group (assuming the group is supportive).

**REFERENCES**


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grandchildren.

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En Mi Viejo San Juan
(In My Old San Juan)

Richard Beck

AT WHAT LEVEL DO WE INTERVENE?

When leading a group, we listen at many levels and have the option of making interventions at (1) the level of the individual, (2) a dyad in the group, or (3) the group as a whole (Lindenman, 1993, personal communication).

Those are the only choices we have in terms of where we chose to intervene. When a group member speaks, they might be speaking for themselves or they might be unconsciously speaking for the entire group. We just need to listen more closely.

INNER-CITY DAY TREATMENT POPULATION

The group leader worked in an inner city, day treatment program for adult chronically mentally ill substance abusers. He had been leading a psychoeducational group for monolingual and bilingual Spanish-speaking members, with the focus on current events.

One morning, the administrator of the clinic spoke with the group leader and informed him that a decision had been made to shift the name and focus of the group to “Enhanced Communication Skills.” This was told to the group leader without warning or discussion.

The leader felt perplexed as he entered the group room, where the usual ten to fifteen members sat seated around a table in the room. One floridly psychotic group member kept his chair away from the others and against the wall, as he had for the previous three years that this group had been in existence and led by this leader.

Feeling a need to say something which would stimulate communication among the group members, the leader thought for a moment as to how best to intervene and came up with the following: “Como comunicar un bebe antes que el quido usar palabras” (how does a baby communicate before it can use words?). For the next two months, the group, which met once a week, tackles this question, with a variety of responses from the group members. The leader felt a sense of satisfaction that some communication was occurring in the group, but was also filled with a sense of boredom and frustration. The members of this group were compliant in answering a question posed to them and responded in ways that they felt were meaningful. These communications were primarily from the client to the person of the group leader but in this particular group, rarely, was there any interpersonal dialogue among the members during the entire group session.

THE INTERVENTION: “HUM LOUDER”

The intervention described is based upon the group leader listening to the “words and
music,” which one particular group member uttered. Both the member’s utterance and the leader’s attunement to it and subsequent intervention dramatically shifted the meaning of and depth to which this group worked.

In one session, a moment occurred that forever altered the life of the group and its members. As the group members were answering “the question” posed to them, one group member was humming something barely audible to the members and the leader. The group leader encouraged the member who was humming to hum even louder, to amplify the feelings that they were expressing.

The member, as it turned out, was not humming, but was singing quietly to herself. “En mi Viejo San Juan” was the name of the song, and soon, she was joined by a few other members of the group who were also from Puerto Rico.

At the next group meeting, rather than continuing with the question about how babies communicate, the group leader asked if there were other songs that the group members knew and wished to sing.

Another song was sung, only this time it was a religious song, and now a few more members of the group joined in. Gradually, members began to sing songs from their countries: Cuba, the Dominican Republic, Puerto Rico, and soon the entire group began to sing together, alternating songs from their countries with songs from their churches.

**RESPONSE TO THE INTERVENTION**

As the members of the group were encouraged by the leader to sing whatever songs they wanted to, the members began to relate in greater depth to one another. The affective level within the group increased exponentially. People were smiling as they sang or listened to others sing, resonating with the powerful connection to their homeland and with the powerful spiritual and religious beliefs that each of them held.

In one group, the floridly psychotic group member, who for three years had sat with his chair against the wall, moved his chair to the table, smiled at the members in the group and began to sing with his group members. The group leader had waited patiently for three years for this group member to join everyone else at the table.

Everyone in the group clapped as this member joined the group, deeply moved by the songs which the members had now been singing each week for several months.

I told one group member, who had attempted suicide three years prior, that the group needed him, since he was our only baritone, and that he needed to agree never to attempt to kill himself again. He agreed to this contract and you could hear his powerful voice resonate with feeling as he sang all the songs that the group sang, “En Mi Viejo San Juan” was his favorite, since he was born in a small town near San Juan.

**CONCLUSION AND CONTRAINDICATIONS**

Group members often speak for the entire group. In the case of this group, the leader was in tune with one group member’s humming. Rather than view this as a resistance to the work of the group, the group leader enhanced the volume of the humming, believing that this group member was deeply in touch with a very meaningful and underexamined aspect of each group members’ life, namely, missing their country of origin and their strong religious faith.

The contraindication to this type of intervention would be if a member, when asked to
amplify his or her “words and music” felt shamed by the leader in this intervention. By listening to both how the member as well as the group responded to the leader’s encouragement of the amplification of the humming indicated that indeed the group member was speaking for the group with the song, and that the group leader was in tune with this process.

When we listen to the words and music of each group member, and attempt to find meaning in it, the group will benefit tremendously, as was the case for the members in this “Spanish Communication Group.”

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“ZOOM”
Barney Straus

A QUICK WAY TO GET A GROUP PLAYING TOGETHER

“Zoom” is a word passing game described by Le Fevre (2002). Its key asset is that it quickly engages all group members in a common task. It is useful in uniting groups of people who may have trouble connecting with one another. It can also help subgroups experience themselves as having a common purpose. The game can be used effectively with almost any group, as it is easy to play and nonthreatening. It is often used toward the beginning of a group’s development, or as an ice breaker for a training event.

Essentially, “Zoom” is played by group members. They pass the word “zoom” around a circle in various patterns. The game can be played with increasing complexity and variations. The primary function of the game is to foster a sense of spontaneity and fun within the group. Furthermore, the game can be used as a way to explore dynamics occurring among group members (Gass, 1993).

CLIENT POPULATION

“Zoom” is an effective intervention. Because it is enjoyable and easy to understand, it can be used with many populations. Likewise, it can be played with groups ranging in size from ten to fifty. I have used this game successfully as an ice breaker at professional conferences and I have used it with a wide range of therapeutic groups. Among those that have played “Zoom” profitably are a class of fourth graders, members of a psychiatric day-treatment program, college students, older adults at a retirement center, and groups in between.

GUIDELINES FOR INTERVENTION
The group leader invites members of a group to participate in a brief game. Depending on the nature of the group, this may require more or less explanation. Some groups are accustomed to trying new physical activities together while many are only accustomed to sitting and talking together. Zoom can be played either sitting or standing, though all group members should be in a circle.

**Procedure**

- First, the group leader says that he or she is going to pass the word “zoom” around the circle. This is done by turning toward the person to his or her right and saying “zoom.” The next person then passes the word to the group member to the right and so on until the word makes its way back to the group leader. Next, the group should try to increase its speed while completing the same task.
- After two or three rounds, the group leader asks the group what zoom spelled backwards is. After someone answers “mooz,” the leader then says that he or she is now going to pass the word “mooz” in the opposite direction, that is, going around the circle to the left.
- Next, the group leader explains that there is going to be a race. “Zoom” is going to race “mooz” around the circle. The group leader will start both words simultaneously and see which one gets back to him or her first. It is fair to warn the people just opposite the group leader that they should be on their toes as someone may get hit with both words at just about the same moment. This generally elicits some nervous laughter from the group.

Try the race several times. As you announce which word “won,” ask the group members whether they felt affiliated with one word more so than the other. Often those people closest to where a word starts feel like that is “their” word. The group leader should point out that in order for a word to make it all the way around, everyone needs to be involved in each word. This is a good opportunity to talk about subgroups that may be happening among the whole group.

**Variation**

- After “zoom” and “mooz” have both been passed around the circle, explain that group members have the option of “putting on the brakes” when a word gets to them. They can do so by making a screeching noise like the sound of car brakes. They then send the other word in the opposite direction. If the same people keep “braking,” allow members in different parts of the circle to start. If the group is really feeling ambitious, you can start two or three “zooms” at the same time. This then presents an opportunity to talk about the difficulty of group members perceiving all the information in a group at any given moment.

**CLIENT RESPONSES**

People generally respond very positively to this activity. There is almost always laughter as the group attempts to complete a new and, what is for many, a novel task. Often a collective sense of delight is felt as the group may be momentarily engaged in an uninhibited, true sense of collective play. All too often, adults lose the sense of play that is such a vital aspect of childhood.
(LaFevre, 2002). Generally, the opportunity to rediscover this quality, however briefly, is met with a smile.

**CONCLUSION AND CONTRAINDICATIONS**

As mentioned, this game can be played with just about any group. It is a fun group exercise that brings the group together in a common task.

The group leader needs to be cognizant of the possibility that there might be one member of a group who is so seriously impaired, either cognitively or, have hearing problems, that he or she may not be able to follow the instructions. If that is the case, that person might become the focus of other group members’ negative attention. In any event, it is probably best to offer group members the option of observing if they are uncomfortable participating actively for any reason.

The leader of this activity is in a more directive role than are most group therapists. Keep in mind that group members will experience you differently when you move into the role of activity facilitator. Although they may have feelings about this, their central experience is likely to be one of collective enjoyment.

**REFERENCES**


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**Naughty or Nice: A Technique for Exploring the Mischievous in Us**

Lise Motherwell

**THOUGHTS ON PLAY AND NAUGHTINESS**

Freud attributed healthy adult development to the ability “to work and to love.” Terr (2000) argues that the ability to play is an equally important aspect of social, cognitive, and emotional development. Winnicott (1971) writes, “It is in playing and only in playing that the individual child or adult is able to be creative and to use the whole personality, and is only in being creative that the individual discovers the self” (p. 54). Play, which involves the capacity to pretend and to shift attention and roles, provides a natural setting in which a therapeutic experience or change may take place.

Naughtiness is a specific form of play: playful misbehavior directed at or against rules, authority figures, or propriety, in which one may get “caught,” but which is not likely to hurt anyone else. Naughtiness evokes pleasure, excitement, and delight rather than guilt or shame.
The authority’s reaction to naughtiness has a big impact on how the subject feels about his/her naughtiness. Thus, naughtiness is a relational interaction, almost always an action in relation to an authority (rule/person/group)—to them . . . so it is a topic for group therapy.

**DESCRIPTION OF GROUP**

This technique can be used in a time-limited group, in ongoing therapy groups that periodically use exercises or techniques to enhance treatment, and in workshops. It is particularly useful in groups where clients have been parentified in childhood. Such clients who define themselves as “good children” may have lost touch with the side of them that takes pleasure in being naughty.

**DESCRIPTION OF INTERVENTION**

**Step 1. Address Childhood Naughtiness**

I say to clients: “Share an experience you had as a child when you felt naughty. What was the situation, how did you feel, and what was the response?”

This exercise raises a lot of affect. Clients recall situations when the parental response was shame, humiliation, or punishment (instead of playful acceptance), which taught them to repress feelings of naughtiness. Children’s literature, which contributes to the healthy ownership and integration of difficulty affects, is filled with mischievous acts, which lead children to erupt into laughter. Naughtiness tugs on our wish to thumb our noses at authority and the pleasure of doing so without getting caught. Naughtiness in children’s literature helps children both grapple with and integrate their feelings of aggression toward authority.

**Step 2. Address Adult Naughtiness**

I give clients an index card and say: “Write down on the card something naughty you would like to do but feel would be hard for you to do.” We put the group’s cards in a hat and one at a time a client chooses a card at random to read aloud. The group responds with associations or feelings.

This step is best done anonymously to minimize client shame. Clients are curious to know whose naughty act was whose, so it is important to set and maintain the boundary in the beginning about whether the information will be shared or not. Usually, the group views the naughty act as less bad than the individual who proposed it. This metabolizing by the group allows the individual member to reintegrate that part of himself or herself without the shame and humiliation from the past.

**Step 3. Discuss the Difference Between Naughty and Destructive Behavior**

As the “Cat in the Hat” says, “It’s fun to have fun, but you have to know how!” (p. 18, Seuss, 1957). Some clients do not know the difference between what is naughty and what is destructive. Clients who grow up in families where sadism and abuse were the norm may think that teasing, sarcasm, and malicious mischief are naughty rather than destructive to the self and others, so it is important to discuss how naughtiness is playful and does not really hurt anyone else.
TYPICAL RESPONSES

Clients find this exercise both anxiety-provoking and playful fun. It engages strong affect, so it helps when a group is flat, stuck, or being overly good. Feelings associated with naughtiness include guilt, pleasure, excitement, shame, delight, power, fear, and a sense of “badness.” Clients tend to relate to one another’s wishes to be naughty as adults, which helps them connect and diminishes shame. Discussion of naughty acts evokes play and humor in a safe environment, and may help clients learn about hidden sides of themselves.

CONCLUSION AND CONTRAINDICATION

If we can encourage our clients to be naughty with us and the group, they may learn to play in other ways, and ultimately find their true selves. While I have not experienced any contraindication to this exercise, one caution is that some clients initially experience shame (i.e., evoked old feelings) when revealing their naughty acts. The leader must be aware of the strong feelings that can arise, and must be able to guide the client through any shame or humiliation he or she may feel. A playful leader can help reduce shame and help the group itself become playful.

REFERENCES


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Look at How I Feel: Art-Assisted Affect Expression

Carol Lark

Several members of your group have been simmering for weeks with unexpressed anger: They seem to be waiting to be invited to express it but, when given an opportunity, they deny they have any feelings and are “just interested” in what the group is talking about. The other members appear unbothered by the palpable emotional energy in the room and fill the interpersonal void with repetitious stories from their admittedly traumatic histories. The group’s defenses against experiencing and articulating feelings in the here and now seem impenetrable. It is clear that the group is in a full-scale retreat from the experience of being embodied human.
THE EMOTIONALLY DISCONNECTED GROUP

Expressing and working with emotions in the present moment of the group often represent a major challenge to people who are disconnected from their feelings and/or acculturated to presenting a “nice,” accommodating stance in the presence of conflict. This reluctance to express so-called negative feelings is often closely associated with a suppression of body awareness and, therefore, little access to emotional awareness that can be stated in words. These disconnections can be bridged by the use of sensory and kinesthetic modes of expression, such as art, movement, and drama (Lark, 2001; Lusebrink, 1990, 2004).

The following intervention is a simple art task that can help a group increase its awareness of the affective-cognitive disconnections between their usual interpersonal patterns of behavior and the way they actually feel. Using art materials activates somatic involvement, which increases awareness of the feeling state and enlarges the amount of the brain used to process this awareness. This intervention can be used in a group that feels emotionally stuck or that expresses inhibitions around expressing unpleasant feelings directly within the group.

GUIDELINES FOR INTERVENTION

*Materials:* Oil pastels, chalk pastels, markers, 12” × 18” drawing paper, a surface to work on (clipboards, pieces of cardboard to serve as lapboards, or table tops), writing materials (pens, pencils, and writing paper, such as inexpensive copy paper).

*Method:* A brief warming-up period may be needed to acclimate the group to the use of art materials. Simply suggesting that they “play” with the materials often gives the necessary bridge from making marks to more deliberately creating imagery. Once the group has warmed up with the materials, it is time to move into the more specific intervention. There are several variations on the intervention that can shape and/or extend the experience.

**Instructions for the Task**

**Step 1: Preparing the Group to Focus**

The leader comments on the group’s “politeness,” “unspoken feelings,” or other concept that the group can accept as a truthful observation, and suggests that the group might benefit from using other parts of their brains to create a “language” with which to speak about what they are feeling. The drawing paper and boards are passed out, and the supplies are placed in easy reach of the group members.

The warm-up phase begins with the directive, “Make as many different kinds of marks, shapes, lines, movements as you can in the next five minutes.” This will become a sort of “visual vocabulary” that is often a source of amusement and wonder within the group. Members usually enjoy seeing the variety of imagery within the group. Once the group has had the experience of using the materials and seeing what’s possible, begin the more focused part of the intervention.

**Step 2: Basic Directive**
Pass out a second piece of drawing paper and say, “Allow yourself to become aware of how your body feels right now and find the color(s) that come close to matching that feeling. Using your arm and hand, make movements that correspond to the feeling and then make marks on the paper using these movements. As you continue to make marks, allow your body, hand and arm to create an image of your feeling.”

After the group has drawn for a few minutes, ask them to stop and look at what they have created. Ask them to write down their immediate impressions of their own work, what it seems to mean, what it looks like, and freely associated words that come to mind. Tell them that this does not need to make logical sense.

Step 3: Beginning Articulations and Processing in the Group

After the group has freely associated words to the images, ask them to show their work and use the written language to describe how they were feeling while they were creating. A variation is to ask them to say out loud what they have written beginning with the words, “I am. . .”

Step 4: Variation and Extension of the Work

Prior to processing in the group, you can ask them now to fold their paper in half. On the front side “Draw how you would like to be seen right now (or, “How you would like the group to perceive you”). On the back side draw or write “What I fear will happen if I express my inside feeling directly.”

This variation provides an even more explicit bridge between the internal, nonverbal feeling state and the “rules” the group members have learned about how to be and what the consequences are for being honestly emotional and direct.

CLIENTS’ RESPONSES

This set of interventions can increase awareness of embodied feeling states and provide a verbal bridge to express those feelings. This is integrative at a brain-body level, while providing a buffering for the directness of the encounter through the use of produced images. Usually group members feel supported in this activity by witnessing others’ work and being witnessed in return. It then becomes possible to assist the group to a more affectively genuine state within the session.

A variation of this intervention can then be used later in the group to encourage more direct encounters with one another. For example, if the group seems unwilling to tackle a conflict within the group, it could be asked to “portray what you think is going on in the group right now” on the inside of the paper, and on the outside to “portray how you would prefer to be seen or experienced at this moment in the group.” After a few sessions in which art is used to support these observational and self-reflective skills, the group should be able to speak more directly to the questions.

CONTRAINDICATIONS

This task is relatively benign. However, it can feel overstimulating to some group members if the sudden release of repressed feelings excites them to a more manic state. This would be more
likely if only the first set of instructions is used. Conversely, the now physically experienced feeling state may make them feel too exposed or vulnerable, causing a quick return to habitual defenses. If the members appear unable to contain the feelings, or begin to defend against what they have drawn, immediately go to Step 4 to engage their cognitive strengths and to concretize the experience in a less affectively direct way. I have found that interspersing image making and verbal language assists emotional self-regulation that does not deny the experience of feeling.

REFERENCES


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Stress Reduction for Students in Elementary and Middle School

Robert L. Slavin

LOSS OF MORALE AND MOTIVATION

Many educators, teachers, principals, and superintendents, within school settings, are suffering an overwhelming loss of morale and motivation regarding their ability to make positive change in our educational system. They have become defensive, blaming others for their anger, and adapted a position that there is nothing they can do. Furthermore, they may deny that there are problems or difficulties (Slavin, 1997). These attitudes and feelings also impact on the feelings and attitudes of students (Slavin, 1996; Slavin, 2002).

For example, a kindergarten teacher shrieks at her five-year-old student: “Juan, how dare you yell and scream when I am talking. Go stand at the back of the room!” Juan is crying uncontrollably. The teacher ignores him. Which attitudes and feelings toward education will become fixed due to this kind of treatment? At upper grades, what causes older children to disrupt a lesson? Basically, many of the factors that cause stress in adults also cause stress in children. There is one big difference in that children are at varying degrees of maturation, emotionally, intellectually, or socially. Although schools have taken on the challenge of intellectual maturation, emotional and social maturation have been neglected.
DESCRIPTION OF GROUP POPULATION

Students in the elementary school and middle school where I worked were basically black and Hispanic. The schools were located in an economically deprived area of the Bronx, New York. Many of the children’s families were receiving welfare, or parents were receiving less than average wages. A number of the children were being treated for chronic illnesses such as asthma and bronchitis. Many of the students were underachievers, and had moved many times during the school year. A few students were receiving some kind of therapy at mental health clinics.

INTERVENTIONS

I had to keep strict time boundaries such as the length of the school period (fifty minutes) and the period of the day I could work with the children, usually the teachers’ break period. I worked to create a safe holding environment by being noncritical, showing interest, and emphasizing the value of each member’s contribution (Winnicott, 1965; Yalom, 1995). Other important issues included recognizing the maturational level of the children, emotionally, cognitively, and socially (Flavel, 1963; Mahler, Pine, & Bergman, 1975). Following are some examples of group work in schools.

Example One: The Day the Class Went Silent: Death of a Classmate

I entered my assigned elementary school. The principal was waiting for me at the door. He rushed me to a second grade class explaining that many pupils in this class had witnessed a class member fall from his apartment window. He added that I should help them. I entered the class. The students silently stared at me. I asked if all the children knew the boy. A few nodded. No one spoke. I acknowledged that a terrible thing had happened and told them that I was sad even though I did not know the boy (being with them in feelings). I then told them that we would work together to help one another (instilling a sense of cohesion). I told the class to join hands and close their eyes (giving them a kinesthetic sense of cohesiveness). I started by taking the hands of the children on either side of me. I made sure that every child was holding hands. Then I closed my eyes. A few minutes later I felt a jolt go through me. I began to feel stronger. I opened my eyes and told the children to do the same. As I looked around, their eyes seemed to have more life in them. There appeared to be less tension in the room. Several said they felt better but an aura of silence was still in the room. I told them that by holding hands we told each other that we were there for each other and that helped us feel stronger. I gave out paper and told them they could write or draw anything they wanted to and that I would collect their work and keep them all together. When they finished, and the papers were collected, I said, “When sad things happen you will know that others are there to help you.”

Example Two: Feeling Demeaned

Eight students, in middle school, members of my third period group, came screaming and yelling into my room. I asked, “Kids, what happened?” They continued to scream and yell. Again I asked, “What happened? We cannot have a session if everyone is screaming.” They slowly went to their seats mumbling angrily. I gave each of them a chance to talk. One student
said the teacher is a rat. They all shook their heads yes. I asked what happened. Pete says he does
not have time for breakfast so he buys it on the way to the school bus. He then adds, “The
teacher says I make too much noise and will not let me eat it.” Another student: “The teacher
always says mean things about me.” Still another child complains the teacher always criticizes
her work but does not explain how to do it. I tell the children that it sounds like the teacher needs
a lot of help. The group in unison says “Yeah, yeah.” I then ask them how we can help her. Their
first reaction is negative. I tell them that if we don’t help her she will continue to be mean and
unsympathetic. The general reaction is “maybe.” I ask them is she really so mean or do they have
fun making her angry? They respond, “Well, maybe.” I ask if they can try some method of
making the teacher feel good. The group should let me know if their methods worked or did not
work and we will discuss them.

In this session, the group felt assaulted and demeaned. I focused on the person they were
angry at. In another session when they were less enraged, I had them consider their behaviors
that might create difficulty for the teacher. By giving the members an opportunity to help the
teacher and view their own behavior, they were in a position that would enable them to make
positive changes without anyone saying, “You must!”

CONCLUSION AND CONTRAINDICATIONS

In Example One the children were emotionally isolated from one another and within
themselves. The methods I used enabled them to undo the isolation—my empathy for their
sadness and fear, as well as sharing our togetherness by joining hands and jointly working on a
project that I said I would always keep together. I instilled hope by letting them know that each
was important to each other as well as each of them being important to himself or herself (Yalom
& Leszcz, 2005).

In Example Two I had a very angry group of children entering my room. If I challenged their
anger they would have felt further attacked and their anger would have increased. It was
important for them to talk directly about their feelings. Certainly the teacher needs help in how to
work with angry children; by deflecting any responsibility from the children and asking them
how they could help her, it affords the children time to examine the teacher’s feelings, as well as
review their own behavior. This must be done in a way that does not belittle or criticize them.

I do not believe there are any contraindications for the interventions that were used. I do
believe that the methods I used in working with these children are necessary at all times because
they show respect and instill hope, thus helping the children learn to respect themselves as well
as others.

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**Nurturing the Community Development Dimension in Groups As a Preemptive Intervention**

**Avraham Cohen**

*CREATING THE CONTAINMENT FIELD FOR GROUPS*

My family argued a lot and did not know much about encouragement. We were not very emotionally close and saying what mattered to me was not easily done, unless I could be angry at the same time. I have come to appreciate a number of things about my family as an adult, but as a young adult and later as a beginning therapist I only appreciated that my experience had provided me the motivation to look for something more meaningful and alive for my life. I was looking for emotional safety and connection and it occurred to me that perhaps I was not alone in this pursuit. It slowly dawned on me that what created a sense of safety and encouragement for me was being with a group of people that I knew and who accepted and encouraged me. Over time I began to wonder how to create this condition for myself and how to create it in therapy groups, and educational contexts. I discovered that my need was a common one. What follows is a general framework and then some guidelines about how to create this positive and compelling circumstance in groups.

The intervention that I will describe is in the service of creating an environmental atmosphere that is safe enough to encourage and support personal risk-taking on the part of group members. Its inception is based on my own work (Cohen, 2006) and the ideas of Deep Democracy as described by (Mindell, 2002).

It is a preemptive intervention in that it establishes a consistency and structure that can be counted upon and also provides an opportunity for each participant to express, hear, and be heard by the entire group. The content of the sharing is variable but includes where a person is at in the moment, what happened to him or her since the last meeting that is significant, issues related to being in the group, issues with another group member, and issues with the group leader. The
group is “taught” that this is an experience to create connection opportunities within the group, to get to know something about the current life experience of the group members, to know their in-the-moment experience, be known, develop the community dimension of the group, and establish an optimal level of safety. This process becomes a predictable and consistent part of the group’s process and structure, which meets needs for predictability and security while providing an opportunity to check in.

**DESCRIPTION OF GROUP AND CLIENT POPULATION**

This preemptive intervention has proven to be effective in both educational contexts and psychotherapy groups. I have rarely found anyone who was a good candidate to be in a classroom or a psychotherapy group who did not fare well and appreciate this approach. Individuals who were not good candidates were those who came from very dysfunctional families and whose initial experiences with family, school, religious institutions, and peers was very abusive and/or neglectful. In fact, I have found in classrooms where I do not have the opportunity to screen for suitability for group context, for some who came from such extreme backgrounds the classroom experience was actually healing as it provided an alternative view to the early experience.

**DESCRIPTION OF INTERVENTION**

*Case Example*

This particular example involves a man who was deathly afraid of speaking in groups. For many weeks he said as little as possible and concealed his fear. He eventually shared with me that he had this fear. We discussed the possibilities for addressing this. I suggested that he could say something about it, tell someone else and have that person share his fear, I could say something, or continue as he had been doing with an emphasis on self-reflection to learn more about the process. He decided that he would share this fear himself in the next group during the opening group process. The group was very interested and supportive. Others with similar fears shared their experience. Most importantly, there was a shift. His dilemma became the group’s dilemma. His silence was seen as a loss for the group—whatever he might have to share was not available. Questions arose. What was it about our group that fed the fear? What could we do about it? How could we track the process? This man became a representative of the silent and fearful part of everyone. His response was quite emotional. This process unfolded over a couple of months, became part of the group’s oral history, and culminated with him coming to the group one evening dressed up in a costume and performing a piece of theater that involved the group as audience and participants. Essentially, the identified problem, fear of speaking out, became a seed experience for individual growth, community development, and an example of a deeply democratic process (Cohen, 2004, pp. 158-159).

**Format for Issue Resolution**

Each group or class begins with an invitation to check in and to participate in a personal and community process experience.

A time frame is established and closely adhered to. This adherence helps to establish a sense
of safety and the frame for whatever form of psychotherapy is being utilized. Expectations that everyone will have an opportunity are stated.

The content that fits and does not fit is described. In educational environments what does not fit in this initial process time is course content, questions about assignments, grading issues, and any other content that might be construed as informational. In psychotherapy groups what does not fit are questions about administrative issues or processing of issues that are raised.

Develop a group culture that is safe with an opportunity for everyone to do whatever he or she needs to become more fully present in the moment. Build trust and a “containment field” by eliciting the opportunity for process and facilitated inner work. The containment field is the psychological environment within which the major work of the group will take place. Encourage content that is personal and inclusive of in-the-moment experience, recent significant life events, personal responses to any and all aspects of the course, memories, dreams, and reflections.

**TYPICAL RESPONSE TO THE INTERVENTION**

Group participants have invariably reported very positive responses to this pre-emptive intervention in groups and educational settings. The sense of belonging is a profound counterpoint to the experience of most in group, family, and organizational environments. The experience of being an agent in creating this experience is transformative for many.

Most members describe learning important things about themselves both individually and relationally. As well, participants report that the initial time in the group helped them feel more relaxed and secure in the time period in the group that is devoted to the central focus of the group whether personal therapy or the study of curriculum material.

**CONTRAINDICATIONS**

A concern and possible contraindication, for group leaders and educators, is that the personal process time will take over and that the identified focus of the group/class will be lost. This may not seem like a problem when it comes to a psychotherapy group, but in fact it is. The frame will be securely established by allowing opportunity for everyone, including the group leader, to check in and holding to the time frame. In educational environments the concern is that the curriculum material will not be addressed. In either context, the art and skill of the leader are crucial. Holding the boundaries, sticking to the content of this initial process for each meeting, reminding members of the limits when they seem to be going outside the boundaries, and attending to an artful and minimalist facilitation during the process and during the ending of this time in the group are important and central foci for the leader/facilitator. If a leader is not skilled in facilitating group process this is the most major contraindication for this intervention.

**CONCLUSION**

In a typical process time you might hear that someone is tired, another is excited about her child’s success, someone else has lost a parent, another person is animated about what he has been learning about himself in response to the group’s process, and so on. The task of the leader is to hold the environment in a place of acceptance and containment. Occasionally, issues will arise, usually between people that require facilitation. These interactions provide an opportunity for a deepening sense of the group’s meaning and sense of community.
This intervention depends on the ability of the group leader to facilitate, move fluidly between primary and secondary process, hold the boundaries, make connections with participants, facilitate connections between participants, and notice when the group has taken over an “executive” function. This allows the leader to step back and “let the group do it,” which models for the group that they can, indeed, hold the energy and participate substantially in the process.

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Humor As a Defense Mechanism in War Veterans

Vivien Henderson

SELF-HUMOR AND GALLOWS HUMOR

In a doctoral dissertation titled “Humor as a Defense Mechanism in the Holocaust” Ostrower (2000) found four subtypes of self-humor and gallows humor provided the main forms of humor as a defense. With Australian Vietnam veterans there appears to be a similar percentage of humor used as a defense.

Group psychotherapy has been regarded as the most effective intervention in the treatment of Vietnam veterans with post-traumatic stress disorder, (PTSD) (Brende, 1981; Walter & Nash, 1981; Koller, Marmar, & Kanas, 1992; Howard 2000). It has been proposed by Howard (2000) and other theorists that one of the central tenets of trauma theory is the need for getting in touch with the feelings associated with the traumatic memories. Once the feelings have been accessed, then words need to be found in order to work through the trauma (Herman 1992; Parson, 1993; Goodwin & Weiss, 1998; Howard, 2000).

DESCRIPTION OF THE GROUP

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

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

THE INTERVENTION

Humor is considered to be one of the more adaptive defense mechanisms. Gallows humor and self-humor have helped many people to survive exposure to very traumatic experiences.

However, when humor is allowed to continue within a therapy group, it prevents the patient from accessing the feelings behind the humor and prevents the working through of the trauma. This is specifically salient in an all-male group where humor is mostly used as a defense against the cultural stereotype of “being a man.” A man does not express vulnerable feelings.

Stages of Intervention

Stage 1

Develop cohesiveness within the group. This will enable the therapist to make the forthcoming intervention so that it does not seem persecutory to a specific group member or the group-as-a-whole.

Stage 2

When a patient seems close to being emotional and the members of the group distract the whole group away from this man due to their personal discomfort, the psychological flight from affect and feelings of vulnerability becomes manifested in gallows humor. At this time, the therapist can draw the group’s attention to how they are engaging in this behavior and an exploration of the underlying feelings, which are pushing them into avoidance.

Stage 3

There is an educational component to this intervention and it is important to engage the men in discussing the stereotype of “being a man” in their culture and what their beliefs are about men expressing emotions. Suppressing feelings in war was useful and helpful at that time but now this behavior conflicts with their recovery. It necessitates their getting in touch with their feelings and finding words to put to those feelings, which go with the images of the trauma in their minds.

TYPICAL RESPONSES TO THE INTERVENTION

Initially, such an intervention is likely to draw a response of surprise from the men, as if they have been caught off guard. They may ignore or deny the initial interpretation by the therapist or respond with embarrassment that their “ploy” has been “seen through” by the therapist. Veterans as a rule, tend to hold a belief that civilians do not understand how they think, feel, and behave.

Usually, if denial is the first response, then the therapist usually does not have long to wait
before the behavior occurs again. The therapist just keeps gently drawing the group member’s attention to how he is using humor to avoid feelings.

It is important to remember that avoidance is one of the many symptoms of PTSD and it is important for the therapist to gently keep bringing the men back to these difficult feelings.

CONCLUSION AND CONTRAINDICATIONS

It has been shown that gallows and self-humor tend to be used by individuals as an important defense mechanism when exposed to extremely stressful traumatic situations.

This intervention is not recommended if the group is not cohesive or if the therapist is uncomfortable with strong affect as the ultimate goal is to elicit strong suppressed affect that has been correlated with a traumatic experience.

It, too, is contraindicated if there is a preponderance of paranoia and or persecutory anxieties among group members. Conversely, gallows and self-humor, if colluded with by the therapist in group psychotherapy, prevents access to deeper feelings enabling the “working through” process and the subsequent healing to take place.

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Trouble to Resource

Miriam Iosupovici

Where there is much light, the shadow is deep.
Johann Wolfgang von Goethe (1749-1832)

RECOGNIZING DUALITIES AND RESILIENCE

From literature and nonfiction, “good luck/bad luck” tales, and proverbs of many cultures, the reality that problems can directly or indirectly lead to paradoxically positive outcomes, self-knowledge, and resiliencies has long been part of human awareness. The concept of “reframing,” originally developed in family therapy contexts, has been broadened and utilized in other therapies, including resiliency interventions (Wolin, S.J. & Wolin, S., 1993). With longitudinal developmental research such as that reported by Valliant (1995) and the Kauai studies (Werner & Smith, 2002), reporting unexpectedly positive life trajectories for multiply stressed subjects, and further stimulated by the influence of positive psychology, the realities of adaptive lifelong functioning are being incorporated into theoretical perspectives (see Fredrickson, Mancuso, Branigan, & Tugade, 2000; Fredrickson, 2001). As Hemingway, in his semi-autobiographical novel, *A Farewell to Arms* (1929) wrote: “The world breaks everyone, and afterward, some are strong at the broken places” (p. 226).

POPULATION

Interventions focusing on dualities of experience can be utilized in many types of groups, depending on the comfort of the therapist with the suggested process within their preferred style of group work, group stage, and population (see “Contraindications”).

INTERVENTION: FOUR PATHWAYS

Clients are asked to talk about a behavior or event(s) in the past that resulted in any kind of outcome they define as “trouble” (could be one-time event or continuing, major or minor), an experience that has been filtered through their thoughts and actions, becoming a resource in their current lives. Therapists can model the intervention utilizing an example (or more) from other client experiences while encouraging disclosures far different from the ones used as models.

Pathways

1. Introduction

In dyads, group members utilize this question as part of talking about their life experience as an initial level of self-disclosure in group. This avoids stereotyped methods of self-

I wish to thank Erv and Miriam Polster for introducing me to this question during a Gestalt Community meeting in La Jolla, California.
presentation and can be combined with other beginning introductory questions. When utilizing this question at the beginning of a group, it is likely that the examples will be less powerful than later on, yet it can still be very useful.

**Example:** Client reports that he was shy in high school, less so now, and this has taught him that shy people are waiting to be discovered so he tries to reach out to them.

2. **Organic Manifestation**

Client discloses experience in life that was problematic for him or her, ended in censure or punishment, and the client talks about self-awareness that includes this event (or repeated events) as a resource that is positive in his or her life and/or how they have used the event as a source now. If client does not notice this capacity in life currently, either you and/or another member can report your knowledge of this skill, awareness, resource. Polster (1992) notes that when heroism is exercised by women, it is often under conditions of daily life or in the collective, and thus may not be seen either by the client or others because our narratives privilege the “lone hero.” This may also be true for different cultural populations, as well. After there is sufficient support regarding the original trouble (which can range from acknowledgment to much fuller exploration), therapists can underline this important awareness of “benefit” as one of the inherent dualities of life, and ask the client to respond more if she or he wishes to. Then, bridge to other members of group and ask if they had similar awarenesses.

**Example:** In the working phase of group for survivors of abuse and molestation, a client talks about her fierce determination to play piano at age five even though her brother would hit her on the head when he would walk by, abuse of sufficient severity, to cause partial deafness. The client describes her drive to succeed despite the brutality in the family and notices that she uses that skill in the dynamics of her very competitive graduate school. Group expresses rage at brother and anger at lack of parental protection, with high level of affect including tears. This is followed by statements of respect for client, noticing numerous behaviorally specific examples of her ability to focus and persevere in the midst of adversity and her support of others in the group. Other members, with some leader support, find parallel events in their own lives.

3. **Go-Round**

Many groups utilize a go-round as a way of beginning each group. This exercise can be utilized as an alternative, evocative way to start a group process, including after a break in the group due to vacation or holiday. When used at the first meeting of a group, the question tends to interrupt stereotyped styles of self-presentation, and may allow parts of self perhaps not yet visible to group to emerge.

**Example:** Client returns from visit home and reports that a sibling had thanked her for the care she had given him/her when they were growing up. Client acknowledges sacrifice and stress, and talks about what she had learned from making this choice.

4. **Psychoeducational Format**
Within a group that combines content and process, clients may be taught a “vocabulary of resiliencies” or be presented with a model like the “Resiliency Mandala” before they explore how they fit into this schema (see Wolin, S.J. & Wolin, S., 1993 and/or Web site for Project Resilience).

**Example:** After presentation of the model, a client in ACA (Adult Children of Alcoholics) group recognizes resiliencies developed in childhood that were useful growing up in a home with alcoholic parents who were episodically neglectful and deficient role models. He realizes that he was not only “parentified” but acted with planning and initiative on principles of moral choice. He is able to identify how he continues to do so in his new family, while expressing sadness that he was unable to receive what he gives his children. He discusses how he has created positive rituals for holidays, which were often ruined by alcoholism in his childhood home, that are now sources of joy and pleasure for himself and his family.

**CONTRAINDICATIONS**

Some life experiences may not have this duality and the client’s frame is to be honored. This intervention is not a simplistic generality, nor a “If life gives you lemons, make lemonade” cliché. As reflected in the Japanese proverb “The other side has another side,” all sides of the narrative are to be honored. Therapists need to be aware of their countertransference to narratives of abuse or other difficulties and only utilize such an exercise for sound clinical reasons: i.e., supporting clients’ awareness of both sides of life experience to enhance their functioning. For this reason, some therapists may feel that this structured intervention is more appropriate to a working phase of group, when both members and leader(s) have sufficient experience with one another to create depth in processing.

However, the timing of the intervention would vary depending on the severity of trauma experienced by clients. With traumatized clients, this intervention is recommended only within a longer-term framework and in the working phase of group when the pain of the experience has been acknowledged sufficiently that clients have been validated. The intervention also requires a level of intellectual and emotional functioning allowing for a conceptual holding of duality in human life.

In order to fully utilize the strengths of this intervention, a theoretical schema including resiliency must be integrated by the therapist. In some instances, therapists fluent in asking questions about difficulty may not be as skilled at exploring resiliencies. Clinicians may find useful models for exploring the behaviorally specific aspects of resiliencies through the lifespan in Wolin, S.J. and Wolin, S. (1993) and online at their Web site Project Resilience.

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**Remembering When: Therapist As a Historian**

Mary Jago Krueger

If we possess our *why* of life we can put up with almost any *how*.

Nietzsche

**MAKING THE UNCONSCIOUS CONSCIOUS**

Listening intently to the language of others offers us the opportunity to create images that stimulate the senses (Barlow, Fine, Pollio, & Pollio, 1977). Telling stories of lived moments is a creative opportunity to verbally image a moment in time that can provide a perspective from which a shared experience can elicit visceral responses in the group process. Words have an energy that can ignite the listener; it is the awareness of the storyteller that dictates the power of the words. Words weave into stories. Sharing these stories with the group allows for authentic and meaningful connections among the members (Brunner, 1986; Moustakas, 1994).

As a psychodynamic group psychotherapist with humanistic and existential psychological leanings my role as a facilitator is to work with the group and its members to make conscious material that may not yet be fully conscious, conscious. Conscious awareness allows the clients to take personal responsibility and to make conscious choices. In service of tracking the development of the group as a whole and its members as well as offering gentle process interpretations, I use “group produced” historical material. I will recount a story shared earlier in the life of the group by a group member. This approach not only provides mirroring to the participants, it aids in the grounding of the group and acclimating newer members.

**THE GROUP PROFILE**

The groups are primarily open-ended, long-term psychodynamic groups. The groups are
limited in number with new members entering when a space becomes available and the timing is appropriate for the group and the potential new member. Each group operates under an agreed-upon set of rules which include how a member announces his or her leave-taking. The groups are both homogenous in gender and/or issue or heterogeneous. The groups are all outpatient. Even though the structure of each group begins in a similar fashion, each group develops in a unique and persistent manner. The personality of each group remains intact even when the participants change.

**THE INTERVENTION**

The overriding goal for my psychotherapy groups is for the participants to view themselves less as targets of others’ “ill will,” a result of poor parenting, or as individuals who are innately “bad” in a world of good people. By working toward conscious awareness, each participant has the opportunity to rewrite his or her own view of their world. It is in this rewrite that he or she is able to take responsibility when needed and forgive when necessary. The work for the therapist in this intervention is to avoid blame, whether toward client or others while delicately reminiscing.

The first example is the retelling of an individual’s story to a group participant. The reason for the sharing of this story was to identify a recurring pattern in this client’s mode of relating to immediate family members and to open up the client and the group to the exploration of how she has changed that pattern of behaving. The secondary reason for the intervention at this juncture was to intentionally and gently alter the material the group was empathically reinforcing.

A woman in group was sad and angry. She was feeling as though she had not “moved much” and was “still where she was ten years ago . . . without anything real or of her own.” She had lost faith in her ability to continue to follow her dream to finish her education in the medical profession.

As the group joined her sadness “over her lost dream,” I intervene with the individual rather than the group as a whole.

**TH:** “Yes, I remember when you decided to go back to school. It was during the time you volunteered to have your mom convalesce at your home. I still have the picture in my mind of the two of you lying in bed every morning talking while she waited for her meds to take effect.”

**GROUP MEMBER:** “Wow, I had totally forgotten that. Yeah, that time was something else, we became so close . . . finally, and I realized I was good, really good at this stuff!”

This type of intervention promotes self-reflection among the group members and the group as a whole. It also opens the discussion for group members to process what was happening in the room as prior to this intervention.

The second example is the retelling of a group member’s “entrance into group.” The reason for sharing this story was to gently interpret the difficult process for a newer member to join an ongoing group. This intervention could be made at a time that the group may be stuck due to a newer client’s apprehension.

As material keeps emerging during the group that speaks to trust issues, and “how to enter the group” I turn to a group member and ask her “What do you think may be going on (with the other newer group member) tonight? As I listen, it sounds as if in this group session you have
decided to let us all have it’ as you said.”

Newer Group Member: “What did she say?” The group chuckles, and I ask the group member for permission to recount that evening. She affirms my request. I quickly recount that night “she told us all [that] she would never want to know us, could never trust us.” At this point the group member whose story I began jumps in and talks about that evening and how she had to feel angry to join. That anger was how she lived in the world. The rest of the group begins to share their entry points.

This particular intervention, recalling events and recounting stories, offers the group and its members the opportunity to observe changes in development and meaning of the events. Group members also discover that their own affective response changes with each retelling of a story, allowing for new, consciously scripted meaning to emerge.

The process brings cohesiveness to the group by retaining the history of the group as a whole, thus new members feel they are part of something solid and established.

**CONCLUSION AND CONTRAINDICATIONS**

Recalling historical stories for group members is a simple intervention. When recounting a previously shared account back to the group, the facilitator will most likely find that other group members will also be able to add details or corroboration.

The primary contraindications are not to recount a story in a hurtful or shaming manner. It is important to be very clear that the intent of recounting the historical tale is in service of supporting or reinforcing a current situation that is being addressed with different choices. Of course one other contraindication would be to recount a story to a group member either incorrectly or attribute the story to the wrong group member.

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Mary Jago Krueger, MSEd., CGP is a Licensed Clinical Professional Counselor, Clinical Supervisor and educator for over 20 years. She currently splits her time between her private practice and a not-for-profit clinic in Illinois.

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

*Sharan L. Schwartzberg*
INTRODUCTION

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

In this chapter, I propose a rehabilitation model, the functional group (Schwartzberg, Howe, & Barnes, in press), as a theoretical basis for determining the degree of structure as a component of the group design. The assumption underlying the model is that by changing the degree of structure a leader can facilitate outcomes such as group alliances, empathy, and cohesion. The processes used in the group have a direct bearing on the group outcomes and former aims both tacitly perceived and empirically known to be of a value. In a functional group the group and tasks are structured to achieve maximal involvement of members through group-centered action, spontaneous involvement, member support and feedback, maximal sense of individual and group identity, and a “flow experience” where the challenges for action are balanced with the members’ capabilities and culturally orientation.

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

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

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

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

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

**DESCRIPTION OF INTERVENTION**

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

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

**TYPICAL RESPONSE OF THE INTERVENTION**

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

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

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

Group structure, verbal interaction, and emotional cohesion are empirically supported treatment factors bearing on group treatment and the therapeutic relationship (Burlingame, Fuhriman, & Johnson, 2001). I encourage leaders to examine their theoretical model and identify how the structure influences desired group outcomes. Each of the models have indications and contraindications regarding the type of structure to impose on member selection, group size, composition, and group processes.

REFERENCES


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**Therapist Self-Disclosure**  
As an Intervention Toward Normalizing and Eliciting Hope

Scott Simon Fehr

Intervention: n. from (inter) between and (venire) to come, to come between. Interventionist: n. one who advocates or practices intervention.  
(McKechnie, 1963).

**TO FEEL ALONE**
One of the profound benefits of group therapy is for clients to hear other clients speak about their particular problem and not feel so alone in their own intrapsychic world (Fehr, 1999, 2003). Yet at times, a client may present something that no one in the group can or is willing to identify as an issue salient to them. Thus the disclosure, of the client, is met with group silence strengthening the possibility of future inhibitions where there is less probability that personal information will be divulged.

The concept of “therapist self-disclosure” is one that often elicits some form of professional discomfort for most of us (Fehr, 2003). Throughout our academics and training, self-disclosure is reinforced as a factor that creates boundary and ethical issues and needs to be avoided (Gutheil & Gabbard, 1993).

Specifically, there is the polarization of the orthodox Freudian stance of never disclosing as it demystifies the therapist and inhibits projections and transferential opportunities, whereas in the more humanistic, especially relational therapies, therapist self-disclosure is not as structurally implemented, (Jourard, 1964, 1971). Often, the catch phrase my colleagues use is “for whose benefit is the disclosure?” Obviously, the client has not come to us in group or individual therapy to hear about us nor are they here to help us with our interpersonal difficulties and conflicts (Corey, Corey & Callahan, 1998; Fehr, 2003; Weiner, 1983). But it is here, in fact, that therapist self-disclosure might be the intervention of choice for normalizing and giving hope to a client or clients in group therapy. This is especially true when the disclosure of the client reinforces existential aloneness. If no one in group identifies with the disclosure, the client may perceive his or her difficulty, as unique or bizarre.

GROUP MATRIX

This particular intervention is effective with both time-limited and ongoing process groups. It is recommended solely for those clients who do not have difficulty with abstract thinking, as it requires the ability to be introspective. It is not recommended for those clients who fall at the lower end of the normal curve in intelligence or those clients who are so sadly disturbed that they cannot go beyond only seeing themselves and cannot make connections or identifications with other individuals.

AN INTERVENTION OF THE THERAPIST SELF-SEARCH

Therapist self-disclosure, if and only if it is in the interest of the client, may be the prescribed intervention. Over many years of running groups, I have found that there are very few interpersonal conflicts or experiences presented by clients with which I myself could not identify in varying degrees. In fact, I use the totality of my being in order to understand what a client is trying to relate in the hope of feeling what the client is feeling. This is similar to two tuning forks resonating on the same pitch (Fehr, 2003). In my mind, I run through my personal history and only disclose those factors that are salient to the issue at hand specifically if no one in the group identifies with the group member’s disclosure. This self-disclosure is only presented if I have personally and successfully resolved the issue presented by the client as an intervention to help him or her not feel alone and to elicit hope that there can be a resolution although it might not be identical to mine.

The person of the therapist is the intervention as is the self-disclosure. Two very simple examples of the efficacy of this intervention are put forth: Example one is of a mixed-gendered
group, which I run. One client strongly confronted another berating him on the fact that he bites his nails. The client went on and on about how she would never date a person who bites his nails, that it looked disgusting. No one in the group either came to this man’s aid with any form of identification, as he was truly embarrassed, nor did they come to his defense concerning her diatribe. Throughout my adolescence and early twenties, I too was a nail biter. I was not about to leave this client “hanging out to dry” and feel public humiliation and shame without aiding him. In order, for me, to normalize his behavior so he would not feel alone, and to give him hope that his compulsive behavior, nail biting, could be resolved, I disclosed an aspect of my history specifically related to his problem.

Analyzing the root of the symptomotology of the nail biting, I felt, would be of little help or value, at that moment. Normalizing and eliciting hope would be the most effective intervention. I disclosed that I had been a nail biter years before and found that becoming consciously aware of each time I brought my fingers to my mouth eventually helped me overcome this compulsive behavior. The relief seen in this man’s face was quite remarkable. He thanked me profusely as he related that he felt so alone and so embarrassed throughout his life. His family and practically everyone in his interpersonal sphere had focused, at some point, on this behavior, which he felt was completely out of his control. Interestingly, two other group members disclosed, after my disclosure, that they too had been nail biters but were not about to disclose it after hearing the diatribe from the other group member. After helping to normalize the situation, other related issues came forth from the group-as-a-whole, which probably would not have taken place or may have taken place much further down the road in this group’s history.

The second example is the case of a man who is about ten years younger than I am in. He was in his fifties. He had related that basically everything was going rather well in his life. His relationships with family and friends were good. Economically he was doing well but he felt lost and directionless and was not sure from where these feelings were coming.

The group worked effectively with him and he worked effectively with the group but could not find what might be the underlying issue that was stimulating this sense of loss of direction. I remembered how he would talk about the many times throughout his life that there were people he looked up to as guides in helping him navigate the capriciousness of life. I, personally, had heroes throughout my life but now for a number of years I had none. I thought about the opening line in the book, David Copperfield, “Whether I shall turn out to be the hero of my own life or whether that station will be held by anyone else, these pages must show” (Dickens, 1991, p. 1). I disclosed, to this client and to the group, that I no longer had heroes in my own life to look up to for direction or to emulate their achievements and goals. I explained that upon this realization, which was about ten years earlier, I felt sad and lacked direction but realized that it was now my time to forge ahead on my own.

The client, upon hearing this disclosure, immediately said, “I think that’s it.” He related that over the past few months he had been feeling somewhat lost and directionless because there was no one whose footsteps he had wished to follow. He further disclosed that somewhere inside of himself he knew that a new direction of being was coming but could not figure it out. He smiled and said, “I guess it is time for me to be my own person and find my own direction” and like David Copperfield he became the hero in his own life. I wondered, at that time, after this man’s insight if he would remain in therapy or leave but he stayed for another two years pursuing the self-search.

**TYPICAL RESPONSE**
The typical response to this type of intervention has always been positive for me with respect to a client. It appears to normalize what he or she is experiencing and gives hope that another person, whom they theoretically respect, had a similar issue and worked it through. I also disclose to my clients that I am not Superman and feel, in many cases, that if I can do something I truly feel others can do it as well.

**CONTRAINDICATIONS**

This intervention can be loaded with contraindications as boundary and ethical violations could easily be manifested. Because of this, keep in mind that the self-disclosure is for the client. Due to countertransference issues, many therapists are unaware of what they are doing and of the consequences of their self-disclosures. This often can take the form of competitiveness. The client discloses some issue and the therapist discloses a similar issue but with greater intensity, i.e., “if you think your divorce was difficult you should have seen mine.” For whose purpose is that type of disclosure as it is a complete negation of the client’s feelings? That type of therapist self-disclosure is related to unresolved issues in the therapist’s life that have been “set off” by the client’s self-disclosure. To again reiterate, if you are considering disclosing personal information about your history, as an intervention, it must be an intervention and you must always remember, **“FOR WHOM IS THE DISCLOSURE DESIGNED?”** and what could be the possible consequences of demystifying your person in the eyes of your clients.

**REFERENCES**


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