NEWSLETTER

NEW YORK STATE SOCIETY FOR CLINICAL SOCIAL WORK, INC. SUMMER 1992 • VOL. XXIII, NO. 2

ANNUAL MEETING ISSUE

The Healing Power of Groups

By Isaac Zeke Youcha, MSW, BCD

We are all members of several groups, some more important than others, e.g., professional, personal interest, civic, religious/ethnic, family, gender, work-related. As individuals, we have developed further than the groups we are a part of. And, although violence and chaos prevail in conflict among groups, humans have been struggling to bring order out of chaos since the beginning.

The Primary Group

What is this awesome power that groups have? Mammals, especially primates and humans, have managed to survive because of our ability to function as members of a group. We humans require a prolonged period of dependency for full development and, in fact, the need for another remains throughout our lives. Kohut and Maslow considered union with others a lifetime necessity. During the early years of fusion, symbiosis, self-self-object union and oneness we integrate the external caretakers, weaving them into the fabric of our being. We relate to our selves the way we were related to.

A primary group, then, consists of individuals who have internalized these same imagoes, internal objects of internal presences, which can be passed on from generation to generation. This group shares not only common internal objects and genes but also preferred food, smells, values, language, familial features, gestures, expressions and a long shared heritage. The concept of the individual's existing as a separate entity apart from the group is recent. Primitive tribes did not even have the idea of individualism; one was a part of the group and separation from it usually meant death. The worst punishment was to be exiled or banished from one's group, the organism upon which survival depended—and survival of the group superseded all else.

Healing Within the Group

As individuals we still depend upon our several groups for survival. We would all starve and freeze to death, for instance, were it not for the efforts of other members of our national group. We become distressed when its integrity is threatened: the recent rioting in Los Angeles evokes anxiety in all of us.

The power of the group over the

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Annual Meeting Features Group Treatment Issues

Speakers Discuss Therapeutic Models

The New York State Society for Clinical Social Work, Inc. held its 25th Annual Meeting on Saturday, May 9, 1992, at the Association of the Bar in Manhattan. Some 135 members and guests attended the meeting and clinical conference, "Working With Groups: Enlarging the Context of Therapy."

The morning session, introduced by Conference Chair Maura deLisser, MSW, BCD, included the President's Report, given

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Still Struggling for Parity

CSWs in Dispute with HMO

Reported by
Camille Matthews, CSW, ACSW
Rochester, NY

Since the spring of 1991 a group of 53 clinical social workers in Rochester has been involved in a contract dispute with the individual practice association (an HMO) for which they are providers. In February 1991 the HMO notified these clinicians that their allowed reimbursement level for psychotherapy services would be cut by 25%. Fees for psychiatrists had already been increased, and clinical psychologists' fees remained the same. This rollback took effect in April 1991.

The clinical social workers joined forces, established their own provider advocacy committee and legal defense fund. They hired legal counsel and filed for arbitration as allowed in their individual provider contracts, which are renewed automatically for each calendar year.

A primary reason for the rollback, according to the HMO, is "over use" of the services of clinical social workers, adding strain to this budget allocation. On the other hand, psychiatrists' fees have risen each year. Another issue fueling the action is the use by the HMO (in this instance) of Medicare guidelines for reimbursement. However, while Medicare requires an MSW plus 2 years of postmasters experience, the HMO in question requires the CSW-R certification for membership on its provider panel. This advanced credential—the most stringent certification in the state—places the clinical social worker on a par with other disciplines.

Legal action is continuing currently. This

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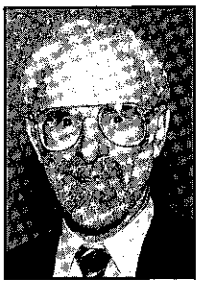
EXECUTIVE REPORT

From Broad Scope to Specific Focus: CSWs and Their Specialties



One of the major complexities in the development of an organization such as the Society for Clinical Social Work is that the members are often both generalists, sharing a common education and a commitment to social work values, as well as specialists who have specific types of advanced training and practice interests. Clinical social workers join our organization because, in part, they share with us important professional goals such as those of licensing and finding a voice for social work within managed care. At the same time, many of our members wish to share professional contact with colleagues around practice specialties such as psychoanalysis, family practice and group psychotherapy.

Specialties Enrich Profession for All

These dual interests have been recognized by the formation at every level of the Society of membership committees devoted to the development of a number of specialty interests within clinical social work. These committees have repeatedly enriched the Society by their educational programs for members; by their conferences, which have publicized the Society to many prospective members; and by the liaisons they have established with similar specialty committees within other professional organizations. Our very successful Spring 1992 Annual Conference, for example, chaired by Maura DeLisser of the Met chapter featured a program planned by the group psychotherapy practice committee (chaired by Maria Warrack of the Nassau chapter) and is only the most recent example of the important contributions that "specialty committees" have made to the Society.

On the Federation level, the position of the national specialty committees was a primary focus of the recent efforts of the national task force on the restructure of National Federation. I was a member of this task force, as was Rosemarie Gaeta of the Staten Island chapter, who is also chair of Federation's committee on psychoanalysis, a national membership committee. The preliminary report of the task force was presented at the recent Federation meeting in April.

Clinical specialties can enhance the overall professional focus.

The portion of the report that was most enthusiastically endorsed by the Federation's board was that part that called for a further formalization and development of the role of specialty committees within Federation. Implementation of these recommendations has now been turned over to a working committee; Rosemarie Gaeta and I are both members. Additional members of this committee from the New York State Society include Cecily Weintraub, DSW, of Nassau and Marga Speicher of Met. I believe that these are important and far-reaching organization developments that will help to ensure that clinical social workers who have specialty practice interests will continue to find a home within the Society and will continue to contribute to the organization through their participation and activity.

David G. Phillips, DSW
President

Landmark Legislation

After 2 years in preparation by the Society for Clinical Social Work, a bill to license clinical social work in New York State was introduced in the July session of the State Legislature. The bill provides a scope of practice definition of the function and clinical practice of social workers and is similar to legislation already passed in 23 states.

Chapter presidents will contact all members as to how they can act in support of the bill (A.12280/S.8872). Meanwhile, this is a good time to contribute to the PAC!

—Marsha Wineburgh, CSW, BCD
Legislative Chair

ANNUAL MEETING *(continued)*

by David G. Phillips, DSW, BCD; a brief report by Executive Director Sue Heller; and committee reports by Marsha Wineburgh, MSW, BCD, legislative chair, John Chiaramonte, MSW, BCD, vendorship chair; and Mark Dworkin, MS, BCD, chair of the managed care committee. New diplomates were presented (see story, page 3) by Society president Phillips and Haruko Brown, CSW, BCD, co-membership chair.

Keynote speaker Isaac Zeke Youcha, MSW, BCD, presented "The Healing Power of Groups," (story, page 1), followed by Phyllis Wright, MSW, BCD, who discussed "Psychoanalytic Concepts, Self Psychology and Object Relations Theory: Applications for Group Treatment." The third speaker was Elliot M. Zeisel, MSW, PhD, BCD, who addressed "The Power of the Here and Now in Group Life."

After a brief coffee break, clinical workshops took place from 11:45 until the close of the meeting at 1:30 p.m. The clinical conference was organized by Maria Perini Warrack, MSSW, BCD, program chair. Eight workshops were given: reports on several of these begin on page 4. □

EDITORIAL OFFICE
a j collier/communications
239 park avenue south
new york, new york 10003
212/598-4530

Editor
Alyce J. Collier

Editorial Consultant—NYS Society
Haruko Brown, CSW

Graphics Designer
Stanley Isaacs

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Advertising for Fall 1992 issue due October 1.

All advertising must be camera ready.

DIPLOMATES 1992

David Grand, CSW, BCD

In full-time private practice since 1982, David Grand has designed and presented a series of workshops on practice development and management for the private clinician. He lectures, consults and writes on these issues. The "practice resistance" concept illustrates psychological obstacles of many therapists that prevent their achieving success.

From 1989-1992 David served as president of Nassau chapter; as member of the state vendorship committee, 1985-1987. He has been a contributor to the state *Newsletter;* presented a workshop at the Society's annual conference, 1991; presented at the Annual Clinical Conference, committee on psychoanalysis, 1990.

"[David] has made outstanding contributions both as an innovator . . . and because of his strong and steady leadership in state and chapter affairs over the last 8 years."

Diane Kramer, DSW, BCD

Dr. Diane Kramer has maintained a private practice since 1981; her area of specialty in psychotherapy addresses crisis situations. She is a supervisor at NY School for Psychoanalytic Psychotherapy. From 1985-1989 Dr. Kramer designed and taught in-service courses for Nassau and Suffolk Counties: "Helping Children Cope With Grief and Loss in the Classroom".

Her research on "How Women Relate to Terminally Ill Husbands and Their Subsequent Adjustment to Bereavement," provided seminal data in the study of bereavement, observing anticipatory bereavement for the first time. Publication includes "Anticipatory Grief: A New Perspective," in *Preventive Psychiatry,* 1989. From 1984 to the present Dr. Kramer has conducted workshops for various audiences on topics related to grief, loss and illness. The chapter president notes that she "epitomizes the qualities necessary for diplomate status . . . ."

Joy Perlow, CSW, BCD

Joy Perlow is a founding member of the Syracuse chapter (president 1987-1991) and has been involved in the creation and development of all facets of the chapter, which now has 65 members. In private practice for the past 20 years, she also supervises therapists. Joy was adjunct professor at Syracuse University, College of Human Development, from 1976-1984 and currently maintains an active relationship with the Dean of its School of Social Work to foster relations between the school and the Society.

She spearheaded the successful action by the chapter to overturn the decision by the Board of Zoning Appeals of the City of Syracuse to allow CSWs to practice in home offices.

Joy has served on the state's executive search and public relations committees. A chapter, "Women and Competition in Group Psychotherapy," is due for publication this year in *Women, Gender, and Group Psychotherapy* (NY, Guilford Press).

"[Joy] has nurtured [this chapter] into a thriving . . . organization which has provided clinical social work with a sense of prestige and respect . . . in this area. [Her] . . . commitment to professional excellence is evidenced by . . . clinical expertise, professional accomplishments, and dedication to the continuing growth of . . . clinical social work."

Roberta Ann Shechter, DSW, BCD

Dr. Roberta Ann Shechter, in private practice since 1981, serves as consultant for organizations and as a treatment supervisor. She teaches at Hunter College School of Social Work and Washington Square Institute for Psychotherapy; from 1986-1990 at Postgraduate Center.

Roberta will serve as president of The Postgraduate Psychoanalytic Society from 1993-1995. On the New York State Board of Social Work, she is currently focusing on the "P" and "R" criteria for short-term treatment. She is book review editor for the *Journal of Analytic Social Work.*

Dr. Shechter has made several presentations at national and international conferences including these in 1991: 14th Annual International Psychohistory Association Convention: "Treatment Issues in Cross-Cultural Therapy"; the 7th Scientific Conference, International Federation of Psychoanalytic Societies, Stockholm; the 20th Anniversary Clinical Conference, National Federation. Her "unusually strong dedication to the Society and the field" is noted by the chapter president. □

Tell Your Story...

To: ***All members***
From: ***Committee on Managed Care***

The committee on managed care needs information from members about their experiences. In order for the committee to address how managed care is influencing and intruding on clinical practice, members are urged to send in hard data on case management procedures, payments, or other ways in which the managed care system is infringing on their practices. Please forward information to Mark Dworkin, CSW, BCD, 251 Mercury Street, East Meadow, NY 11554. Please do not telephone.

WORKSHOPS

A Self-Psychology Approach to Group Psychotherapy

Presenter Robert Friedman, MSW, PhD
Report by Jeanette Hainer, ACSW

This workshop was experiential. A demonstration group was formed that included the following "cast of characters": a) the co-leader; b) the over-achiever; c) the under-achiever; d) the seductress; e) the altruist; f) the depressed; g) the angry. Remaining participants were observers and were assigned specific group members on whom to focus, to determine whether their needs were being met by the group and/or the leader.

The demonstration was enacted at the "third" group session. The leader broke the interaction periodically to communicate specific theoretical concepts and to observe whether they were taking place, and asked for feedback from the observers.

The key concept of a self psychology group, according to Kohut, is repair through filling in the deficits. This is similar to earlier self concepts of Rank, Horney, Rodgers and others who emphasize the role of creativity, health and self-actualization. Kohut's viewpoint helps us recognize and handle certain basic narcissistic issues previously neglected. This self psychology view can then be combined with other classic approaches that stress interpretation of the individual, interpersonal dynamics and the group-as-a-whole.

Self psychology describes three types of infantile relationships necessary for the development of healthy narcissism: 1) idealization of parent figures who provide values and goals; 2) mirroring, i.e., parental recognition and validation of the child's grandiosity, exhibitionism and ambitions; 3) twinship relationships with adults and peers, which provide a deep sense of belongingness to a "group self."

Group Model Focuses Repair

Group therapy provides a natural matrix for correction of self pathology when these basic needs have been unmet. Early narcisistic relationships between each group member, the leader and the group-as-a-whole provide the opportunity for group members to slowly uncover ego injuries and undergo a healing process of repair and restitution. An environment of trust, safety and empathy for the underlying narcissistic needs is essential for this restoration; lacking this, new injuries may be inflicted. This model focuses on the "power of the here and now" as in classic interpersonal theories, with a secondary role for interpretation of individual history as in classic psychoanalytic theories.

Self psychology emphasizes the importance of "shame" as a factor in the resistance to treatment. While shame may be more easily disclosed in individual sessions, the potential is greater for curing this pathology in a group by vicarious identifications, overcoming shame-induced isolation and by the group's empathic response to one's disclosures.

Three areas in which a self psychology approach to group work may be weak and needs augmentation with other modalities include: 1) The focus on empathic identification provides limited discussion of anger and does not provide the curative ways in which the group can control, challenge and confront the angry self in group; 2) The lack of focus of gender and sexual issues in group as these occur on an "oedipal level," i.e., a complete model of group therapy should address all issues of sexual attraction, envy, rivalry, etc; 3) The failure to appreciate resistances to cure which occur after narcissistic injury has become internalized as part of the personality structure. Injuries and rages that have been split off and repressed are difficult to uncover and heal through empathy. A model of group therapy must include all useful techniques, enabling us to contain, confront and handle these internal resistances. □

Facilitating the Use of Group Therapy by the Socially Inhibited/Phobic Adult

Presenter Estelle Rauch, MSS, BCD
Report by Ramona Goldman, CSW, BCD

This workshop dealt with the treatment of a particularly difficult patient population within the group setting. Ms. Rauch began with a description of four types of socially phobic adults who might be referred for group therapy, or whom the therapist might select from her own practice. There were: people whose avoidant behavior poses a problem on the job or in social settings; people with paranoid personality disorder, for whom hostile behavior forms a defense against a vulnerable core; people who fear social interaction because they believe it will lead to humiliation; and long-term alcohol or substance abusers for whom chemicals have provided the only means of attaining social ease. Common among these people is the intense underlying rage that they believe will destroy the other person or, perhaps, themselves.

Ms. Rauch described behavioral techniques that can be used to prepare the patient for group therapy. The first of these was setting up a hierarchy of group experiences. Patient and therapist choose nonthreatening group situations which the patient might enter. These could include 12-step programs, if appropriate, or hiking clubs, where interaction is optional and format is structured. This allows the patient to rehearse being with people without being forced to converse, eliminating the threat of failure. As these experiences grow easier, the patient comes closer to readiness for group therapy.

Another preparation technique is visualization. In this work, the patient imagines a frightening situation and envisions what will take place when he gets there; the patient then visualizes the therapist accompanying him. The scene can be modified to depict his entry into the group.

Ms. Rauch gave clinical examples from her own practice, describing her work with

socially anxious patients and their eventual participation in group. These cases showed varying levels of success and served to delineate the hazards as well as the curative aspects of group treatment with this population.

Several participants described their own treatment experiences, illustrating further the importance of underlying rage. The patients commonly fear that closeness will bring about violent conflict in which they will destroy the other, and/or suffer retaliation.

Ms. Rauch then focused on the internalized self-and-object world of these patients and its devastating impact on social interaction. A major difficulty, she noted, is that the patient may bring to the group his internalized object world, replete with frightening and debilitating self and object images. A task of the group therapist is to help the patient contrast his perceptions with the more realistic ones of the other group members, gradually to modify his world view.

Participants thought that the workshop had clarified their perceptions of this patient group and pointed the way to specific, yet empathic, treatment approach. □

Separation and Loss in Group Psychotherapy

Presenter/Report by Ramona Goldman, CSW, BCD

Entering the Dewitt room 10 minutes before the workshop was to begin, I was seriously disappointed. I was looking forward to an intimate process oriented group experience and instead found a wide conference table in the center of the room. My energy now focused on how I could change the room's arrangement. After speaking with the conference committee, I returned to a room full of workshop participants, many of whom were puzzled by my disappointment in the setup of the room. I shared my thoughts about the group environment and my preference for a round circle and asked the group for suggestions. Within 5 minutes a group moved the table, rearranged the room and set up a circle to seat the 20 workshop participants.

My trivial experience with loss, my attempt to fight and not accept what was, the impinging reality and the need to confront and deal with it rather than to change the external environment of the room became the theoretical introduction to the workshop. Concepts related to creating a suitable environment for the work were explicated and the group contract was articulated. In the brief 1-hour session the group became a cohesive unit, sharing professional reasons for being at the workshop and later their personal issues and experiences with loss. As the group moved forward, more personal material emerged: death of a child, death of a parent, death of a therapist, etc. With 15 minutes left, the professional personae became more prominent and the group dilemma became the ambivalence of continued investment, knowing that the experience would soon end and, on the other hand, defensive protective interaction that allowed members to decathect from the experience, albeit before the experience was over. The group struggled with the loss of the experience and ended silently.

The last 15 minutes were spent processing what had happened dynamically in the group: the major themes, as well as individual and group resistances. The leader's own countertransference dilemma (the pressure to extend the sessions and suspend the traditional boundaries) when working in this arena was discussed in depth. Despite my ambivalence, I chose to maintain the original contract, announce the 15 minutes left, and end on time. This choice reflected my own belief that the best way to help others come to terms with the realities of loss (particularly in a group setting) involves accepting and validating the limitations and constraints that exist in the therapeutic environment and acknowledging the ambivalence and loss that this reality imposes for us as well as for our patients. □

Combining Group and Individual Psychotherapy Treatment: Forming the Group

Presenter Alan Shanel, MS, BCD
Report by Marna Scharof, CSW, BCD

For this workshop, Alan Shanel, MS, BCD, organized the participants in a circle. He asked us to introduce ourselves by name, after which he invited anyone with questions or concerns to begin. Although we were all aware of the distinction between an educative workshop experience and a therapy group, there are for each of us those consistent truths that arise in situations among others. Who would speak first? There are some things I'd like to know, but I'm new to this Society—maybe I should wait and see what others do. Who are these people? How will I be judged?

Conducting the workshop in this format put each of us in touch with the impact of group dynamics. Members in this workshop varied from those with individual practices and no group experience to those who had been running groups for up to 20 years. Following comments from Alan one member shared that after considerable individual treatment, she had tried group and found that her feeling experience was far more intense in group than it had been in individual therapy. Others nodded in agreement.

That raised the question of the type of experience and/or training required to run a group. It was noted that, although courses are available and always helpful, at minimum one's own group experience as a patient is important. Another participant felt that was not so necessary and that much can be generalized to group from work with individual patients.

My interest in this workshop was prompted by my individual practice and my feeling that my patients could benefit from group experience. I wanted to know about methods others have used successfully to expand into a combined practice.

When to Suggest Group

The question arose as to when it is appropriate to suggest group for an individual patient. Members expressed concern that a patient who is referred to group because he seems "stuck" in individual treatment may actually represent a failure to work through the transference

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individual self can be used for good or ill—to heal or to manipulate and control. This overcoming of individual ego by the group has been witnessed in Nazi Germany, China, Pol Pot's Khmer Rouge in Cambodia. By the same token, in many societies healing takes place within or in front of the group: a sick person is surrounded by the group, which is involved by the healer in the healing process. Crisis units in this country used to bring in relatives from all over the country so that the family could lend support to a mentally ill patient. This form of intervention proved very effective.

The worst punishment in primitive societies was to be exiled or banished from one's group.

Current directions in therapy foster the individual's maintenance of her/his self while in relation to others and encourage development of a strong enough self to resist intense group pressure. An important goal is to enable people to merge with another and then to reemerge. Cults attract those who are isolated and fragmented, enabling them to join with others; reemergence or separation, however, is prohibited.

Cults attract those who are isolated and fragmented, enabling them to join with others; reemergence or separation is prohibited.

A therapy group is a wonderful arena in which to develop the ability to merge and reemerge and to practice the skills required. People differ in the amount of stress they can tolerate, however, and some forms of group therapy are quite stressful; a stressful mode for someone whose tolerance is minimal can do harm. The concept of the borderline personality disorder evolved because patients in analysis often decompensated. Dr. Knight at Austin Riggs thought such people to be on the border between neurosis and psychosis—thus borderline. To avoid this problem, analysts could use projective tests to screen patients who could not tolerate the stress of classic analysis. Therapists must consider their patients' tolerance and the amount of stress and anxiety inherent in treatment methods. If they fit the patient, groups can be very healing. Alcoholics, for example, do well in the structured 12-step program employed by AA, but do poorly in an interactive analytic therapy group.

Groups in Therapy

Let's consider the makeup of groups I work with. These group members are themselves mental health professionals. They are "ordinary" depressives, have character disorders (e.g., narcissistic and borderline features) like most of us. As in most other groups, they are hardworking and likeable people who are dealing with a variety of emotional injuries, malformations and wounds, most of which occurred in infancy and early childhood. Their parents, their family, their first group, was experienced as unsafe.

Since the first imperative of life is survival, we adapt and fit into the world we are born into and this often means that we must eliminate or not use much of what we were born with. As infants and children our potentialities become a threat to our existence. We learn what is acceptable and what we cannot allow to show.

Those in our groups learned to hide their true selves from others and from themselves and form adaptive selves. Because they did such a good job of hiding, they lost their true self and didn't know it. This loss leads to feelings of inner emptiness, pain, depression and anger, as well as other feelings that interfere with the ability to enjoy their lives, no matter how successful. Those buried, undeveloped and unexpressed parts of self experience hurt, rage, frustration and futility. We all do what we must and live "according to the rules"—against which the true self rages and often sabotages. The inner self rages against the adaptive self; a conflict ensues between the "true," more gentle self and the tougher adaptive self. Children and adults often say they hate their weak, helpless self.

Many, then, are unable to maintain long-term intimate relationships; they can trust no one with their inner, true self. For them, group therapy can be very helpful. The group must be made a safe place, often requiring a prior period of individual therapy, during which time a trusting relationship is formed with the therapist. The injured infant in the adult often requires a long holding period to establish trust. The therapist must create a quiet, safe and ultra-sensitive environment in which the true self can emerge.

Many breaches and repairs take place in individual therapy before group treatment is appropriate.

Many breaches and repairs take place in individual therapy before group treatment is appropriate. Moreover, when these people enter a group they need a period of combined therapy. They may be easily injured in a group and need constant attention. It is hard work to form a long-term, safe and holding group environment for such people.

Not everyone who requests group membership is placed. One wrong person can contaminate a well-composed group. As noted, the transition from individual therapy to a group involves combined therapy so that injuries that occur during group can be repaired in private therapy.

A well-composed and established group can work wonders, providing a sense of trust and safety many group members have never experienced before. The group mirrors back to them reflections and aspects

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As reported in the Spring issue, Allen A. DuMont, CSW, BCD, resigned as treasurer, having been nominated for a second term. We omitted the fact that he is now serving as member-at-large from the Queens chapter. Sorry, Al.

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with the therapist. The workshop leader made an interesting point in response, suggesting that it is important to acknowledge that at times individual treatment *can* get stuck and having other forces involved can help to resolve resistance. Participants pressed their fear that if an individual patient was not able to resolve a difficulty in group, it might sabotage individual treatment, and the patient would drop therapy. This is apparrently a common concern for practitioners, which the presenter said "hardly ever happens".

Particularly helpful were guidelines in the selection process for group members. The decision to suggest group for a patient must come out of the patient's issues. We were warned not to act out pressure we might feel to recruit too quickly new members for a group whose number has diminished. Patient issues that indicate a good group potential are 1) a patient's sense of isolation in his/her life; 2) repetitive patterns in relationships which the patient has not been able to see in individual treatment; 3) an impasse in individual treatment; 4) a dyadic relationship that is experienced as too frightening in individual treatment; 5) patients who want and can make good use of mirroring. When considering a patient for group, the therapist must question the patient's tolerance for sharing the therapist as well as seeing this person as less than ideal. It is helpful to ask what the patient hopes to get from group and to offer a realistic perspective.

The last part of the workshop included an outline of points to cover in contracting with the patient for group therapy and some general rules for conducting the early group sessions. The only thing missing in the format of this workshop was some written hand-out material: an outline of some of the content and possibly some suggested readings. All in all, it was a worthwhile and informative experience! □

Using the Therapeutic Contract to Study Resistance and Countertransference

Presenter/Report by Lena Furgeri, EdD, MSW, BCD

The goal of the workshop was to discuss and demonstrate how group members express their resistance and transferences in relation to the contract. Countertransferential issues were to be identified.

Following introductions Dr. Furgeri set the contract for the workshop: a short presentation followed by a half hour of experiential group and the last half hour spent on didactic issues, i.e., questions and comments. There were about 15 people in the group, some of whom had never had a group experience.

Dr. Furgeri noted that the therapeutic contract for a group usually involved arriving on time, paying on time, advising the group of anticipated absence, putting feelings and thoughts into words, taking an active part during the session, and no outside contact with members of the group. Resistances tend to be expressed, she noted, when the therapist breaks the frame as for example when the therapist: a) has to cancel, b) goes on vacation, and c) brings in new members. Resistances are often expressed by acting out, exemplified by coming late, not paying on time, bouncing checks, overpaying, underpaying, breaking appointments and, at times terminating in an abrupt way.

Following the didactic presentation, the leader announced the experiential portion over the next half hour. Resistances manifested at this point. There was confusion and upset for many in this group. She wondered what she had done not to make the contract clear. At this point there was active involvement by many participants. Some said they were not expecting an experiential group; others clarified that this had been specified by Chair Maria Warrack, CSW, BCD, in the morning conference; still others pointed out that the brochure clearly stated the experiential and didactic nature of the workshops. One member then said that he thought Dr. Furgeri was the person he had seen at a funeral of a mutual friend several years ago, thus setting up a transference-countertransference situation which the leader handled by discussing it in terms of their feelings. A lively, dynamic interchange followed and several members expressed feelings of transference stating they did not feel that the leader was creating a safe, nurturing, supportive atmosphere. Others differed, observing that they felt safe because it was a place where they could express negativity.

During the final and didactic half of the workshop many said they had understood a great deal as a result of the experiential portion. □

GROUP PSYCHOTHERAPY TRAINING

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HEALING POWER *(continued)*

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Isaac Zeke Youcha, MSW, BCD, is senior supervisor and training analyst, group department, Postgraduate Center for Mental Health; assistant professor of psychiatry, Albert Einstein College of Medicine; past president, Eastern Group Psychotherapy Society.

STILL STRUGGLING *(continued)*

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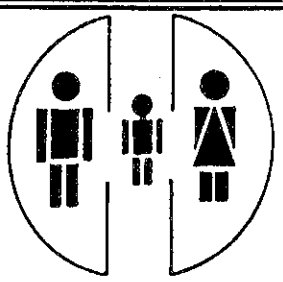

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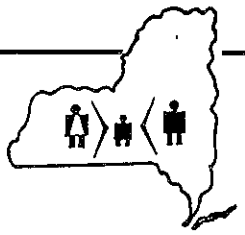

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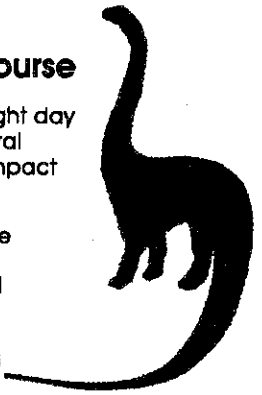

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