

Group Psychotherapy Column

The Co-Therapist Model in Groups

It is an unfortunate reality that many group therapists run a group therapy session by themselves and while this may appear to be an obvious income generator by the organization, I consider such a practice to be a significant professional error and I will list my reasons for this statement.

1. A single group therapist, no matter how skilled, cannot conceivably keep up with the richness of group experience. Important cues, particularly nonverbal ones, are in danger of being missed.
2. Running a group by yourself significantly increases the possibility of therapist burn out since there is no way that you can pace yourself.
3. Running a group by yourself falls below the minimum benchmark of approved professional practice and can damage you, your clients, and the agency for which you work.
4. Last, but not least, running a group by yourself is dumb; spelled D.U.M.B.

I feel so strongly on this subject that when young professionals ask me for my support, I am only too willing to supply them with "the letter," which comes in three flavors: Mild, spicy, and hot. An example of a mild letter follows:

Director of Training
Mercy Day Hospital
Anywhere, New Jersey

Dear Mrs. Campana,

A young professional in your organization, Thomas D. has asked for my opinion as to the practice of having a single mental health worker running a group by himself. I don't think that this is a wise idea, and I'm willing to share my thoughts on the subject, as I am a national and international specialist in the area of group therapy under discussion.

No therapist, no matter how experienced or skilled, can possibly follow the complexity of group process without running the risk of significantly missing important cues.

In addition, because of the stress involved, it is all too possible for beginning therapists to become quickly burned out.

From a professional point of view, running a group with one therapist falls below the minimum professional requirements in the mental health field, and I'm sure your organization would not want to be in a position of giving that impression to mental health regulatory agencies.



John "Sparky" Breeskin, PhD

The sad fact is that the young man under discussion has many demonstrable potential skills to become a fine therapist. It is my concern that unless he works within a supportive professional environment, he will become discouraged and seek another professional career.

With respect to finding an appropriate co-therapist, nothing could be easier. Asking for a volunteer and qualifying that person through a volunteer training program will cost the organization nothing. There are many fine group therapists, who, it is embarrassing to say, have never set foot day one in any graduate school program: They are naturals and relate to people in a very positive and empathic manner.

I hope these comments have been helpful. If you have any questions, please do not hesitate to contact me.

Respectfully,
John Breeskin, PhD, ABPP

Many times, in my career, I have been asked to consult to co-therapy pairs. I have not at all been surprised to find it that this compares very closely with couple's therapy. The problems, although they come wrapped in different packages, are quite similar. The pair involved has not been able to acknowledge, let alone resolve, the power differential that exists between them. To say that "we are both the same," is a copout. This can never be true. One person in the pair may have higher academic degrees, may have more initials after his or her name, may be more charismatic, or may have more time in the organization. The nature of the power differential imbalance is immaterial, but it must be acknowledged by the two people involved in order for them to work smoothly together.

The pair has the opportunity to model collegial support and respect by their interaction for the group participants. It is not too strong a statement to say that their interaction must be seamless. They must practice picking up on each other's comments in a non-competitive manner.

If Bob and Alice are running the group together, Alice says, "picking up on a comment of Bob's, I would like to add...." Bob says, "that comment of Alice's helped me understand what just happened...." This kind of collegial support and respect will provide a powerful interpersonal model for the group participants and will significantly diminish the amount of anxious gossip that the group members exchange with one another in the parking lot just after the group meeting.

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I always choose a woman to be my co-therapist in a group. This creates issues that must be addressed. In terms of dysfunctional dynamics, it is all too easy to consider my co-therapist and me to be parental figures and the clients to be the children. If not carefully anticipated, this dynamic can turn into potentially disruptive sibling rivalry based upon the scarcity model. My second wife was a psychologist herself and we did groups as a co-therapy pair for 10 years. This could have provided a rich screen of fantasy and projection on the part of the clients since my wife and I were not only working together but we were sleeping together as well. This

is still another reason why a co-therapy pair must model healthy relationship behavior in front of the group participants.

Additionally, according to my group developmental model, the person who is taking the lead for the first third of the group history, steps down, and the indigenous leaders, with the active support of the co-therapist, takes over the leadership of the group in stages two and three.

I am a superb bus driver; the passengers will get to their destination safely, and they will hear an interesting rap about the journey itself. I am also a loyal and helpful bus passenger provided, of course, that I trust the bus driver. This is still another positive role model that co-therapists can offer to their groups.

Group Cohesion Via Collaborative Story Building

Letitia Travaglini, MA; Tara Lynn, MA; Christine Seaver, MS; & Tom Treadwell, EdD, TEP



Letitia Travaglini, MA

This workshop was recently presented at the 2010 American Society for Group Psychotherapy and Psychodrama (ASGPP) Conference in Philadelphia, PA. Based on cognitive behavior therapy (CBT) and psychodrama techniques utilized in group work at West Chester University, this experiential workshop was aimed at building cohesion among group members through collaborative story building and telling.

The group consisted of 12 members: 6 adolescents and 6 adults who had been attending the ASGPP Conference. The six adolescents were all part of a teen psychodrama organization that presented earlier in the conference, and were therefore an already relatively cohesive group. Two of the adult members were friends, while the rest were not familiar with each other. The workshop began with a brief introduction from the group facilitators (authors), followed by the group members introducing themselves. For many of the group members, this was their first ASGPP Conference.

Sharing of Common Memories

While it is not necessary for groups to form based on a common theme (i.e., bereavement, substance use, etc), a common thread allows for better cohesiveness regarding a group's collective undertaking (task cohesiveness) and the sense of closeness among group members (interpersonal cohesiveness; Craig & Kelly, 1999). With this in mind, we decided to focus the group on a common theme: that of trauma memories. We defined trauma not by the DSM-IV criteria, per se, but allowed members to share any memory in their past that elicited a negative emotional response.

To begin the sharing process, a group member was asked to volunteer based on their level of comfort sharing with the group. Once a group member volunteered, the sharing of memories continued in a counter-clockwise fashion. If members did not feel comfortable sharing a memory, they were able to pass. Once all group members were given the opportunity to share, those

who initially passed could share a memory. It was not required for all group members to share. Ten of the 12 group members shared a trauma memory with the group. Memories included such topics as familial conflict, injury, work-related difficulties, and substance abuse.

Collaborative Story Building and Telling Exercise

After group members were given the opportunity to share, the facilitators divided them into subgroups so as to avoid grouping together the teens who were already acquainted. The purpose of the subgroups was to work collaboratively to build a "group story" based on the memories that were shared. Three subgroups (four people per group) were formed by having members count off by threes. The subgroups were instructed to work together to create a poster, utilizing magazine clippings and/or writing implements to build their group's collaborative story.

To prevent the group process from being rushed, a specific time limit was not provided at the start of the collaborative project. Group facilitators observed the subgroups and checked in regularly to determine how each subgroup was progressing. While in the small collaborative groups, group members engaged in dialogue regarding their trauma memories while they searched for clippings and determined how to create their posters. One group member who did not share a memory in the large group was willing to share with her small group, and others shared additional memories based on peers' recollections.

Interestingly, all three subgroups engaged with each other differently. The following points were observed by the group facilitators:

- **Group #1:** The group appeared disconnected; all four participants were silent and cutting magazines independently. In this group, a participant passed during the ice breaker and did not contribute to the poster, only reading the magazines.



Tara Lynn, MA