

The Chronicle

The Newsletter of the Canadian Group Psychotherapy Association

Volume 22, Number 1

Spring 2008

Check it out!

- **Our First Distinguished Fellow Dr. William (Bill) Powles**
(p. 5)
- **Expanding our Circle through Student Sponsorship**
(p. 9)
- **Remembering Sally Erdogan**
(p. 15)

More information at www.cgpa.ca

Inside this issue:

Letter from the Editor	1
From the Desk of the President	2
Council Changes	3
Fellowship Awards	5
Student Sponsorship	9
Section News	12
Group Therapy Research	17
Consultation Corner	21
2008 Conference	27

Letter from the Editor

The first thing on my mind is my appreciation to you, the members, for your ongoing interest and support. This was demonstrated in a very tangible way through the number of items submitted for this issue. Thanks to you we have an issue that reflects us as an organization - our thoughts as clinicians and researchers, our commitment to training, our recognition of outstanding contributions to the field, our ongoing support of each other through section activities, and the leadership of our able council.

There are some minor changes in this issue. I have not included author contact information and some submissions are longer than the suggested guidelines. This issue's Consultation Corner made me reflect on the "boundaries" of the Chronicle. The initial guidelines I have been using are outlined below and more detailed guidelines are under review by the Executive. Please let me know if you have any suggestions or comments about the guidelines, the content, or format of the Chronicle. For example, you may wish to comment on articles you read here – we could have a Letters to the Editor column.

Initial Chronicle Submission Guidelines:

By submitting an article the author agrees to have the article edited by Chronicle editor, and to have the article published by CGPA in the Chronicle (in print as well as online format).

Authors will be asked to provide the correct way to present their credentials, as well as a work phone number and email address as a signature line at the end of the article. Requests for privacy regarding contact information will be respected.

Suggested length is a maximum of 1200-1500 words.

Preferred method of submission is a Word document as an email attachment.

As always, I look forward to hearing from you!

Colleen Wilkie, PhD, RPsych
Chronicle Editor
(604) 525-9214
colleen.wilkie@shawbiz.ca

Next Issue: October 2008

Deadline for submissions: September 12, 2008

From the Desk of the President

At the CGPA National Conference in Toronto in 2007, new members of the Executive were approved by the membership – Terry Simonik from Toronto as President-Elect; Alina Isaac also from Toronto and Linda McFadyen from Winnipeg as Secretary. As well, Neleena Popatia assumed the role of Past President and I stepped into the role of President. The members of the executive have already been hard at work supporting the ongoing business of the organization and continuing the long tradition of volunteerism that has made CGPA viable through almost 30 years!! It is so gratifying to work with such dedicated individuals.

I wanted to pay tribute to the CGPA members who have left the Executive.

Dolina Watson, Treasurer

Dolina had to cope with a significant workload over her term. She carried this out with her usual calm, focused manner and, by the end of her two years as Treasurer, she had established a strong bookkeeping system and had begun the process of moving us into the electronic world. Dolina is exceptionally humble and I know that she would not acknowledge her contributions to stabilizing our financial processes but her persistence and steadfastness has brought results. She has been a great asset to our organization.

Ruth B Z Thomson, Secretary

Ruth started on the Executive as Treasurer and actually agreed to stay on for an additional two years, moving to the position of Secretary. Ruth is eternally optimistic and she has always been supportive of new ideas and trying out different ways of working. She faced the challenge of moving to spreadsheets as a means of tracking our finances. Even though we are a relatively small organization, keeping on top of our financial operations is complex. Ruth introduced the idea of moving some of our surplus funds into safe financial instruments and we have benefited from improved returns on our savings. Ruth can always be counted on for her enthusiasm and I will personally miss her contributions.

Linda Goddard, Past President

Linda has been exceptionally dedicated to CGPA over the years. She is one of the original members of the organization and has served on Council for 18 years in one position or another! She also stepped in and served an additional year as President when we needed someone. Linda has many friends in CGPA and she knows the organization and its history. Her experience has been so valuable to many of us. In fact, there are very few positions on Council or Executive that Linda has not held!! I think that she is going to enjoy the freedom from responsibility within CGPA this year and she truly deserves the opportunity to be a regular member of the organization that she has helped to build over time.

Thanks to all of you, both past and present, for your willingness to dedicate your precious time to the continuing evolution of CGPA as an organization.

Jim Merchant, BA, MBA, RSW, FCGPA
President

Council Changes

Welcome to Our New Council Members

Treasurer: Alina Isaac, MSW, RN, BScN

Alina Isaac has a Master of Social Work Degree and a B. Sc. Nursing degree. She is currently working in Health Promotion – focusing on community capacity building projects - and will be starting a new position as a Mental Health Nurse Consultant in April 2008. She also does occasional work in Addictions. Alina completed the CGPA Training in Toronto in 2000 and enjoys applying the principles of group process in a variety of settings.

Web Master: Gloria Jacobucci, PhD, RPsych

Gloria Jacobucci earned her MA in Psychology and Ph.D. in Clinical Psychology at Simon Fraser University in Burnaby, BC. She is working part-time in the Outpatient Mental Health Program (OPMH) of the Calgary Health Region (CHR). Having interned in this program in 1995-1996, she was always keen to return to the CHR, and did so in 2002 after working in the Yukon for three years. There, she conducted Cognitive Behavioural groups and was exposed for the first time to interpersonal process groups, and she was hooked! Training with Linda Goddard at OPMH fanned the flame of enthusiasm, and now Gloria co-facilitates an interpersonally oriented Young Adult Group as well as a Waitlist Group. Also along the way, she acquired some training and did some work in the CHR Dialectical Behavioural Therapy program, including DBT groups. While therapy is her main love, agreeing to work on the CGPA website is both exciting and intimidating, since computers are definitely not her forte! But with kind offers of help from Jim Merchant and Colleen Wilkie, she's taking a leap of faith and looking forward to contributing to making the site an increasingly useful resource for CGPA members and others.

CGPA Council List

Executive Officers	Phone	Fax	Email
Jim Merchant, President	(403) 297-4986	(403) 297-7160	jim.merchant@calgaryhealthregion.ca
Terry Simonik, President-Elect	(416) 736-5225	(416) 736-5782	tsimonik@rogers.com
Linda McFadyen, Secretary	(204) 958-9644	(204) 958-9618	lmcfadyen@matc.ca
Alina Isaac, Treasurer	(416) 220-3428	(416) 338-8550	alinatree@hotmail.com
Neleena Popatia, Past-President	(604) 760-9355		npopatia@telus.net
Local Section Representatives	Phone	Fax	Email
Sarah Larocque, Calgary	(403) 943-3822	(403) 943-2357	sarah.larocque@calgaryhealthregion.ca
Lina Filomeno, Edmonton	(780) 482-1717	(780) 488-3755	aristidem@shaw.ca
Linda McFadyen, Manitoba	(204) 958-9644	(204) 958-9618	lmcfadyen@matc.ca
Sal Colletta, Ottawa	(613) 737-8025	(613) 737-8895	
Lois Goodman, Prince George	(250) 565-2181		lois.goodman@northernhealth.ca
Joan Wilson Jones, Vancouver	(604) 535-7558		jwilson22@shaw.ca
Standing Committee Chairpersons	Phone	Fax	Email
Budget & Finance, vacant			
Allan Sheps, Constitution	(905) 889-4551	(416) 222-4430	asheps@rogers.com
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Sandy Ramsay, Membership	(250) 565-2151	(250) 565-2016	sandy.ramsay@northernhealth.ca
Nominating, vacant			
Program, vacant			
Colleen Wilkie, Publications	(604) 525-9214	(604) 525-9214	colleen.wilkie@shawbiz.ca
Gloria Jacobucci, Web-Public Relations	(403) 943-2453	(403) 943-2441	gloria.jacobucci@calgaryhealthregion.ca
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Dawn McBride, Training & Education	(403) 317-2877	(403) 329-2252	dawn.mcbride@uleth.ca
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Ad Hoc Committee Chairpersons	Phone	Fax	Email
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Anne Oakley, Institute	(416) 591-2000	(416) 591-2000	bpcwresearch@hotmail.com
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Linda McFadyen, National Conference	(204) 958-9644	(204) 958-9618	lmcfadyen@matc.ca
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Fellowship Awards

New Fellow – Susan Farrow

As per 8.05.01 and .02 of our Constitution:

To be admitted as a Fellow, an applicant shall unless waived by a unanimous vote of the Council, have been an Ordinary Member for a continuous period of not less than five (5) years; and have demonstrated, to the satisfaction of Council; outstanding performance in the field of Group Psychotherapy in at least two (2) of the following areas: contributions to the work of the Corporation; clinical practice or administration; teaching; research; and publications.

At the 2007 conference Susan Farrow was recognized as a Fellow of CGPA. Susan is an occupational therapist and an Assistant Professor at in the Department of Occupational Science and Occupational Therapy, University of Toronto. Her previous employment included coordinating the Group Therapy and Group Psychotherapy Training Programs in the Department of Psychiatry at Toronto General Hospital. Similarly, Susan's contributions to the Canadian Group Psychotherapy Association have also focused on training. She is a faculty member of the Toronto Section Training Program; developed a proposal for a national CGPA group therapy training program which is a topic that continues to be a focus of the Training and Education Committee; and has presented at CGPA national conferences, particularly in offering workshops for the beginning group therapist. You may also remember her previous contributions as Chronicle editor.

First Distinguished Fellow – Bill Powles

A new category of Fellowship was created November 5, 2005 and our Constitution now reads: 8.06.01 Distinguished Fellows. The Distinguished Fellowship award may be granted by the Council of the Corporation, acting upon the recommendation of the Fellowship Committee, to any regular or retired Fellow of the Association whose professional career has been such as to distinguish them as among the top theoreticians, practitioners, researchers or trainers in the group psychotherapy field or whose leadership in the Association has been marked with utmost distinction. A three-fourths vote of those members of Council present and voting shall be required for approval.

Our first Distinguished Fellow is Dr. William (Bill) Powles who reflects below on his career in group therapy and his many contributions to the development and ongoing support of CGPA.

Biographical Note: Bill Powles and CGPA

I am highly touched at the recent honour CGPA has bestowed upon me in the form of Distinguished Fellowship. And most grateful to Fern Cramer-Azima and the Fellowship Committee for proposing me; and to Allan Sheps, who put my name forward, and arranged the telephone hook-up whereby I could take part in the presentation ceremony (while Edie, my wife, sat crying by our other phone!). I have the beautiful "Distinguished Fellow" diploma hanging over my desk, suitably framed.

Some background: I served in the Medical Corps in WWII, did general practice after the war, then trained Psychiatry 1948-52 in the McGill programme. Got hooked on group psychotherapy in my first year, under Dr. Bert Moll's preceptorship. Conducted various types and sizes of group thereafter – ward parliament in mental hospital, alcoholics, young adults, chronic neurotics, adolescents, couples and couples' groups, etc. – a great deal of it unsupervised.

Joined the American Group Psychotherapy Association in 1953 and went to my first meeting in 1958, giving a paper on our work with adolescents at Essondale Hospital (who paid my trip expenses). There, as the only Canadian present, I got buttonholed into committee work. Then stayed active in AGPA over many years, sitting on the Board, chairing a couple of committees, and instructing in the Institute. From 1977 I also got involved in the International Association (which was propped up over some critical years by Jay Fidler of Philadelphia) chairing the Nominating Committee, which I've learned is a good way of getting to know people!

In 1958 I went to Cincinnati to firm up my rather loose training, under Dr. Don Ross, a Canadian group psychotherapy pioneer. Ended up helping run the large group therapy training programme in the Psychiatry Department, before returning to Canada and Kingston in 1966. Became more active in AGPA and became a Fellow; also became president of the regional Tri-State Group Psychotherapy Society. In Kingston went on doing and teaching group therapy, among my duties. A long-term, open-ended adult group which I handed over to a colleague when I fully retired in 1995 had been running for 18 years!

It was good to meet Canadian colleagues at AGPA conferences over the years; Canada is such a long skinny country that we didn't meet much at other time. Energetic nuclei of group therapists were extant in Montreal (Fern Cramer-Azima et al.), the Ontario Group Psychotherapy Association around Toronto (Martin Fischer, Vi Head, John Salvendy, many others); Calgary was beginning to boom (Kent Mahoney, Roy MacKenzie, et al.); Eric Jackman was in Chicago then. John Salvendy began to prod us energetically to start up a Canadian Association, and we had several preliminary meetings in Toronto before CGPA finally was born, incorporated, and had a constitution in place. We had our first Banff conference in 1980, a resounding and exciting success, thanks to all the work of the Calgary associates.

I worked my way up the CGPA executive, got elected a Fellow, and became President in 1986-88. We ran head office from my Queen's University department, with the invaluable help of Irene Meagher, my secretary, and with Bill Piper as treasurer in Edmonton. The Council and General meeting had mandated me to inaugurate membership and fellowship certificates, which we lettered and distributed; and to set up a parallel organization to hold monies, do public education, and otherwise promote group psychotherapy. This developed into the CGP Foundation, of which I was later secretary-treasurer and more recently honorary president. It was a lot of work.

One thing I thought it important to do as president was to visit the sections of CGPA and a couple of nascent centres of activity: Calgary, Edmonton, Vancouver, Sudbury, Toronto, Montreal. These visits, particularly out West, were much appreciated. Later I also was invited to visit enthusiastic and somewhat isolated colleagues in Thunder Bay Psychiatric Hospital. I kept active in CGPA over the years, partly by the device of getting appointed Constitution Committee chair, thus being also on Council; this job made me somewhat of a lawyer, as well as custodian and maintenance man of our Constitution. Allan Sheps now does a fine job in the position.

The first CGPA conference I missed was in 1993, when I chose to attend the 50th anniversary reunion of my medical class at McGill. Since then my attendance has been increasingly spotty, due to old age (I'm 88 now) and health problems; but I still feel very much a part of CGPA and its fine membership, as well as ties with many old friends. My wife Edie (an old friend and supporter of CGPA) and I have recently moved to a retirement residence outside Ottawa, where we're trying to brush up our rusty French!

Bill Powles

Wm. E. Powles, MD, DFCGPA
Emeritus Professor, Queen's University



Student Sponsorship

Expanding the Circle:

Student Sponsorship is Alive and Well at the CGPA Conference

CGPA is committed to student involvement and to raising awareness about the value of group psychotherapy. In keeping with the idea of "expanding the circle" and "creating space for new possibilities", the Local Arrangements Committee communicated with Toronto members as well as other CGPA Sections to find out if there was support for the idea of offering student sponsorships. The responses received were unanimously in favour. The LAC therefore offered sponsorship on behalf of the Toronto Section to two students to attend the national CGPA conference in Toronto on November 7-10, 2007. The Calgary section also decided to sponsor a local student.

Three students were awarded the sponsorship and attended the conference free of charge: Kara Frampton, MSW student from Wilfrid Laurier University; Christina Yager, MSW student from University of Toronto; and Sanjeev Sockalingam, Psychiatry Resident at University of Toronto. It was a joy to see all three students participating, making connections with one another and with group therapists, and fitting in so comfortably. I asked Kara, Christina and Sanjeev to chronicle their experiences of the conference, and they did. I certainly hope that they remain involved with CGPA and continue to pursue learning and practice in group process and dynamics.

Alina Isaac, MSW, RN, BScN

Student Reflection: Karen Frampton

I was extremely excited to learn from a member of the Faculty of Social Work at Wilfrid Laurier University that the Toronto Section of the C.G.P.A. was sponsoring students to attend the annual conference. I had recently completed an internship in mental health, where I had the opportunity to learn about group psychotherapy from professionals from a variety of disciplines. The power of group work energized me and this placement left me with the desire to learn more about group psychotherapy.

I felt quite anxious and intimidated upon my arrival to the conference, but I was immediately put at ease by Alina Isaac, Allan Sheps, and Terry Simonik of the Toronto Section and introduced to many members of the association. This feeling of belongingness and acceptance continued throughout my participation in the conference in a way that I would imagine mirrors the feeling of becoming a part of a group of people. The most powerful impact that I felt throughout the conference was the discovery that many of us from different disciplines, age groups, and experience levels all shared many of the same personal and professional experiences. This was very reassuring to me as a fledgling practitioner. I would like to warmly thank the Toronto Section for their support in my attendance. My desire to continue to pursue training and work experiences in group psychotherapy has been strengthened and I look forward to seeing everyone at the conference next year!

Kara Frampton, MSW
Wilfrid Laurier University

Student Reflection: Sanjeev Sockalingam

I had the fortune of attending the CGPA 2007 conference in Toronto on a student scholarship award supported by the Calgary CGPA Section. This was my first CGPA conference and I was pleasantly surprised by the overall experience.

As a fifth year psychiatry resident at the University of Toronto, I have attended several mental health conferences over the course of my residency. The CGPA conference was truly unique with regards to its strong interprofessional focus and collegiality. I was impressed with the involvement of workshop facilitators from all disciplines. Each workshop offered innovative skills that could be used by therapists at all levels. The theme of interprofessional learning also extended to the workshop I co-presented at the CGPA, which generated a rich discussion. Furthermore, I was impressed by the multidisciplinary representation on the CGPA governance, which truly highlights its strength as an organization. Given the strong emphasis on interdisciplinary treatment within the current health care system, the CGPA's strong interprofessional presence is both timely and important in trainees' development, including my own.

In regards to my individual learning, the CGPA conference was truly a valuable experience for me. My background in group therapy has mainly consisted of training in a group intervention for individuals with recurrent suicide attempts at St. Michael's Hospital. In the coming years, I hope to expand my use of group psychotherapy to treat medically ill patients, predominantly patients suffering from liver disease. The CGPA had several workshops complimenting my interests and enhancing my skills. I enjoyed the introductory pre-workshop and found the content to apply to group therapists at all levels. I also attended the research presentation and was exposed to the CGPA's growing support of group therapy research. I personally found this helpful in developing a framework to pursue my own group research ideas in the future.

Overall, I found my first CGPA conference to be a valuable and enjoyable experience that revitalized my group interest. Moreover, I was able to network with experienced group therapists and increase my awareness of group therapy activities across Canada. In my opinion, I feel the student scholarship awards are an excellent way to attract young trainees and to recruit future CGPA members. As a result of my participation at this year's CGPA, I plan to advise my colleagues and other trainees currently involved in or interested in group to attend future meetings.

I would like to conclude by thanking the CGPA, especially the Calgary Section, for their sponsorship. This experience would not be possible without your support. I look forward to seeing everyone in future meetings.

Sincerely,

Sanjeev Sockalingam, MD
PGY5 Resident in Psychiatry
University of Toronto

Student Reflection: Christina Yager

What an Inspiration!

I feel very fortunate to have been given the opportunity to attend the CGPA conference in Toronto. From the first evening of the conference, I was pleasantly surprised by the welcoming attitude of CGPA. Having attended one very large conference last summer, I was amazed at how well everyone knew one another and how welcoming you all were towards Kara, Sanjeev and me. I am very thankful for how included I felt in the workshops and social events during the conference. Due to the accepting environment, I was able to learn much more than I had anticipated about group process and the importance of the co-therapist relationship. As I am so early in my education as a therapist, these lessons were of incredible value to me. Learning from skilled professionals in the field was very inspiring and my interest in becoming a group therapist has definitely been solidified.

Since the conference, I have actively pursued opportunities to learn more about group practice in both my coursework and my practicum. I will begin in January 2008 a five-month rotational practicum at Mount Sinai Hospital. In the first of three rotations, I will have the opportunity to observe and then become a co-therapist in groups in the Department of Psychiatry Day Treatment Program. I am very excited to embark on this experience, one which I have sought out due to my positive experience learning about group practice at the CGPA conference.

I would like to thank CGPA, especially Alina, Terry and Allan for affording me this incredibly valuable experience. I am looking forward to future opportunities of continued education in group practice with CGPA!

Christina Yager, BAH, MSW candidate
University of Toronto

Section News

Prince George Section

Lois Goodman Reflects on Forming our Section

I actually met with Dr. Kent Mahoney in Calgary in the late 80's to assess whether it would be a possibility for me to get my Group Certification. That visit confirmed for me that the thought of getting my 'Full Membership/Group Certification' was totally out of reach (that was unless I won the lottery). Living in a geographical area where no Group Psychotherapy Training Program is on site confirmed this reality for me. I have been a member of CGPA since the mid 1980's and it was not until the late 1900's that I even had a slight hope of upgrading my membership status to 'Full Membership.' It was when Dr. K. Roy MacKenzie offered 30 hours of Experiential Training in Group Psychotherapy and this training coincided with education monies granted to Nurses in the North (for which I was eligible) that making application for my 'Full Membership' even became a sliver of hope. During this time with the financial support of Northern Health, Sandy Ramsay, in the role of coordinator in Day Program and Linda Schmidt in her role as Regional Education Director, arranged for Linda Goddard to deliver formal, long-distance group psychotherapy training in accordance with National Standards. Large numbers attended the workshop/seminar components. Twelve of us attended the Experiential Process Group (90 hours). It is important to mention that from this Process Group all of us who participated in this Process Group and are still in the city and working in this area are now members of the association. From May 2001 to August 2003 a handful of staff (me included) were able to benefit from ongoing supervision with Linda Goddard via videotaping and teleconferencing. Dr. Griffiths in her role as Clinical Director of Day Program was involved and assisted in financing a good chunk of ongoing supervision. This training provided the impetus for a few of us to contemplate forming our own Chapter.

On November 10, 2003 Sandy Ramsay, Donna Bernard, Marlace Susut, Dr. Brenda Griffiths and I met to discuss whether or not we would proceed with forming our own Chapter. In order for us to form our Chapter we required 10 or more members within our geographical boundaries and we had six. At this meeting we decided our focus would be on promoting membership and education via workshops. Due to our limited membership we would opt out of sponsoring a Conference as part of our Chapter Inauguration. With the financial support of Northern Health via Day Program we decided to invite Linda Goddard to promote membership in conjunction with presenting her workshop on 'Resistance/Defense Mechanisms' & 'Formulating Group Member Goals in Short-Term Groups'. Sixty+ attendees were in attendance at the workshop. The workshop was also on videoconference to Terrace, BC.

We advertised and held several meetings inviting members to join these meetings and learn more about the Association. Attendance at these meetings was always very small. Beginning January 2004 we decided we would take on the formal roles of an unofficial chapter. After discussion between Sandy & me, we decided that initially I would act in the role of President, Sandy in the role as President-Elect, Donna Bernard agreed to the role of Secretary, and Marlace Susut agreed to the role of Treasurer.

Over the next couple of years it was very helpful to me when Linda Goddard approached the National Executive Council and obtained their permission to have me sit in on the Council meetings at the Conferences. It was helpful to me in that I gained more in-depth knowledge of the organization and felt supported, accepted and encouraged by the members on the National Executive Council. Another helpful thing that Linda Goddard did was obtaining the National Executive Council's approval to have Sandy Ramsay and me act as Co-Chairs of the Membership Committee. For Sandy and me taking on the role of Co-Membership Chairs enabled us to promote and increase our membership base within the context of acting as referees for new members.

In 2006 we had enough members to forward a proposal to form an official Canadian Group Psychotherapy Chapter in Prince George. On March 11, 2006 with the assistance of Blaine Powel, who is very talented with computers and a very supportive member, I forwarded our proposal to form an official Canadian Group Psychotherapy Chapter in Prince George to the Canadian Group Psychotherapy National Executive Committee. It was at the October 11 –14th, 2006 Conference in Winnipeg that the Prince George Group Psychotherapy Chapter was inaugurated!!

Lois Goodman, RN
Prince George Section President

Vancouver Section

Vancouver Section Report March 2008

On March 29, 2008 Dr. Melyn Leszcz will be in Vancouver to present "Integrating the Existential and the Interpersonal in Group Psychotherapy". We are pleased to have the support of Providence Health and the Fraser Health Authority in sponsoring this event with our section. We are looking forward to welcoming registrants to this important event for Group Psychotherapy in our community.

Another Group Psychotherapy event will be Dr. Ingrid Sochting's presentation at our Annual General Meeting, Saturday, May 10, 2008. Dr. Sochting is the Chief Psychologist at Richmond Mental Health Services. She has developed a variety of groups including CBT for OCD and panic, cognitive/interpersonal for depression and interpersonal/interactional for older adults. She has been involved with various treatment outcomes and most recently has been working with Dr. John Ogrodniczuk at UBC. Dr. Sochting's presentation "Getting Involved in Group Psychotherapy Research" will focus on her project with a Changeways Group and will encourage the audience to bring their experiences and engage in a discussion.

During the fall we can look forward to Allan Sheps, MSW workshop on Men's Issues. He will be presenting for the Prince George Section and he has kindly offered to do a similar workshop for the Vancouver Section in September. We will advertise the date and topic in a flyer during the early summer.

Submitted by
Joan Wilson Jones , RN, BScN, MEd
Vancouver Section President

Calgary Section

The following are highlights of the activity occurring in the Calgary Section. The Section hosts a yearly conference in the spring (the Dr. Kent Mahoney Annual Spring Conference) and holds a Dr. Ron Aldous Memorial Lecture with their Annual General Meeting in the fall. Information on how to nominate a colleague for the Group Therapist Appreciation Award is available on our website at www.cgpa.ca.

New Executive

President – Sarah LaRocque
President Elect – Danielle Rousseau
Secretary-Treasurer – Alison Johnson
Member-at-large – Patricia Kelcher
Member-at-large – Karen Daniels
Member-at-large – Sylvia Gorham
Member-at-large – Kirsten Buhr
Member-at-large – Jeff Gilchrist
Past-President – Chris Marcil

Recent Events

September 13, 2007 Dr. Aldous Memorial Lecture 2007
Presenter: Ross Watson

Upcoming Events

April 18, 2008 Dr. Kent Mahoney Annual Spring Conference
Presenter: Donna Marie Perry
Topic: Transactional Analysis

October 22-25 2008 Calgary Section hosting CGPA conference

Dolina Watson, RN
Calgary Section Newsletter Editor

Sarah LaRoque, MSW
Calgary Section President

Manitoba Section

The following are highlights of the activity occurring in the Manitoba Section. In addition, the Manitoba Section holds monthly meetings to discuss group (see our website at www.cgpa.ca on how to get involved).

Executive

President – Linda McFadyen (Croll)
Past President – Dorothy Strang
Secretary – Pauline Steinberg
Treasurer – Ruth B.Z. Thomson
Training Chair – Joan-Dianne Smith

Recent Events

March 18, 2008

Presenter: Dr. Karen Dyck
Topic: CBT (Cognitive Behavioural Therapy) Groups

Upcoming Events

April 15, 2008

Presenter: Tanis Dyck, MA
Topic: Art Therapy in Groups

May 9, 2008

Presenter: Dr. Elspeth MacEwan
Topic: Contemporary Gestalt Techniques in Group Therapy

June, 2008

Potluck Windup

September, 2008

Presenter: Dr. Stephane Treyvaud
Topic: Mindfulness in Group Therapy: A Day for Extraordinary Living

Linda McFadyen, MSW, RSW
Manitoba Section President

Toronto Section

Remembering Sally Erdogan

Sally Erdogan, our last president of the Toronto section passed away in early March. Sally experienced a recent recurrence of cancer. Sally's death is a great loss to our group community. She was a very committed member of CGPA who played many roles at both the local and national levels of our organization. I know she was very proud to have been the president of the Toronto section and was also proud of her accomplishments as the first webmaster of our original CGPA website (with the assistance of her beloved son, Levent). Dr. John Salvendy, a valued mentor and friend of Sally's, aptly described her recently as "a loyal friend, a reliable and hard working colleague and a warm hearted, kind person." In my own experience, I initially found Sally to be quite a private person. However it was my good fortune to get to know her better during our work on the 1999 annual conference local arrangements committee. Sally was funny, smart and intensely loyal. I remember in particular, one trip that our local arrangements team made to Hockley Valley Resort where we toured the resort and then sat for a while afterward to share some good food and a great conversation. I learned that day how much Sally loved doing group and I could clearly see how her knowledge and experience had informed her commitment to being a good group member herself. She also spoke that day about her family and it was the first of many conversations we had over the years where we shared family stories. Sally's husband and her son were unquestionably the centre of her world.

It seems a fitting tribute to Sally that the Toronto Section of CGPA is meeting this week to plan a spring symposium. We are grateful for her contributions to keeping our local group going and would like to hold this learning event in her honour. I have no doubt that Sally would be very pleased indeed to think that a group will gather to share ideas and energy about group therapy.

The circle continues....

Terry Simonik, RN, MEd, FCGPA

Although I initially got to know Sally through our joint involvement in a monthly group therapy learning group it was her love for CGPA and belief in group therapy that drew us together over the years.

When Sally was President of Toronto Section I asked her if she would become CGPA's first webmaster. Sally didn't know much about the web but she felt she could learn what was required and most importantly, if this was what was needed, this was what she would do. When it came to planning CGPA's 2003 National conference in post SARS Toronto it was a period of chaos and uncertainty. Again Sally stepped forward to co-chair the LAC and kept us focused on getting the job done. Sally's spirit was a key factor in making that conference happen.

As I got to know her I came to realize just how loyal and focused she was. I once asked about her ability to be so focused. She attributed it to her career working in organizations such as St. Michael's Hospital and the Hincks-Dellcrest Centre for Families. She said that since there were so many things to get caught up in, she learned how to conserve her energy by focusing on what mattered. Years later I realized that her previous encounters with cancer had taught her a lot about focusing on what matters.

Over the last year Sally knew her health was failing. When we spoke about this latest return of her cancer Sally expressed her appreciation for having had the time to live her life and to see her son grow up and establish himself both professionally and in a relationship. She felt that she had been given a reprieve and rarely talked about her pain. Ever the social worker Sally would offer comments and helpful suggestions that others could apply in coping with cancer.

So long Sal, I'll miss you.

Allan

Allan Sheps, MSW, FCGPA
March 23, 2008

Group Therapy Research

Editor's Note: Many thanks to Dolina Watson for suggesting this submission (and doing the initial leg-work to make it happen) based on a presentation from the Calgary Section's Spring Conference in 2007.

My Experience and Reflections on Using Paper-and-Pencil Measures Clinically

My name is James Nieuwenhuis. I am a psychologist working for nine years in the Outpatient Mental Health Program of the Calgary Health Region. We have a great team, with Linda Goddard, Christi Alloway, and Gloria Jacobucci. We provide both individual and group psychotherapy to an adult population.

A few weeks ago, I was asked to speak at the CGPA Calgary Section Spring Conference about what I have been doing with a couple of measures in my clinical practice. You may know of the measures; they are by Miller and Duncan, the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). I was asked to tell you about the process I went through to get to the point of using measures in my clinical practice, and about some of my experiences since I started using them.

This presentation is about my experiences in using measures in my individual psychotherapy practice. Let me begin by saying that I realize I am speaking to group therapists about using measures with my individual clients. Although the modality is different, I suspect that the process of actually deciding to use measures in clinical practice might be similar. I also want to say that I am not presenting a model of ideal research for others to copy. I hope my experience merely invites you to imagine how you can do something similar in your own clinical work.

The Process of Deciding

The process began with one of my personal hopes as a therapist: that people are benefiting from my therapy. My way of gauging benefit used to be to ask clients for their sense of progress and to compare my experience of them over time... I realized of course that my clients and I were both relying on our memories to do this. I thought that when I got more organized and found the time to look into it, I might include a paper and pencil measure to gauge clients' progress.

The next step was a practical one. I happened upon the Inventory of Interpersonal Problems (IIP-64) I asked Linda Goddard, our team leader, about using it and she thought it was a good idea. She arranged for the purchase and, since the fall of 2002, our group therapy team has been collecting IIP-64s from all of our Interpersonal Group therapy clients, both when they start group therapy and again when they end group therapy. We use the IIP results for feedback to clients, at the start to clarify goals, and at the end to gauge progress. We have intentions of looking at the data for group therapy clients as a group, but it's has been an extra step that we haven't gotten to yet. Using the IIP-64 was an important step in actually using a measure with clients.

The next motivator for me came from a CGPA spring conference when Tony Joyce and Gary Burlingame talked about the CORE-R battery of measures for group therapy. What caught my attention was Gary's talk about "practice-based evidence", in contrast to "evidence-based practice" and "empirically supported treatments." "Practice-based evidence" gave me a language for what our team was already doing and what I wanted to collect with my individual clients.

When I attended a workshop by Scott Miller and Barry Duncan, I found two simple measures: the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). These measures were free (from www.talkingcure.com), which addressed the common complication of how to legally use measures without incurring extra cost. And the measures were such simple, minimally intrusive measures that I could use them every session! And that's what I have done for all of my individual therapy sessions for the past two years.

The ORS and SRS in Practice

The Outcome Rating Scale (ORS) asks clients how they have been over the last week in four general areas (individually, interpersonally, socially, and overall). I ask clients to complete the ORS at the start of every session. Basically I am asking clients to rate four areas on a 0-10 scale. Then I simply add up the four numbers which is a total out of 40, and graph it. Clients typically take anywhere from 10-30 seconds to complete the ORS and I can score and graph it in less than a minute, so it takes up very little time.

The graph has one column for each session, with cutoff lines for the ORS and the SRS. The ORS cutoff (around 25/40) is the score around which most people "tend to live" when they have some problems in their lives but are still coping well. It is useful in setting realistic expectations for change and not feeding fantasies that life can be perfect or therapy can fix everything.

As I score the ORS, I usually ask clients if they feel like they are doing better, worse, or about the same as last session. After I score and graph the ORS results, I ask if the results fit with their experience. Mostly they do. If there is a big change in the total ORS score from the previous week, I will ask if they know what has caused the change. That may lead into the first focus for the session. Sometimes the client and I reflect on the graph of how they have been across time. I use the graph to explore patterns of gradual deterioration or improvement, lack of change, or dramatic change. Sometimes I will refer back to something about the graph at a clinically opportune time in the session.

The Session Rating Scale (SRS) follows the same format as the ORS. I ask clients to fill out the SRS at the end of sessions, to tell me how the session has been from their perspective. The areas of the SRS are similar to the subscales of the Working Alliance Inventory (WAI) (e.g., agreement on goals and tasks of therapy along with the client's bond with the therapist). I score the SRS in the same way as the ORS and plot it on the same graph. The SRS cutoff score is 35/40. When clients rate the session at 35 or higher, then the therapeutic relationship is probably solid and the risk of drop-out less.

I have been most consistent using the ORS at the beginning of sessions. It took me a while longer to use the SRS consistently. Sometimes I forgot, and sometimes I didn't want to interrupt the emotional tone at the end of the session, but I gradually overcame those apprehensions. I have clients fill out the SRS but I also ask for verbal feedback about the session. Because the SRS can seem so much more like an evaluation of my performance, and because clients are often careful not to criticize me directly, I do make a point sometimes to say that the SRS is not about

giving me compliments; that their truthful reflection of their experience in the therapy hour is most helpful to me.

There were of course practical details to work out in using these measures. I had to get organized. This meant getting a clip board, a pen, a ruler to score the questionnaires, and enough copies of both measures and the graph to last for a week or two. I also had to decide what to tell clients. I am very open with clients about my wanting another way to gauge how they have been coping that doesn't rely only on memory. I have had a minority of clients complain once in a while about the measures. They aren't always sure for themselves about how to answer them, or the different areas can be confusing and not discrete enough. Nevertheless, I have been persistent in asking clients to do the measures, even if they don't immediately find the results useful. In those cases I might acknowledge that they are doing it more for me, especially with the occasional client who really protests. I always thank clients each time they complete the measures. And clients do get into the routine of doing it; they readily take the clipboard from me at the start of the session and fill out the ORS. Most give me the quiet space to quickly score and graph the ORS results. Sometimes, at the end of a session, when I might have forgotten, clients will remind me that I want them to complete the SRS.

A Few Brief Case Examples

In terms of the pattern of ORS scores across time, sometimes I see the gradual, steady improvement that looks like an example of effective therapy. This is encouraging for both myself and my clients and helps us to feel ready to end therapy. But I see other patterns as well that are also useful.

In one case, a client told me over several sessions that he felt he had deteriorated since the last session, but his ORS scores were consistently and significantly improving. This prompted my client to reassess his habit of negatively estimating his functioning.

In another case, a client had a consistently low ORS score over the first nine sessions and told me that this was how he had always been and always would be. But he was surprised when there was a noticeable improvement in the profile after a vacation. This was new information for my client; that a future of low functioning was not inevitable, and from then on my client was better able to tolerate difficult weeks knowing they aren't forever.

A few clients who had ORS patterns of dramatic swings between lows and highs used their ORS scores to aim for more stability, by turning the lows around before they went as low as before, or tolerating less intense highs.

Sometimes clients' patterns of ORS scores simply track their journey through difficult times, such as dealing with a loss and then facing a painful anniversary of the loss. Drops in their ORS scores at these times allow me to normalize the reactions to anniversaries and draw on past higher ORS scores as hope that they won't always feel as badly as that week.

Less often, I focus on the pattern of end-of-session SRS scores, particularly when there had been a rupture in our therapy relationship. The SRS score shows that a rupture has happened and helps me to address it directly. Later we can take pleasure in the successful resolution of the rupture as we see the SRS scores return to their previous higher levels.

Of course, clients' patterns of ORS or SRS scores sometimes show dramatic improvements that have nothing to do with the therapy provided, or serious deteriorations in the alliance that I tried but could not change in time before clients ended therapy.

Personal Reflections

While I am glad to be using these simple measures, I have to admit that after doing the ORS maybe a thousand times over the past two years, the experience is not as fresh to me about how doing this differs from my old practice, which was to not use them. But if I imagine stopping now, I would really miss having that extra “practice-based evidence” to reflect on with clients.

I also realize that I had to overcome a few emotional barriers and ego fantasies to get to the point of using the ORS and SRS with my individual clients. I had to sort through my many worries about clients’ reactions to the measures. And I’ve had to sort through with a small number of clients, their actual, negative reactions. I had to be prepared for some negative results like clients getting worse during their time in therapy with me, or reporting that they didn’t feel heard, understood, and respected by me. I had to accept that the measures didn’t always make sense to clients. I had to accept that sometimes the measures did not add much obvious value to either of us. I had to give up the fantasy of finding the perfect measures. I had to acknowledge that many times clients’ improvements are because of things that happen outside of therapy, and that I am often just the witness to changing circumstance rather than a powerful facilitator of healing.

But in the end, the emotional barriers were not so significant. And the fantasies were just that. I do think that my regular use of simple, clinically relevant measures have added to my satisfaction and effectiveness as a therapist. I think that I pay attention sooner to patterns in people’s functioning. I think that I recognize sooner when something in therapy needs to change. I’ve seen that sometimes a visual record of clients’ functioning across time can give them an additional view of themselves that helps them to focus their change efforts. And the ORS scores across time often give my clients and me reason to reflect and celebrate when their lives do improve. So in the end, I am getting what I hoped for, another way to gauge how much the people that I am seeing are benefiting from the therapy I am providing, and/or seeing improvements in their lives while in therapy.

Consultation Corner

Editor's Note:

The Consultation Corner offers an opportunity for us to vicariously receive consultation on the group therapy work that we do. The CGPA members who have graciously provided the clinical dilemma and the consultation allow us to "observe" the consultation process.

Compared to supervision, in consultation the responsibility for providing sufficient and accurate information rests with the clinician, and the decision of how best to make use of the consultation rests with the clinician.

Of course, with the process conducted in writing, there are some limitations. The requests for clarification and getting a "feel" for the clinician and the work that occur in a verbal exchange are not available in this format.

Below is the group therapy dilemma provided anonymously by a CGPA member. Following are the responses of two consultants.

Group Therapy Dilemma

This is a group program dilemma. It concerns boundary issues that seem to recur on a regular basis. Our Psychoeducational groups and our Interpersonal groups all have boundaries concerning attendance. One miss is allowed for groups 10 weeks and under in duration, and two misses for groups over 10 weeks in duration. The ongoing Long Term Interpersonal Groups are allowed 6 misses in the year.

Some of the scenarios that are difficult for us are when a client misses their permitted number of sessions early in the life of the group, then attend regularly and become an integral part of the group. They are engaged with the group and are working on their issues. Then they need to miss as the group is winding down, with only one or two sessions left, usually due to illness, weather conditions, or other seemingly unavoidable situations.

When this occurs we are torn with the need to be consistent as a program, and what would be most therapeutic for that patient and that particular group. To give you a specific example:

In a long term group, one of our participants missed his 6 sessions within the first four months of the group, 2 for holidays, 2 with illness, and 2 to attend to an ailing parent. He then attended for 5 consecutive weeks, was working and engaged with the group. He then missed a group due to a crisis in his work situation, and came back to group in great distress. The decision was made in group to extend the boundary to 7 misses, and he was able to stay in the group. He has not missed any sessions since, and is a hard working member of the group. The worry though is with 6 months to go before the year is up; what if he misses one more session near the end of the group? How would we best handle such an eventuality?

Consultant Response: Anthony Joyce

My name is Anthony Joyce. Trained as a psychologist, I've worked in the same setting since 1981, the outpatient service of a university's department of psychiatry. The service consists of three clinical programs (a psychiatric assessment and treatment clinic and two partial hospitalization programs) and an affiliated psychotherapy research unit. The service is psychodynamic in orientation and places a high priority on group interventions. In the past, I served as a therapist in the clinic. I currently function as the leader of the research team but maintain a clinical role, in both group and individual therapy.

The dilemma described addresses the group's norm for attendance by the members. Such a norm is critical for the group's functioning because of the adverse impact members' absences can have on the process. For example, other members may feel inhibited (or disinhibited) about bringing up issues that involve the absent member, or feel that certain material cannot be expressed without the support of the absent member. A range of feelings regarding absences are possible and their expression should be encouraged. In effect, the norm is based on the rationale that consistent attendance is important to the health of a working group. Attendance is also obviously important to the continued progress of the individual member.

In the situation described, the group norm does not appear to be part of the "culture" developed in the group or in the program. Rather, it appears that the norm is based on a decree by the group leaders that "only X number of absences are permitted." Though not stated, the implication is that a member who logs the tolerated number of absences is then unceremoniously "booted" from group. It's not surprising that the member in the specific example "came back to group in great distress" after recording the tolerated absences plus one—this "rule" must represent something of a threat to the members.

It could also be suggested that the attendance "rule" is experienced as an *autocratic* decree, in the sense that a rationale is not mentioned as having been conveyed to the members. Do they even understand why consistent attendance is a critical element of the healthy group? I offer a double-barrelled suggestion for addressing the bind our correspondent describes. First, the group leaders could acknowledge that decreeing a "rule" about attendance, with an absolute number of absences being grounds for discharge, is perhaps not the best approach to take for groups of responsible adults (i.e., a tacit admission that this approach was unnecessarily infantilizing the members). The leaders could then indicate that they wished to institute a new approach to the issue in *collaboration* with the members. Second, the leaders could go on to educate the members about the rationale for insisting on consistent attendance by making reference to how absences can impact the group process. In line with this rationale, the leaders would want to emphasize that planned absences should be announced early enough for reactions to be considered, and that members should be free to address feelings about unplanned absences on the absent member's return. Certainly, the leaders should also emphasize that attention to the *meaning* of absences in the context of group events and the individual's progress in therapy, at the time of the member's return to group, is also an important task during sessions. The core idea here is that, sometimes, absences are a convenient way to avoid confronting difficult feelings or issues in therapy. This rationale should also be reiterated whenever a new member is being prepared for entry, or begins in group. Addressing the impact or meaning of absences in a productive fashion during the group session will only reinforce the rationale and serve to make it part of the group's culture. Ideally, the members will begin to assume responsibility for addressing the meanings of absences, particularly if defensive, as part of their group therapy process. This approach insures that addressing the issue of

absences is part and parcel of the group process, and not experienced as an arbitrarily imposed standard with penalties.

Consultant Response: Sam Mikail

Sam Mikail is a psychologist and clinical director of the Southdown Institute, a private residential mental health treatment facility serving church professionals. Dr. Mikail completed his graduate work in clinical psychology at the University of Saskatchewan and his internship training at the Holy Cross Hospital in Calgary. It was there that he received the majority of his group therapy training under the mentorship of Dr. Kent Mahoney, Dr. Dennis Martin, and Ms. Linda Goddard. Dr. Mikail's approach to group psychotherapy draws on principles of attachment theory, interpersonal theory, and psychodynamic principles. For the past 12 years, Dr. Mikail has been co-leading a group comprised of church professionals. The group meets for 70 minutes each day and several of the group members are seen by either Dr. Mikail or his co-leader in individual psychotherapy.

The therapeutic frame is an essential dimension of group psychotherapy. It serves to create a safety that allows group members to risk revealing personal vulnerability, forsaking established defenses, and testing new ways of relating to self and others. The frame is created and maintained through group rules and norms, including rules governing attendance and absences, session start and stop times, confidentiality, managing interactions between group members outside of the group, etc. In defining these parameters it is important to consider the context in which the group occurs. For example, in an inpatient or residential treatment program, it is unreasonable, and perhaps counter productive, to insist that group members refrain from interacting outside of sessions. The nature of these programs is such that extra-group interactions cannot be avoided. Often these interactions are an important vehicle for interpersonal growth. A more reasonable expectation is for members to ensure that they are open to exploring what occurs between them outside of group sessions.

Similarly, group rules governing attendance and absence should be guided by the length of the group and the reality of the members, including the leaders. In the group program described, six absences are permitted. Putting aside the members for the moment, let's consider the typical reality of most group leaders. Most professionals have three or four weeks of annual vacation, attend an average of two continuing education events, and are likely to get sick at least once in any given year. This does not take into account absences from clinical duties due to administrative demands, committee work, and so on. For the average, reasonably healthy clinician, eight to ten absences annually would not be unusual. The same is likely true for group members, whether or not they are employed. I would suggest that a maximum allotment of six missed sessions is too restrictive and places pressure on group members that may be counter productive.

Given this analysis, the question becomes, what is a reasonable number of missed sessions? I would suggest that a long term group not have an established number of "permitted" absences. Group members are expected to attend regularly unless faced with an emergency or illness. The group should be told of any anticipated absences (vacations or planned work trips) and the group leader contacted in the event of an unplanned absence. Establishing a norm whereby a group member is dismissed after exceeding a set number of absences is punitive. Instead, repeated or extended absences, including illness and work, can be dealt with as a clinical issue by the leader and other members of the group. In some instances, such

absences may be a form of resistance, escalating as one approaches painful or threatening material. In other instances, absences reflect an unexamined lack of balance in one's life, poor coping, or a lack of self-care or self-worth. Any of these issues constitute rich clinical material that would be unavailable if an individual is terminated or artificially adheres to the norm outlined above. In private practice settings where a leader's livelihood depends on some degree of predictability in income, it is acceptable to establish the number of sessions that can be missed without financial penalty (i.e. paying for missed sessions). The exact number can be defined using some of the considerations outlined above. As for the immediate question, "what should be done with the group member described above?" I would suggest that the program review its guidelines at present and consider revising its rules regarding absences in line with the above recommendations.

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