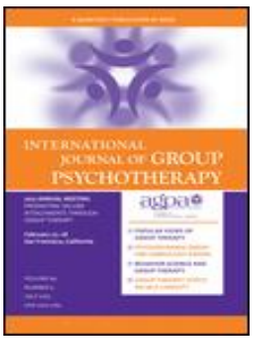

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The Courage of the Group Therapist

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ABSTRACT

This report strives to legitimize for the field of psychodynamic group therapy the reflection on and study of courage. The authors surveyed group therapy leaders, asking them to describe courageous moments in their own group practice, and then explored the common themes arising in these examples, including openly confronting their mistakes, facing their own and group members' anger, and dealing with unexpected moments in group sessions. Attending to courageous leader moments–and the feelings of hope and pride that they engender–help to neutralize the negative emotions that group leaders are constantly invited to contain. Paradoxically, accessing courageous moments can also evoke feelings of shame in the leader. If we are to require ourselves to embrace the sometimes terrifying challenge of journeying into the unknown with our patients, we must learn to be honest not just about our mistakes and our weaknesses, but also about our successes and our strengths.

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The authors remember Dr. Anne Alonso for her helpful comments, while we were writing this article.

> *The world is not respectable; it is mortal, tormented, confused, deluded forever; but it is shot through with beauty, with love, with glints of courage and laughter; and in these, the spirit blooms timidly, and struggles to the light amid the thorns.*
>
> George Santayana, 1905–1906.

With the advent of a two–person psychology permeating the Zeitgeist, a clinician cannot honestly focus *solely* on the *patient's* willingness to do the deep work involved in a therapeutic encounter, be it in the context of individual or group treatment. As Lieberman (1989) writes in an article entitled, "Dyadic Inquiry: The Courage to Know,"

> . . . within the shared experiential field, the transference is illuminated so it meets and intertwines with the analyst's countertransference. What transpires is the analysis of the "here and now" experiences of the patient, his experience of the analyst, the analyst's experience of the patient, and their experiences of their shared reality (p. 115).

If the therapist is willing to meet the patient in such an endeavor, then he/she must consistently display the same characteristics required of the patient. If we can acknowledge and appreciate the courage that it takes our group patients to do the work of exploring and experiencing oneself in the context of the group (Gans, 2005), then we also need to recognize the courage that it takes to consistently lead the group members in this exploration and experience. The authors have three major goals in writing this article on leader courage: (1) to legitimize for the field of psychodynamic group therapy the reflection on and study of positive feelings, (2) to learn about and document what experienced group therapists consider to be their courageous responses, and (3) to acknowledge and celebrate courageous leader moments—and the feelings of hope and pride that they engender—in order to help neutralize the negative emotions that we are constantly invited to contain and deal with.

MAKING THE CASE FOR GROUP LEADER COURAGE

How do we psychodynamic group therapists endure the challenges of group therapy leadership? The rough affective terrain that we encounter makes it difficult for us to keep our footing. Our patients buffet us about with the difficult emotions it is their prerogative to express. They load up the "mother group" with polar opposite feelings that, for a time, they cannot bear and integrate (Malcus, 1995). They bring in their shame (Gans & Weber, 2000) and they shame us (Weber & Gans, 2003). They rebel (Billow, 2003), they lie (Roth, 2004), and they unleash destructive forces (Nitsun, 1996). They often wish to annihilate ambivalently held new members (Rosenthal, 1992) whom we have carefully selected for the group. They envy each other and they envy us (Dubner, 1998); they sometimes diminish each other and us to avoid such envy (Kreeger, 1992). Were it not for our sufficient self–esteem and facility with the therapeutic use of countertransference (Hayes, 1995), their entitlement would unleash our envy, envy that could otherwise easily overwhelm.

Additionally, many of us worry about keeping our groups alive when our group census gets low. Somehow we have to sustain our sense that it is worth our efforts to keep our groups going despite periods of time when our individual patients are not requesting group, our colleagues seldom think to make a group referral, and the frightening and frustrating emotional aspects of running groups, as mentioned above, threaten to overwhelm us.

Group leadership exposes the clinician to other phenomena that can also be extremely stressful. The constant observation by some eight other people heightens the fear of exposure. There are happenings over which the leader has only modest control. The complexity of multiple transferences can defy an accurate understanding of what is taking place. Countertransference impulses such as greed and favoritism are often multiplied. In addition, the leader must cope with frightening fantasies of mob attack and mass exodus. All of these factors add up to leadership being a very challenging and stressful pursuit.

In the face of this challenging pursuit, it is no wonder that several papers address the topics of therapist burnout, countertransference difficulty and the leader's shame, and envy and hate. However, the authors believe that the group leader needs a reminder that there is more to group leadership than those negative topics. As Jamison (2004) writes in her latest book, *Exuberance: A Passion for Life:*

> Psychologists, for reasons of clinical necessity or vagaries of temperament, have chosen to dissect and catalogue the morbid emotions—depression, anger and anxiety—and to leave largely unexamined the more vital, positive ones . . . my colleagues and I have tended more to those in the darkness than to those in the light. We have given sorrow many words, but a passion for life few (pp. 3–4).

Our experience also leads us to wonder how much affirmation group therapists receive in other venues such as supervision or case conferences. How many of us are afraid that in seeming proud of the way we handled a very challenging group situation we will be (silently) viewed as self–serving, boastful, naïve, superficial, or insecure?

Another impediment to an exploration of the group leader's courage is the moral connotation to the word "courage." Indeed, the association of courage with moral writings has clouded the field and left us reluctant to explore the psychological foundations of courage. One way to place the concept of courage squarely back in the psychological arena is to make the connection between the display of courage and Morrison's (1984) notion of the ideal self. Morrison defines the ideal self as "a representation of the goal of perfection in the subjective experience of the self, with failure to approximate that representation leading to a sense of self–defect and shortcoming central to the experience of shame" (p. 479). We as group therapists may need to take risks, to display courage, in order that we meet an internally set standard of the good-enough therapist for our patients. The calibration involved in determining what constitutes a good–enough group therapist is a delicate one.

If we aim too high, if we pursue a grandiose professional ideal (Brightman, 1984), we focus more on the fears to be overcome than on the courage needed to overcome them. The result is a sense of shame. If, on the other hand, we opt for a realistic professional standard, we are more likely to accept our fears and to take pride in the courage to face and deal with them.

REFINING THE CONCEPT OF LEADER COURAGE

One of the challenges of writing this article is distinguishing between the usual stressors in dealing competently with group processes and the more extreme and unexpected provocations that call for a courageous response. Such provocations could occur within the leader, such as feelings of humiliation or dread, or outside of the therapist as when a group member suddenly becomes psychotic or threatens violence. Such a distinction is not always clear-cut or easy to make. However, for the purposes of this article, we explore clinical exigencies that challenge the clinician to act courageously. In these encounters, we step forward not just in our role as therapists but also as fellow human beings. If these moments proceed well, two important affects emerge: hope that enlarges therapeutic space and pride that invigorates leadership.

To try to make this distinction, we should first document the many acquired clinical skills that enable us to deal with uncomfortable, frightening, and painful feelings and situations without considering the notion of courage. We learn what distinguishes therapy from friendship. We discover the differences between being nice and being useful. We understand and interpret transference. We confront where indicated. We appreciate that many natural reactions to our patients are not helpful and many helpful reactions do not come naturally; as a consequence, we strive to use our countertransference for therapeutic purposes. We understand the importance of boundaries and call attention to their violations. However, as a rule, we do not think of ourselves as courageous even though most of us can recall situations in our groups when, in fact, we responded in a way that overcame some of our major fears.

We expect that competent group therapists will possess the above skill set as well as what some might call a "stomach for the work." However—and this is our focus—there are times when we are faced with even more extraordinary affect, and it is at these moments when we are put to the test: Are we able to maintain our engagement with our patients or do we hide behind our role and use technique defensively? It is our supposition that documenting the courage of the group therapist can help us not only to endure but also to optimally function in the midst of the extraordinary challenges of group therapy leadership. To this end, we decided to undertake a study of leader courage.

THE SURVEY

Courage is the mental attitude of facing and dealing with one's fears without any guarantee of a positive outcome. Courageous responses cannot be inferred by simply observing behavior; the same action that reflects courage for one person may constitute fear or cowardice for another. Thus, in order to study the phenomenon of leader courage in greater depth, the authors surveyed 405 certified group psychotherapists in five cities (Boston, Chicago, Houston, New York, and San Francisco), asking them to describe "a courageous moment in their group practice, how or why it felt courageous, and what internal obstacles they overcame in the process." They were asked to describe their emotional and bodily experience of the courageous moment.

We purposely did not define courage in this survey, assuming that the examples of courage that therapists selected would reflect their own idiosyncratic fears and strengths. Thus, while some of their examples seemed commonplace to us, the fear conquered to achieve them was extraordinary. Conversely, some of the examples were sufficiently challenging or even terrifying that they would call for courage from most of us.

We received 30 responses, mostly from senior clinicians whose orientations are mainly psychodynamic but also relational, here–and–now, self–psychological, and psychodramatic; most

have been in practice for at least 25 years. Therapists reported examples of leader courage in a variety of inter–related roles: as group therapists, instructors in workshops and institutes, supervisors, and task group leaders in institutions and organizations.

We classified the responses into the following categories, some of which will be elaborated upon below and which are presented in descending order of frequency: confronting mistakes openly, facing members' and/or our own anger, dealing with the unexpected, facing the devaluation of our skills or our profession, persevering during times of personal crisis, departing from one's theoretical framework or standard practice, standing up to authority, and confronting prejudice and hatred in self and other.

EXAMPLES OF COURAGE

Confronting One's Mistakes Openly

One therapist had the dual roles of administering a step–down program and also serving as a group leader for a psychodynamic process group within the program. These competing roles contributed to her being overly strict about attendance with a patient who, although likable and bright, was paralyzed by shame and self–sabotage and who attended the group only sporadically. Her allegiance to the integrity of the program and treatment frame won out over her attempts to be therapeutic; she told the patient that he could not return to the group. The group was predictably angry at their now former member but even more furious at the therapist for being rigid and not sustaining connection with someone who needed therapeutic flexibility to tolerate any connection at all.

She initially responded internally with frustration and helpless rage at the group's reaction to her but held to the belief that she had acted correctly. Over time, she became dissatisfied with her stance as she listened to the group's appreciation for what the banished patient needed. She reversed her position and tried to re–engage the former patient from her revised perspective. She

told the group that she had made a mistake, "I think that the group contract is very important but the way I enforced it is not the best way of protecting the integrity of the group or its members."

The therapist felt that it was in her complex admission that her courage resided. She admitted her mistake to the group and decided to live in a realm of greater ambiguity where "right and wrong" cannot be so easily invoked or relied upon in absolute terms. She felt good about her willingness to be more human and real, and to live on the level that she invites her patients to occupy all the time.

Courageous responses often occur against the backdrop of a therapeutic relationship that has been appropriately conducted with the therapist occupying a professional role and employing useful therapeutic technique. They also provide patients with a much fuller, more present—one could say a more real—experience of the therapist. This is so because courageous leader moments are often filled with a variety of feelings and states: autonomic reactivity, vulnerability, uncertainty, and transparency, which are not part of patients' usual experience of us. In contrast to the usual professional role of the therapist to which the patient can direct powerful and unreasonable feelings, the courageous leader moment temporarily exposes the therapist as a real person.

This brief glimpse of the therapist as a person reverberates with therapeutic potential. Such moments, as Benjamin (1995) has pointed out, afford the patient an opportunity to recognize the therapist as a person, as well as a presence to be internalized. Just like the mother who is there primarily for the child's growth, development, and well–being, there are those occasional times when the child must experience the mother as a person with limits and needs, and not just as a self–object. Ulman (2001), in discussing the unwitting exposure of the therapist's private life, maintains that these destabilizing moments in the treatment present an opportunity to deepen the exploration of the patient's experience. Indeed, sometimes hitherto denied or repressed feelings surface in the patient and therapist alike. These are moments when the

therapist's being a real person may cause the patient to feel less alone and more able to empathize with another's emotional state.

Deviating from One's Theoretical Framework or Standard Practice

Another respondent described his courageous experience in the context of a therapy group that he ran for individuals who had worked at the World Trade Center and whose company lost over 250 lives during the 9/11 attack. The sessions had been taking place in their office building but, approaching the first anniversary of 9/11, the group asked to meet in the pub where they had mourned their dead friends and colleagues since the attack. The therapist agreed to the change in venues, making a shift in what was already a very permeable frame. Upon his arrival in the pub, the group members were sitting at two tables and were expecting many more colleagues. Already ashamed of this "frame–boundary extension," the therapist joined the group in having a beer and listening to their stories. He stayed for the length of the scheduled group, as people from the company came and went during the night. In doing what he felt was therapeutic although certainly not usual practice for him—changing the spatial frame and joining them in drinking—the therapist felt that it took courage to withstand the criticism of his internalized mentors and teachers.

This example illustrates not only the departure from one's usual practice, but also reflects the category of "Standing Up to Authority," although in this instance the "authorities" were internalized ones. Whether actual mentors and teachers of this therapist would have or should have disapproved of his decision to alter the frame could certainly be argued. While we hope that major deviations from one's standard practice are discussed in supervision or with colleagues, the wisdom of the therapist's decision is less important for the purposes of this article than the felt experience of courage that accompanied his decision. Nonetheless, it is important to point out that there is no necessary correlation between what is courageous for a given therapist and what proves to be therapeutic for the group members. While it was courageous for this thera-

pist to attend the group meeting at the bar, some of the members may have found his presence therapeutic, others might not have. Correspondingly, if it had taken courage for this therapist not to attend, there would likely be members who would have found that decision therapeutic and others who would not.

Persevering During Times of Personal Crisis

A third therapist developed serious complications during the sixth month of her pregnancy that led her to decide to terminate the pregnancy. In thinking about what to tell the all–women's group, she had to decide what she thought the group could handle and what she could say without completely breaking down. In addition to feeling overwhelmed by what was happening to her, she also felt powerless to conceal the public nature of her condition. She decided to tell the group that she was having complications in her pregnancy and would miss the next group meeting because she was going into the hospital for tests. Conveying this information to the group required great courage, given the enormous sense of vulnerability that she was experiencing. Her throat was dry and her entire body was sweaty as she spoke to the group. When she returned to the group after a two–week hospital stay, it took further courage for her to tell the members that she had lost the baby.

She did not reveal what ensued in this group, leaving us with unanswered questions. Did the therapist's admission of her vulnerability elicit concern from the group members and, in the process, deprive them of the space to acknowledge and express such emotions as rage and malice for fear of damaging her? Did the therapist's admission of a terrible loss encourage similar honesty regarding vulnerability on the part of group members? Because leader courage often involves spontaneity, authenticity, risk, and a departure from the usual, group members, caught off guard, often react in ways that bypass usual defenses. The disclosure of new material often results, coupled with a heightened degree of honesty, a turning point in the group's development.

The above example also illustrates how professional training

cannot adequately prepare us for the challenges that await us when there are crises in our personal lives. However, we need to maintain our professional role and be of use to our group members, some of whom may be healthier, at the moment, than we feel. Another therapist found herself having uncontrollable bouts of crying after the break–up of a serious relationship. There were times when she literally wiped away tears before entering her office to run her group. She needed courage to remind herself, despite all of her doubts, that she still had something positive to offer her clients. Fieldsteel (2005) describes the guilt, sadness, and sense of exposure in the complex process of therapist–initiated termination of a group practice. She used this experience of the blending of the personal and the professional aspects of her life as a stepping stone toward a deeper self–understanding. This in turn allowed her to be more available to her group patients in their unique journey towards separating from her and the group, and reminds us of the opportunities provided when we persevere in times of upheaval in our personal lives.

Confronting Prejudice and Hatred in Self or Other

Another respondent recalled an incident when he was a graduate student, working as an intern at a VA hospital where he was invited by a senior clinician to co–lead an inpatient group comprised of Vietnam veterans. The group was informed, and was not happy, that another intern, a Chinese American woman, would also be joining the group as a co–therapist. The intern was not well known to the patients, but those who had met her did not like her. In one session, while the senior clinician was absent, the patients vented their outrage that "a gook" was being brought into the group. Several veterans suffering from PTSD complained that their symptoms were triggered by proximity to Asian Americans and they threatened to boycott the (mandatory) group if she were to join.

Thus the young therapist found himself sitting in a room full of loud, disgruntled Vietnam veterans, many of whom were hurling racial epithets. As he considered how to intervene, he noticed that

his mouth and throat had gone dry and that his heart was pounding. He was terrified by the escalating anger, including his own. Finally, he summoned the courage to speak and said, "God, I wonder what it will be like for Ms. Symbol"´ to come into this group." One of the patients joked, "I wouldn't want to be her, I can tell you that." The therapist replied, "It's not easy to be the different one. But then, some of you already know that all too well." An African American veteran recalled the days when he was forbidden from using public bathrooms or drinking from a "White water fountain." Another man described the shame of growing up poor and being spit on at school for wearing clothes with holes in them. Still another spoke of being spit on and called a "baby killer" when he returned from the war. The therapist felt relieved by this developing empathy towards Ms. Symbol"´ who did join the group the following week.

Beginning group therapists frequently treat very sick patients before they have become comfortable in their professional roles and before they have accumulated clinical experience. Doing so often requires courage. In this example, the therapist was terrified by the intensity of hatred in the group. Although his inexperience precluded his understanding that part of the terror he was feeling was a projection of the members' own fear, he still found a useful way to summon the courage to confront their rage. As a result, the group was able to react nondefensively and, in so doing, address its fear and shame. The pride that he felt as a result of his courageous intervention proved to be an important ingredient in the consolidation of his evolving professional identity.

Another therapist who offered an example of confronting a destructive group consensus explained his fear and initial rationalization as follows: "I'll be hated and thrown out of the human race. I have no right to impose my opinions on others. Why not go along with the flow and run with the crowd?" What allowed him to overcome this fear was his childhood experience of forming intuitive opinions about people and events that proved to be accurate though unpopular. Thus, this therapist defined courage as the "ability to act on one's perceptions without support or even, at

times, without overt evidence, and in the teeth of emotional opposition." Indeed, as Billow (2005) points out, the group treatment of hate requires that the leader "must feel relatively comfortable feeling worthless and useless, guilty for feeling worthless and useless, and guilty for hating the patient for provoking these feelings" (p.147).

Dealing with the Unexpected

The news of the sudden death of a highly valued group member devastated one of the respondents. He reported that sharing the news with his group required a great deal of courage. He knew that not only would he have to cope with the many intense reactions of his group members, but also with his own grief and sense of outrage. In particular, he stated that he was especially afraid of becoming tearful in front of the group (which he did, nonetheless) and anxious about navigating the experience of going to the member's funeral when the rest of the group members decided to attend as well. This was the most difficult moment in his group therapy experience, but one that had profound repercussions for himself and his group that included greater intimacy among group members, a distinct sense that the members felt more trusting of and warmly toward him, and a heightened appreciation of the preciousness of the time allotted to each individual.

Another example that illustrates courage in the face of the unexpected involved a therapist whose experience of courage occurred in a delayed reaction. This therapist dealt calmly and effectively with a group member who became psychotic during the early portion of an intensive workshop, but when the workshop was over, the therapist found that she was shaking all over as she recounted the experience to a colleague.

DISCUSSION

While space considerations preclude providing a detailed description of every example provided, certain aspects of leader courage

embedded in these examples deserve attention. The respondents seemed proud of their interventions. Some seemed pleasantly surprised to learn, as a result of their courageous responses, that they had more inner strength than they realized. Others seemed pleased with the seemingly unusual opportunity to speak of their positive experiences or qualities. The courageous responses reported appeared to exert a positive effect on the therapists' professional self–image that was disproportionate to the frequency of their occurrence. These positive effects appear to help neutralize the toxic emotional field in which we often work.

We also perceive an interesting paradox in reading the accounts of leader courage. On the one hand, we had experienced many of the situations described or could easily identify with those we had not; on the other hand, we realized how infrequently we have heard our colleagues recount such pride–filled moments. Has our training conditioned us to keep our successes to ourselves?

We wondered whether those who failed to respond to our survey request were afraid that, if they could recall one example of their courageous actions, they would be accused of bragging. Perhaps they were concerned about being judged by their internalized supervisors and mentors as dangerous or treading a slippery slope (Slavin, 1998). Perhaps some balked at the term "courageous," due to its spiritual and moral overtones, as we discussed earlier. Another reason that therapists may have difficulty talking about their courageous moments is that courage involves the overcoming of a fear. Admitting the existence of a fear can diminish one's sense of self–worth. Such self–diminishment and its accompanying shame exist in dynamic tension with a sense of pride. Courageous moments can temporarily neutralize fear but not extinguish it. As a result, the sense of shame sometimes trumps the sense of pride. Thus, when therapists recount their courageous moments, they may, paradoxically, be suffused with a sense of shame.

Some courageous leader interventions that appear to be enactments or deviations from neutrality reveal, upon deeper reflection, a theoretically informed response. One respondent described confronting a group member on her tales of her husband's

nearly abusive behavior toward their daughter. While this leader was used to maintaining neutrality and responding to patients' descriptions of their external lives in a more metaphorical mode, the therapist felt that this situation called for a direct confrontation, despite the group member's generally retaliatory style in the face of confrontation. What appeared to be an enactment involving superego countertransference difficulty was actually a thoughtful and courageous response for this highly trained psychoanalyst. Perhaps the fear of being seen as caught up in an enactment is another factor that inhibited potential respondents from sharing their experiences.

Omissions can sometimes be as telling as the examples that are provided. Except for the example of the pregnant therapist and another example of a workshop that partially dealt with sexuality, no other examples dealt with the body or sexuality. We find it difficult to believe that these topics have not led to more group situations that have called upon leader courage. Nitsun (2006) points out that desire and sexuality are key components of human experience that have been marginalized in the group therapy literature. Perhaps the shame that sometimes attends such encounters interferes with therapists' perception of their courage.

CONCLUSION

Groopman (2005) has noted that courage and hope exist in a reverberating positive feedback loop. Not only does a hopeful outlook facilitate courage; courageous responses produce hopefulness. Given the many frustrating and demoralizing aspects of group leadership, anything that generates hope is a welcome and needed factor in our clinical approach. For it is hope, that uniquely human attitude that envisions something that presently does not exist (Reading, 2004), that enlarges the space in which group work takes place.

The authors hope that the examples of courage provided by the respondents will serve to remind us of what it takes to be always present for our group therapy patients, week in and week out. On

the best of days, being a group leader is a demanding job, requiring us to contain and reflect the swirl of projections that enable our group members to do their emotional work. On the most difficult days, it takes not just technical skill but a certain kind of courage to, as Hammer (1973) writes, "not blink away the truth . . . to face inroads into the unknown and the 'unbelievable' in human nature." If we are to require ourselves to embrace this challenge, then we must learn to be honest not just about our mistakes and our weaknesses, but also about our successes and our strengths.

REFERENCES

Benjamin, J. (1995). *Like subjects, love objects.* New Haven, CT: Yale University Press.

Billow, R.M. (2003). Rebellion in groups. *International Journal of Group Psychotherapy, 53,* 331–351.

Billow, R.M. (2005). A sinking depression: Therapist response. In L. Motherwell & J.J. Shay (Eds.), *Complex dilemmas in group therapy.* New York: Brunner–Routledge.

Brightman, B. (1984). Narcissistic issues in the training experience of the psychotherapist. *International Journal of Psychoanalytic Psychotherapy, 10,* 293–317.

Dubner, M.A.P. (1998). Envy in the group therapy process. *International Journal of Group Psychotherapy, 48,* 519–531.

Fieldsteel, N. (2005). When the therapist says goodbye. *International Journal of Group Psychotherapy, 55,* 245–279.

Gans, J.S. (2005). A plea for a greater recognition and appreciation of our group members' courage. *International Journal of Group Psychotherapy, 55,* 575–593.

Gans, J.S., & Weber, R.L. (2000). The detection of shame in group psychotherapy. *International Journal of Group Psychotherapy, 50,* 381–396.

Groopman, J. (2005). *The anatomy of hope.* New York: Random House.

Hammer, E.F. (1973). Creativity in the therapy situation. *Art Psychotherapy, 1,* 1–6.

Hayes, J.A. (1995). Countertransference in group therapy: Waking a sleeping dog. *International Journal of Group Psychotherapy, 45,* 521–535.

Jamison, K.R. (2004). *Exuberance: The passion for life.* New York: Alfred A. Knopf.

Kreeger, L. (1992). Envy pre–emption in small and large groups. *Group Analysis, 25,* 391–408.

Lieberman, P.L. (1989). Dyadic inquiry: The courage to know. *Contemporary Psychotherapy Review, 5,* 113–126.

Malcus, L. (1995). Indirect scapegoating via projective identification and the mother group. *International Journal of Group Psychotherapy, 45,* 55–71.

Morrison, A.P. (1984). Working with shame in psychoanalytic treatment. *Journal of the American Psychoanalytic Association, 32,* 479–505.

Nitsun, M. (1996). *The Anti–group.* London and New York: Routledge.

Nitsun, M. (2006). *The group as an object of desire.* New York: Routledge.

Reading, A. (2004). *Hope and despair: How perceptions of the future shape human behavior.* Baltimore: The Johns Hopkins University Press.

Rosenthal, L. (1992). The new member: "Infanticide" in group psychotherapy. *International Journal of Group Psychotherapy, 42,* 277–286.

Roth, B. (2004). Negativity and lies in analytic group therapy: An inquiry in Bion's ideas of K and –K. *International Journal of Group Psychotherapy, 54,* 477–489.

Santayana, G. (1905–1906). *The life of reason.* New York: C. Scribner's Sons.

Slavin, J. H. (1998). Influence and vulnerability in psychoanalytic supervision and treatment. *Psychoanalytic Psychology, 15,* 230–244.

Ulman, K. (2001). Unwitting exposure of the therapist: Transferential and countertransferential dilemmas. *Journal of Psychotherapy Practice and Research, 10,* 14–22.

Weber, R. L., & Gans, J.S. (2003). The group therapist's shame: A much undiscussed topic. *International Journal of Group Psychotherapy, 53,* 395–416.

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