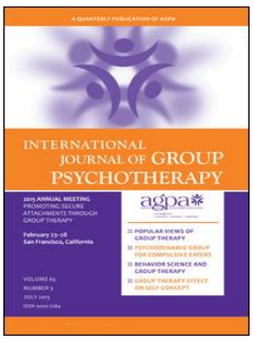

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Adapting Group Therapy to Address Real World Problems: Insights from Groups Offered in the Bahamas

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ABSTRACT

This article presents a cultural adaptation of a group therapeutic approach that is being offered in the Bahamas. "The Family: People Helping People" project was designed as an intervention to improve socialization in New Providence, the Bahamian capital and its most heavily populated city. "The Family" group model offers support and training to improve communication in relationships and to encourage constructive emotional expression. This article will provide an overview of "The Family," address key elements of this approach that are culturally tailored, and offer clinical examples and note implications for group therapy training. This cultural adaptation offers helpful insights for addressing community problems, such as violence and societal fragmentation, and may inform the development of community-based group interventions in other settings.

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Most therapeutic groups are offered in clinical settings on an outpatient or inpatient basis. Community-based groups provide the opportunity for community members to benefit from a therapeutic group experience. A special issue in the *International Journal of Group Psychotherapy* (2015, Issue 4) provided an overview of group therapy around the world and included select European countries, as well as Canada, Egypt, Israel, Australia, and Brazil. As expected, the history of group therapy, access to group therapy training, prevailing theoretical approaches, and the cultural context varied among these countries. In some international settings, such as the Bahamas, where there are few trained group therapists but challenging societal problems that have interpersonal dimensions, it may be even more important to develop group intervention models that maximize the ability of professional and lay persons to provide assistance to community members. Lay counseling models have a longstanding tradition in some religious contexts of professionals providing training to lay persons, and this partnership provides enhanced services to communities (Garzon, Worthington, Tan, & Worthington, 2009; Tan, 1991). Critical considerations in developing community-based interventions would be how the unique features of this specialized group might require a modification of traditional group techniques (Yalom & Leszcz, 2005) and how training and interventions might need to be culturally tailored for this population (Pasick, D'Onofrio, & Otero-Sabogal, 1996).

BAHAMIAN CULTURAL CONTEXT

The Bahamas is an archipelagic nation situated between Florida in the southern United States and Cuba. The population comprises a majority of persons of African descent and a minority of Caucasians originating from the United Kingdom and the United States. Traditionally, the country has been a deeply community-bonded, family-based society held together by strong Judeo-Christian values. However, the countrywide cocaine epidemic of the 1980s and its continuing sequelae, the international economic downturn, post-colonial development issues, and vastly diminished educational standards have led to social fragmentation. This crisis, manifested by widespread family and community disintegration, has resulted in burgeoning murder and violent

crime rates, domestic violence disputes, and the formation of violent youth gangs.

> In response to the social crisis in the Bahamian community, "The Family" is a group-based resocialization intervention designed to confront the prevailing community chaos. "The Family" is based on a group process model. In theory, the group creates a therapeutic replica of a home-based family, allowing members to confront their issues in a safe and nonjudgmental environment. "The Family" provides support and advocacy for its members, allowing them to discover themselves and grow as individuals. More important, "The Family" offers a sanctuary from the normal Bahamian culture, and encourages the expression of emotions that are normally taboo (such as grief, empathy, love, and hope). The primary goal is to improve socialization despite high rates of crime, family disintegration, and economic impoverishment. (Allen, Carroll, Allen, Bethell, & Manganello, 2015, p. 290)

Reduced feelings of anger and decreased desire for revenge have been associated with participation in "The Family" (Allen et al., 2015).

CULTURAL TAILORING

"The Family" was culturally tailored to be consistent with Bahamian values. The American Psychological Association Ethics Code (American Psychological Association, 2002) outlines the importance of cultural sensitivity as stated in Principle E: Respect for People's Rights and Dignity.

> Psychologists are aware of and respect cultural, individual and role differences, including those based on age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language and socioeconomic status and consider these factors when working with members of such groups.

Pasick, D'Onofrio, and Otero-Sabogal (1996) define cultural tailoring as "the development of interventions, training practices and materials to conform to specific characteristics" (p. 145).

In making cultural adaptations of psychotherapy, Hwang (2006) identified six domains:

dynamic issues and cultural complexities, orientation, cultural beliefs, client-therapist relationship, cultural differences in expression and communication, and cultural issues of salience. While all of these domains are relevant, three were particularly central to the development of "The Family": cultural beliefs, cultural issues of salience, and the client-therapist relationship. The predominant religion in the Bahamas is Christianity, with over 90% of the population identifying as Christian. The integration of spiritual beliefs in these groups—and incorporating spiritual interventions—was an important cultural adaptation (Thompson, 2016). Other dimensions of a culturally responsive approach for Bahamians include integrating traditional healing practices, beliefs, ways of thinking, and political and social realities into individual and group practice (Thompson, 2016).

Despite the centrality of spiritual beliefs, there is recognition that religion may be a source of comfort and/or strain (Exline, Yali, & Sanderson, 2000), and members may use religion in maladaptive ways or use negative religious coping. Group leader interventions need to be respectful of this complexity and address maladaptive religious coping (Abernethy, 2012). In "The Family," these maladaptive responses are addressed. In addition, culturally consistent spiritual interventions, such as corporate songs, spirituals, and prayers, are incorporated in the work to foster bonding, group cohesion, and catharsis.

Second, key cultural issues of salience include societal fragmentation, violence, trauma, and shame related to mental health. Members frequently share their emotional, cognitive, behavioral, physical, and spiritual responses to these experiences. Stigma still exists regarding mental illness and therapy. Despite the acute need for supportive services, feelings of shame are associated with mental health challenges and help-seeking. In recognition of this shame, the groups are designed as community offerings to improve Bahamian society rather than an overemphasis on an individual's problems. Individual problems are recognized, but placed in a larger communal framework. This reduces stigma for the individual. In addition, the interactions among societal and individual responses are noted, so that individual responses such as violence are seen in the context of traumatic exposure. The name of the groups reflects a sensitivity to this stigma. Instead of calling the group a therapeutic group, it was intentionally named "The Family" to reflect Bahamian values related

to family. Although there are many different groups with subtitled names that distinguish them, such as East Street, the groups are known and referred to as "The Family." So even in their diversity, they have a common name: it's "The Family" on East Street, rather than the East Street group.

Third, the member-leader relationship is different. While leaders are clearly leaders and facilitators in the group, they are also community members exposed to similar trauma, violence, and community fragmentation. Given a small country such as the Bahamas, members may know the leaders and/or their family members. Members who are mourning a family member may be well known to a leader. This familiarity between member and leader may also be present for community-based groups in rural communities, small towns, and urban community mental health centers. As in all groups, leader disclosure needs to be in service of the group rather than the leader, and a leader's empathy may not only be related to feeling with members, but also to their own mourning. Their ability to disclose their own grief can be a powerful tool for facilitating growth for both members and leaders. There remains a clear frame for the group, but the boundary between leader and member is not as thick as it might be in most groups.

This more porous leader-member boundary also influences training, as members who are potential leaders participate in training. The monthly training that is provided for the leaders and prospective leaders who may be current members of "The Family" seems to provide not only important instruction in group leadership, but also a community of support where leaders have the opportunity to hear didactic presentations and join smaller groups where they are able to share their concerns and obtain support. Leaders are more likely to experience vicarious traumatization, the cumulative effects that occur for therapists related to their empathic engagement with patients who are traumatized (McCann & Pearlman, 1990). In a qualitative study of peer-nominated master therapists, several protective factors were identified as key for mitigating the effects of traumatic exposure: countering isolation (in professional, personal, and spiritual realms); developing mindful self-awareness; consciously expanding perspective to embrace complexity; active optimism; holistic self-care; maintaining clear boundaries; exquisite empathy; professional satisfaction; and

creating meaning (Harrison & Westwood, 2009). Several recommendations were made to combat the challenges of isolation, including ongoing involvement in consultation and supervision as well as being connected relationally in communities of support. Small group consultation and supervision that is offered only to leaders also provide important support and an opportunity for reflection and addressing countertransferential concerns.

DEVELOPMENT OF "THE FAMILY"

"The Family" is a supportive process-oriented community-based group intervention. The approach is an integration of interpersonally oriented, role-playing, and supportive techniques based on the Contemplative Discovery Pathway Theory (CDPT; Allen et al., 2014). The CDPT describes the process where shame ("Self Hatred Aimed at ME") impedes the development of a true self. It is proposed that early experiences block the child from adequate unconditional love and as a result lead to the shattering of their dreams of safety, meaningful relationships, and a sense of empowerment. The related pain from this and other trauma contributes to cultivation of a Shame Self involving abandonment, rejection, and humiliation. Shame is such a powerful, ubiquitous master emotion that it challenges the individual's psyche. An individual compensates by developing a defensive Shame False Self involving self-absorption, self-gratification, and control. The Shame False Self, a pervasive rescuer, hijacks lives into the wilderness of fear and leads individuals away from authenticity. A process of desocialization occurs in which individuals become victims of the negativity of shame, where they think less of themselves, others, and their community, and they may engage in destructive behavior. In contrast, resocialization may be defined as the process of becoming liberated from the negativity of shame to move beyond one's limitations, and to experience one's potential, characterized by the positive emotions of love, humility, forgiveness, and gratitude. In "The Family," the loving support of the group allows members to share their stories. As they surrender the grief and shame of their pain, they release their negativity and destructiveness and embrace the positive healing emotions of love and support. As a result, the Shame False Self melts away, giving rise to discovery of the Authentic Gracious Self

characterized by love, community, compassion, humility, and gratitude.

Sharing painful experiences in a contemplative atmosphere of love, mindfulness, and non-judgmental listening develops a powerful healing bond. Referring to Daniel Siegel's work, Kurt Thompson explains that recent studies in neuroscience have demonstrated that empathic listening can "re-wire" our thinking.

> An important part of how people change—not just their experiences, but also their brains—is through the process of telling their stories to an empathic listener. When a person tells her story and is truly heard and understood, both they and the listener undergo actual changes in their brain circuitry. They feel a greater sense of emotional and relational connection, decreased anxiety and greater awareness of and compassion for others' suffering. Using the language of neuroscience, Dr. Siegel labelled the change as "increased integration." (Thompson, 2010, p. ix)

"The Family" started with one group in 2009, but has now grown to 30 groups offered to over 500 members. Some of the groups are smaller, with 8–10 members, but a few are larger groups of 25–40 members. The groups meet for two hours and are open-ended. There is no fee for the groups. New members are expected weekly and attend the groups following an initial assignment based on either a phone intake and/or screening if they are referred by a mental health or law enforcement professional, are on medication, or have a history of domestic violence. Prospective members are screened by the mental health staff from "The Family." If members have significant mental illness, they are referred for psychiatric treatment. Similar to an inpatient group with fluid membership, leaders manage the arrival of new members and also seek to foster group cohesion. Members typically stay for over a year. Participation is optional, with interaction being guided by the leaders. The facilitator provides a summary at the end of each session and offers a psychological/spiritual teaching to foster education and character development.

DEVELOPING A SPECIALIZED GROUP

"The Family" project has developed a group approach that fosters the inclusion of some of Yalom's traditional therapeutic factors: interpersonal learning, imitative behavior, universality, self-understanding,

and the instillation of hope. Yalom and Leszcz (2005) highlight three considerations in developing a specialized group: assessment of the clinical situation, formulation of goals, and modification of the technique.

Assessment of the Clinical Situation

Key factors in assessing the clinical situation include the number of patients, availability of co-leadership, type and severity of pathology, and duration of therapy. The frame for these groups, including decisions related to the number of members and the duration of groups, is more flexible. Haim Weinberg (2016) in the 2016 Annual Foulkes Lecture, "Impossible Groups That Thrive in Leaking Containers," describes the importance of greater flexibility in frame-related dimensions of certain groups, such as trauma-focused, demonstration, and community-based groups. Given that these groups are offered in a community-based versus treatment context and the urgent need for support, "The Family" was designed to reach more members than most treatment groups, and the groups are typically larger in size and may range from 8 to 40 members. Most of the groups have between 12–20 members. In the groups that have more than 12 members, there are typically two primary co-leaders and one to three additional leaders in the group. In addition, the leaders of these groups include professional and trained community members. Some of the leaders are former group members who have been trained in group leadership.

It was recognized that these groups would not be for patients, but for community members in various settings and locations including church sites, juvenile delinquent settings, prisons, and homeless outreach settings. While the severity of problems and pathology facing these group members varies greatly, they share common difficulties related to shame, loss, exposure to violence, and societal fragmentation.

Formulation of Goals

Despite the diverse backgrounds, unique problems, and pathology of its members, common goals are identified. The theoretical lens of listening for the development of the Shame Self and its associated

challenging affects, including hurt, pain, and anger, and moving toward a process of resocialization, provide a common context for articulating goals for members. Members may identify early or current experiences where they did not feel valued and express a sense of shame or sadness related to them. Others may present with anger and a desire for revenge in response to the violence directed toward them or a family member. Their shame may be associated with the recognition that this retaliation is not appropriate even if they believe it is justified. There is a focus across groups on shame as a response to deep hurt and rejection and related feelings of worthlessness, hopelessness, and helplessness. Members expect group members to respond in a similar unloving and rejecting way. The group offers a corrective emotional experience. Common goals in these groups include the development of interpersonal skills, self-esteem enhancement, anger management and conflict resolution, revenge elimination, community bonding, affective learning, and mature spirituality.

Modification of Technique

In addition to the clinical situation and goal articulation, these groups required a modification of technique. First, the common presence of more than two co-leaders with varied levels of professional training complicates the process. As noted earlier, the role of the group leader is different in these groups due to the leader's level of group training as well as the size of the group. All groups are led by a trained therapist who may be partnered with one to three lay facilitators who have received training in group facilitation provided by psychologist Dr. Marie Allen. Dr. David Allen is centrally involved in the training of the core professional leaders as well as the lay group leaders. Typically, leaders receive monthly day-long training over the period of a year before they lead a group. Ongoing consultation and supervision frequently address the challenges associated with group size, varied pathology in the groups, and co-leadership. While the two primary leaders are identified and the most active, the additional leaders may intervene, especially either in response to an invitation by the co-leader or in response to affective expressions, such as crying, that might be occurring in their physical proximity. At other times, members may move to different chairs in order to be closer to the

primary co-leaders and continue their work there. While a leader's secure presence is important in all groups, Weinberg (2016) argues that more flexible boundaries are possible in these "impossible groups" in the presence of a leader with a secure presence. This security and stability is a critical counterbalance to the volatile and traumatizing context of members' lives. The secure presence of the leader helps to contain the group: often the senior professional leader embodies this presence.

Although certain groups may incorporate the arts in the work, a unique feature of "The Family" is the spontaneous use of song during the process. The use of song in "The Family" is consistent with the salience of music in Bahamian culture. In addition to a closing song, music is typically introduced by the leader at unpredictable moments; these songs, often spirituals or hymns, foster cohesion, express the unexpressed, or deepen emotional connections. A common spiritual sung frequently in group is, "Sometimes I Feel Like a Motherless Child;" this song has a key phrase, "a long, long way from home." In "The Family," home represents the place of safety, peace, and rest, a place where one experiences the positive emotions of love, humility, forgiveness, and gratitude. This particular song captures universal themes of abandonment, loneliness, and sorrow, and more recently has helped to express the increasingly unrecognizable landscape of a violent, disintegrating Bahamian society. In some ways, these spontaneous songs serve as a musical metaphor. Abernethy (2002) noted that, "to engage with others' metaphors provides an opportunity to connect with their creativity and their individual and cultural selves" (p. 220). Metaphors may catalyze group process and promote understanding.

Flow of a Typical Group

While the integration of meditation is more common in some groups, a typical "Family" group begins with a period of guided meditation and silence that is culturally tailored to the natural beauty of the Bahamas. Participants are encouraged to relax, breathe deeply, and focus on the color blue, which characterizes the Bahamian sea and sky. The technique seems particularly effective in allowing members to come home to themselves. Members

of the prison groups, for example, have reported that the exercise is deeply liberating, as they can see the sky and imagine themselves afloat in the clear Bahamian ocean. Through deep breathing, clients move into a deeper sense of consciousness by blocking the incessant flow of thoughts, preparing them to allow their authentic stories to emerge. Depending on the situation, the silent meditation ends with a brief prayer asking God (or a higher power) for guidance and healing in the group. At this juncture, new members are welcomed, and individuals who are willing to share their stories, disclose. "The Family" facilitators are trained to demonstrate and encourage member sharing within group sessions. If there is resistance, a facilitator may share some aspect of his/her personal story from the week, or ask the group about community incidents, perhaps a shooting death, violent crime, or other tragic event.

The posture that is cultivated during "Family" sessions is one of listening, allowing participants to open up, not only to the content of what is shared, but also to the sense of connection and bonding that may occur among group members during a given session. When something deeply painful is shared, such as childhood sexual abuse or the murder of a relative, facilitators are trained to call for a period of silence to allow members to feel what is occurring and to digest their thoughts. These points are labeled "holy moments" because they represent the "still point" or the "now" (Eliot, 1944). The still point occurs where chronological pain is intersected by the feeling of love or the "kairos" of God's presence. In "The Family," the still point often occurs in deep silence as a sense of oneness develops in the group. Often, the still point seems to invite members to share at an even deeper level. For example, a person might share how he had watched his wife being murdered. The facilitator responds by calling for a still point. Following group silence, the facilitator asks whether the person wants to share anything else. The group is then asked how this story affects the "Family." When members genuinely share, there is a ripple effect that tends to open and deepen the moment for the entire group.

At one session, a woman—one of six sisters molested by their father—expressed a desire to share. She had been in the group for three months, saying very little, often with tears streaming down her cheeks. On this day,

she was finally able to express the pain of having been threatened by her father to keep the incest a secret. Over time, most of her sisters had died. Suddenly, she erupted into a loud, cathartic scream that continued for almost two minutes. The moment was deeply touching. It so resonated with members that others who had experienced abuse in their lives joined her in the scream. Others remained silent, some crying, some meditating, others praying. Later in that session, the group processed this experience.

Such group sessions frequently unleash "hot points," moments when someone says something that jolts the group: "I was abused," "My grandson was shot and killed," "Someone was murdered in front of me on Wednesday afternoon," "Somebody shot me," or "Someone raped me." Facilitators are trained to recognize hot points and process them.

Unaddressed hot points can lead participants to rationalization and intellectualization, and they can create an "elephant in the room" that overwhelms the group session and might eventually threaten the group itself. One of first principles of "The Family" therapeutic groups is to help its members become healthy through authentic self-expression. Hence the mantra, "Jaw-jaw stops war-war, " that highlights the importance of talking versus engaging in violence, resonates deeply within the group. A related principle involves helping group members move from alexithymia to discernment between thoughts, feelings, and behaviors. Many members are able to recognize thoughts but repress feelings and go directly to behavior (violence). "The Family" works to make sure the process of the group identifies thoughts and remains open to feelings. Over time, individual and group behaviors tend to become more responsive and less reactive.

As sessions near their end, facilitators may call for another "rest period" of silence. Then the facilitator may call for a song, or a group member may "raise a chorus" like "Be Still and Know That I am God" or "We Shall Overcome." Negro spirituals and gospel songs have powerful resonance in the Bahamas, which has strong kinship affiliation with African-American communities in the Southeastern United States. In the two most marginalized "Family" groups, one hymn closes almost every session: "Blessed Be the Tie That Binds." This hymn provides comfort, strengthens community, and inspires members to face life with new determination and drive.

KEY MECHANISMS OF CHANGE

Yalom and Leszcz (2005) have identified imitation, identification, and internalization as key mechanisms of change that occur in typical groups. In "The Family," at least two of these mechanisms are operating as members engage in imitation and identification. The leaders assist members in working through feelings of shame, sadness, anger, and revenge. Allen and colleagues (2014) note that, "developing a meaningful therapeutic alliance with a client in therapy requires patience, understanding, and compassion. As the client re-experiences shameful thoughts and events, the therapist may become a disavowed object of hate, rejection and disgust" (p. 3). In "The Family," the leader may not only become a negative repository for these affects, but also have the potential to become a positive transferential object. This use of positive and negative transferential feelings is consistent with psychodynamic approaches.

In addition to the leaders, members learn from more seasoned members and imitate healthier responding. Role-playing is sometimes in dyads with a leader, but also may involve two members. Members have the opportunity to shift roles and gain more insight into and empathy for other members' perspectives, including the perpetrator and the survivor.

Abernethy (2009) noted that when a person has been offended, he/she has an opportunity to follow models that encourage scapegoating and sacrifice (pursuing justified blame, including revenge-seeking and retaliation) or to imitate the desire of God, who demands mercy and not sacrifice (transcending blame). "The Family" provides individuals with models of an orientation toward transcending blame in response to relational offense. These include peer, group leader, and spiritual models. If individuals seek to follow this example, this destructive cycle is reversed, relationships are healthier, and more positive health outcomes may emerge. A transcending blame (non-sacrificial) perspective moves away from a focus on justified anger, penalty for disobedience, and violence and moves toward forgiveness, transformation, healthier individuals, relationships, and communities.

CLINICAL ILLUSTRATIONS

Poverty and Social Deprivation

Rejected by his family, John left home at 13 years of age to fend for himself on the streets. Living on the beach and in abandoned buildings, John hustled daily to make ends meet. He was severely abused—physically and sexually. Later on, John was shot in his face and side and admitted to the hospital. On the third day of his hospitalization, the person who shot him was also shot, admitted to the same hospital, and placed two beds away. Angry and filled with thoughts of revenge, John wanted him dead. The next day, John's gang came to the hospital, seeking to kill the person who shot him. They begged John to point the shooter out to them, but he refused. Instead, John surrendered his feelings of revenge and prayed for a better life.

After being released from the hospital, John experienced further challenges. He wound up living in a tomb in one of the cemeteries before eventually being referred to "The Family." Facing a loss of confidence in himself, John was shy, ashamed, and unable to speak. The group was very receptive and showered him with love, giving him odd jobs, clothes, food, and money. After a number of sessions, John began to speak freely and socialize with the participants in the group. A few months later, he shared that when he first came to "The Family," he felt his life was hopeless. He said he is now determined to live again because of the love he found in our sessions. John is still in "The Family," has a job, and volunteers in "The Family" basketball outreach program to marginalized youth.

Discussion. John's early life experiences were characterized by neglect and abusive violence directed toward him. These experiences resulted in his feelings of shame, low self-worth, and anger. "The Family" provided him with a corrective emotional experience, where instead of being violated, he was supported and affirmed. The leaders and members demonstrated genuine care for him and continued to work toward reducing his desire for revenge. They provided feedback and support, which encouraged him to learn how to effectively relate to others and to share his emotions in a constructive way. Consistent with the collectivistic cultural context of these groups, not only was emotional and informational support

provided, but also tangible support, including financial and other resources. While this might pose a challenge in traditional therapy groups—and the meaning of these exchanges would need to be weighed—this was an important part of the socialization and supportive process. For some, this mutuality might be considered confusing or a potential frame or boundary crossing, but it also might be a way of understanding the power of "The Family" in this communally oriented country. A more porous boundary does not mean that there is no boundary.

Revenge and Its Destructive Effects

Many people in "The Family" have experienced either murder, violent attack, or abuse of a loved one. As a result, revenge is a major issue in "The Family" and may include wanting the perpetrator killed or his family injured.

A young woman visited "The Family," and after sitting quietly for a while, she shared that her only sister had been murdered by her husband. As the group listened attentively, she said, "I am angry, and I want revenge. My sister is dead, and I have the responsibility of now caring for all of her children." Suddenly, she stopped and said, "This is too painful. I can't talk about it." As the group waited in silence, the facilitator asked her if she would join him in a role-play in which he would act as her sister's husband. After much reluctance, she finally agreed. The woman and facilitator moved into the center of the group. As the facilitator looked at her, she screamed, "I hate you! I hate you! You killed my sister! You are an animal and I hope you suffer the rest of your life! Do you know that you destroyed our whole family? We knew that you were no good for her. You always tried to keep her from us. You would never let her come to our family gatherings. Now she is gone. I wish you were *dead*!" Then, she suddenly stopped. Looking intently at the facilitator, she said, "If you are bad enough, come out on bail and you'll see what happens!"

Shocked and confused, the group again became silent as she wept profusely, shaking her head in disbelief and pain. The group ended, and people slowly and reverently left. Saying goodbye to her, the woman expressed to the facilitator that she felt relieved at being

able to release her pent-up feelings. She was visibly shaken. Thanking her for coming, the facilitator responded, "Letting go of painful, revenge feelings takes time, patience, and is a long, long journey."

Discussion. This interaction allowed the facilitator to become a repository for this woman's anger and frustration. She was able to express both her anger and her desire for revenge in a safe, supportive place. The leader modeled a secure presence for her to express her anger and her sadness. While the intensity of these feelings may have scared her and other members, the group was able to bear the intensity of this pain. The facilitator did not resolve these feelings, but offered compassion, hope, and perspective that the process of healing is a journey. This modeling was important, as other members had similar feelings and were encouraged that the group, particularly the leader, could handle the intensity of their affect. The collective, reverent response of the members also conveyed a sense of solidarity in this pain so the member was able to experience universality as she became aware that she was not alone in her feelings.

CONCLUSION

This innovative community-based group approach for responding to societal fragmentation builds on standard group therapeutic principles, but it also extends and adapts these approaches to tailor them to the cultural and psychological needs of the community. This adaptation can serve as a model for community contexts where there are few mental health professionals, where there is a need to serve a large number of people, and where there are significant challenges related to community violence and societal fragmentation. While there are potential challenges associated with this adaptation, including boundary crossings, leader disclosure, and vicarious trauma, these groups also seem to possess a potential for change and transformation. Members who might otherwise follow a destructive spiral toward violence have the opportunity to engage in a group experience that offers an opportunity to work through these associated feelings and to imitate member, leader, and spiritual models that transcend blame and eschew violence. "The Family" illustrates how community-based (or embedded) groups may be designed to accommodate the cultural

context and how classic group therapy may be adapted to be responsive to real world problems. Principles from this adaptation could inform work in other settings where community members are exposed to violence and trauma. Responsivity to the unique cultural values of these settings would be a critical component of this adaptation and increase the likelihood of fostering change for individuals and communities.

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