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Whittingham's text is a rich, accessible, and creative synthesis of the evidence base that guides the expert practice of focused brief group therapy (FBGT). FBGT is tailored to real world, time-sensitive, clinical environments. The FBGT model comes to life through Whittingham's illuminating the central importance of interpersonal communication and connectedness, and the powerful ways group therapy fosters that connectedness. This book will be of great value to both beginners and experienced group therapists, students, and teachers.

—**Molyn Leszcz, MD, FRCPC, CGP, AGPA-DF,** Professor of Psychiatry, University of Toronto, Toronto, Ontario, Canada, and Past-President, American Group Psychotherapy Association

This book is an incredible resource for group therapists of all levels of experience—from graduate students to advanced group therapists. Whittingham seamlessly integrates evidence-based theories and assessment into a new model of focused brief group psychotherapy that offers short-term group treatment to people with diverse needs, including interpersonal struggles and loneliness. His model can be applied to groups in private practice, counseling centers, and hospital settings. He focuses on research-based assessment, thoughtful screening strategies, and important interventions for before and after group therapy begins. Readers will be able to quickly apply his model as he has provided many interesting and useful clinical examples throughout his book. I will definitely recommend this book to my students learning group therapy and to colleagues who are looking to strengthen their group practice.

—**Cheri L. Marmarosh, PhD,** licensed psychologist in private practice and associate professor, George Washington University, Washington, DC

Whittingham takes an empirically sound model of interpersonal interactions and applies it skillfully to create an innovative brief focused group therapy. This book is a must-read for anyone who wants to do brief group therapy that goes beyond simply educating patients and that harnesses the power of groups to create lasting change. Whittingham blends the best research evidence and clinical wisdom in his focused brief group therapy model.

—**Giorgio A. Tasca, PhD,** Professor, University of Ottawa, Ottawa, Ontario, Canada

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INTRODUCTION

Overview and Rationale

Relationships provide the fuel for our happiness. Longitudinal data from Harvard's study of adult development (Waldinger & Schulz, 2023) showed that the most significant factor in lifelong happiness is the quality of social relationships. The authors described the concept of *social fitness*—of being able to navigate relationships successfully—as an essential component of that journey. Thus, our lifelong happiness is significantly determined by how successful we are in establishing and maintaining high-quality relationships. However, problems in relationships can also prove problematic to people's well-being. Such problems have been particularly pronounced in recent years: Loneliness, for example, has been described as an epidemic (Weissbourd et al., n.d.).

INTERPERSONAL RELATIONSHIPS AND MENTAL HEALTH

The importance of interpersonal relationships has catapulted into the public consciousness in the past decade. In a summary of loneliness research, Heu et al. (2019) reported that loneliness increased in the United States from

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11% to 17% in the 1970s to more than 40% for those middle-aged and older in the 2010s. They also pointed out similar increases internationally. COVID-19 lockdowns brought a heightened focus on the role of loneliness in mental health. People locked down in their homes were unable to establish or maintain the social relationships necessary for their sense of well-being; as a result, mental health problems worsened across the world (Ernst et al., 2022; T. Wu et al., 2021). Concerns emerged that loneliness would cause significant increases in mental health problems (Killgore et al., 2020). This focus on the connection between relationship quality and mental health honed in on how interpersonal relationships contribute to one's mental health.

Loneliness

Mental health problems are closely tied to poor relationships and loneliness, and research has shown that loneliness is linked to everything from depression, suicidality, and social anxiety disorders to personality disorders (Beutel et al., 2017; Lutz et al., 2020). As Marmarosh et al. (2009) pointed out in their review of the literature, attachment style—the corollary of interpersonal style—has shown that insecure attachment impacts how people cope with stress (Mikulincer, 1998), regulate affect (Fonagy, 1999; Fonagy & Target, 1997; Fonagy et al., 2002, F. G. Lopez & Brennan, 2000; Schore, 2000), how they relate to romantic partners (Collins, 1996; Collins & Read, 1990; Mikulincer, 1995, 1998), how people deal with conflict in close relationships (Simpson et al., 1996), and how they deal with the transition to adulthood (Rholes et al., 2001). Further, depression, substance abuse, eating disorders, and suicidal ideation all have links to problems with attachment (Dozier et al., 1999; Flores, 2006).

The link to suicidal ideation is particularly notable. Studies have shown that increased levels of suicidal ideation relate to thwarted belonging and loneliness (Ogrodniczuk et al., 2023); that is, people's inability to meet their needs in terms of desire for relational connection was strongly related to thoughts of suicide. As Klonsky et al. (2021) described in their three-step model of suicide, now one of the most cited models in suicide research and treatment, "Whereas pain provides the push away from life (Step 1), connectedness provides the pull toward life (Step 2). Thus, connectedness can make life worth living (despite the presence of pain that is not expected to abate)" (p. 2). They found that pain *plus* loneliness and then lack of connections to others were responsible for two of the three steps toward suicide (with the third step being capability). Thus, connectedness and belonging form important mediating and protective factors against an increase in suicidal ideation. Satisfying relationships make us more resilient.

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Rejection and Pain

Social connection is also something that can be broken, and the consequences can be equally deleterious. Research has shown that social pain, such as rejection, ostracism, and betrayal, lasts far longer in the memory than physical pain (Meyer et al., 2015). Social pain leaves an indelible mark that people can relive throughout their life span. The pain of exclusion, according to research, mirrors that of physical pain in our brains (Eisenberger et al., 2003; Kross et al., 2011).

Relationship Quality

Whether loneliness affects mental or physical health, the scientific literature is clear about loneliness as a definition. It is not always just social isolation. Rather, loneliness is a dissatisfaction with either the quantity or quality, or both, of one's relationships. Therefore, loneliness depends on many factors, ranging from personality and attachment style to cultural expectation or contextual factors (Ernst et al., 2022). It is not just the absence of relationships but can also result from the presence of unsatisfying relationships. As Albert Schweitzer reportedly once remarked, "We are all so much together, but we are all dying of loneliness" (Leavitt, 2022, para. 4).

While other humans have the capacity to be our greatest source of joy, they also can cause us the most pain. A large-scale international research study found that the leading cause of nightmares across the world is interpersonal aggression and the top-rated cause of bad dreams is to be in conflict with others (Robert & Zadra, 2014). Feeling misunderstood, taken for granted, dominated, betrayed, ridiculed, ignored, overlooked, and attacked are feelings that lead to sleepless nights and angst and can sometimes cause life-changing reactions. If love, joy, passion, closeness, connection, belonging, and moments of intimacy are what make life living, then the worst human interactions can provide the pain and suffering that lead to misery.

Conversely, the presence of positive relationships provides broad-based effects and impacts on mental and physical health. Pietromonaco and Collins (2017) in an overview of the field pointed out three main benefits of positive relationships: (a) support to moderate against stressful life events (i.e., safe haven support); (b) support when striving to meet goals and trying new things (i.e., secure base support) and cheerleading during positive life events; and (c) love, intimacy, and belonging. These and other factors not only provide protective factors against mental health episodes, but they also promote movement toward physical health and existential goals.

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RELATIONSHIPS AND PHYSICAL HEALTH

The link to physical pain extends beyond just experiencing it as equally acute. Relationship quality and quantity have also been found to affect not just happiness and mental health but also physical health. The absence of or poor quality of relationships has been shown to shorten life spans and increase the risk of physical diseases, such as cancer, heart disease, and even joint pain (Mushtaq et al., 2014; Quadt et al., 2020). This action occurs through the mechanism of *cortisol*, a hormone released when the body is under stress (Cole et al., 2015). The persistent presence of cortisol resulting from loneliness acts as an inflammatory agent in the body, creating a negative impact on organs, musculature, and physiological functions.

Further research has pointed out that loneliness also has downstream effects. It can lead to unhealthy coping behaviors, such as overeating, excessive drinking, and smoking (Kassel et al., 2003), all of which have health consequences. Research has suggested that loneliness may have as much impact on mortality as smoking seven cigarettes a day (D'Ippolito et al., 2017), leading to a life expectancy that is shortened by 15 years.

However, much as we would wish for a utopian life in which everyone treats everyone else with dignity and respect, a more realistic stance is to be able to move toward responding as effectively as possible to the meet the challenges of connecting to others. People can seldom control how others respond to them, but they can be at play in determining how they approach and respond to others. Although this stance will not magically solve every situation and will not result in permanent blissful happiness, it will allow people to be more agile in pursuit of what they want from relationships and to ultimately find ways to make relationships more satisfying and meaningful. So, how can psychotherapy help?

TREATMENT FOR INTERPERSONAL PROBLEMS: FOCUSED BRIEF GROUP THERAPY

With constant innovations in mental health ranging from use of genetic testing and brain mapping to psychedelic-assisted therapy, it is easy to forget the practice of mental health is based around the *biopsychosocial model*, which posits that social aspects of functioning are one of the primary factors in mental health. The endurance of this model as a premise is based on decades of supporting research. It all points to one major thing: Humans are social animals (Aronson, 2018), and treatment should address social relationships. People are hardwired to live and function in groups, and although societies and individuals within them find different ways to coexist, the need for

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human contact is universal (Feldman, 2017). As Stack Sullivan (1947) first pointed out, a great deal of human distress and symptomatology emerge from problems with relationships. Therefore, carefully evaluating and treating the cause—difficulties in relationships—should be a central part of any treatment.

Establishing treatment pathways requires an understanding of the core constructs underlying interpersonal problems. Sheffield et al. (1995) found a clear correlation between mental health problems and interpersonal distress (see also Hardy et al., 2011), and a recent study even showed links between interpersonal cognitive inflexibility to greater problems related to individuals with psychosis (García-Mieres et al., 2020).

Focused brief group therapy (FBGT) is a model that addresses the underlying causes of interpersonal distress. It is a semistructured, integrative, interpersonal process group approach designed to reduce interpersonal distress in fewer than eight sessions. FBGT offers a greater application to a wider range of clients and engenders improved client flow in an agency or practice. It is also transdiagnostic: FBGT addresses etiology, not symptomatology. It is a strengths-based approach that tailors treatment transparently and collaboratively around the client's strengths as well as their self-identified highest level of interpersonal distress. This model is designed to address loneliness and belonging by helping the client either develop new relationships or improve existing ones. The approach allows the therapist to blend the science and art of therapy, strengthening the working alliance so that treatment goals are both achievable and measurable. By marrying process-based therapy with individualized treatment goals, FBGT provides a means of providing focused treatment in a way that accelerates change (S. C. Hayes et al., 2019).

FBGT also blends principles and techniques from Yalom and Leszcz's (2020) interpersonal process model, interpersonal circumplex theory (Horowitz & Strack, 2011; Kiesler, 1996), and measurement-based care (MBC; Lewis et al., 2019) into a multiculturally responsive (Owen et al., 2011) model of therapy. FBGT is based on the idea of mobilizing evidence-based processes and evidence-based relationships (Burlingame & Strauss, 2021; Norcross & Wampold, 2011), that is, how to use all that is known about the evidence-based processes in therapy at every stage of treatment. It relies on the fact that evidence-based relationship variables between the therapist and the client (and also between the group and the therapist) offer considerable explanatory value for the size of treatment effects. Wampold and Imel (2015) showed that effect sizes for relationship variables, such as the alliance, unconditional positive regard, and multicultural competence of the therapist, accounted for stronger outcomes than specific techniques in therapy.

More recent evidence is now also showing that the use of MBC has a statistically significant impact on treatment (Lewis et al., 2019). This set of learnings

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infuses FBGT throughout. Evidence-based relationships inform every aspect of treatment, including serving to enhance outcomes and reduce premature dropout. These relationships work within the idea that being multiculturally sensitive and responsive is an essential part of being evidence based (E. C. Chen et al., 2008). Further, FBGT involves developing methods to help therapists work better with clients who typically are considered "difficult to treat." FBGT is part of a new wave of therapies that are process based and led by evidence-based, relational mechanisms of change that have been proven to work (Hofmann & Hayes, 2019).

Interpersonal Flexibility and Mental Health

Reducing interpersonal distress in ways that feel meaningful to a client can have an impact on their overall distress (Allison & Whittingham, 2017). *Interpersonal flexibility*, the ability to adapt to various interpersonal responses and situations—and the main mechanism of change in FBGT—has been linked to improved mental health (Wei et al., 2021), and working on becoming more proficient in meeting needs of the self involves expanding skills in being able to manage the needs of others.

FBGT work focuses on reducing a client's highest interpersonal distress score by adding interpersonal behavioral options. A greater range of behavioral choices allows for the client to have a broader range of possibilities for adaptively responding to situations (Wright et al., 2022). This is an important concept. Sometimes people's interests are served by getting along with others or sometimes by standing up for themselves, even at the cost of a relationship or a wide range of responses in between. People's value systems, sense of identity, cultural and religious beliefs, career goals, dreams, and aspirations are all lived out in the social sphere. Without the skills to navigate that sphere, the choices that might lead people to their goals and having their needs met become more elusive. For one person, this might mean finding ways to ease back on pleasing others at the expense of themselves. For another, it might mean finding ways to let go of the need to excessively protect themselves in situations in which they are seeking intimacy.

Each person has their own set of life goals, from achieving career success to establishing relationships, managing a romantic relationship, or just living their own truth. Whatever a person's raison d'être, they also bring a different set of social strengths *and* inflexibilities to the table. People are capable of considerable interpersonal skills, but it is not uncommon for them to develop along narrow corridors of functioning. One person might be a highly skilled arguer, who lays waste to courtrooms with precise language, skilled oratory, and ruthless confrontation of inconsistencies. However, at home, this same

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person may not always find it as easy to meet the emotional needs of their partner or to offer softness and warmth to their child. Everyone has blind spots in their interpersonal functioning: Sometimes they are highly skilled in one or more areas but may have large deficits in functioning in others.

That lack of skill may be difficult for others to identify because it is easy to be blinded by high levels of functioning in areas of strength, such as a CEO of a billion-dollar company who is conflict avoidant, an actor who is painfully introverted, or a child care worker who prefers considerable interpersonal distance. All are examples of people who might still thrive in their chosen professions, who may rise to the challenge of flexibly adapting to a situation they value. The type of interpersonal problems people deal with are both generalizable in form but also unique to them in terms of situations and contexts. How one person's social inhibition will play out is different for them based on their respective life choices, cultural contexts, and life circumstances.

Brief Treatment

Providing the work of FBGT is manageable and well defined; clients will fit work into the available time (e.g., Corpas et al., 2021). Once clients understand the parameters and are in agreement that the tasks and outcomes are achievable and realistic, then work takes place more rapidly. In groups, this process can be sped up by tailoring therapy before the group even starts, an essential task in brief groups in which quickly finding a focus is vital (Piper & Ogrodniczuk, 2004).

In personalizing therapy (Fisher & Boswell, 2016), the therapist uses assessment to tailor treatment to each client's unique distress patterns and identities (Norcross & Wampold, 2011). This use of MBC (Lewis et al., 2019) involves a collaborative assessment with the client. FBGT uses both personalized therapy and MBC to propel clients toward change. This approach provides an opportunity to craft individual goals ahead of time and use the group to act these goals out. Participating in an individual session once group sessions have concluded helps clients to cement their interpersonal learning and consider how to continue their growth in their natural environments outside of group.

FBGT does not provide a one-size-fits-all solution but, rather, collaboratively generates new strategies for growth for each client. It also provides a psychologically safe space to practice behaviors that are new for them.

So, if there is only a brief treatment period to address this duality—that people bring considerable strengths but also significant deficits in social relationships—how does treatment begin? Therapy must treat people as individuals with specific life circumstances, identities, and goals while also

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finding ways to connect people around common solutions. That's no easy task. Longer term therapy groups have the luxury of allowing people to both come together and establish their own identities among one another. Short-term groups seeking to mobilize those same mechanisms of change need to organize them very differently. As top chefs will tell you, good food can take a long time to make but can also emerge from a more rapid process, providing there has been enough thoughtful preparation and planning. With the right preparation and organization of contents and good processes, the same outcome can take place in far less time.

PURPOSE OF THE BOOK

This book aims to help psychotherapists understand the premises behind FBGT and offers strategies and techniques for implementing the approach. As a semistructured process, FBGT provides enough guidance so the therapist has a clear rationale for every intervention, understands the mechanisms of change, and knows what they are working toward. However, the therapist must understand themselves, be mindfully centered, and be aware of the techniques at their disposal that permit the art of this therapy to take place. The therapist uses key elements from science in the art of the here-and-now of therapy. They also use measurement, not to replace clinical judgment but to inform it. Therefore, the art and science of therapy are intended to mesh in ways that allow the therapist to find the right balance between having structure and allowing an organic process to develop.

Although the approach integrates assessment into every stage of therapy, the book is not a technical manual for every instrument. It does not have chapters that show how to score instruments in minute detail. Rather, the practitioner using the instruments in FBGT should avail themselves of the instruction manuals and available trainings (see https://www.focusedbriefgrouptherapy.com). However, the book does explain how to think about the assessment tools and how to integrate multiple data points to enhance the therapeutic process. Where there are more concrete examples of instrument use, the clinician should always consider how the client in front of them can benefit from that case example—and also how the client may differ from that example.

The book is also a guide to, but not a substitute for, reflective, deliberate practice. Use of consultation and supervision is essential for this approach. Group therapy is a specialty, designated as such in 2018 by the Commission for the Recognition of Specialties and Subspecialties in Professional Psychology (Whittingham et al., 2021); this recognition acknowledges that group therapy is not just individual therapy in a group. This book can give

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considerable guidance on how to implement the model as intended, but it would be well supported by an attitude of continuous movement toward expertise in group therapy in general and FBGT specifically.

SECONDARY PURPOSE OF THE BOOK

Readers will find applications of this book useful. Practitioners are now reporting using the 32-item Inventory of Interpersonal Problems (IIP-32; Horowitz et al., 2000)[1] for a variety of purposes in clinical and training work, including in training physicians in interpersonal skills, working with clients on interpersonal problems in individual therapy, and working on understanding group dynamics. Others may find the book useful for understanding more general principles of the practical application of interpersonal theory or as an aid to running brief groups. The theory behind FBGT has innovative approaches to deconstructing group dynamics, conceptualizing transference and countertransference, predicting into and preventing premature termination, and understanding coleader dynamics. Each of these theoretical and practical applications has potential value.

Equally, FBGT may be of interest to those who find it difficult to get groups started and to prevent premature dropout. Because this model was developed in a real-world setting, it was designed from the beginning to consider how to form a strong enough alliance to ensure that therapies "stick." FBGT, which focuses on what is needed for a brief therapy to work in a practice setting, is instructive for anyone attempting this kind of work. Both the underlying theory and the specific techniques (e.g., inoculation, which is outlined in Chapters 2 and 6) shed light on the reasons why groups fail and how to prevent the causes of those failures.

FBGT is an example of how to enact MBC and to tailor group therapy (MacNair-Semands & Whittingham, 2023). This book offers an exemplar of how to tailor treatment using assessment collaboratively with the client. MBC is becoming more widespread around the world (Lewis et al., 2019) and is now required as a part of clinical practice in countries such as the United Kingdom and Australia (Whittingham et al., 2023) because of its proven

[1]Inventory of Interpersonal Problems (IIP) items reproduced by special permission of the Publisher, Mind Garden, Inc. Further reproduction requires the Publisher's written consent. Copyright © 2000 by Leonard M. Horowitz, Lynn E. Alden, Jerry S. Wiggins, & Aaron L. Pincus. All rights reserved in all media. Published by Mind Garden, Inc., www.mindgarden.com

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impact on a variety of client outcomes. Models that have thoughtfully integrated MBC have a strategic advantage in this endeavor because they are not adding a measure onto an existing intervention; rather, those models have woven measurement into the therapy from the beginning, resulting in a proliferation of uses for each measure.

FBGT provides guidance on group leadership and coleadership supervision and training. Its use of the circumplex to inform coleadership dyads and to help leaders understand themselves, their coleadership issues, and their place in the overall dynamic can provide guidance for the supervisory or consultation process. FBGT also has implications for groups and teams in general, with applications to sports, to the military, and in educational settings (e.g., Whittingham, 2021). Applications of interpersonal theory have the potential to shed light on a variety of conditions, such as the prediction of how people with different interpersonal styles might react when encountering a trauma (Whittingham, 2022). Further, FBGT's use of Kiesler's quarter turn (described in Chapter 2) to understand the pathways to interpersonal change has implications for groups and individual therapies that deal with everything from assertiveness training to substance and alcohol abuse.

STRUCTURE OF THE BOOK

This book explores how FBGT provides the personalization of group therapy to match clients' individual needs by offering guidance on how to create a safe space where members can work interdependently. It does so by providing phenotypic examples from which therapists can personalize and individualize treatment. It explores how to use the common factors of therapy (Wampold & Imel, 2015), how to integrate assessment with multicultural concerns and contextual variables, and how to manage groups according to principles of evidence-based relationships.

This Introduction gives the background and rationale for FBGT. The rest of the book is structured into two major sections: Part I consists of four chapters that offer an overview of the underlying constructs, integrated theory, and overall structure of the approach. In Part II, Chapters 5 through 10 focus on implementation of the model. The final chapter offers future directions for FBGT.

Chapter 1 explores the theoretical underpinnings of the model, paying particular attention to the key role of interpersonal theory in informing the model. This chapter focuses on understanding key constructs and principles that underlie the thinking behind FBGT. However, each of these principles is woven into the model at different stages. For example, polyvagal theory,

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although important throughout, has particular significance during the therapy, pregroup preparation, and screening (TPS) session. Equally, homeostasis and habituation are particularly salient during debriefing. Therefore, this chapter represents the Rosetta stone for many of the other chapters.

Chapter 2 explains the structure of FBGT and its main mechanisms of change. It also outlines inclusion and exclusion criteria. In terms of implementation, the chapter offers concrete steps that guide the practitioner in how to both plan and execute the model.

Chapters 3 and 4 represent a shift in the book to more concrete details about clients and therapists. Chapter 3 outlines the eight subscales used in the approach that are based on the main instrument, the IIP-32. The chapter explores the strengths, challenges, and implications of each phenotypic client and therapist style, serving as a foundation for a more thoughtful clinical integration later.

Chapter 4 explores core leadership attitudes and techniques that inform the model as a whole. It serves as the foundation for Chapters 6 through 13, which explore the model step by step.

In Part II, Chapter 5 discusses the all-important process of intake referral process and inclusion/exclusion procedures. It explains how to set up a successful referral process to ensure thoughtful referrals take place. It also provides the first look at how to use and interpret the assessment tools that are so vital to the implementation of FBGT. The chapter also covers assessment administration and interpretation and gives case examples demonstrating how to begin to form the tentative hypotheses that drive the TPS session.

Chapter 6 explains the TPS session, which is the foundation of the approach. A successful TPS is essential to the success of FBGT. The TPS session is complex and requires much of the therapist, but successful completion of the task sets the rest of the group up for success. This chapter outlines tasks that need accomplishing and includes key innovations coming from the model, such as inoculation, that can promote good outcomes and prevent premature dropout.

Chapter 7 covers Sessions 1 and 2 because each has specific tasks to accomplish that are different than those of the middle to later sessions. These two sessions set the stage for the middle sessions and therefore require slightly different techniques and levels of activity of the therapists.

Chapter 8 outlines the middle and later sessions, explaining leadership techniques ranging from here-and-now activation to working the axes and managing alliance ruptures. It also offers suggestions on how to maintain fidelity to the treatment while allowing clinical flexibility. The chapter covers termination and outlines how to close the group. It also reintroduces structure from the group leader and illustrates how to manage the competing forces and agendas in the group as members struggle with the idea of ending.

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Chapter 9 explains the process of triangulation of data. This process involves combining multiple data points: outcomes prepost, leader observation of behavior, a count of the number of times a goal was attained, and other relevant clinical data as determined by the therapist.

Chapter 10 covers the all-important debriefing session. This involves taking the hypothesis from data triangulation and working with the client to determine for them the success or otherwise of the group. Debriefing also entails managing the process of generalization and transfer: where to implement change and where not to as well as preparation of the client for any homeostatic pushback from contexts.

Chapter 11 covers directions for the future. It describes possible applications of the model and research projects emanating from the approach.

All clients and therapy sessions described in this volume are amalgams used to illustrate certain dynamics in group therapy and are not based on specific clients. Three appendices for this book are available at https://www.apa.org/pubs/books/focused-brief-group-therapy and require a password to access. Appendix A is the Group Therapy Questionnaire–S (the short form of the questionnaire). Appendix B is a diagram of the interpersonal circumplex model; you might find it helpful to print it and refer to it when reading this book and in clinical practice. You can also use this diagram to map out a score for a client. Because the original circumplex uses labels that are more pejorative and less person centered, this tool is better for working collaboratively with clients than the ones supplied with the instruments itself. It can be helpful in reminding those seeking to learn the approach where the different subscales are in relation to each other. Appendix C is a sample referral sheet.

For this approach to be implemented successfully, clinicians should purchase the IIP-32 from Mind Garden (https://www.mindgarden.com).