Chapter 5

Repairing the Irreparable

The Flow of Enactive Engagement in Group Psychotherapy

Robert Grossmark

Introduction

This chapter will advance the view that dynamic change in group psychotherapy is effected by an enactive form of free association which I term the “flow of enactive engagement” (Grossmark, 2012b). I will build on ideas expressed long ago by Foulkes (1948) and Durkin (1964) that placed group free association at the center of the therapeutic action of group analysis and group therapy. I will then outline the phenomena of trauma, dissociation, and enactment that have been central to the relational conception of psychopathology and therapeutic action drawing in particular on the work of Philip Bromberg (1998, 2006) and D.B. Stern (1997, 2010). I will suggest that the engine of a contemporary group psychotherapy is the group’s flow into and out of group enactments of traumatic phenomena and states. This flow can be allowed to move along unimpeded by an engaged and involved yet unobtrusive group analyst just as a more classical analyst might have listened to the flow of a patient’s free associations. In the model I will describe the associations as things that happen in the group rather than the verbal associations of the members, and the group analyst is embedded in the process rather than abstruse or neutral as in the original Freudian conception. From this flow of enactments emerges the narrative of the unconscious and dissociated life of the group members and the group as a whole. These enactments can often involve the group in painful, disruptive, and distressing affect and experience for group members and group therapist alike (Grossmark, Chapter 4 this volume), and I will offer clinical examples that illustrates the work of group therapy from this perspective.

Group Free Association

Writing at the inception of the practice of group psychotherapy, Foulkes utilized and embellished upon Freud’s concept of free association. Freud, you will recall, asked his patients to say whatever came into their minds, to avoid censoring any thoughts according to what they might deem irrelevant or unpleasant. He told his patients to:

Trauma and Dissociation in Group Therapy

Much has happened since the days of the abstinent and neutral analyst and the free associating patient in analysis and in group. The concept of free association has been deconstructed (for instance, see Hoffman, 2006) and the contemporary relational environment has emphasized that the therapist is always embedded in the field of the treatment whether it be group or individual. The careful use of the therapist’s own experience has been accepted as a useful and transformative element of intervention rather than a failure of technique (for instance, Bromberg, 2006), and psychoanalytic treatment and therapy has been cast as a mutual enterprise (Aron, 1996). As this volume attests, the theories of intersubjectivity (Benjamin, 1995), social construction (Hoffman, 1998) and most importantly dissociation and enactment (Bromberg, 1998, 2006; Stern, 1997, 2010) have replaced the psychoanalytic world of drives and their derivatives, analyst neutrality, and abstinence. Altogether contemporary relational psychoanalysis seems to be a much more accessible and welcoming abode, and would seem to reflect more generally held contemporary authority relations.

I will review here the concepts of dissociation and enactment and rely heavily on the work of Philip Bromberg and D.B. Stern. They and others (such as Howell, 2005) have suggested that dissociation is the primary way that the human mind is structured. From this perspective, dissociation is regarded as both adaptive and maladaptive and is seen as a continuum that embraces normal everyday adaptive dissociation through to profound and pathological dissociation, the kind that one encounters in dissociative identity disorder. From this position the mind is viewed as comprising self-states. The primary motivator in psychological functioning is the maintenance of self continuity. Optimally this is achieved by a flexibility and fluidity among self-states that enable people to live creatively and to adapt to life’s challenges. This adaptation is constrained by what is affectively safe. When affect is overwhelming and self continuity is threatened, as in massive or cumulative trauma, the normal process of dissociation is magnified and rigidified and a dissociative structure will predominate the personality.

Dissociation is not in essence a defense, but rather a normal hypnoid capacity of the mind that facilitates the everyday adaptations of life. It is hard to imagine a person without any ability to dissociate. Such a person would not only lack flexibility in adapting from one moment to the next, but also be barely able to organize his or her mind. I am reminded of Funes, the character created by Borges (1941) who has no ability to forget, and is rendered unable to function and live by this condition. Borges describes Funes with the idea of memory in the foreground, but it also seems to me that what is conjured in Borges’s sublime tale is the specter of one who cannot dissociate. Funes is not able to access different self-states and alternate registers of human functioning and relating. For him, self-states that enable repose and mirth, for instance, were unavailable. There was no respite from the overwhelming press of stimuli from the world. Living and thinking itself are impossible without dissociation.
Let me distinguish dissociation from repression. In repression, as formulated by Freud, ideas are banished from awareness because of conflict and displeasure that incompatible ideas would generate. This implies that the experience has already been formulated. It exists or has existed in symbolized form. When repressed, it is put away, but exists in a form that can be retrieved. Wachtel (1977) plays with Freud’s archeological metaphor and calls this the “woolly mammoth” hypothesis, which sees the unconscious as containing fully formed bodies, like a fossilized woolly mammoth that exists perfectly frozen in time waiting to be unearthed by the archeologist/psychoanalyst. I grant that this is a greatly oversimplified rendition of an extremely complex and subtle theory of mental functioning, but perhaps it does capture a certain spirit of psychodynamic thinking against which I would like to contrast the dissociation approach.

The idea of dissociation is distinct. The formulation and linguistic coding that creates experience is not taken as a given. The processes that make experience are overwhelmed and impeded in trauma. Events are not pulled together into a coherent experiential or linguistic form. They are unformulated (Stern, 1997). In dissociation, a whole self-state is isolated and sequestered, because to be a self-state is to threaten the self with annihilation: it is unbearable. Accordingly, intrapsychic conflict is neither at the center of this theory nor this approach to treatment. Indeed, from this perspective, intrapsychic conflict is an achievement that follows the integration of dissociated self-states, rather than the primary cause of psychopathology.

D.B. Stern (1997) distinguished between dissociation in the strong and the weak sense. In the face of massive trauma we see dissociation in the strong sense as an adaptive response, a human response to the terror of dissolution of selfhood. We can say that trauma becomes overwhelming when there is an absence of recognition by significant others. The affective destabilization is then overwhelming and the events cannot be experienced and thought about. The hyper-arousal of terror or confusion cannot be managed and transformed by thought. The experience cannot become a part of “me.” The person’s self continuity is hence protected by dissociation, but at a great price. The normal pathways that allow experience to become recorded linguistically and hence become available for memory, part of one’s own narrative, are overwhelmed.

There is no recognition or witnessing that can make these events and the emotional pain real and therefore recoverable. The experience, sometimes the actual memories and representations of the experience, and often the affect connected to the experience are dissociated. The point is, they do not go away. They become part of the sub-symbolic (Bucci, 1997) somato-sensory realm that can then come to “haunt” (Bromberg, 2003) the person.

These non-processed psychic events reside in an unformulated (Stern, 1997) yet-to-be-known realm. They are not available for interpretation. Crucially for group therapy, we can say that they can only become known in enactments. That is to say, these unformulated aspects of the person that are not part of the person’s sense of “me” are encountered in relation to others. In the treatment situation, and most profoundly in group, it is via enactments between the patient and therapist, between the patient and the other group members, or of the group-as-a-whole that the “not me” becomes manifest.

Susan, an Italian-American woman in her forties told the group a story of terrible violation and abuse. She had been sexually abused by her male cousins during family summers at a country house. She had never told her parents or anyone at all, up until this moment in group. Up until this moment she had been a friendly and open presence in group, able to offer help to others. She had talked mainly about her problems dating. However, she told of the violation and abuse in a manner devoid of any affect. Group members, many of whom had suffered terrible abuse themselves, reacted with violent intensity. Jenny was enraged that Susan’s parents had not noticed or in any way protected Susan. Susan protested that her parents were exemplary. She had never wanted to upset them. Jenny’s rage turned to fury and she screamed that she wanted to burn the whole of Susan’s family alive for what they had done. George, whose father had been incestuously involved with his younger sisters, wanted to know more details about the actual sexual abuse. Julian, who had been sexually abused by a neighbor as a child, said that he wanted to leave the room because he was feeling nauseous and accused George of being a pervert who was trying to get some kind of stimulation out of Susan’s painful story. I myself was overwhelmed and feared for Susan’s mental safety. I feared that she could not withstand this onslaught and would be re-traumatized. I told the group that these intense and terrifying emotions were of extreme importance, because we were entering into the actual experience of abuse and violation. In this group enactment, which continued over many sessions (interspersed with other self-states and forms of relatedness) the group came to live through what Susan had yet to experience. The affect—terror, pain, disgust, violence, perversion—that had been dissociated and unthinkable up to this point emerged within and between the group members. Furthermore, each of the other group members entered the fields of dissociated trauma that they had yet to fully experience. George’s horror and contempt for his father; Julian’s dread and revulsion; Jenny’s rage at his abusive parents all became activated in the group enactment. The group indeed felt for a while that it was “on fire” with intense affect and the combustion of previously dissociated affect.

Gradually through many sessions the group members were able to talk to each other with more reflective function and to observe the dynamics of trauma and offer support for each other: For instance, George was able to say to Susan that he was sorry for his intrusive questions, but he understood that
this was a terrible legacy of the incest in his own household. He had, in fact, been a compulsive snoop, at times even stalking women he had developed an interest in. He had never considered himself as anything but respectful of women. This perverse side of him was previously consigned to an alternate dissociated self-state, and regarded as “not me.” Jenny asked Susan to understand her rage. Jenny connected to rage that she was previously unable to own. She listened carefully to the group’s suggestions that she pushed people away with her burning rage at the whole world. Susan herself had never considered that she was angry with her parents. She gradually filled in a much fuller picture of a complex family system that seemed characterized by denial and dissociation. Most importantly, she began to experience affect as she talked about her family. She also began to reassess how it came to be that no relationship of hers ever lasted beyond a few weeks. She had always regarded this as simply bad luck.

The group had enacted all the parts of the violations and abuses suffered, and even perpetrated (in George’s case) by the group members. They came to emotional life within the group sessions. The point here is that until the experience that has been dissociated is actually lived through in an enactment, and is recognized and becomes graspable as lived experience in all its pain and sorrow, it cannot become “really real” and will remain as an invisible force impeding the patient’s ability to live fully and meaningfully. All the members I have mentioned here were shocked by the virulence of their own emotions during this period.

Trauma can be manifestly massive, such as that suffered by Susan and the other group members, or it can be subtle and almost everyday, such as the cumulative experiences of a child whose expressions of selfhood are met with controlling or shaming responses, or are disconfirmed by non-recognition. These then become dissociated not-me self-states that can lead to many forms of symptomatology. We see, for example, the hardened concreteness of black and white thinking, disowned hostility, avoidance, and much more. The dissociated experiences become the story that cannot be told. Yet in group the narrative unfolds as enactment and interaction. It is lived through and begins to become real and graspable.

Dissociation also implies a breakdown in the normal and creative process of making experience and making meaning. Here is the weak or everyday dissociation, the consequence of cumulative developmental or relational trauma. This applies to the stories that are prevented from being told, not because they absolutely must be avoided, but because other stories are more dominant. We find a narrative rigidity. This then shapes and constructs attachment patterns which then, to a large degree, govern one’s life. Susan was unable to think beyond “bad luck” about her inability to make relationships work. Jenny had lived in quiet and lonely resentment never considering that her own reservoir of rage might keep others from staying close to her.

Enactment in Group Therapy

As I mentioned above, what is dissociated and unformulated and “not me” finds form and expression in enactment. Enactment involves the patient, the therapist, and the other group members in interaction. Meanings and narratives that were unthinkable before emerge in these interactions. The internal pressures and hauntings that have constricted the patient’s experience become interpersonal group dynamics that involve everyone including the therapist. As the above example attests, these enactments often involve painful and abrasive interactions and experiences in the group. Rather than being seen as blockages or resistances to the harmonious working of the group, from this perspective, these enactments are the very point of the exercise. The group with Susan may have felt extremely difficult, even disorganizing to me and the members, but I do believe that the work that was done during this enactment was the very reason we were there. Enactments may be regarded, as Bromberg has suggested, as the “royal road” to the unconscious and to change (Bromberg, 2000). Indeed, the affective storm unleashed in the group after Susan’s telling of her abuse opened up areas of emotion and experience that had not been available for these group members in this way before. Rather than seeing such a storm as a problem, I would see it as the group enactment equivalent of the “royal road.” I will later take up the idea of allowing the enactments to safely unfold, just as Freud would listen to the unfolding free associations of his patients.

But first, a few more words about enactment. For me, the idea of enactment has helped me uncouple myself from the pejorative sense in the concept of “resistance.” Rather than a resistance-based idea that would construe group process in terms of what is being avoided and not done, I would rather be curious, as to what the group or group member is doing. I would rather be curious and open to what is being created, within the enactment, what story is being told, rather than divining what is not happening and what is being “resisted.”

From this perspective, treatment takes place through entering, living through and finding some meaning and resolution through the enactments. Sometimes these can feel benign, interesting, even quirky and entertaining, and at other times they can feel like entering an abyss of pain and torture.

A brief—and less traumatic—example from another group. A patient came late to group. I would rather not think about resistances to the task of the group or challenges to the frame of therapy. I would rather let myself not know what is happening and try to see where the flow of the group and my experience will take us, and anticipate the emergence of some as yet undefined meaning. The patient who was late to group was a punctual and impeccably responsible person in his life. It turned out that he had been sleeping and had not woken up on time for the group. He had, however, been dreaming. I held in my mind the idea that one does
not have to be physically present in the room to be in treatment, and asked about the dream. The dream was full of dread, loss, and being left. The group picked up on this profound theme in the man’s life and gradually put together that they had experienced a painful absence when he had not shown up for group on time. One of the group members talked with emotion about her dread that the late patient had forgotten about or even abandoned the group. I myself had harbored some similar worry. My take on this was that we were involved in an enactment. When the group expressed their feelings, what emerged was the articulation of a previously dissociated agony. The group played the part of the man as a child, dreading that he was emotionally abandoned and forgotten, and the man himself inhabited the experience of being lost and forgotten as well as the role of the abandoning parent. When not interfered with, with too quick interpretations, the group can find themselves living out what had previously not been formulated. In its behavior, the group had told a story: his story, that he could not have told in words, because it was never formulated in his mind. He had never been attended to in such a way that his experience could be made real. The abandoned little boy was finally getting recognized and did not have to continue life as “not me.” He did not have to live forever compelled to be obsessively thoughtful, punctual, reliable, and perfect to the point of psychosomatic anxiety symptoms.

This brief and very simplified example captures the idea that rather than seeing the patient or group as not doing something, as resisting, I would rather see what the patient or group is trying to create. I will see the patient as looking for or even forcing the therapist and group into some form of recognition of what the patient has yet to know about themselves. It is a silent scream from a dissociated self-state that the patient has had no access to. Rather than trying to understand or interpret the situation, which might only lead to an intensification of the rigidity of the dissociated, not-thinking state, the therapist can welcome and engage in the enactment with the other group members and the meaning—as yet unformulated, unknown to the patient and group—will emerge in the interaction. It is in what happens and what is about to happen that the action of the group takes place. Only when something feels personally real for the group members and for the therapist can it become truly known and have meaning. Certainly this applies to the first example of Susan’s group. She and the group members I mentioned were silently screaming for recognition of their unformulated and unknown pain and trauma.

Groups as Creative and Meaning-Making

It is a truism to say that groups are always interacting. As they do so and group members engage with each other, enactments are unavoidable, just like group interaction. They are inevitable. Enactments are constantly unfolding and involve group members, the therapist, and the group-as-a-whole. There are constant oscillations between rigid, dissociated, and unmentaledized states that often cause pain and turbulence for the group and therapist, and more reflective states where the group and the therapist have more space to try to figure out what is going on (see Grossmark, Chapter 4 this volume). It is in interaction and enactment that we find meaning evolving. Here I draw from contemporary psychoanalysts who have emphasized the hermeneutic aspect of treatment (Orange, 2010, 2011; Siern, 1997, 2010). The touchstone here is the philosophical work of Hans-Georg Gadamer (2004). Meaning does not exist such that it can be interpreted, but rather comes into being through enactment itself, through dialogue and intersubjective engagement. Meaning is not regarded as a linguistic formulation, it is an event (Gadamer, 2004). This perspective shifts the nature of the therapeutic action of group and individual treatment. There is a move away from the idea that therapeutic action derives from the interpretation of meaning as a static truth that can be analyzed intellectually from the outside, as it were. (Here we might reference the image I began with, of Freud listening to the patient’s free associations and interpreting the meaning from a neutral and abstinent position.) From the hermeneutic perspective, the work of healing involves the creation of meaning in interaction and enactment. The emphasis here is on the engagement and the emergence of what has yet to be known in interaction. I hope that the above examples illustrate that the cognitive and affective meanings for all group members grew out of the enactment. It, the meaning, is not regarded as a static truth that was buried and was waiting to be uncovered (a woolly mammoth). It had to be lived through together to come into being.

From this perspective there is a subtle shift toward a different image of the power of group. Classically, group therapy has been regarded as a way to situate the patient in a regressive situation. The emphasis has been on the regressive pull of the group situation and group dynamics (for example, see Schermer & Pines, 1994). Just as the analytic setting and the analytic couch was regarded as inducing a regressed state such that more primitive emotions could become manifest (Etchegoyen, 1991), group analysts regarded the group setting as similarly regressive. I believe that anyone who has experienced any kind of group, whether small or large, can attest to the evocation of more regressed phenomena. However, I would propose that this is not the only aspect of group process that is available for the group and its members, I would suggest that we can fruitfully think of regression as the evocation of different self-states, perhaps more fragmented, less developed, more emotionally charged, and so on. I would foreground the primarily creative potential that these self-states and the group offer. I am not here talking about artistic creative potential, although these self-states may also be the font of actual artistic or scientific creation. Rather, I am talking about the potential to create experience and meaning that had not been realized before. I would say that the groups I mentioned above were engaged in creative work. They found powerful meaning in painful moments. I am proposing that when a group is allowed to flow into and through enactments in a safe way, tremendous creative potential to undo dissociations and make meaning where previously there was emptiness and dull repetitions is freed up. Being a part of this creative and vitalizing enterprise is in and of itself a healing experience for many members even when they are not the specific object of the group’s work. In other words, when Susan
and the group entered the area of trauma in an affectively alive way, what followed was not simply re-traumatization, but a shared experiencing and shared reaching for understanding of and with each other. This shared endeavor is exactly what had been missing from the group members’ early developmental lives.

The developmental implications are strong here. There is not space to elaborate on this fully here, but suffice to say that the healing power of this kind of creative group process can be regarded as a version of the growth-promoting qualities of the early mother–child or family–child environment, where meaning is consistently made in interaction between and within the players (for example, Malloch & Trevarthen, 2009; Tronick, 2007). It is the antidote to traumatic non-recognition.

Shame, Repetition, and Witnessing in Group

Shame plays a central role in the formation of dissociative structures and the painful repetitive quality of the lives of patients whose psychology is dominated by trauma and dissociation. Shame is often key to understanding enactments of trauma.

The self-states and needs of the child that are either assaulted or less visibly disconfirmed by the parents create an interminable sense of shame. It is not what one does that is at stake, but an abiding sense of who one is. Therefore there is no opportunity for reparation, as there is when one has done something wrong and can change one’s behavior to right that wrong. When in the grip of shame, there is an inner certainty that there is something terribly wrong and unacceptable about who one is. The patient longs for recognition of her pain and this longing itself is felt to be utterly illegitimate and is itself infused with shame and is consequently dissociated. The patient is, as it were, locked in a living nightmare: the only person who can give the acknowledgment that is so desperately needed is the very person who is causing the shame and therefore the least likely to offer it.

This dilemma is at the heart of what we have traditionally called the “repetition compulsion” that drives destructive enactments in treatment and self-destructive and masochistic behavior patterns in life. Bromberg (2006) sees these enactments as attempts to “repair the irreparable” (p. 94). But the past cannot be repaired: it is only with the truly felt recognition of that damaged past by an emotionally connected group that the present and future can be freed to be experienced. As with all self-states that are dissociated, shame is not brought into group by being spoken about and announced, but rather is found in the sub-symbolic experiences enacted between patient and group. As the above examples illustrate, the group and the therapist will inevitably fail the patient, and will, in this way, come to know the patient’s experience “for what it is” (Bromberg, 2006, p. 94). The lives of all of the patients mentioned in the above examples were suffused with terrible and unbearable shame. None of these people announced this or even were aware that this was so. And as Bromberg suggested, in the case of Susan’s group, the group did come to “fail” Susan and the others. The persons causing the shame and pain became personified in the other group members. It is as if the scenes of abuse were replayed in the group with various group members assigned roles in the drama. But unlike the original others who abused and neglected Susan, these group members were able to attempt to own their part in the enactment and thereby offer some recognition and healing to Susan’s shame. Via the working through of the enactment, the experiences became known by others for what they were in all their pain and despair.

This process involves an “enactive witnessing” (Reis, 2009). This is a contemporary view of witnessing. D.B. Stern has also emphasized the witnessing element of enactments (Stern, 2010). Much trauma literature has powerfully illuminated the healing power of witnessing (for example, see Feldman and Laub, 1992). The literature is too vast to be addressed in any substance here, but let us note that one of the crucial elements in the formation of traumatic dissociation is the absence of a witness to confirm the reality of the trauma and pain, to recognize the suffering. Much of the trauma literature involves the telling of the trauma to an empathic listener or group. The idea of enactive witnessing shifts the emphasis away from the telling and into the “living through.” The anguish of shame and the world of the dissociated, unformulated “not me” does not enter the group through a verbal telling. Rather, as I have shown, it emerges through enactment. When the group connected to and accompanied Susan (and the late patient) into the worlds of trauma and shame and lived within that pain and appreciated it “for what it was,” there emerged a new dimension of witnessing. This is a lived and enacted witnessing. The groups mentioned above offered a witnessing of a previously unseen and unrecognized suffering by living through the suffering in real time in the group. Together. Such powerful enactments make the previously shame-inducing shadows of pain “really real” (Bromberg, 2006, p. 66) for the patient and group. This is how one repairs the irreparable. As in the case of Susan, the traumatized group member knows deeply that the other members have actually gotten it. They now know, from their own shared experience and actual participation, the degree and nature of the traumatic suffering.

Repairing the Irreparable Through the Flow of Enactive Engagement in Group Therapy

Working from this perspective raises questions about the group therapist’s position and technique. Pertinent questions arise about when to draw attention to what is going on in the group, and when to ask the members to help in understanding the enactments (although one may never use such a word when talking to a group). When do we interpret and when do we offer our own experience of what is happening to the group and to us? My inclination is to respect the power of the enactments and the shared living through that the group offers. As I mentioned above, all the normal rules of boundaries and safety apply, because without a safe and predictable structure, there simply cannot be adequate safety for members to do this work. Within that framework, I am inclined to allow enactments to flow. I trust that the meaning will emerge, and would do well to wait and tolerate whatever
difficult experience the group is entering. Unconscious, dissociated affect or traumatic memory is rarely so clear from the outset. I adhere to the idea that when the group can be safely allowed to flow into and through enactments, meaning that is often surprising and potentially reparative will emerge.

This brings us back to Freud’s idea of free association. To recap, Freud regarded free association as the key mechanism by which the psychoanalytic cure proceeded (Freud, 1913, 1923) and he recommended that the analyst in no way interfere with this process. Likewise Foulkes and Durkin recommended that the group therapist allow a free-floating group discussion or group free association. My suggestion is that the analyst similarly not impede or obstruct the emergence of the flow of enactive engagement in group.

There are many ways that a group therapist can impede the unfolding of enactments and there were many moments when I could have done so in the enactment involving Susan and the group. Premature interpretation of individual or group dynamics can bring the group out of the world of engagement with each other into a more intellectual realm where the group is asked to “think about” what is happening rather than continue to interact and struggle within the process. Similarly, too quick an exploration of the here-and-now dynamic in the form of questioning what is going on in the moment can bring members into a more removed state of mind. Certainly both interpretation and exploration can offer much needed containment when the group can feel overwhelming and scary. The group therapist’s tact and open consideration of each member’s needs and vulnerabilities is of utmost importance when enactments of trauma are flowing. Generally I strive for a position that supports the group members as they interact and conveys real curiosity and belief that whatever it is that is happening, it will no doubt ultimately have real meaning for the group. Hence I aim to be both fully engaged and unobtrusive such that the flow of enactive engagement can proceed (Grossmark, 2012a, 2012b). I did support Susan and the group such that they felt held and safe enough in the group, even as they were beset with pain, rage, and overwhelming affect. My encouragement that, even though painful, this challenging time was exactly why they had come to group, and my belief that we would all come through this having achieved some real psychological growth seemed to offer holding and containment even when they felt hopeless and despair.

I use the term “flow of enactive engagement” to capture the essence of Freud’s and Foulkes’s initial vision of allowing the flow into unknown psychological territory. A free (and safe) interacting of the group that allows for the emergence of the unformulated. I also seek to evoke the British independent tradition of psychoanalysis where the analyst does not obstruct into the unfolding of the unconscious life of the patient, as captured by Balint’s (1968) description of the “unobtrusive analyst.” I have adopted this idea to offer a contemporary image of a very much engaged analyst who is also able to be unobtrusive to the unfolding of the patient’s inner psychic world in the treatment (Grossmark, 2012a). Further, the “flow of enactive engagement” shifts the therapeutic action away from the mental, spoken, one-person connotation of free association to the enacted and enactive process in which the group and the group therapist are allowed to enter into enactments in a free but safe manner and are not interfered with by interpretations or demands to know what is happening before it has emerged. Patients like Susan, whose lives are dominated by the psychic sediment of dissociated and cumulative trauma, for whom there are no words for their inner life, and who are inhabited by self-states that defy verbal description, tell their lives, their pain, and their psychological make-up in their own idioms of action and engagement. They are joined by the other group members and therapist who are ready and available to live with and through (Joseph, 1985) these self-states and mutual regressions. It is via the flow of these enactments that the trauma is re-lived. However, rather than a re-traumatization, there is recognition and real-time enactive witnessing of the trauma by the other group members and the therapist who accompany the patient into these areas of previously unbearable pain. The experience becomes real and the dull pain of ongoing repetition is replaced by a sense of repair via accompaniment, witnessing, and shared survival. The experience becomes real and manageable rather than requiring dissociation to maintain the patient’s sense of self and continuity.

I must note, however, that the flow of enactive engagement in group does not imply that the group therapist enters the patient’s and the group’s world and the emergent group enactment and takes leave of his or her own abilities to think and process the experience. Like the analyst’s reverie or even hovering attention, it suggests an altered self-state that exists simultaneously with other states. As mentioned above, it also asks that the group therapist be clear and firm around boundaries while allowing for the inevitable boundary ambiguities (such as the late patient mentioned above) and challenges that occur as part of the treatment when one connects with these areas of functioning.

My Dream About Susan

The group therapist is engaged fully in enactments such as those I have described. Feelings, sensations, thoughts, and dreams often flood the group therapist and it is often hard to hold on to one’s group therapist self-state (Burton, 2012) amidst these storms. The work is to find a way to “stand in the spaces” (Bromberg, 1998) of many self-states at once, so that even as one is immersed in the traumatic enactment of the group, one can also maintain some hold on one’s therapist self.

A few sessions into the enactment presaged by Susan’s revelations of abuse, I had a dream. I dreamed that Susan was on fire. I woke up with a clear thought in my mind. Susan, I thought, is a burn victim. And just like severe burn victims, she cannot be touched, because to touch her would cause even more unbearable pain. I thought of the many other possible psychoanalytic interpretations of the dream involving traumatic sexuality and violation of her body, her own aggression and its consuming quality, and so on. I felt all were useful in conceptualizing and understanding Susan. But I did feel, due to the clarity of my waking thought, that...
the idea of her as untouchable spoke most immediately to the group process and
and to all the other traumatized members of the group. They could not truly touch each
other without unbearable pain. This dream helped me stand in the spaces during
these tumultuous group sessions. The group members were trying to really contact
each other, with all their trauma and pain. The only way they could do so was in
the fiery combustion of these enactments. The pain, aggression, and chaos were
inevitable. The group itself was screaming a necessary scream. This knowledge
guided me and enabled me to allow this enactment to continue its flow such that
the group members themselves found their way to relate to each other from more
than one traumatized self-state. This, I believe, is how the repair of what is
irreparable can unfold.

Notes
1 While this is familiar territory for those within the community of relational
psychoanalysts, it seems to me that it is of value to spell out these ideas for those
readers coming from other approaches to group therapy.
2 I have found resonance between these ideas that stress the failure to make experience
out of events with Bion's work on alpha function (Bion, 1967; applied to the group
situation by Gordon, 1994). Both approaches take an interest in the processes by which
experience is made: There are, however, real differences in these theories and their
epistemologies. There is no space here to address these.
3 See Davies and Frawley's (1994) work on the psychoanalytic treatment of adult
survivors of childhood sexual abuse for a vivid description of the enactment of the
myriad constellations of the participants in the original trauma. For instance, the
therapist may find herself becoming the denying mother, penetrating abuser, or abused
child in relation to the patient.

References
Press.
Labyrinths: Selected Stories and Other Writings (pp. 59–66). New York: New
Directions, 1962.
Bronberg, P.M. (1998) Standing in the Spaces: Essays on Clinical Process, Trauma and
Bronberg, P.M. (2000) Potholes on the royal road: or is it an abyss? Contemporary
Bronberg, P.M. (2003) One need not be a house to be haunted. Psychoanalytic Dialogue,
13: 689–709
Analytic Press.

York: Guilford Press.
Burton, N. (2012) Getting personal: Thoughts on therapeutic action through the interplay
Davies, J.M. & Frawley, M.G. (1994) Treating the Adult Survivor of Childhood Sexual
Books.
Integration of Individuals and Groups. London: Maresfield Library.
London: Hogarth Press.
Gordon, J. (1994) Bion's post-Experiences in Groups thinking on groups: A clinical
example of –K. In V.L. Schermer & M. Pines (eds.) Ring of Fire: Primitive Affects and
629–646.
Psychic Equilibrium and Psychic Change; Selected Papers of Betty Joseph (pp. 156–
Reis, B. (2009) Performative and enactive features of psychoanalytic witnessing: The
transference as the scene of address. International Journal of Psycho-Analisis, 90:
1359–1372.
Chapter 6

Developing Nuclear Ideas

Richard M. Billow

In the course of leading a group, ideas flow in and out of my consciousness. Some seem to originate from within me, although many emerge from the verbalizations and behaviors of others. Even if the group appears to move on, several ideas linger and begin to impinge. They are now asserting influence on me; unavoidably they affect group process. So I think about why the ideas or set of ideas has captured my attention: what they have to do with the clinical situation—present and past—and to my psychology, to the extent to which I understand it.

I consider how these ideas relate to what others are saying and doing—linking together, if I am able, unfolding intrapsychic, interpersonal, and whole group processes. It is at this point of connection that a nuclear idea begins to coalesce, but it must be examined. I try to see if the idea has relevance to others, and is applicable to smaller or larger milieus, or both. This places the idea in intellectual and symbolic contexts, which also have cultural and historical dimensions.

The idea has to feel vital. I can put it aside but not forget about it. Emotional reverberations energize my thoughts, and realizations sometimes occur that surprise me. If I wish to communicate, I must test whether the idea is comprehensible to other group members. Even if they are not having similar experiences, or are having them but do not see things my way, they need still to understand what I am referring to.

This progression, as I reflect, parallels Bion’s (1963) notion of the psychoanalytic object. Bion left the concept unsaturated, to be built upon, although only a few others have written about it, and briefly (Grotstein, 2007, more extensively). I have found the concept helpful in achieving essential therapeutic goals of containment, cohesion, and coherence. As we shall see, developing nuclear ideas provides a way of thinking and working: shifting interest and discussion from “surface” contents to nonconscious or unexplored psychic processes in the individual and whole group, and thus to draw attention to multiple meanings—to the metapsychology of our interactions.

Bion’s theoretical formulations tend to mystify and obscure their broad clinical utility, and also tend to exalt the analyst or group therapist as the “seer” or “exceptional individual” (his terms). Bion (1962) conceptualized the psychoanalytic object as emerging from the “discourse and behaviour of the