Chapter 3

The Group as an Inevitable Relational Field, Especially in Times of Conflict

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Introduction

Participants in a therapy group interact with one another and the relationships formed through the group process become a transformational vehicle. Yalom (1995) defines the process as “the nature of the relationship between interacting individuals” (p. 130). As the group progresses, group members interact more intimately with one another and deeply explore their relationships with the group leader as well, not only through analyzing transferenceal distortions but also as expressions of authentic relationship (Berman & Weinberg, 1998). The quality of therapeutic relationship in itself is critical in predicting positive therapeutic outcome. This important factor, found in evidence-based literature (Norcross, 2002), only strengthens the focus put on relationship in most group theories.

Group psychotherapy is, in its essence, a relationship-based treatment. But is it enough to say that group members interact and relate to one another and to the group therapist in order to perceive group therapy as relational therapy?

Differences in Traditional Psychoanalytic and Relational/Intersubjective Terms

Before exploring the implications of the relational approaches to group therapy, let me summarize the differences between traditional psychoanalytic and relational ideas in general. This summary might seem basic to some readers, but it is necessary as a way to set the scene and describe the frame of reference for the group leader. So what differentiates the relational/intersubjective approaches from other theories?

Relational theory is based on the shift from the classical idea that it is the patient’s mind that is being studied (where mind is thought as independently and autonomously within the boundaries of the individual) to the relational notion that mind is inherently dyadic, social, interactional, and interpersonal. (Aron, 1996, p. x)

If the mind is inherently interactional, nothing is created only by one individual, and we need to look at all the phenomena in therapy as created by both therapist and patient (or, in a group, by all participants). The therapist cannot avoid becoming a participant in this process and should examine his or her contribution to what is going on in the session as well as the patient’s contribution.

Transference and Countertransference

In traditional psychoanalysis, transference is considered a distortion, due to the projection of the past onto the present. In relational approaches transference is not regarded as a distortion but as a different view of the world based on one’s history and unique needs. The therapist’s countertransference, which in traditional psychoanalysis is perceived as a response to the patient’s transference, can actually be seen as the therapist’s transference. As we are talking about what is going on between the two participants in the session, labeling transference and countertransference as different processes, originating from different sources, is no longer legitimate.

Resistance

Resistance is defined as whatever interrupts the progress of analysis or therapy. Traditionally it always resides within the patient, arising because something in the patient’s psyche must be kept from awareness. But is it not possible that what looks like resistance is actually a response to some unearthing acts or misattunement of the therapist? Not all resistant behaviors “originate” from the patient. Resistance has an interpersonal meaning and, in individual therapy, can be understood as the outcome of collusion between the therapist and the patient. In the group it might involve the group as a whole.

Interpretation and Change

In the traditional approach, interpretation is seen as the vehicle of change. According to this approach, good interpretations, given at the right timing, help the patient give up previous faulty perceptions and adopt new ways of understanding of the world, thus impacting the patient’s behavior. Interpretations are offered by the therapist from what seems like an objective perspective. These assumptions are criticized by relational writers both for impossibility of an objective point of view and for being the only way to change.

If interpretation is not the only vehicle of change, what other mechanisms contribute to change in therapy? Stern et al. (1998) explored “non-interpretive mechanisms of change,” discussing “moments of meeting” as a mutative phenomenon. These moments consist of instances where the therapist’s responses are fully in attunement with the patient’s emotional and psychological state, providing the patient an experience of being deeply understood. It seems that in
addition to interpretation, other mutative mechanisms exist, leading to growth and change.

**Enactment**

In relational psychology, enactment is the focus of attention more than the notion of resistance, transference, and countertransference that governed the scene in traditional psychodynamic approaches. Enactment is defined as an automatic, unformulated, non-reflective moment involving all participants in a therapeutic interaction (Wright, 2004, p. 238). The relational theoreticians argue that therapists will inevitably be drawn into enactments with their patients, and that processing or analyzing enactments is a major component of the therapy. We can conclude that enactments express, variously, resistance, transference, countertransference, unconscious individual, interpersonal, group, and social processes, and that the analysis of enactments should include the acts of both the patients and the therapist.

**Dissociation**

Enactment cannot be discussed without mentioning the role of dissociation, for what is enacted is that which is dissociated. Dissociation means that some experience that is incompatible with how one ordinarily sees oneself is split off. It refers to whole experiences, thoughts, or self-states that are not admitted into experience. Therefore they are not thought about, and when they stem from a traumatic nature, they are not even registered. We all have “islands of dissociation” and thus dissociation is seen as an inevitable aspect of being human. However, the greater the degree of dissociation, the more contradictory, unstable, and confusing is the sense of self. Dissociation is different from repression because the latest acts upon experiences that have been conscious. The therapist’s subjective experience during the session can contain aspects of the patient’s experience that have been dissociated. Thus, the patient enacts the dissociative parts, and as long as the therapist cannot reflect on his or her experience and reactions, he or she will participate in the enactment.

**Relational vs. Intersubjective Approaches**

These approaches are usually discussed interchangeably. The difference between them lies more on the focus of attention. We can focus on the relational aspect, namely the contribution of both partners to the interaction, or the intersubjective aspect, namely how the subjective experiences of the partners interact. Intersubjective approaches stress that in every meeting there are at least two subjective experiences that meet, each of them with a need for recognition of their subjectivities. Beliefs and theories about the self and others are regarded as phenomenological rather than objective and are most productively viewed as context-related. The two subjectivities of the therapist and the patient come together in the therapeutic session. The patient needs acknowledgment and recognition of his or her subjective experience (Benjamin, 1995).

Of course, there is a difference between Benjamin’s and Stolorow’s approach. Benjamin (1999) proposes that intersubjectivity depends upon not only correspondence but also difference, and not only upon mutual regulation but also mutual recognition. Stolorow and his colleagues (Stolorow, Brandchaft, & Atwood, 1987) are more interested in the analytic context and see intersubjectivity as constituted by the intersection of two subjectivities: the reciprocal influence of the conscious and unconscious subjectivities of the people in a relationship. For the sake of this chapter, I will use more Benjamin’s ideas about mutual recognition as the ability both to recognize and to be recognized by another: we will see how difficult it becomes when we deal with conflict.

Intersubjective theories follow Stern’s (1985) observations and research about the importance of mother–infant optimal attunement and mutuality. Updated neuroscience research (Cozolino, 2006) even shows how right-hemisphere networks of attachment, social relationships, and affect regulation are built during childhood in an experience-dependent manner through the attunement of parent and child. Self and interactional regulations (Beebe & Lachmann, 2002) are the result of internalizing secure attachment schemas, and their balance is essential to a person’s wellbeing. In therapy, reintegration of these self and other regulation mechanisms is achieved through the therapist–patient attunement. Thus, another important tenet of these approaches is that optimal attunement to the patient’s experience, recognizing the other’s subjectivity, is most healing to the patient. This notion started with self-psychology which emphasized the importance of empathy in the therapeutic process, but contrary to self-psychology, where the therapist serves as a self-object for the patient, which means that the therapist becomes functional for the patient’s developmental needs, in intersubjective approaches the therapist’s subjectivity is important as well. This does not necessarily mean an equal relationship, because the focus is still on what serves therapy and the patient’s growth, but the therapist might become more transparent and look more carefully at the way he or she contributes to the therapeutic situation.

The advantage of intersubjective and relational approaches is that by highlighting the inseparability of mutual reciprocal influence, they enable therapists to be more aware and accept their contribution to the therapeutic relationship, and provide therapists with an attitude that produces a collaborative response to the inevitable enactments.

**Foulkes as a Forerunner of Relational Group Therapy**

Foulkes, the founding father of group analysis in Britain, can be considered the pioneer of relational approaches. Long before the distinction between one- and two-person psychologies emerged, he defined group analysis as “the analysis by
the group, of the group, including its conductor” (Foulkes, 1975, p. 3). The inclusion of the conductor (the group analyst, in Foulkesian terms) in the analysis introduced the notion that the group therapist’s behaviors, thoughts, and feelings are part of the group process and that the therapist is not only the therapist “of” the group, but also “in” the group.

Group analysis preceded its time by emphasizing such intersubjective concepts as multiplicity, mutuality, and radical openness. The idea of the analysis of the group by the group and not by the group analyst grants the group itself a therapeutic position that equals the therapist’s position, and redefines the role of the group therapist. The spirit of group analysis conveys an egalitarian view of the group and its leader.

In traditional psychoanalysis, the interpretation of transference and resistance acquires a central role in the mobilization of change. In his radical approach, Foulkes (1964) argued that interpretation follows change rather than precedes it. Instead of interpretation as a primary technique, Foulkes claimed that the group conductor’s primary goal is to facilitate the participation in group life by the members of the group. By placing patients face to face in a group, it had become clear to him that the minds of all group members are connected in a web of relationships through which unconscious material flows. The shift from the couch to the group is not only a technical change: think of how projection differs in a group from individual therapy, that is, when a group member holds the disowned parts for another member, rather than the therapist.

Foulkes (1964) introduced several new concepts to the group situation that underscore the importance of group interaction and subjective experience, such as mirroring and resonance:

Mirror reactions are characteristically brought out when a number of persons meet and interact. The person sees himself, or part of himself—often a repressed part of himself—reflected in the interactions of other group members. He sees them reacting in the way he does himself, who [sic] are in contrast to his own behaviour. He also gets to know himself . . . by the effect he has on others and the picture they form of him.

(p. 81)

Pines (2003) described resonance as the individual responses that group members make to shared events, each responding at their own level of attunement to the predominant affect in the group. In both concepts the relational aspect is predominant: resonance and mirroring heavily depend on the interactions, relationship, and subjective experiences of the group members to the shared group events.

Wilke (2007) summarizes Foulkes’s core ideas pertinent to relational theories in the following sentences:

First, there is the idea that the individual mind is not self-enclosed but has a translucent boundary through which the ‘We’ of the belonging group can be internalized and projected outwards. The second idea suggests that all of us are linked to a shared and invisible network of minds that Foulkes called a matrix.

(p. 429)

**Group Therapy and Relational Theory**

It seems natural to apply the relational approaches to the group, focusing not just on the relations between the therapist and the patient. In groups we focus on the relationships developing between members, and between therapist and participants. In addition, the more group work deepens, the more we have the possibility to deepen the exploration, expression, recognition, and acknowledgment of the members’ subjective experiences. Surely the way to study and explore this social-interactional mind is in the concrete space where interactions are revealed—the group.

Gergen (1994) stresses the relational nature of the human mind. He claims that meaning is produced by and located in the context of continuing relationships. Psychotherapy, from this perspective, is dedicated to mutual exploration of the interpersonal milieu. If we want to explore this interpersonal milieu and the relationships of more than two people (that one of them is automatically positioned as an authority), we need to move from the dyad to the group arena. All the relational ideas, from exploring relationships in vivo to finding how both therapist and group member participate and contribute to the interaction, are best addressed in the group.

Another advantage of the group from the intersubjective point of view is the ability and easiness of revealing the subjective experience of the participants. The group inevitably creates a conflict between the members’ need to assert themselves and the others’ need for their subjectivity to be recognized. There is a continuous contrast between joining/similarity vs. subjectivity/individuality: we vs. me. These contrasting needs are in the center of any relationship and become a major focal conflict in the group. Sometimes they are more in the background. Other times, like in instances of conflicts in the group, they are in the eye of the storm.

Benjamin (1995) pointed out that intersubjectivity is about these simultaneously existing conflicting needs, and that healthy relationships prevail when both partners’ subjectivities are recognized and acknowledged. Where else can we strive to achieve this goal if not in a group? In every group session the patient is called upon not only to express his or her subjective thoughts and feelings but also to relate to the problems and personalities of the other members, being sensitive to their needs too. In short, the patient is asked to bring forward one’s subjective experience, while simultaneously serving as a quasi-therapist to the other, recognizing the other’s subjective experience. Finding a way to do both can be best learned in a group, where group members are peers whose individualities should be taken into consideration.

The group is also a suitable space to witness and experience multiple self-states. According to the intersubjective approach, we have multiple parts or states
of mind that possess varying degrees of compatibility with one another. Different relational contexts reveal different self-states. Because the group is rich with possibilities for different interactions and relations, we can easily explore how a member’s different self-states emerge in response to others in the group.

Billow (2003) uses Bion’s concepts and ideas to illuminate intersubjective processes in the group. He claims that “the concept of container-contained describes relationships that are dynamic and fluctuating, cognitively multilevel, and interpersonal multidimensional. We come to learn about and represent intersubjective experience at various developmental levels of thought” (p. 112). Billow relates especially to the relational nature of projective identification as described by Bion (1962). According to Bion, the normally empathic mother introjects her baby’s projections, elaborates, processes, deciphers, and communicates them back to the infant aspects of his or her psychic experience beyond his or her cognitive and emotional capacity. This prototype of projective identification is communicative in nature and involves two persons.

But describing Bion’s approach in groups as relational is quite misleading. It is true that the container-contained concept is relational, but apart from this stance (which was not attributed by Bion specifically to the group leader), Bion describes the group therapist as a “bizarre object” (Bion, 1967), positioned outside the group circle, illuminating the group processes with a beam of darkness. The group leader is not perceived as participating in the group process at all, in contrast to the Fouksian approach mentioned before.

Apart from Billow’s book (2003), only a few papers connecting group therapy to relational approaches have been published, although their number is beginning to increase. A selection of these papers and their main focus follows.

Weegman (2001) demonstrates some of the obstacles and defensiveness arising from the more classical analytic tradition, whether applied to individuals or to groups, and suggests that intersubjectivity theory illuminates group as well as individual processes. He is one of the first to demonstrate the similarity between group analytic ideas and intersubjective ones.

Wright (2004) focused on the concept of enactment and its importance in intersubjectivity and applied it to groups. Enactment typically involves the two partners in therapy. The therapist is unconsciously entrapped in this enactment and contributes to its creation, existence, and maintenance. As relational psychotherapy in practice involves moving from enactment to enactment, the group is the arena for enactments. All the group members and the therapist participate both in creating these enactments and in their exploration.

Grossmark (2007) conceives groups as being composed of many multiple selves, and the process of group psychotherapy as unfolding through enactments that involve the whole group and the group therapist. He focuses on the group therapist’s role of holding and containing intense affect throughout these enactments.

The issue of “the difficult patient in groups” can explain how in relational terms the patient can be seen in a less pathologizing way as understandably protecting himself in the group situation. The term “difficult patient” has come to refer in the group therapy literature, at the very least, to those with borderline and narcissistic personality disorder (Roth, Stone, & Kibbel, 1990). Often it refers to a range of severe personality disorders, including schizoid, paranoid, histrionic, avoidant, dependent, and sometimes even anti-social personalities. Many of these show elements of borderline and narcissistic pathology, including projection of blame, distrust or paranoid thinking, and narcissistic rage, and have a range of narcissistic fantasies. However, Gans and Alonso (1998) applied intersubjective theory to the understanding of the difficult patient in the group. They argue that from this perspective, therapist and group members construct together the difficult patient, without appreciating how they themselves contribute to this construction and what it serves in the group. Their paper demonstrates how intersubjective/relational ideas can be successfully applied to specific phenomena in group therapy, while still avoiding the trap of a radical position that a difficult patient does not exist. Rather than conceptualizing the dynamic as stimulated by the patient’s narcissism, inability to tolerate criticism is seen as context dependent.

The traditional ways of recognizing and disentangling from one’s countertransference in individual therapy are self-reflection, supervision, and the therapist’s own therapy. But when entering the complicated field of enactment, these ways may not be enough: the therapist should be exceptionally thoughtful and honest in understanding his or her own contribution to this mutual dance of transference–countertransference enactment. Bringing the situation to supervision tackles the difficulty of telling the story only from one point of view. The same problem goes for the therapist’s therapy: the patient is not in the room, and the therapist’s therapist cannot observe the interaction in the here-and-now.

But when we move to group therapy, the solution to this problem lies at hand, and is right in front of our eyes. The group itself is there to witness the interaction and comment on it. The therapist does not have to tell the supervisor what happened, because the group, serving as a covert supervisor, can help both sides explore and understand the process. Wright (2005) has written that “the group therapist is particularly fortunate, for, in addition to these methods of discovery, the group therapist has the group” (p. 400). Of course, the group therapist who wants to use the group members’ minds for analyzing the process, including the therapists’ contributions, should drop defensiveness and be open to the participants’ comments. Allowing oneself to participate in the enactment together with the group members, and then non-defensively listening to what the members have to say, and verbalizing the therapist’s subjective self-experience, can be a very powerful tool in the group process.

The Role of the Group Therapist in Relational Group Therapy

Yalom (1995) counts three fundamental tasks of the group therapist: creating and maintenance of the group, culture building, and activation and illumination of the
here-and-now. Rutan and Stone (2007) mention that the most useful activities of the group therapist are internal ones, such as feeling, empathizing, and hypothesizing in order to further understanding for group members. Although we can find many lists of group leadership skills needed for group therapy or group counseling (see Corey, 1995, for a list of twenty-two detailed skills), in general, we can talk about the cognitive roles of the therapist (thinking, analyzing, interpreting) vs. the emotional roles (feeling, empathizing, containing).

These two aspects of the group leader’s role connect with the two tiers Yalom (1995) mentions in relation to the here-and-now: the experiencing tier, and the illumination of the process level. “Accordingly, the therapist has two discrete functions in the here-and-now: to steer the group into the here-and-now and to facilitate the self-reflective loop (or process commentary)”(p. 130). Unfortunately, Yalom does not discuss the emotional involvement of the therapist in the here-and-now as associated with the experiencing tier. He sees the therapist’s task as “steering” the group, usually by focusing on the interactions and how people feel one toward the other.

Fortunately, other authors did relate to the therapist’s emotional involvement as important in the progress of the group. This is especially true of Ornont who wrote: “the worst therapists are those out of touch with their feelings … the best therapists experience a great range of feelings. They let themselves feel nearly everything” (1992, p. 52). Ornont assumes that it is simply a question of whether therapists let themselves feel. He seems to ignore the existence of feelings that therapists are unaware of, and these are very much what the relational approach deals with.

Actually, the role of the group therapist is deeply connected with the theory that the therapist holds. In the traditional psychodynamic theories, the group therapist is a transference object and should interpret the underlying emotional themes around this transference as well as the unconscious dynamics taking place in the group (such as the basic assumptions according to Bion, 1962). When it comes to relational/intersubjective theories, the presence of the therapist as a subject and the quality of the therapeutic relationship is more important for change than insight acquired through interpretations. Interpretations made in the absence of the therapeutic relationship are probably not very useful, although they certainly are significant in patients consolidating the gains they have made and an understanding of what has happened to them in their therapeutic relationship. The empathic attunement of the therapist is crucial to the healing process.

Stone (2001) emphasizes the role of the therapist’s affect in conducting treatment, and recounts many sources for the therapist’s emotional responses, whether they arise from the therapist, the relationship between therapist and patient, the patient, social and cultural values, and so on. The group introduces additional pressures that have a powerful impact upon clinicians’ feelings. When enactment in the group unfolds, the therapist must be able to contain and hold the group through this process. The strong enactments that groups create call for adding a different role of the group leader: “Such a group leader is effective by being engaged, moved, and changed along with the group” (Grossmark, 2007, p. 495). Group therapists should not (actually cannot) avoid being drawn into these enactments, but they need to let the emotions flow through them, staying in touch with the feelings, even living a short period of confusion, anxiety, and instability, while emerging from this process with more understanding of what is happening in the enactment.

The above statements do not mean that group therapists should totally give up confrontation, interpretation, or analysis of group processes and even resistance. For example, when an anti-group phenomenon occurs (Nitsun, 1996), the therapist should point out the destructive forces and help the group change this process and use them in a creative way. When scapegoating governs the group scene, it is imperative for the group therapist to intervene in order to prevent damage for both the excluded-attacked member and the other group participants. Still, this could be done from an intersubjective point of view. (For an example of an intersubjective perspective of scapegoating, see Cohen & Schermer, 2002.) Some enactments are worthy of limit-setting, confrontation, and interpretation, although these therapist-based responses are also intersubjective responses and enactments in their own right.

Some readers might wonder whether the idea of mutuality, central to relational theories, does not mean that the group therapist becomes one of the group members. Aron (1996) stresses that mutuality does not equate symmetry or equality. He explains the word mutuality as a sharing in common or a sharing between people. He brings the example of mutual admiration between a teacher and a student, while each maintains the status and position.

The Task of the Group Leader in Times of Conflict

In times of group conflict, the safe space is threatened. An intense conflict between two or more group members, usually breaking out suddenly and escalating very quickly, can become very distressful for both the members participating in the fight and the observing group members. Such a conflict, if unresolved satisfactorily, may lead to the emotional withdrawal of some of the members (both those involved and those who did not seem to be part of the conflict) and even to premature group termination of one of the parties involved (usually feeling hurt and misunderstood). It might create more caution of group members around self-disclosure or giving authentic feedback, and can have a long-standing impact on the group, demonstrated in a kind of an impasse as if the group is stuck. Sometimes, even months after the event seems to be forgotten, the group is still conflict-avoidant and tiptoes around any expression of difference of opinions.

The development of such a conflict usually involves massive mechanisms of projections, splitting, and productive identification. Both partners feel misunderstood and misinterpreted. Usually, the outburst of the conflict is not only due to difference of opinions or simple disagreement (that can regularly be resolved by discussion and negotiation), but also involves hurt. One group member
usually feels deeply hurt by the other (whether for justified “objective” reasons or as a result of narcissistic vulnerable self). As a result, this member retaliates and attacks the other person, believing that this attack is justified, and in an effort to hurt the other in return. The end result is that both parties are deeply hurt and as the conflict evolves, it does not matter any more who started the fight. They see the other as their “enemy” and project on him or her the characteristics of a bad object. The “other” is perceived as mean, full of negative intentions, untrustworthy, and threatening. Just as it happens in social conflicts, perceiving the “other” as such means that we focus on how different and better we are, leading to depersonalizing and even dehumanizing the person with whom we have a fight. When happening in the group, the fact that other members observe the scene exerts more pressure on the conflict-participating partners. Both feel that they are totally right and the other is totally wrong. More than that, they feel that injustice is done to them and they demand justice. They might become righteous and fight viciously to prove their justice. Because this struggle takes place in front of the others, an element of shame and “saving face” is added to the fight, and each of the partners becomes sensitive, counting how many people support them and how many do not. Group members who do not support them are easily considered against them, and when someone gives any negative feedback to one of the partners in conflict, he or she belongs to the “enemy” side. Each partner tries hard to convince the group that they are right and to recruit more group members to support them. Thus, splitting becomes prevalent and an atmosphere of Us and Them governs the scene (Berman, Berger, & Gutmann, 2000). Similar processes are observed in social conflicts, and can easily be analyzed in large groups (Weinberg & Schneider, 2003). They are strongly personified in a small group.

Using Ghent’s (1999) terms of submission and surrender, we can say that in times of conflict described above, each partner is stuck in a submission position. In this situation there is no ability to move and the participants are locked and submit to their subjective experiences. Laor (2009) describes submission in a way that is very relevant to conflict situations: “In such situations, each partner is driven (unconsciously) to an “I am Right!” position, I am the victim of the situation, I only wanted what was best, and so on” (p. 489). In contrast, surrender “convey a quality of liberation and expansion of the self as corollary to the letting down of defensive barriers” (Ghent, 1999, p. 213).

What is the role of the group therapist in these incidents from the intersubjective point of view? Apparently, the therapist should help the participants move from submission to surrender. The task is to restore the safe space as a place of reflection and processing. The main difficulty of such conflicts is that the participating partners lose the ability to see one another’s subjectivity (Benjamin, 1998), and unless this ability is restored, each of them continues to be convinced that they are holding the “objective” truth, while only the other is inflicting pain and creating injustice. Hurt and pain make people very self-centered and disable their ability to see that the other suffers as well. From an intersubjective perspective, these group members (and sometimes all the others actively or passively involved in the conflict) fall into the trap of believing that injustice is done only to them and that they themselves are not doing any injustice. It is almost impossible to keep in mind the relativity and subjectivity of the experience, and, moreover, it is very difficult to remember that the other’s subjectivity is legitimate. This is where the group leader is called upon to intervene. Perhaps in times of conflict the group therapist should move slightly and temporarily from being a participant in the interaction, to standing outside of the action. The therapist can use a different part of his/her self in order to restore the group safety. The concrete task of the leader is to help the parties see the other’s subjective experience, acknowledge the legitimacy of the different points of view, confirm the fact that all partners involved are hurt, and gently help them to take responsibility for the pain they inflicted upon the other. Mutual recognition of the other’s suffering and hurt is the best end-result of such a conflict. The therapist can still use a reflective expression of his or her own subjectivity to enable participants to shift their self-states.

In order to achieve this end-result, the group therapist cannot stay passive. This is the time for a very active effort to help both partners express their feelings. Usually, when a group member feels injured, the last thing they want to do is to express the hurt, as they feel so vulnerable and try to avoid exposing themselves to repeated attack. The group therapist should stay tuned to the sound of pain beyond the expression of anger and sometimes rage, and bring those sounds to the forefront. It is a difficult and delicate task to help people who suffer, to open their mouth to express their hurt, to open their cars to listen to the suffering of the other, to open their eyes to see the subjective experience of the other, and especially to open their hearts to acknowledge and recognize the other’s pain.

But what happens when the therapist is one of the partners involved in the conflict? The above perspective may not actually work in practice, as the therapist is drawn to enactment, becomes involved in the anger, and often has trouble hearing the pain.

A Group Vignette Analyzed According to Two Different Approaches

In a supervision group I had led in Israel for group facilitators, the only Islamic member, Mustafa, started behaving in a very defiant way. It happened after he had talked about an event from his work: he was leading a group of battering men and one of his group members became angry with him, after he had cut him off when the man monopolized the group session. Mustafa received some feedback from the supervision group members focusing on how he probably contributed to this situation at work. The group members said that he could have responded to this monopolizer in a gentler way, and tried to convince him how his reaction to the battering man might have come across as
aggressive. Mustafa could not listen. My subjective feeling was that our group members gave him legitimate feedback in a way that I saw as constructive and that Mustafa could learn from these responses, and I said that in the group. Mustafa clearly did not see it this way. He said nothing about the feedback, but withdrew into silence and passive compliance, although he had been more active in the group before this event. When other group members asked him what is happening, Mustafa dismissed them and said that nothing has happened, although it was clear that his behavior in the group has changed. Some of the members tried to tell him about the distance that they feel in their relationship with him, that were warmer before, but he dismissed that too, and said that he does not want to talk about it. I became more and more annoyed at him. I tried to approach him in any possible and creative way I could think of: I asked him if he needs some help to get out of his silence. I suggested that he was hurt from something that occurred in the group. I looked for a parallel process between what happened in our supervision group and his group for battering men. I talked about the possibility that he felt criticized by me or the group. All in vain: Mustafa stayed silent and irresponsible to any of the interventions. He also adopted what seemed like passive-aggressive patterns, such as leaving the group ten minutes earlier without explanation and when asked by group members, he gave a practical excuse about it. In fact his behavior was quite provocative, suggesting that he was holding the group hostage—he could abandon them at any moment.

I decided that I could not ignore him and I made a final attempt to approach him. On one session, two group members discussed a conflict that had occurred in their groups. When the timing seemed appropriate, I turned to Mustafa, assuming that the issue of conflict relates to him and his group too, and suggested that he joins the discussion. Mustafa said that he is not inclined to do that. I responded that I respect his decision, but I wonder if he can share with us what is the reason for that. He said that there is no reason. He just does not want to do it.

At this point I lost my patience and harshly told him that this is going nowhere and that maybe he should leave the group because he does not seem to benefit from it anymore. He clarified that he is not ready to do that either. We had some stormy moments of interaction: he accused me of being very demanding and expecting more from him than from any other group member. The other group members helped me to get back to my group leader’s position, by commenting that I seemed very angry and that I was drawn to engage in an unproductive interaction. When I asked Mustafa why he thinks that I behaved the way I did, he blamed me with racism and said that it is probably because he is a Muslim. We processed the group reactions until the end of the meeting.

Before describing how we resolved the situation later in the group, let us analyze this vignette from two points of view: a traditional psychodynamic one and a relational one. Practically, these approaches are not necessarily so extremely contradictory, but for didactic reasons I will emphasize and exaggerate the differences.

In the traditional approach, Mustafa’s behavior shows maladaptive ways of handling negative feedback, hinting to narcissistic personality features and vulnerability. His withdrawal and passive-aggressive attitude could be understood as representing a fragile self, with internalized persecutory objects. We can conclude that he holds a lot of aggression inside of himself. His response toward me after I lost my temper clarifies his projections, unresolved issues with authority, to the extent of distortion of reality (if we assume that my behavior and reactions toward him had nothing to do with his social or religious identity). My angry reaction can be interpreted as countertransference, either as an objective one—assuming that any group leader might become frustrated and angry with such a member’s defiant behavior—but probably with a subjective element due to my inappropriate comment that maybe Mustafa should leave the group. I was clearly not acting only in the best interest of Mustafa or the group. We can also speculate about projective-identification mechanism working in the background that pushed me to express overt anger and intense feelings while he was avoiding expressing his anger and feelings. Perhaps I identified with his projected feelings? Parallel processes around ways of expressing and responding to anger might also exist between what happened to Mustafa with his member in the battering men’s group, and between Mustafa and me.

But what if we look at this vignette intersubjectively, and analyze the relational interchange, focusing on how each of the participants jointly created this escalating event? Although we can analyze the chain of events as starting and resulting from the group members’ initially commenting on Mustafa’s work, at least from a certain point in the interaction, it looks as if the impasse was not created due to a specific member’s (Mustafa’s, group members’ or leader’s) contribution. Mustafa probably felt that he needs to protect himself from the members’ and leader’s pressures and expectations, and did the best that he could to avoid further communication that might lead to more criticism and dissatisfaction with him. We can also say that he had his own issues with aggression and did act in a provocative and not just protective manner, but according to self-psychology, aggression is considered more a reaction to narcissistic hurt and in the service of protecting the self. Adding now the relational perspective, this behavior triggered more pressure from group members to get him out of his protective silence. It is interesting to note that no one seemed to identify with him, which means that he probably represented something to the group members, which they did not want to own. My addressing Mustafa was a sign for him that I joined the group pressure and that he needs to be more cautious and protective of himself. The group acted upon the assumption that he is angry with them, while I thought that he is hurt, and tried to find ways to connect with him, but for him it just seemed more threatening.
More than that: the more I tried, the more it seemed that he withdrew because he felt attacked by my good intentions, using the only patterns he knew—being defiant and provocative. As I became more and more frustrated, I started reacting also out of my hurt because my benevolent intentions were rejected. The situation escalated into a powerful enactment of a clash between Mustafa and authority, to which we both contributed. It was a co-created explosion.

At this point, some readers might wonder whether any clash is “co-created” whenever a conflict escalates, both parties are hurt, both become angry too and retaliate. This is very true. As I described in the previous section about the therapist role in times of conflict, the mechanisms of splitting, projection, and projective-identification are very active when a clash occurs. Unfortunately, when you are part of the conflict, you cannot see the incident as created by both participants, and a therapist entering such a situation in a group is no exception. Being a therapist and looking for the patient’s maladaptive patterns, might blind the therapist to her or his own contribution. In the above example, the interpretation handy for the therapist was that Mustafa’s behavior is defiant and passive-aggressive, thus labeling it as pathological and residing inside the patient.

To support the notion of a co-created conflict, let me share with you some of the thoughts, feelings, and associations that went through my mind during and after these events. Mustafa’s behavior felt like a threat to my leadership, and a challenge to my therapeutic skills. I felt as if all the group members are observing our interaction, hoping that I will find a way to deal with this conflict, expecting me to do something extraordinary to resolve the situation. I was under a lot of pressure. I tried to understand the source of this pressure and was reminded of my mother’s expectations of me to excel. When it became clearer to me, I embarrassedly had to recognize and own my dissociated parts in this enactment.

In addition, there was a political context to consider. Biran (2003), following Bion’s concepts, showed how difficult it is to transform Beta-type elements to Alpha-type elements in the case of two societies (large groups) in conflict, which blocks dialogue between Israelis and Palestinians. The same thing happened in my group. In fact, trying to keep a balanced-liberal attitude, I did everything to avoid relating to Mustafa differently from the other (Jewish) group members. In an effort to stay “objective” and avoid prejudices, I tried hard not to see his behavior as having anything to do with his being the only Arab in a Jewish group led by a Jewish leader, or with being a minority in Israel. At the same time, from time to time a stereotyped thought crept into my mind: “All Arabs have a problem with authority.” I was reminded of a famous sentence that right-wing politicians used to repeat: “Arabs understand only the language of power.” I was ashamed with these thoughts that did not suit my self-image and political attitude and tried to ignore them. Was I just angry at Mustafa or also with myself and my denied and dissociated thoughts?

Enactment involves the therapist as participant caught up in the relationship rather than observing it. It is also accompanied by some dissociated and disowned parts. The group acted as a good enough consultant, pointing out my futile anger, and I was able to listen to them. The ability to analyze the events the way I presented above helped me free myself from the enactment. Looking at the situation the relational way, I could get back to the group and describe the chain of events from the intersubjective point of view, admitting my mistake, and normalizing Mustafa’s behavior as an act of self-protection. I also said that maybe we can learn how conflicts escalate by misinterpreting the other’s behavior as hostile and (sometimes passive-)aggressive, when in fact the other subjectively sees it as legitimate ways of self-defense (which can probably be broadened to the social context of the Israeli–Arab conflict). In response, Mustafa tearfully thanked me and described how, as a minority, he was expected by his father to be better than others (interesting how this reflected my subjective experience of the pressure to excel!), and how much he had to face misunderstandings from authority figures during his life in Israel, developing caution when approached by authority (perhaps an almost anti-thesis of my pre-conscious stereotypes about Arabs and authority). He remembered a traumatic encounter from his childhood with an Israeli policeman, where he was humiliated and called nasty names by this policeman while other kids were watching, although he had done nothing wrong. We could now better understand Mustafa’s reaction to me and to the group.

The group members joined in, by reflecting on their subjective experience both when they could not reach Mustafa, during the intense encounter where we had our strong conflict, and now, after it seems that communication was restored in the group. They were relieved that peace was restored but did not ignore Mustafa’s considerable aggression and its effects on all group members. In the new atmosphere of mutual acknowledgments, some of them talked about their fear of aggression, either their own or the other’s anger. Mustafa himself began exploring his passive-aggressive ways and their impact on the other group members.

**Conclusion**

The above example demonstrates well the usefulness of the relational paradigm in group therapy. The group leader in that vignette carries a double burden, both being drawn to an enactment which emotionally impacts his reactions and participating in a conflict with a group member, thus losing the ability to see the subjective experience of the other for a while. He was unconsciously caught in a submissive position (Ghent, 1999). The group served as a good supervisor, helping the therapist restore his therapeutic role and observing ego and moving into a surrendering position. Only when understood from an intersubjective point of view and analyzing the shared contribution of both the leader and the participant(s) to the situation, we could resolve the conflict in the group. One of the influences of the relational approach on the therapeutic relationship, as manifested in this vignette, is the effective negotiation of conflicts and differences, facilitating the repair of disruptions. Insisting on a traditional object relations point of view, this group member would have been labeled a difficult patient.
Gans and Alonso (1998) have already clearly described how group therapists and group members can co-create a difficult patient in a group.

The political context of this vignette needs more consideration, as clearly the attempt of the therapist to avoid acknowledging the fact that Mustafa was the only Muslim in the group and ignoring the impact of this fact on the group, only complicated the situation. As a minority in the group, more was asked of Mustafa all the time, so it was not only his imagination but also some real enactment of his father’s expectations by the group. Furthermore, we can connect the events in the group to the larger political situation, and see them as an enactment of a moment of cultural trauma: Mustafa is isolated by the group who puts all the aggression in him and then attacks it. Suchet’s article (2010) shows how the therapist cannot avoid the political and social environment, even against her will: “As the work unfolded I find myself thrust into a psychic and social space I had not wanted to inhabit, into the Israeli–Palestinian conflict and the turmoil of Jewish identity” (p. 158). Actually, it is always there, as part of the Social Unconscious (Weinberg, 2007; Hopper & Weinberg, 2011).

In retrospect, the enactment with Mustafa seems to be an enactment of trauma, part cultural and part personal, and contained some thoughts, feelings, and processes that were traumatic and dissociated in that group.

In addition, this vignette shows how strong enactments in a group can become, drawing into intense emotional involvement group members and even experienced group therapists. The group therapist cannot (and should not) escape participation and the emotional impact of the enactment, but needs to examine the process and understand it from a relational point of view. The therapist can be helped by the group members who are not involved in the enactment to point out what is happening and help the therapist out of the “trap.” Thus the group serves as the best supervisor.

A possible difficulty arises when the whole group participates in this enactment process. It might be almost impossible for the therapist to distance himself or herself and examine the situation more from a distance and in such a situation external supervision might be helpful. If this supervision is done in a group setting, it is probably very useful to pay attention to the parallel processes and explore the repeating enactment in the supervision group, thus enlightening and deeply understanding the situation in the original therapy group.

References

Chapter 4

The Edge of Chaos
Enactment, Disruption, and Emergence in Group Psychotherapy

Robert Grossmark

To jump into the unknown from what is known, but intolerable. Béla Bartók

Introduction

In this chapter I will introduce an approach to group therapy that is based on the idea that group psychotherapeutic process and change involves a constant movement into and through enactments that involve the group as a whole, the group analyst, and each group member. It is a truism in the group therapy field that a group is always interacting. This group interaction is the primary unique resource of group psychotherapy. It is out of this interaction that each group develops its particular group culture and the “group matrix” (Foulkes, 1975) from which change and growth emerge. As the group members engage with each other and bring in their whole personalities, enactments are unavoidable, and just like interaction, inevitable. In this chapter I will examine the process of these enactments from the perspective of current relational theorizing that emphasizes the presence of multiple self-states in the group and the embeddedness of the group analyst within the group enactments. These enactments are constantly unfolding and involve the group as a whole and the group analyst in repetitive and unmentaled states. Therapeutic action, in part, involves the ongoing work on the part of the group analyst and group members in attempting to understand what is going on in the group. This is achieved by accessing alternative self-states that allow the therapist or group members to think about and try to understand what is happening and thus turn unmentaled (Fonagy et al., 2002), “un-understandable” (Pines, 1998) and painful interaction into psychological learning and development. This process often involves the group and the group analyst entering into difficult and sometimes painful passages of group process together. With the therapist’s help in containing the painful and disowned affect, new experience and meaning can emerge for the group members from the unmentaled, unformulated, and rigid repetitive self-states that characterize the enactments.