READER'S FORUM

Being Seen, Moved, Disrupted, and Reconfigured: Group Leadership from a Relational Perspective

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This paper describes a relational approach to conducting group therapy. Relevant psychoanalytic concepts such as enactment, transference, and countertransference are defined from this perspective. Two concepts central to this school of thought, mutuality and recognition, are also reviewed. Finally, the topics of self-disclosure and emotional turmoil related to leading therapy groups from a relational point of view are discussed.

I entered group therapy with Hugh Mullan in 1960 and he and the group had a profound impact on my life. I was a young man of 24 at that time and was having difficulty getting along with people, and particularly having a difficult time successfully connecting with women. These problems were due to a number of family and

cultural factors, chief among those being the dissonant nature of my relationship with my mother.

There were two sources of help for me in the group: the group itself and Hugh. There were a number of psychologically sophisticated members in the group, two women in particular, who, shall we say, vigorously de-constructed my conflicts and fears regarding women and intimacy. Hugh's help came largely from the way he behaved in the group. This was the heyday of classical orthodox psychoanalysis and the blank screen, or non-involved, objective therapist. Hugh, however, was no blank screen. To the contrary he was open, emotional, and very spontaneous. He would do things that at that time in the evolution of psychotherapy were quite unorthodox. He would act in a fashion that could appear puzzling, "not nice," and even weird from a conventional perspective. For example, he would tell his own dreams, disclose feelings, make non-logical associations, and in other ways reveal his own raw subjectivity. He modeled unguarded, authentic, affective involvement. His way of behaving was, oddly enough, comforting for me in that it established that I was not alone in my own "weirdness." Or in a more benevolent way of saying it, I was not alone with my own unique subjectivity. Using the language of contemporary psychotherapy, I felt held by his behavior.

One event took place with Hugh that I believe was especially helpful for me. One day he was sitting in group next to another group member, a woman, with his eyes closed and looking very relaxed; in fact he looked like he could be asleep. A group member commented to him, "You look very comfortable Hugh, why's that?" He opened his eyes and immediately responded with "Because I'm sitting next to a woman." Now I don't remember how other members responded to that unguarded, apparently very spontaneous expression of his, nor do I know what he might have been responding to that was going on in the group process at that time. In fact he didn't appear to be concerned about the group process at all. He looked like he was, as he said, simply enjoying his own inner experience of sitting next to a woman. I do, however, know his response had a big impact on me and continues to do so

to this day as demonstrated by my addressing it in this paper over 40 years later.

Here was a high status psychiatrist who personified and occupied the role-defined hierarchical aspect of the therapeutic relationship that Hoffman (1998) discussed, openly revealing, in a professional situation with a number of people looking at him, that sitting next to a woman made him feel comfortable enough to close his eyes and rest. This really impressed me because up to that point I could never have admitted in public that I had such feelings about women, or even have admitted such feelings to myself for that matter. I had concluded that women could only be sources of comfort in a sexual way. Beyond that they were trouble and needed to be kept at a distance. Hugh's response in that context stimulated a whole new way of thinking and feeling in me; namely, that it's safe to relax in mixed company, if you will. When I first joined the group I had concluded in a semi-conscious fashion that I would probably never marry since marriage didn't work, as vigorously demonstrated by many of the members of my original family. However, I did know I had to find a way to get along with people, particularly women, since I definitely needed and wanted them. When I left the group after 5 years I was solidly married and have stayed married to the same woman to this day.

Let it be noted that this interaction with Hugh, that turned out to be so important for me, could not have occurred in individual therapy because there would not be a woman present for Hugh to respond to. His willingness to reveal his own feelings with such directness presented me with a real life drama that stimulated me to move in new directions, directions that were out of conscious consideration until this event happened.

Hugh's willingness to do this—disclose his unguarded subjectivity—made us equals in our humanness and need to be connected and this approach is consistent with notions of contemporary relational authors such as Aron (1996), Benjamin (1992), Hoffman (1998), Miller (1976), and Mitchell (1988). To my mind the incident I just described and other aspects of Hugh's work, including his publications, show that he was ahead of his time. He was al-

ready functioning as a relationalist and moreover was doing it in group therapy. With regard to the latter, he was even ahead of the contemporary relationalists just mentioned in that he understood that a relational approach to therapy could be practiced in group therapy in addition to individual therapy, something most of the relational writers have not addressed at all. Thus the model I'm presenting here is not so new after all. Gifted or intuitive therapists like Hugh Mullan have been practicing it all along. It was just not as codified or formally worked out as it has been in the last 15 to 20 years.

As mentioned, the notions developed by the relationalists have not been fully applied to group therapy and I would like to select and review some of the ideas coming from this school that I think are particularly applicable to the conduct of analytic group therapy. An analytic group, as distinguished from other kinds of groups designed to help people with psychiatric problems (e.g., social skills training groups), is one that focuses on dysfunctional relationship patterns and the goal is to bring about personal change and particularly change in the way group members relate to other people.

A notion of central importance to many relational theoreticians is that of *enactment*. It is hard to know exactly when this term started to be used in psychotherapy discourse. Eagle, Jacobs, Kohut, and McLaughlin have all been credited as using it starting in the late 1970s and/or 1980s (Ellman & Moskowitz, 1998). There is no agreed upon definition in the field and the term appears to mean different things across different theoretical positions. For example, classical psychoanalysts tend to see it as a difficulty, while others view it as a desirable event in the therapeutic interaction. The school of thought I'm reviewing here falls into the "enactment as desirable" category.

An enactment is typically defined as an automatic, unformulated, nonreflective moment involving all participants in the therapeutic interaction. It can be deleterious or beneficial, repeating old traumas or advancing new experiences of growth. It differs from acting out in that it is mainly an interactive concept reflecting

what occurs in the relationship between patient(s) and therapist; that is, it refers to the ways in which patient and therapist act upon one another verbally and nonverbally in the therapy setting. It is also thought of as the only method available to the patient to communicate an inner inchoate experience that he/she wants to address in therapy. In addition, it's stressed that the therapist is usually unconsciously involved in the process. The interpersonal psychoanalysts Levenson (1983) and Wolstein (1993) emphasized this part of the process and described therapists as "unwitting coparticipants" in the interaction. This notion of unwitting or unconscious participation by therapists gets to the heart of the matter for relationalists. They espouse the inevitability of therapists' using and communicating their own subjectivities, or, to use the more traditional term, countertransference, in the therapeutic interaction. Thus from this school of thought enactments are inevitable, bidirectional, mutual, and contain great therapeutic potential.

Davies (1999), a leading relational writer, stated that the relational model is most accurately defined in terms of continual movement from one enactment to the next (i.e., in doing relational psychoanalytic psychotherapy we move from enactment to enactment because that is the way the unconscious reveals itself). We only "know" the territory we have "left" because we have some perspective on it. But we have far less knowledge of the territory we now "occupy" because we are right smack in the middle of it and can't yet feel its borders. Therapy from this perspective then is the ongoing examination or processing of these enactments or unwitting interactions between patients and therapists. This means both parties must not only be willing to be observed or seen, but that it is inevitable; it's beyond the therapist's control. The therapist, however, does know about enactments and inevitable countertransferential reactions and is therefore prepared to step back and examine the interactions. This is the observing part of the notion of "observing participation," which portrays the therapist as both in and outside the interaction.

Group therapists have known about this matter of examining the interaction for some time and have addressed it through what Yalom (1995) calls "process commentary." Here he is referring to the analysis of the here-and-now interactions and behaviors that unfold between group members and between the leader and members during a group session. He's distinguishing between attending to the verbal content of a discussion on the one hand and the nature of the relationship between individuals who are interacting with one another on the other hand. This, of course, is a core procedure in analytic group therapy. Yalom, however, does not attend very thoroughly to the issue of the subjectivity of the group therapist and how that may manifest in the interactions with the group or individual members. This appears to be the case generally in the group therapy literature with the exception of the work of Hugh Mullan, as mentioned earlier.

Writers from the relational perspective also conceive of transference and countertransference in nontraditional ways. Transference has usually been understood in the context of psychopathology and treatment and has been seen as a distortion of reality, a carrying over of representations and anxieties from the past into present life and especially into the treatment situation. The relationalists (e.g., Aron, 1996) have redefined it, emphasizing perspectivism, the philosophical view that the world may be understood through a variety of belief systems and that there is no one true vision of reality. From this point of view transference is not thought of as distortion, but rather one way among many to perceive and understand experience. Each view is a plausible construction. That is, there is no one authoritative independent view of reality, but many plausible versions other than one's own.

Relationalists (e.g., Slavin, 1994), in addition, define transference positively as a developmental and adaptive phenomena. Looked at this way transference can be seen as an effort by patients to induce or compel a complementary response from others to meet their needs; it's an effort to regulate the other. Humans, due to developmental experiences, are striving to maneuver oth-

ers to provide the gratifications they need. From this angle it is not a distortion of the present by the past but rather a creation of a past reality in the present and it may serve either adaptive or destructive purposes depending on how it fits with the present social environment.

Thus people engage in mutual efforts to pull each other, or try to pull each other, into some sort of response that matches preconceived wishes, expectations, and needs. In sum, we try to make present others more like the people we have known in the past. People do this to their therapists and we describe this as transference. When the therapist inevitably responds to the pull, often in a complementary fashion, we call that countertransference and the interaction is called an enactment.

This way of looking at transference, as well as the perspectivist view, puts us in a better position to understand its resolute and determined nature and, consequently, the powerful impact patients can have on therapists and the groups we place them in. As Slavin (1994) puts it, "we're targets, and we put ourselves there" (p. 269). Improvising on this metaphor, it might then be said that doing group therapy is a bit like putting oneself in front of a firing squad. However, and to paraphrase Aron (1996), since our goal is to facilitate patients' awareness of their impact on us and our awareness of our impact on them and, when doing group therapy, to facilitate members' awareness of their impact on each other, we therapists must be prepared to be closely examined, analyzed, and influenced by patients in the service of their psychological needs.

From this perspective group therapy might be thought of as a sensible effort by therapists to get help in coping with these powerful transference maneuvers and the resulting emotional or countertransference responses. Thus not only is group treatment helpful for many of the reasons discussed in the group literature, such as providing multiple sources of feedback rather than relying only on the therapist's ability to understand, it also provides additional "eyes" to see what's going on if and when the therapist's vision is impaired by her or his own inevitable subjectivity.

Additionally, it can be argued that the blank screen approach to therapy as well as other technical strategies such as assigning homework, hypnosis, structured group exercises, and sitting out of sight of the patient are, at least partially, efforts to avoid what the patient is trying to do to the therapist. That is, they can be regarded as attempts to defend against the powerful and often distressing and disruptive feelings stimulated by unfettered transferences.

From a relational point of view, then, the primary therapeutic task is not so much striving to gain genetic insight as it is an effort to offer patients a safe place and enough genuine concern so that their inevitable effects on the people they are relating to can be examined and processed. This stance does not require a deliberate courting of enactments or undisciplined self-disclosure by the therapist. It does require, though, that therapists' responses be seen as part of a complex relational situation in which the patients' efforts to influence and the complementary responses to those efforts be sorted out. The central matter is not the origins of the therapists' countertransference but the therapist's capacity to make the entire process examinable and not simply unconsciously enacted. In dyadic analytic therapy interaction is limited, by definition, to two participants. Analytic group therapy has the advantage of providing a forum where a variety of transferential perspectives and consequent interactions can emerge for examination; for example, peer transferences as well as authority transferences.

Another reason for examining members' and leaders' relational enactments and associated beliefs, needs, and expectations is to create doubt in group members' minds regarding their perspectives on how to relate and/or develop relationships. The therapy group is especially valuable in such an enterprise because so many different perspectives on relating are revealed during group interaction; there is a pluralism of perspectives on display. As the group culture comes to reflect the norm that all perspectives are subject to examination, members, including leaders, have the chance to re-visit and reconsider their own idiosyncratic constructions of reality.

In addition, this processing or examining of all the group inter-actions, including the leader's, serves to model mutuality to all members. Mutuality is prized by the relational school. It refers to the fact that all parties in the therapy setting are undergoing expe-riences and reactions, and that each influences and is being influ-enced by the other or others in an ongoing fashion. In mutuality one extends oneself out to the other and is also receptive to the im-pact of the other. In short, the therapeutic process is reciprocal.

Writers (e.g., Miller, 1976) associated with The Stone Center at Wellesley College have developed a theory relevant to this discus-sion called the Relational-Cultural Model of human development. They especially emphasize therapy as a process that helps build mutuality or, to use one of their related terms, relational compe-tence. According to them, developing mutuality skills means see-ing the self as interactive and growing through relations with oth-ers rather than developing a separate, cut-off, autonomous self. Relational competence skills include the abilities to integrate while vulnerable, to negotiate and work through conflict while in relationship, and the ability to be responsive rather than defensively closed to others.

Jessica Benjamin (1992) addressed this matter of responsivity to others through her notion of mutual recognition. This refers to the need of the self to be recognized by another. Being recognized means one is acknowledged by another person as "an equivalent center of experience" (p. 28), and begins "with the other's con-firming response, which tells us that we have created meaning (and) had an impact" (p. 33). Group therapy is a particularly apt way to develop these skills. Members learn mutuality skills by ob-serving them in action between members and between leaders and members. These skills, or ineptness at such, are always on display or being demonstrated in unstructured, primary groups. The ana-lytic therapy group is designed to promote enactment and examination of the mutual impact people have on each other.

Pollack and Slavin (1998) used the notion of agency to discuss this matter of recognition in some detail. According to them, agency is represented by the internalized experience of being able

to have an impact on one's relational world and that the disruption of this experience is the source of emotional trouble. The idea is that the therapist must be seen as seeing or recognizing the patient and also being moved or affected by the patient. This facilitates patients' development of a sense of personal agency, a sense that "I matter." They and Benjamin describe an oscillation that takes place between an assertion of personal agency and self-interest and a state of mutual recognition and vulnerability. This takes place on both sides of the therapy relationship. In order to establish a real connection both parties must have an impact on each other; that is, both must allow the other to have an impact on one's self.

From this perspective therapists must relate to patients in a fully authentic way that reveals or exposes parts of themselves. Any obfuscating by the therapist "undermines the patient's chance to regain not only a sense of the potential accuracy of her own perceptions but also of her agency as a perceiver and as an agent in the real interpersonal world" (Pollack & Slavin, p. 866). Further, the validation must be real and authentic rather than a self-conscious attempt to attune oneself to the patient's perceptions. The authors add that when therapists act in a way that is not congruent with their own experience, they rob patients of their sense of agency because therapists are immersed in their own agenda about what is in the patients' best interests. This amounts to a refusal to let the patient have an impact on the therapist, rather than entering into an authentic negotiation of responsibility and agency. They argue that a blank screen approach and other technical innovations are efforts by therapists to guard against the patient's impact and ways to avoid being moved in real, unpremeditated ways—they are defenses against vulnerability. Mullan's behavior, in the clinical vignette described initially, accords with this point of view. His willingness to allow a member of the group to impact him, and to allow that impact to be seen, turned out to be quite beneficial for me.

This raises the controversial issue of therapist self-disclosure which is presently under discussion by many schools of therapy,

and it also refers to a significant difference between self psychologists on the one hand and relational psychoanalysts on the other. These two models of psychoanalytic psychotherapy have much in common but differ on this matter of therapist self-disclosure. The position of Pollack and Slavin (1998) just summarized represents the thinking of a number of the relational analysts cited here.

Other contemporary psychoanalytic writers challenge this position. Teicholz (1999), for example, discussed this matter in considerable detail. She reviews a debate between self psychologists and analysts from the relational school (she refers to the latter group as "the postmoderns"). The latter, as described above, call for the spontaneous expression of the therapist's subjectivity, arguing that it is in the patients' best interest for therapists to be seen by them as they really are. Patient's active exploration of the therapist's subjectivity, according to this view, is required for the patient to develop his or her own subjectivity. Self psychologists (as well as some relational analysts, e.g., Slochower, 1996), on the other hand, contend that therapist subjectivity needs to be "set aside" for some patients until they are developmentally more advanced and can tolerate subjectivities different from their own. They say we need to vary our responsiveness to patients accordingly, lest it be experienced as traumatic impingement.

This ongoing debate is complicated and may never be fully resolved given the complex and varying nature of human personalities. As group therapists, however, we may consider the possibility that the group approach may help us address this dilemma. If the therapist is unable or unwilling to be present in his or her full, authentic subjectivity, either because of personal style or theoretical position, or if an individual patient in a group cannot tolerate the therapist's raw subjectivity, there may be others in the group who may be able to be there for the patient in the way that is needed. For example, counterdependent group members, as a consequence of their particular transference, often find relating to an authority figure like the group leader to be quite a toxic experience, no matter how the leader behaves. They often can only get the kind of connection they need to continue the work of therapy

through bonding with peers, people who do not have any kind of authority over them.

There's another variable to consider when thinking about the disagreements over the matter of therapists' disclosing their subjectivity to patients. It is possible that patients may vary as a function of their character structure or defense style regarding which of these approaches they may need. Or patients may vary in the course of their therapy, requiring one approach at one stage in their therapy and the other at some other point in time.

McWilliams (1991) presented some related ideas that may help with this dispute. She has written on mothering and fathering processes in psychoanalytic treatment, and, according to her, patients emphasize the *attitude* of the therapist when describing what helped. Specifically, they distinguish between a mothering attitude that emphasizes the expression of understanding, affective resonance, and flexibility of technique and a paternal attitude that stresses the importance of boundaries, interpretation, expertise, and distance from contaminating countertransference.

She found that, in fact, both attitudes are necessary and that effective therapists, irrespective of actual gender, are able to express both attitudes when necessary. Patients often need one or the other at different times and the therapist may need to respond accordingly. Thus self-disclosure may be helpful at one point in therapy, but not at another. It's also interesting to note that these two attitudes parallel the evolution of psychoanalytic therapy with the early classical model resembling the paternal style and the more contemporary relational style corresponding to the maternal.

As illustrated by my history I regard group therapy highly; however, from time to time over the years, I have run into psychotherapists, often psychoanalysts, who have a very negative, even hostile attitude, toward group therapy. For example, one very prominent and senior analyst at the psychotherapy training program I attended in the 1970s said to me upon learning that I was conducting a therapy group, "You do *that*?" As she uttered "that" the expression on her face contorted into one of great horror. This was an attitude that prevailed then and still does to this day.

I'd like to explore some of the possible sources of this defensive reaction on the part of many therapists to group work and also point out that even group therapists have considerable resistance to doing group therapy. Billow (2000) made the point that the kind of "emotional thinking" that accompanies examining or analyzing enactments in therapy hurts, and, I would add, doing it in group, can amplify the hurt. He described a universal tendency to avoid suffering the process of meaning making, and further stated that "the therapist, as well as the group and its members, ambivalently approach emotional thinking since it causes mental pain, and (the group) makes unconscious 'decisions' at various moments to evade or modify the meaning-making process" (p. 245). In short, thinking hurts both group members and the group therapist and may lead to evasive action.

Emotional thinking leads to changing, disrupting, and/or re-organizing one's emotional and psychological structures. Said again, analyzing enactments and one's part in them is a thinking/meaning-making activity and this hurts. Revealing or exposing one's self in public (i.e., in group) runs the risk of setting oneself up for shame and humiliation. It's noteworthy that many of the interactions around fees, payment of money, and scheduling between clients and other professionals in our society like medical doctors, dentists, and lawyers are often handled by the professional's secretary. These professionals therefore are protected from the conscious and unconscious feelings both parties bring to such transactions, particularly money transactions. These are exactly the interactions and associated feelings and possible enactments that may well need to be observed and analyzed by psychotherapists and therapy groups. Calling attention to enactments around such matters, catching people off guard if you will, can stimulate anxiety and even rage.

Billow (2001) noted that forming a new group or adding new members can stir difficult feelings for all involved. For example, adding new members to an ongoing group causes disruptions of the status quo for all members of the group, including the leader. New enactments are inevitable, thereby forcing new analytic work

to take place. The group leader, in particular, has to stretch and accommodate to the new interactions and face her or his own "unwitting coparticipations" and accompanying emotional experiences.

The notion of complementarity is helpful here. New patients and new group members evoke new parts of the self and cause internal and external reconfigurations for all. Further, new members lead to different subgroup combinations, which, in turn, may well pull new parts from the therapist that were not induced in the old combination of patients. All of this of course may be unconsciously enacted by the group therapist in front of group members, thus compounding the therapist's exposure to being seen as possibly "wrong" or "foolish" by many as opposed to only one. When dealing with only one observer we may be able to get away with covering it up (or possibly summoning the distortion view of transference to rescue us), but when there are many eyes seeing us we are likely to stand revealed and have to face our own contributions to the unfolding, possibly very tumultuous, drama.

Being seen making mistakes or doing "bad" can be shame and guilt producing. Shame, guilt, and humiliation are some of the most painful affects humans can suffer. Also, the chances of being "caught" in an enactment are much greater in group because there are so many more people observing the leader. Said another way, and in the spirit of postmodernism, there are many more possible constructions of the leader by the group.

One can also feel guilty over disrupting the status quo in striving to foster growth by undoing through analysis the stability individuals and groups work hard to attain. Additionally, there is the fear that can emerge when the de-stabilized group directs its rage at the leader for disrupting them. The group can threaten him or her with loss of control and/or aggression.

Another unattractive feeling we group therapists can experience (and perhaps being observed experiencing it) is envy of smart, insightful group members who may pick up things we do not. Group members often have greater wisdom on topics unfamiliar to us. Although we think of the increase in the number of

observer/analysts as one of the advantages of group therapy, it may also generate competition and envy in us.

In sum, examining enactments disrupts the status quo, and the quest for certainty and freedom from anxiety and unpredictability is undone. Stimulating or creating new social configurations means we must be prepared to tolerate the anxiety and stress that accompanies these new arrangements or new internal and external structures. Finally, these emotional experiences can be amplified or inflamed for the group and therapist by whole group processes such as emotional contagion, groupthink, deindividuation, and group polarization dynamics.

Given all this we might consider the possibility that therapists may select people for their groups who fit what Mitchell (1988) has called our "internalized relational configurations" in order to minimize discomfort. To what extent do we select members for our groups who are consciously and unconsciously familiar to us and thus "safe?" Might we select according to ethnic, racial, sexual orientation, or religious similarity? Or could we select people with personality styles or defense mechanisms and/or needs that complement our own, thereby protecting ourselves from being seen, moved, and re-organized?

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