Disorders heal each other in Group Analysis - a relation pathology perspective

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Abstract

In this article, the author discusses the concept of pathology in its relational aspects, and the ability to obtain a therapeutic effect by group analysis, which takes into account both intrapsychic experiences, both interpersonal attitudes.

The novelty consists in considering the relational disorders according to a broader view, considering the effectiveness of the therapeutic effects are obtained by group analysis that is able to manage the relationship patterns, rather than focusing only on the individual.

The interest is thicker toward the pathology of the individual because it is more visible, while in the group unconscious relationships are more difficult to discern.

Keywords: group, disease group analysis, pathology relational, relational disorder

<<As in the individual field, in psychoanalysis, so in this multipersonal, supraindividual field, the study of the pathological proved most fruitful, opening the doors to dynamic unconscious forces which are otherwise closed and barred. It is not accidental therefore that observation and discovery in the therapeutic group are of special significance. Group-Analysis as here conceived, should prove a contribution to a truly social, transpersonal psychopathology and transcultural anthropology>>. (Foulkes 1964, p. 7).

<<The latter insight, namely that psychodynamics are not only interpersonal but transpersonal phenomena goes to the very roots of any approach to group psychology and requires a fundamental turn of mind, for which the undergoing of group-analytic treatment is perhaps the best preparation>>. (Foulkes 1964, p. 18).

<<[…] in this type of group all forms of human reactions may be expected to be encountered, normal or abnormal, physical or mental, psychoneurotic or psychopathic, psychotic or psychosomatic conditions. Hitherto all these disturbances have been investigated largely from the endopsychic point of view. Here they will be seen as facets

of the multipersonal network of interaction in which the individual's disturbances are played out. ....it is believed that even part reactions, e.g. symptoms, are interdependent. Hence it can be expected that light can be thrown on the dynamics of individual psychopathology in the course of such an approach>>. (Foulkes 1964, p. 72).

Introduction

<<Our answer to the question how group concepts are applied to the individual in the group has been so far: by exposing him to the particular dynamics which prevail in the condition created by us and which act upon him and through him>> (Foulkes 1964, p. 160). Group analysis is about changing the suffering through working both with intra-personal and interpersonal attitudes. One of the unique traits of the group analytical approach seems to be thinking in terms of relational patterns rather than exclusively intra-psychic dynamics. This interpersonal approach seems to be especially under-developed also when it comes to specify differentiated indications criteria for patients in order to create an optimal therapeutic environment.

Both the lack of good indications and the absence of developed relational perspectives seem to me detrimental in the optimal use of the group analytic therapy's advantages. Without them the full potential of the group may remain unexploited, leaving inclusion criteria to the group quite random and therapeutic gains in the realm of pre-conscious experience. Both difficulties may also imply therapists' countertransference aspects, e.g. self-security, the intuitive ability to use interpersonal aspects to further growth and health.

Participating in Group Analysis means for me to 'think the thoughts'. Patients together with the therapist create a space that makes their containing abilities available again. They establish an elaborating partnership in which difficulties of different kinds may then be worked through, reciprocally contained. While working-through, the therapist (1) may move from a structured pole, which will possess certain guidelines, to the unstructured pole that Foulkes described as "trusting the group" and Bion (1970, p. 51) described as <<the capacity to forget, the ability to eschew desire and understanding>>. Structure instructs where to look, whereas non-structure facilitates emotional processes on the margin of consciousness. In spite of the simplification, I believe it is the growing integration of structured and non-structured aspects that help us improve as therapists. This article presents second thoughts about the guidelines a group therapist follows in thinking about pathology and translating it into their interventions in the group.

<<The term 'relational' presupposes that the dyad, the smallest group, is indivisible – that we can no longer speak of the patient or the therapist as an isolate. Likewise, we

cannot speak of the group leader as separate from his group>>. (Grotstein 2003, p. 13). For me this means that everyone in close contact will participate in the 'action' and will be involved (unconsciously and consciously) in a process of reciprocal influence. It may also mean that a (interpersonal) <<characteristic, like an assumption, will be co-created, maintained and worked through intersubjectively by the linking objects<<. (Billow 2003, p. 40). For me the term "relational" is more in line with Bion's container-contained relationship (Bion 1959, 1962) and with Winnicott's (1960) notion that there is "no baby without its mother" than with therapist's disclosure aspects of intersubjective approach to the therapy. It is neither necessary for the therapist to share his countertransference with patients, nor to adopt a non-neutral or non-abstinent therapeutic position.

Group therapists deal with both positive and problematic aspects of the Psychoanalytic heritage of Group Analysis. Foulkes and his followers worked hard at the translation and transition from Individual, Dyadic Therapy, centering on an Intra-Psychic view, to the multipersonal, intersubjective space of Group Analysis. Through the inclusion of a Relation Disorders approach, a new view of pathology and possibly a further development of the group analytic approach as coping both with personal and interpersonal may be promoted (2).

How "Relational"is Group Analysis?

One important achievement for the novice group therapist is to be aware of the relational patterns and address them during therapy, instead of concentrating only on the individual. Although in theory it is accepted that the Conductor's job in Group Analysis has everything to do with coping with relationships in the Matrix, our automatic reactions in group therapy are very much to the individual's problems. We treat individuals as if they were closed systems. Instead of considering the whole network of communication, such as Resonance, Mirroring, Amplification and Condensation, therapists "regress" to treating the individual member only. There is much to say in favor of addressing the individual and efforts to understand and change personal pathology. For example, if a person is overly involved in conflictual activities, interpreting his personal violence or envy may be necessary. But many therapist's experience is that often personal interpretations remain fruitless and usually with good reason: individual changes usually 'surrender' before powerful influences of interpersonal patterns reenacted inside and outside the group. These interpersonal patterns may be universal, social or cultural givens or predominantly self-made as a result of Projective Identification processes (Rafaelsen 1996; Nitsun 1996). Either way,

Freud's (1912) concept of transference as a primary relational process is basic in the understanding of (trans)formative human interaction.

Group Analysis has developed major practical guidelines that further the therapist's interpersonal perspective – and may be considered relational through and through. In the basic Foulkesian way to see the group as the matrix of intersubjective influence, mirror reactions are…. <<aspects of the self reflected by members of the group through image and behaviour, allowing identification and projective mechanisms, enabling the individual to become aware of these hitherto unconscious elements>>. (Kreeger 1991, p. 76). "Resonance" is <<the phenomenon of intensification or amplification of a particular theme or conflict within the group, resulting from shared, largely unconscious communication between its members>>. By "Exchange" Foulkes (1948, 1964) described the sharing by members of the group at different levels of depth, including the most emotionally sensitive issues concerning relationship to self and other. This contributed to the <<supportive and socialising functions of the group>>. (Nitsun 1996, p. 23).

The basic Foulkesian view of the therapeutic effectiveness of group analysis per se may be concentrated in the following citation: <<The therapeutic impact is quite considerable, intensive, and immediate in operation. By and large, the group situation would appear to be the most powerful therapeutic agency known to us>>. (Foulkes 1964, p. 76). A close presence of others (3) will have strong unconscious influence on the individual. <<The group situation highlights the internal interaction, transgresses the boundaries of the individual, of what is usually considered internal, intrapsychic, and shows it to be shared by all>>. (Foulkes 1973, p. 230).

Resonance, Mirror reactions and Exchange are definitely relational events that promote reciprocal working through of emotions as a process that can be defined also as the relationship between (alternating) container and contained (Bion 1959, 1962, 1970). Containment means initially the capacity to bear, identify with the projection, then to process and transform difficult to digest emotions into operational and communicative entities that feed-back in different ways (Ogden 1987). Resonance and mirroring are direct and indirect containment processes of difficult emotions. Exchange implies some measure of digestive aspects. Analytical groups viewed as having permeable psychic boundaries are relational in every interpersonal and intersubjective container-contained sense. These differentiated concepts may promote a better use of both countertransference reactions and projective identification aspects and refine interpersonal elaborative functions in the group. Thus it would be important to develop the conductor's ability to detect who is containing and working through some difficult

emotion for whom? Who is immersed in relational processes? This may be a crucial part in our multi-faced professional approach, implying again that if our attention is invested into relations we may be able to work with process that a focus on the individual dynamic cannot detect. Swaying the attention from the individual to the group and back maybe only a first step to this process.

The attraction to individuality

There seem to be quite a few reasons for the pull to address individual pathology. The individual is often the easiest visible entity in the group, while the unseen group, subgroups and complicated and unconscious relations are more difficult to discern. Our conservative education at the University adds by teaching us individual nosology. Group conductors being usually also individual therapists, when in stress, find the habitual intra-personal dynamics easier to address (consciously and unconsciously). After all, we have been used to individual medical treatment from very early in our childhood, without blaming others or ourselves for the suffering. Finally it was Foulkes (1975, p. 65) who called our attention to an (socially embedded) unconscious wish to avoid responsibility for the pathology of others as a hidden motive of an individual-centered Nosology. What would happen if we would be guilty of the fate of social outsiders, scapegoats, deficient or victims of society's needs?

Reflecting on how long it took to accept the existence of transference and then to understand it as an intersubjective relation, emphasizes the importance of further developing a reciprocal relational perspective. Group Analysis certainly tried to promote this view in from its beginning, both for therapy as well as for diagnostic purposes. Foulkes (1975, p. 65) thought you should treat the <<neurotic disturbances, as multipersonal ones" and he continued (p. 66): "It is not very helpful to speak of individuals in terms of conventional diagnostic labels and to answer the question of indication and counterindication in such terms>>.

Pathology and the Social: interpersonal characteristics of disorders

There have some efforts to describe the interpersonal aspects of the personality disorders relations with others.

a. Bion's categories of the container/contained mechanism:

Bion's subtle attempt to categorize the container/contained model (Bion 1970) offers a first pathological perspective that includes containment quality and results. He thought the relationship between container and contained could be either a healthy one (commensal), a regressive-linking one (symbiotic) and even a destructive one

(parasitic). Billow (2003, 2004) rephrased the three categories of Bion's containment, and translated them into "symbolic", bonding and antilinking. Commensal is a "good mother" relation, a reciprocal intersubjective containment partnership influenced by a good-enough developed relationship in which symbolic activity is reached. In a "symbiotic" link, a container/contained relationship is prone to a more regressive bonding. An antilinking connection with a destructive 'parasite' is an unconscious relation with a lethal terrorist.

Developmental aspects add a further complexity to the relational perspective. <<The psychoanalytic problem is the problem of growth and its harmonious resolution in the relationship between the container and the contained repeated in individual, pair and finally group (internal and extra psychically)>>.(Bion 1970, pp. 15-16). Rather than a repetition, it seems to me that in every interpersonal context there is a unique quality of growth to achieve. Individuals go through several relational transitional developmental settings: the primal dyad, pair, triangle, small group and large group promote specific qualities of personal and social maturity. Piper and McCallum (1998) have worked out five degrees of "object relations quality", having investigated the growth of the container/contained relationship. These qualities may be considered as (non-exhaustive) degrees of social maturity achieved. This maturity may also be situation- dependent: if under stress, even 'developed' people regress (either manifestly or latently) into dyadic fantasies and relationships. Later, when acute crises are overcome, more developed relationships can be attained again. <<It may easily happen that an individual mem¬ber of a family is put by some others, or by general consent, into a particular situation, for instance that of 'bad object', or scapegoat. In later life, in new surroundings, this person already bears that particular stamp and will find it hard to make a new start, to free himself from the particular perspective from which he has been forced to see the world, his world […]>>. Foulkes (1975a, p. 283). Much of the hidden advantages and dynamics of individual therapy is founded on these initial critical aspects, which have to be included for the consideration of indication (4) and selection for group therapy.

A different perspective offer attachment theory that link between the attachment type and behaviour: The Secure type is comfortable with intimacy and autonomy, the Preoccupied type is anxious about relationships, the Dismissing type is dismissive of intimacy and behaves Counterdependent, and the Fearful type avoids social intimacy (Brennan et al. 1998).

Relation Disorders – Categories

What is the essence of pathology? Is there a single element of sickness, e.g. the individual response to separation processes (Mann 1991)? (5) Is it social, interpersonal or internal object related? I will try to present an interpersonal point of view integrating other perspectives. I regard Agazarian's (1994) descriptions of Containing Roles a good starting point for a primary Categorization of Relational Disorders. She describes a group member who takes on himself to be a container for the group's emotional difficulties in every developmental stage.

1.I have maintained elsewhere (Friedman 2002, 2004) that interpersonal containment seems to be an integral part of healthy and pathologic development. For me dreaming represents working through in an autonomic, first containment stage and could be complemented by an external container in a second, interpersonal developmental step. The concept of Containing Roles is thus expanded here to fixed interpersonal patterns that seem to be the result of ill-containment in the intersubjective, reciprocal, conscious and unconscious interaction. The degree of a relationship's ill containment (6) may be further characterized by Bion's quality of containment. The emphasis is that they are Relational Disorders; new categories of Pathology that may help us treat better in group analysis. (7-8).

1-Deficiency relational disorder

A relationship established and maintained in a predominant atmosphere of compulsive sickness and suffering of a member or subgroup and the assistance of others. At the centre of this kind of object relations are interactions between a powerful (sub-)group with a disempowered individual or subgroup. In the reciprocal latent and manifest communication weakness and power, sickness and health, may then be misused as interpersonal inclusion criteria. Difficulties in containing deficiency and integrate them into existing relational patterns result in splitting and projecting weaknesses and strengths onto identifying others, thus creating split and partial object relations. The (unconscious) guilt towards the distressed plays an including role in this disorder, reinforcing relationships continuously based on assisting deficiencies instead of stimulating strengths. A similar pathology used to be called <<the Identified Patient>> (Minuchin 1974), used in the context of reciprocal projecting and identifying mechanisms in family relationships. The communities' inability to properly contain deficiencies, distress and weakness, may result in relational disorders through the establishment of two human spaces-in-relation: one which cannot feel Safety if there is weakness, and another which learns not to feel Safety without exhibiting deficiencies.

2-Rejection relational disorder

This shared illness results from the failure of the environment to contain aggression. It creates high degrees of rejection together with a scapegoat who is to become victimized. This relational disorder includes a fixation on pathological interactions that base both consciously and unconsciously on strong hostilities. These are too difficult to contain, and are acted out instead towards weak, needy and deviant members of society. Displaced hate, violent rejection and expulsion create a community's atmosphere that may culminate in the exclusion of the distressed. A group's illusionary Safe Space is achieved by denying the Rejected a Safe Space (Kotani 2004; Friedman 2004) of his own. Conscious and unconscious guilt play here a rather destructive and rejective part instead of moderating the relationship.

3-Selfless relational disorder

A society in need of a sacrifice will push those who fail to contain separation to self-less heroism or self-destruction. Social pressure together with the individual's willingness to be influenced may cause in the end of the process great suffering both to the individual and to parts of the community. The use of power and education to promote selflessness in some and selfish abuse of others colludes with social and individual failure to contain separation and autonomy processes. If the individual Self does not have his own Safe Space in which to develop, the result may be both the physical and psychical martyrdom of the individual. The society will be endangered by harmful patterns, including tendencies to over-dependency and excessive use of violence to coerce the devoted.

4-Exclusion relational disorder

The more a community copes with social failure and disappointment through splitting, projection and evacuation, the more it will exclude and create outsiders. Failure to contain deviation will result in emotional gaps and physical distance between members included in the centre of society and (borderline) social marginal individuals. The community may fixate personal isolation using unconscious marginalization mechanisms creating estrangement and loneliness. In this relational pathology a Safe Space central members (often a powerful majority) establish an excluding relationship with its outsiders. The reciprocal relation between the excluders and the socially weak will maintain itself by the influence of intersubjective processes that fixate ill-containment of inclusion. It leads to social unproductiveness, suffering and the activation of powerful passive-aggressive components.

From personal diagnosis to interpreting relations

Therapeutic analytic work focuses on the development of mature forms of togetherness. From autistic through symbiotic until more complex togetherness everyone engages in the repetition compulsion of early established relational patterns that match the individual developmental level. The analytic group may provide enough space for a transformational encounter, enabling growth to a more mature relationship (9). The first two described relational disorders may be considered as more regressive pathologies, the last two disorders as more mature, from the point of view of the intersection between personal development, interpersonal (ill-) containment and resulting social aggression and splitting mechanisms. The individual's participation in the analytic group he may go through a developmental process from being a weak and needy member of the community to more advanced forms of togetherness. A protagonist of Rejection Relational Disorder may grow if he unties himself of the compulsion of re-enacting rejection and moves to being 'only' an excluded and marginal member of society. Exclusion is regarded here as more benign than Rejection, and in spite of the difficulties of marginalization, being banned from the community has a universal dreadful social valency. In the same line feeling chronically weak and sick feels worse than being a somewhat passive member of society who connects to power mainly through projecting it on its heroes.

A second aspect of the relational perspective is a contribution to organization of the therapist 'mind' while working in the group analytic setting. Relational categories may be used to address the cure and growth of interpersonal processes. As described before, interventions that attend the interaction like resonance, mirroring and exchange are still a very good advice for the group analyst that thrives to change. Interpreting the involvement of all parties while promoting understanding of the reciprocal interpersonal mechanisms. Focusing on interpersonal pathology may provide complementary understanding of relational aspects. Thus working with individuals will be complemented by addressing intersubjective communication contributing to the relational process of pathologization or healing.

Approaching therapy through the relational focus, group participants will then share ever more what they feel in the interactions, making it possible to develop more mature containment of various projections.

Examples

Four examples will try to apply the understanding of interpersonal pathology to the therapeutic process. The first three give only a condensed taste of the relation disorders,

the fourth is a more detailed account of a group analytic process. Addressing intersubjective patterns, neither necessarily group-as-a-whole nor strictly personal, may sometimes by a complex endeavour.

As a first example of the Deficiency Relational Disorder let me describe a group that 'allows' one specific participant to present herself invariably as inferior and needy. The group's overall positive response to her obsessive manifestation of weakness and deficiency seems to reinforce the fixation of a pathological relational pattern. The group's collaboration with the continuous invasion and dominance of its space by the participant's feelings of depressive worthlessness promotes her weakness instead of giving her security for her valued self. It also seems to draw even more projections of split-off feelings of deficiency onto the member willing to identify with weakness. For the group to understand the process of finding Safety from weakness was essential in sharing their difficulty. It seems that most of the group participants could achieve some understanding of they place their own weakness onto someone who accepts it because she is used to feeling safe only if she/he feels weak. The relational therapeutic approach to this example was to challenge in many ways the mutual, unconscious agreement that one special participant was deficient while the others healthy. What worked was interpreting to the group-as-a-whole, subgroups and individuals their general disavowal of their dreadful weakness, while at the same time addressing the deviant individual's motivation to constantly play the patient.

An example of the second relation disorder can be seen in a group in which quite a big subgroup 'decided' that a specific participant was only faking her emotions. This both elicited strong tensions in the group as well as the tendency to discharge them in violent ways; participants had difficulties containing their motivation to expulse and exclude the 'fake'. It seemed as if a Safe Space for authentic work and truthful interaction could only be established by angry acting-out onto a scapegoat. This aggression, directed previously towards the emotional leaders of the group seemed to have been partly displaced onto the scapegoat. Rather than interpreting individual latent destructive motivations, a relational therapeutic effort interpreting the defensive, displacing purpose of all participants together with the resulting aggressive interactions that followed, seemed more efficient. Working on the violent tendencies in the group with individuals in subgroups and their difficulty to contain tension and anxiety and the resulting aggression went along with the investigation of the scapegoat's own contribution to the group's rejection. In this example the rejected was especially insensitive to the group norms of behavior and expectation. He started to monopolize exigency and demand from both conductor and participants, thus becoming a hated figure in the group.

A self-less 'bitch' exemplifies the third relational disorder. T was a handsome woman(10) in her late forties, at first glance appearing very sure of her. Still, she seemed depressed and if asked what she wanted from her life, she would deny any ambition about herself. Her only wish to drive away, to tour the world without responsibilities was in complete contrast to her actual life, which was full of what seemed to be identification with her many commitments. Two of her children and a huge gamut of choirs were always demanding her. Her husband called her "a giver". Only after a year of similar exchanges with others in the group did she start to understand her lack of choice in her 'giving' pattern. Her overly developed detector for the needs of her human surroundings matched a compulsion to react promptly to any dissatisfaction or depression registered. All her human environment—children, friends, and neighbors—would as the most natural process accept her assistance without any big remorse. Such kind of relationship seemed to have been established already in her childhood – where she collaborated with her split family in taking the responsibility for the care of a mentally sick sister instead of her non available mother.

In the here-and-now of the group she helped anyone in need and for more than a year, she found it was difficult to address her own difficulties. If questioned for having a problem, she had a talent of being able to immediately return to the other's problems. This was seemingly done with the greatest pleasure, as if feeling safe only in the endeavor of helping others. This attitude of hers was quite astonishing – it was as if she gave up every opportunity to work through her own difficulties without any bad feeling or rancor and no narcissistic hurts. The simple truth was that her own difficulties were not 'kept secret' from the group but at the beginning she did not really know what her difficulties were about, besides feeling occasionally depressed. Or rather – it was an Unthought Known (Bollas 1987), as she later found out. Not really surprisingly, real and mature bonding with others did not occur. What looked like a commensal containment at the beginning seemed a regressive-linking one (symbiotic) later, and her situation did not improve at all. Her initial "bad moods" and efforts to endure the stress seemed to result in a wish to avoid close relationships with anyone, including her husband, with whom she had had a very strong bond until some time ago. Only after a year that she agreed that her sacrifice of her Self was not helpful for her.

Interpreting her individually, both through her history and reasons of her depression – seemed not to be influencing enough. It was as if the translation from the individual progress in the group to the interpersonal outside was doomed to fail because of the strong social influence of others in her life. It was only when I started to address the relational aspects of the interaction between her and others that a change could be

detected. It started to highlight the recurrence of the "normal" situation – she engaging time and again in helping her fellow members. Once the group started to accept that they were using her, it also surfaced that everyone knew but denied thinking they also were "misusing" her. The collusion with her Selflessness culminated in an accepted declaration she was something like "the mother of the group". This seemed to further enable the group to take advantage of her "giving" in order to repetitively and compulsively satisfy personal needs. Her selflessness was a dream come true for a selfish group. But paradoxically, finally accepting Selfishness in others as a legitimate feeling to choose and even to adopt as an interpersonal skill facilitated her change.

Thus one disorder might cure another.

Maybe this is what Foulkes (1983, p. 29) meant by: <<The deepest reason why these patients, assuming for simplicities 'sake, psychoneurotics, can reinforce each others' normal reactions and wear down each other's neurotic reactions is that collectively they constitute the very norm from which, individu¬ally, they deviate>>.

<<Collectively>>, he suggests, <<they can do what individually they fall short of, acting as each other's therapist>>. (Foulkes 1983, p. 170).

The title "a selfless bitch" was given by D, a fellow patient who was one of the main recipients of her compulsive giving. She could not stop her compulsive 'treating' him, and he felt exasperated by what he felt was her ever-growing expectation to change him. One session, in a rare rebellious mood against this pattern, he once sniped at her: "You selfless bitch….". He demanded independent and not selfless assistance, emphasizing both the relation disorders aspects and the opening of different communication channels that promoted healing each other.

Paranoia and exclusion in the group

Joining an analytic group in October 1999, N, a 50-year-old technician, stayed for five years. According to the DSM may be described as a paranoid character disorder. Married for the second time, he had a teenage daughter from his present marriage, an adult daughter from his relatively short first marriage and he helped raised the son of his second wife since he was three. In spite of working at a very high-powered enterprise, he used to have periodic conflicts, usually stimulated by his fears of being rejected. Both his pervasive envy and suspicion of rejection could be induced by the smallest frustrating interpersonal interaction. Any response of his wife, children, his parents or friends (and later the group) could be experienced as not being 'good enough' and would cause him to feel unwanted and all his efforts to build a safe space shattered

(Friedman 2004). His self-presentation was recurrently as a rejected "Scorpion", thus introducing himself unconsciously as a crustacean individual, encapsulated as Defence against the Fear of Annihilation (Hopper 2003). He forgot to present his sting, which served his less conscious sides - he was full of bad internal objects. Often it seemed that his primary interpersonal engagement was an unconscious need to translate this internal world into an external reality by influencing others to react in an (expected) rejecting and aggressive way. This process would be accomplished by a series of projections and provocations that would mould the reciprocal paranoid relationship.

Falling into the Deficiency Relation Disorder

A short while after his joining the group, almost everyone seemed to be entering into the pattern of the Rejection Relation Disorder. In spite of his openly admitted social difficulties in the two preliminary interviews before his joining the group, I had not foreseen such difficulties. My assumption that he could be contained in the group that had already worked for three years and was felt mature enough felt wrong.

Having been in individual therapy for more than a dozen years of his life, it seemed at first a rewarding task to work with him intra-psychically. His envy and jealousy as well as his projections could be addressed rather openly. For about one year we worked in the 'conventional' way, tempted by his "vertical" abilities while using only few 'horizontal', relational interventions mostly to contain the group's rejection. The first fifteen months of therapy were marked by an effort to move the group from a relationship that could reject N entirely into a connection that somehow bears his different presence in the society. The containment process included legitimizing the group's aggressive responses and facilitating resonance, mirroring and exchange that could prevent N's isolation. For a very short while the relationship with him took the form of a potential Deficiency Relation Disorder. The process from a potential Rejection Disorder through different stages until the relationship with him ended as an Exclusion Relation Disorder took more than 3 years.

N (June 2000): "I want you to give me your opinion: my wife chatted for hours in the kitchen with her son. I felt completely left out and started to quarrel in order to draw some attention to me. She 'invests' more in her son than in me. I told her I couldn't bear this, and she sent me to consult my therapy. She actually hinted that she considers me mentally ill".

D (a single man, usually rational): "Do you really believe she doesn't love you because she attends her son? I can't believe anyone healthy could believe this".

N: “I think in reality she does love me, but I get so mad and suspicious”.

R: “I often sit at the table with my wife and three daughters and feel a complete outsider. But I seldom blame them rather I blame myself for not participating in the dialogue. I don’t remember being suspicious about their love to me”.

Conductor: “R’s response seems similar but still different. When you (N) feel envy you describe it as if everything seems to break down and disintegrate”.

He admitted that he could not tolerate the suspicion of not being loved. It seemed, at the beginning, as a great insight with some changing potential. Elaborating on his envy through mirroring (which interestingly was less distorted at this stage than when offered resonance) and by having his catastrophic reaction interpreted I mistakenly thought that he could master alone some of his projections. For a while the group tried to cope with N’s envy and suspicion as a sickness. His break-down potential and suspicion could be healed, the entire group thought. The Deficiency Relation Disorder was short lived and held as long as the group’s guilt towards N had the outcome of some responsibility towards him. Deficiencies have the ability to use guilt in a “positive” way, while in the Rejection Relational Disorder guilt has a rather destructive outcome.

N (some months later): “I confess that not only do I have to continuously handle my own jealousy towards everyone, but I sometimes feel the urge to destroy my wife and marriage”. He talked of his wife as being the ultimate source of envy, and of their marriage as a curse because it made him so needy.

In spite of a variety of seemingly appropriate individual interventions and interpretations the basic difficulty to contain envy and violence persevered. It was as if insight and intrapsychic elaboration had not lasting effects and were especially futile in face of real relationships. It became clear that in spite of what seemed satisfactory analytical understanding his ability to transform his feelings and attitudes towards others was not changed. Interestingly other group members would typically gain more than himself from his openness and insights, which they would appropriate by using them in their real life. An important secondary gain was his growing importance in the group’s emotional network as a result of his efforts and the norms he set on openness. Considering his basic suspicious attitudes the measure of his openness was not clear. Was his open-heartedness in the group a first effort to contain the suspicion or was it a reactive-formation defense to cope with his rage and hatred? Was this his contribution to become a Deficiency Relational Disorder, an identified patient with defined manifest symptoms? The group itself definitely had established in the years previous to his joining an open and authentic communicative atmosphere, which probably contributed

to his efforts. In my opinion the regard and stable responsiveness of the group had great influence on his self security after about a year and a half after his joining.

Through the Rejection Relation Disorder

But very soon everyone's frustrated reactions to perceived attacks started to ignite conflicts between him and most of the participants. Instead of relating to him as deficient, N's encounter with part of the group caused rejection to became the dominant feeling. After a while, without any perceived guilt, the participants' prevailing wish was to ban him from the group on the grounds of his weird accusations. For more than a year N. and the group periodically receded into episodes of aggressive reciprocation to alleged rejection, despise or diverse violence. The group often responded defensively, some still in a mix of guilty efforts to be "good" and to convince him to believe in the group's willingness to like him, and manifest feelings of hostility. About 4 months after he joined, N told the group (again) he thought they would fake their "nice and liberal attitude in order to conceal their disdain" for him.

D: 'I think people try to like you".

R: "You are so attached to your victim feelings that you can't even see what lies around you".

I: "I feel like R, and I had it with you, you just are impossible".

The participants' experience of fearing both his attacks and their own rising violence continued to grow stronger. Throughout the first year and half I tried to help the group to work through their fear of giving N feedback to his attacks instead of responding in a false "mature" way to his allegations. I tried to elaborate the emotional encounter between N and the most rejecting subgroup, those reacting to their guilt by aggressive rejection. N was indeed quite successful in influencing the group's reality and transforming others into reenacting his internal bad persecutory objects.

From projecting and being the rejected scapegoat to the position of an Outsider

It took a long while until N's and other participants' containment of the identifications with aggression improved, in order to be able to cope better with rejection. It helped that participants like R were able to identify with some of his vulnerability and his underlying anxieties. His wife's rejection was but an example of a universal reaction to his projections, an interpersonal process that had to be contained in time by the group. But some progress in the relationship between him and the group must have been made,

because three sessions later he surprised the group by accepting even his occasional hatred towards his children.

On January 2001, after reporting another of his tantrums (fits) at home, because of his wife's relations with the children, W (middle aged woman): "Where was your empathy towards her? Was there not another side to your envy?" Later she adds in a positive way that at least he is authentic and that on second thoughts she wonders about herself feeling that someone else took a lot of place from her. I thought that she was accomplishing the passage of N from a rejected person to becoming a marginal strange and even weird person, having some dark sides that one could even identify with.

The following dialogue taking place a year and a half later seems to be yet another possibility to describe this passage. N and D are 4 minutes late. After half an hour N asks R if he would be honest and answer openly why he welcomed D with more attention than to himself. D wants to protect R from N's attack but R answers immediately that he usually is angry with D about two things: always being late and forgetting his cellular open. "You are usually on time, so I'm attending D, who is known to be a latecomer". N perceived it as a fearless response and it seemed to have helped him more than the effort to protect a "victim" of N's aggression. N commented: "defensiveness only tells me that you are afraid of me and you'll reject me later." It became clearer that he unconsciously preferred to provoke those who were perceived as being less afraid of him and seemed able to contain his projected aggression. It is this the facilitation of this kind of intersubjective containment between N and other participants that helped heal the Rejection Relational Disorder. R and the more aggressive participants were in the same time coping through N's violence with their own vulnerabilities and related therapeutic themes.

From attacking to vulnerability and role reversals

N's attacks were feared and retaliated until understood as vulnerability. In the same summer 2002 N criticized W on the grounds of not being open about her hostility to him. W, who had come to the group because she felt herself lacking ability to openly express her anger against her husband, agreed with him. She wished he would challenge more her avoiding responses and then went on explaining some of them. Then she added that she felt more assertive towards her maid and also thought to leave the group.

Conductor: "I feel that you are saying two things: that you have to leave the group because you are afraid of some of your responses and that you feel more secure asserting N, whom you feel similar to your husband. You seem to be less frightened from N". N had been the transferential object functioning as a container to her fears.

With the exception of N, all participants expressed their sorrow about her leaving. He shared openly that he was really glad to not have her in the group. He described his jealousy towards her place in the group – for him to feel well as her, seemed too strong an emotion. Sometimes he felt himself rejected by even being in her presence. Paradoxically, this painful exchange promoted the feeling that it was possible to be open about one's hostility and envy, without being necessarily feared and rejected. Later N kept remembering this situation in the group later as having been extremely helpful. Was this a role reversal while performing yet another, weird, elaboration of his fear of rejection, or rather marking the end of his being in a rejected position?

There is little doubt in my mind that some of the most important factors in his interpersonal growth were the group's growing ability to reciprocally contain aggressive projections. N was helped more through addressing interactions that included intersubjective elaboration than been forced to comply with the group's culture. Progressively elaborated identifications of his primitive aggressive projections probably helped the group and me in the ability to address these processes better. Again working through conscious and unconscious interactions seemed to be more effective than interpreting the internal paranoid dynamics. Interpreting may sometimes signify the therapist's rejection. Since N started to experience less destructive rivalry and antagonism, I started to intervene more about manifest links between him and other participants. For example I repeatedly addressed the group's hidden emotional response of angry hurt and withdrawal together with N's incredulity of the group's intention towards him.

Experiencing differences

After a summer vacation an exchange shaded light onto his difficulties to separate from the group. He defended against these feelings and the results on the interpersonal actual level by trying to devaluate the group.

N (right after some minutes of the session): "I think the group is like a prostitute: I eject something into a body and although it feels better afterwards, it is without a real connection." No one in the group seemed really to have the wish to grab the issue, and there was no response. But as it sometimes happens in working groups the silence echoed clarity and sudden coherence (Pines 1994). Without a word spoken, the difficulty of the relationship between him and others became clear through the story's content (evacuating into a prostitute) the resulting process (not allowing connections) and the dreaded feelings causing it (fear of annihilation in closeness and vulnerability in interchanging dependency). Two sessions later he related back to these experiences and

agreed with interventions that describe his main defences: distancing and destructive envy.

The soft belly of the scorpion

More than two years in the group, N joined the only two other members of the group present for the first half hour of the group. Interestingly they were silent until N entered the room and started the communication flow. N became conscious to the contribution of his presence – an exclusive experience in an analytic group. His growing feelings of being significant in the group process seemed to encourage his resonance to a dream told by R. I consider resonance to loaded and unconscious material like dreams as an echo both representing and elaborating on identification with projections. At the same time two elements are encountered and processed: the dreamer's unconscious split off aspect and the auditor's identification, the emergent response. Thus resonance establishes both an unconscious connection between the parties and starts the containment of the split. R dreamt his business partner (with whom in reality he was in constant conflict) lying hurt on his back, with blood flowing from his neck. The huge (tall) man, with an enormous belly, was smiling silently. From all possibilities to resonate such a dream, N echoed the softness aspect of the big belly, openly emphasizing the partner's mother aspects. On the one hand he helped reveal R's side of a warm and close link to partner, on the other emphasized R's working through the demonization of his partner, trying to cope with his hate and rejection. Up to this moment R could only split off the soft part of his partner. During dreaming R had achieved some unconscious progress by being able to link between good and bad split off parts of his dream. In my view he had done this piece of intersubjective work both for his own, as well as for N (and maybe other participants in the group). N's joining the work contributed to a further step in the containment of this split and further also marked N's better connection to the group analytic endeavor. N's interpretation was a new statement about his own changing attitude to the better qualities of his "bad objects". His new kind of unconscious encounter with his own introjected parents was being transferred now to his human environment. It made it easier for the others to approach him in a less paranoid and less bellicose way. I even believe R's dream-telling may have been done unconsciously to enlist N's in the effort to establish a better contact with his "bad objects". The session later M told N how it helped her to feel the big belly and C shared how he felt R and N were building the feeling of togetherness and participation. I said something about N's growing willingness to play with change of roles. In hindsight I think that the group's ability to elaborate their aggressions and fears which N consciously provoked by unconsciously projecting them, enabled him to step

out his usual extreme deviant role. He was not only spared of the role of scapegoat but became an "almost" normal participant, willing to resonate the other's "soft belly".

Further changes in the relationship

After this rather dramatic first stage, the group's relationship with N grew to a more stable and stronger connection. N's sharing his complex inner world with the group does gradually make less "waves" as a result of the reciprocal acceptance of his paranoid character. Two and a half years into his therapy, his verbalizations became more organized and he reported that his thoughts became more coherent. About three years in the group, it seems to be a safe space for him, enough to openly share his continuous emotional and cognitive efforts to cope with his distorted perception of the interpersonal reality. When allowing a glimpse into his inner world, he seemed to be continuously engaged in dismissing thoughts assaulting him about others wanting to hurt and to reject him. In face of vulnerability and his inner struggle he gets some sympathy from the others, a relationship that also marks the transition to an Exclusion Relation Disorder, where there is some reciprocal empathy in the group and a measure of tolerance for guilt feelings.

C to N: "This feels like when my girlfriend looks upon some other man, and I can't help it to fear her leaving me".

Ir: "I think I felt like you when my sister was envious of me. I started to restrict and limit myself in order to avoid feeling afraid of her anger – there was in me a wish to disappear which stayed in me for ever".

This mirroring of the fear of being rejected or rejecting seems to facilitate communication about his envy he still feels of work colleagues, his wife and others in the group. As a response, D (himself a bachelor, never having had an intimate relationship) said: "I could never feel such a thing for my wife, but I feel that I envy people whom I later fear. Others joined and I added that I thought that a variety of responses made relationships between envious people easier".

N's response conveyed for the nth time that recurrent legitimization of envy and the 'demonic' part of him helps. But he added that criticism also helped him, as it felt for him more authentic to be critical too and he also had always the need to feel someone was not completely on his side. This was a very strong emotional moment in the group: it made N's attraction to D, who usually would express the superego part of the interaction, more understandable. For me it meant that a paranoid relationship must

always have some object into whom to project and evacuate aggression and helped me refrain from pushing into a relationship with exclusively good feedback.

Bombs "inside" and bombs "outside – a suicide bomber in the vicinity (the Moriahstr. Bus explosion).

The group had to face stress, if not trauma, as they gathered on the 5.3.03, a couple of hours after a suicide bomber exploded himself in a bus some 200 meters from the clinic. In the attack, 18 youngsters returning by public bus from school were killed and many others wounded. The city, already hurt by terror, was appalled. At the group's meeting hour, thousands were still standing in the vicinity of the burned bus and there was a huge traffic jam. But the group gathered without commenting the terror attack with more than three sentences. It was as if the local way of "life had to go on" could not be broken even in this group. One member of the group informed me that he was going to be late. M, a self-centered woman in a domestic crisis, tells the group about an excursion with her husband in the North, near the Libanese border. N comes in almost half an hour late explaining that "I couldn't pass through the barriers and was not able to find a close parking place….". To my astonishment, he even uses the attention focused on him to expand about his envy of his wife's son: he had for the first time brought home a girl friend. They both had become very central during the weekend and N acted out his tensions going into another tirade in order to complain about the relationship. Again his wife has sent him to his analytic group in order to solve this issue. I think to myself that for N the inside bombs are more dangerous than the external threat and he wants to tell about them and watch the others' coping with bombs . The group discusses envy and jealousy and the difficulty to "take" and "give". C a middle aged woman shares her emotional response towards her sister in law, who always is on the receiving end of the relationship. It turns her constantly inward she concludes, and I add that she fears her rage against those who take without giving. Then I point out that C and N are mirroring each other on how to cope with aggression: he can burst out over any small detail, and she can't allow herself at all to be angry without immediately feeling "bad". I wonder aloud about the difficulty to talk about the terror outside: maybe it's easier to talk about the inner terrorist? But I'm not really responded to, not this time nor later.

The group never really talked again about this event, in spite of my efforts to open the issue every now and then. Maybe in a year in which 4 bombs exploded in the city, fears of 'external bombs' were better coped with a series of denials. Only when it gets you personally, the hurt of very close persons cracks these defenses. "Internal" bombs are more difficult to be evaded and maybe N was a living example for such a defense.

Becoming an outsider – exclusion relation disorder

In the small analytic group, authentic person-to-person connection promotes the group members' communicative capacity and facilitates 'knowing' all participants "from within". The implicit relational knowledge resulting from these "moments of meeting" (Stern et al. 1998) allows to fix the individual's placement in the group. Although the intuitive reciprocal relations established are also rich in transformational potential, this complex "affect attunement" does not allow for an unlimited empathic relational development.

Two final examples of such "moments of meeting" may describe N's outsider position. In the group's shared emotional sphere everyone struggled with their own waves of tensions and aggressions in order to cope with N's narcissistic hurt. The greater ability to contain the group's and N's rage and conflicting emotions helped to establish a special relationship between them. It helped all concerned members to verbalize the partly right and partly wrong perception of the paranoid being rejected and hurt by the group. After some shared their aggressive feelings, including retaliation fantasies, a significant drop in tension could be achieved. The result was a growing certainty that there would not be rejection and scapegoating in the social space, but still some measure of alertness to danger in the relationship.

Another example was the time of separation from Ir, a woman who had been in the group from its beginning, who left about three years after N entered the group. N's (partly unconscious) perception of the conductor's relationship with Ir was an important experience for him. Mainly he felt that I missed Ir and that I cared for keeping her in my mind as a good object even after loosing her. Then he also felt that I would care enough about the group and would make an effort to find a suitable replacement. My ability and the capability of others to separate from Ir without taking too much space for myself and without a 'need for someone else' was not of the sort that was known to N: separation left him always empty and desolated.

But he felt he could not really appropriate these kind of relations to himself, leaving him in the loop of desolation, envy and feelings of exclusion. It gave him the feeling of inferiority, eventually fixated on his marginal position in relation to other's better abilities to relate and feel "in".

His comments about his considering the group a prostitute together with the recurring statement that he felt cold to others only endorsed his outsider position in the group. It certainly represented his relational exclusion disorder and social abilities. The group's openness seemed to help him not feel less "crazy in his mind" and facilitated the

member's experience of empathy with his vulnerability and related hurt, envy, hate, rejection and eventual (mostly passive) aggression. His openness helped him to be more 'in', but his contents were felt by most of the participants as evidence of his deep disturbance. N's placement in the group's space never changed to a more central one. N continued to exist as an outsider, definitely deleted from the list of those who should be completely rejected and certainly closer than at the beginning. He was not considered any more the group's patient although even those who tended to identify with N usually felt at same moment some kind of estrangement. They would always feel somewhat embarrassed to be in the same group with someone as eccentric and the more benign Exclusion Relation Disorder seemed the healthiest he could get.

On the difference between individual and group therapy of Paranoia.

In individual psychotherapy the possibility to help would depend on the ability of the therapist to engage as a single object in an all-or-nothing encounter with the paranoid inner world. Containing the therapist's identification with the projected in a mature way is often not simple. "Using" the therapist as object and "attacking" the therapist as a form of relating and testing his survival may often ignite an open conflict demanding major energy investment (Winnicott 1962). In individual therapy the transference often ends by rejection of the only object and termination of the therapy. In group therapy this process may be easier because of the wider range of objects engaged in containing projections while leaving space for non-paranoid sides. With a whole group it is more difficult to split the relation to everyone in order to reject the "bad" ones… Usually changes in fellow participants' ability to elaborate aggression will be considered more authentic than professional "false" responses.

Notes

1) Certainly group analytic patients may be increasingly able to do this too.

2) Developing optimal indications for Group Analysis is strongly connected with a relational pathology view, but has to be dealt elsewhere.

3)And not only the omni-presence of our "internal" group.

4)The therapeutic (and not only indicational) use of the Piper et al. categorization has been overlooked.

5) <<I came to understand that the repetitive series of separations and losses that every human being endures forms the outline of the self-image that each person constructs>>. (p. 18).

6) Are they exclusively interpersonal categories? It seems that not.

7)And again help select the optimal therapy

8)There are some precursors for Disorders that can only be described interpersonally: Follie-a-deux (Bleuler 1972), and Bern's categories in Games People Play.

9)Especially twice a week groups are conductive to the close-enough relationship that furthers intersubjective interactions.

10)Man's selflessness reveals itself often in extreme situation, where the abolition of the Self often has lethal consequences.

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