Work in Progress

Women's Groups: How Connections Heal

Nicolina M. Fedele, Ph.D., &
Elizabeth A. Harrington, Ph.D.

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Nicolina M. Fedele, Ph.D.
Elizabeth A. Harrington, Ph.D.

About the Authors

Nicolina Fedele, Ph.D., is Assistant Professor of Psychiatry at the Boston University School of Medicine. She was the Founding Director of the Women's Program at Charles River Hospital, Wellesley, Mass., from 1984 to 1989. Currently, she is a consultant to hospitals in the development of inpatient programs for women and training programs for professionals. She specializes in women's issues and a relational approach to individual, couple, and group treatment in her private practice.

Elizabeth Harrington, Ph.D., is Clinical Instructor of Psychiatry at the Boston University School of Medicine. Active in the development of the Women's Program at Charles River Hospital, she is currently its Director and the Director of that hospital's Group Psychotherapy Program. She also specializes in women's issues and a relational approach to individual and group treatment in her private practice.

Abstract

Women's groups can provide the mutually enhancing relational contexts that the core group of Stone Center scholars (Jordan, Kaplan, Miller, Stiver, and Surrey) have described. This paper begins with a theoretical discussion of the relational approach to women's psychological development and its application to group psychotherapy. It follows with an outline of four healing factors in women's groups: validation, empowerment, self-empathy, and mutuality. The paper concludes with examples which illustrate specific ways a relational approach informs the understanding of group therapy.

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Introduction

A vignette: A psychologist-in-training had the opportunity to run a women's parenting group in a community health center. Having co-led a women's group the year before, she was eager to have this experience and accepted the group in spite of its history. A more experienced group therapist might have hesitated since two of the four previous group leaders had left precipitously, their good-byes hurried and minimally processed.

The young therapist began the group. It proceeded slowly but, on a superficial level, seemed to go reasonably well for three months. Suddenly, the members of the group spent an entire session expressing intense rage and attacking the leader. The group would not allow the therapist to respond to a vituperative string of accusations: The therapist didn't know anything about parenting; she wasn't very good at running the group; she wasn't a good therapist or even a very nice person. So intense was the experience, the group leader now refers to this session as the worst experience she has ever had as a therapist. She left the session demoralized and unsure whether she could return the following week.

She discussed this experience extensively in individual and group supervision and came to realize that the angry session marked the anniversary of the group's loss of a previous leader. The new therapist, through her many connections with supportive teachers and friends, returned to the group the next week revitalized and able to tolerate their intense feelings. The group expressed shock at her appearance, because they felt they had treated her badly the week before. Members filled the entire session with their experiences of grief and loss in childhood. One woman disclosed her pain at having been put up for adoption by her mother. She had never shared this information with anyone since her childhood. These two sessions provided a context for

processing experiences of loss and anger and laid the groundwork for productive relationships in the group.

This example illustrates the tremendous power of women's groups to heal psychic wounds, both old and new. The therapist initially validated the members' experiences by simply allowing them to voice their feelings and further empowered the members by tolerating these feelings. The therapist herself felt unconnected after the angry session. She spent the week sharing the experience with colleagues and supervisors. This reconnection into a vital, supportive network helped her tolerate her own heightened insecurity and to bear the members' magnified sense of shame, sadness, and loss. These connections enhanced her capacity to affirm the members' experiences the following week. The ensuing group process facilitated the group's reconnection which, in turn, reaffirmed the therapist. This clinical example exemplifies the mutual healing and growth-producing connections that are possible in groups.

The relational model of women's psychological development

Writers at the Stone Center at Wellesley College have developed an approach to women's psychological development rooted in women's articulation of their experience. They begin with the observation that women's sense of self is grounded in making and maintaining relationships with others. They see women as developing through the experience of actively taking part in mutually created and mutually enhancing, empathic relationships. Participation in such relationships generates a greater sense of energy or zest, knowledge of self and other, capacity to act, sense of self-worth, and desire for further connection (Miller, 1986b). In contrast to theories that emphasize increasing degrees of psychic separation as signs of maturity, this relational approach stresses ongoing, mutual, empathic connection as central to psychological well-being. Women seek such mutual relational connections as the primary and essential context for their psychological growth. In the absence of such a context, women's energy diminishes, self-esteem suffers, and they become increasingly disconnected from others.

The relational approach views human development through a lens which focuses on strengths rather than on psychopathology, on adaptation to real human events rather than psychic structural errors. It stresses mutuality in the exchange between therapist and client rather than a more unidirectional view of this relationship. This approach attends to how a woman develops a sense of who she is within relationships. It emphasizes the value of creating new patterns of relationships and articulates the struggle to find the difficult integration between a woman's sense of herself and her relationships — the ongoing dialectic between her needs and the needs of others.

The inextricable link between human needs for integrity and for relationship is not a new notion. Freud described the two essential aspects of life: to love and to work. In the year that Freud was born, Tolstoy wrote: "There are two important things in life: To love one's work and to work for the ones one loves" (Troyat, 1967). Tolstoy's words convey the complexity and interconnectedness of self and relationship in human experience.

Jean Baker Miller (1988) has discussed disconnections and violations early in a woman's life and their impact on a woman's relational experience . These violations lead to skewed adaptive attempts which, although they allow for survival, cost a great price. The adaptive solutions to early disconnections often interfere with a woman's abilities to make and maintain validating relationships and, as a result, thwart the means by which she could develop an adequate sense of self. In some instances, women who enter treatment have suffered a severe loss in an otherwise sustaining relational context. In other instances, extreme distortions or deficits in their relational world have left the women alienated from their needs and unable to voice them. Depression, anxiety, suicidality, eating disorders, substance abuse, and other problems can then result.

The relational approach and group psychotherapy

The relational model's applications to group psychotherapy has historical roots. As early as the twenties, Adler and Dreikurs described our cultural context as one in which a lack of mutual trust and a fear of exposing one's vulnerabilities created a tendency toward emotional isolation (Ettin, 1988). They pioneered early experiments in interpersonal group psychotherapy by using the group setting to work against this emotional isolation. Irvin Yalom, a highly respected contemporary group theorist, continued the focus on interpersonal group treatment (1983). He suggested that people tend to recapitulate their interpersonal problems in the therapy group. Treatment occurs when members process "here-and-now" emotional experiences in the group in order to examine their defensiveness or resistance. Member-to-member feedback plays an essential role in this process.

However, the relational approach to group psychotherapy augments our understanding of the healing power of group process. It differs from previous interpersonal group theories in its focus on group members' adaptation to life circumstances and its emphasis on validation of experiences and strivings for connection. The relational approach concerns itself less with interpretations around defensiveness and resistance to therapeutic change or to self-awareness. It sees psychological growth as occurring via changes in a woman's emotional experience, in her cognitive understanding, in her relational context, and parallel changes in her sense of self.

Women's groups, then, can provide opportunities to work through previous relational wounds within a sustaining relational context. Both the "there-and-then" and the "here-and-now" relational experiences play key roles. As the woman experiences the juxtaposition of the hurtful past and the affirming present in a relational context, healing proceeds. Further, women's groups can provide a framework to understand both each member's unique experience of the world and the commonality of human, emotional experience.

Irene Stiver (1989) has described how the patterns of disconnection in families can lead to a sense of isolation. A woman's family experiences may have a negative impact on her trust, her empathy, and her sense of empowerment. She may alter her inner sense of herself in order to fit into the available relationships. This disaffirmation of her authentic self contributes to a sense of isolation and an inability to interact in ways that lead to growth and change. The here-and-now setting of the group can provide a healing context which affirms a woman's experience. This affirmation begins the process which revitalizes her trust, empathy, and sense of empowerment.

Women's groups versus mixed groups: A controversy

In an extensive review of the literature on women's groups, McWilliams and Stein (1987) found that clinicians consider women's groups the treatment of choice for dealing with particular life circumstances (e.g., post-divorce, single mothers) or with particular clinical groups (e.g., sexual abuse survivors, battered wives or lovers). Clinicians have found women's groups useful for discussing racial experience (Nancy Boyd-Franklin, 1987), homelessness, and chronic alcoholism (Graham & Linehan, 1987).

However, some group therapists disagree on the indications for women's groups. Theresa Bernardez (1978, 1983) considers women's groups the treatment of choice for most contemporary women. Bearing in mind the influences of social context and situational factors on women's development, she emphasizes the impact of women's socialization. She views it as creating difficulties with authority and power and as predisposing women to attend to others at the expense of self. Single-sex groups allow women to focus on their unique experiences as women. According to Bernardez, women can practice assertiveness, redefine goals and notions of womanly behavior, experiment with the dynamic balance between self and other's needs, develop positive identifications with other women, and resolve inhibitions in creative and serious work.

Anne Alonso (1987) holds the opposite opinion. In general, she advocates mixed-sex groups. Her belief that androgynous development is normative in adult life leads her to conclude that mixed groups offer more options for working through gender-linked personality traits.

In fact, both perspectives have merit. At certain times in life, a woman may need to consolidate ideas, feelings, experiences, and a sense of self. The commonality of experience in a single-sex group offers a particular opportunity to clarify and strengthen these developmental areas. Once members have sufficiently validated their experience, become more empowered, and developed a capacity for self-empathy, they may move toward an experience in a mixed group. A mixed group can provide the possibility of integrating women's and men's experiences into a coherent and dynamic understanding of the human experience.

Healing factors

Many group therapists have produced lists of curative factors which reflect their particular experiences and theoretical frameworks. A relational approach suggests that groups which foster particular types of connections between people promote psychological growth and the healing of emotional wounds. The work of writers at the Stone Center lead the authors to propose four salient curative factors in women's therapy groups. These include validation of one's experience, empowerment to act in relationships, development of self-empathy, and mutuality. Clearly, these factors are highly interrelated and occur together. This paper presents them individually to highlight the contribution each makes. However, to separate the components of the healing process is artificial; in life, as in therapy, they work together. Finally, these four factors are not the only ways that connections heal. They are simply the features that stand out for us.

Validation as a healing factor

Connections which validate heal. Unfortunately, society generally has not encouraged women to know and express their experience as they experience it. Women's needs for intimacy and connection are frequently devalued in their marriages and families; in educational, business, and mental health settings; and in many organizations. A benefit generally found in women's groups is that they allow women to express their experience, by making a concerted effort to understand the context of relationships in which women live and women's interpretations of that context. Group members, as part of the here-and-now relational world, can validate each other's experience and foster each other's development in a mutual fashion.

Specifically, a women's therapy group provides a path which allows each member to express her perceptions and desires. The group upholds and acknowledges her emotional experience. It validates her sense of herself as an authentic person. This initial validation, the first healing factor, involves a sense of knowing that one's experience of being alive is understood by another person. The group leader fosters validation when she creates an environment in which a basic sense of respect for another as a unique human being goes hand-in-hand with a sense of respect for each person's adaptive efforts.

After a therapist or group member understands and acknowledges how a woman's relational context has contributed to her particular way of looking at the world or of interacting with people, the road to changing that view becomes clearer. As Jordan has said, healing occurs when a person returns to the pain of the past and finds she is not alone this time (1989). The emotional resonance with the therapist or with the group allows the woman to understand the meaning systems around her pain. Healing occurs not simply in the working through, but in the experience of sharing the emotional impact in relationship.

Empowerment as a healing factor

Connections which empower heal. Power in the traditional sense means having power over people and events that affect us. A relational view of mutual power differs from this traditional one in that it emphasizes the capacity both to be moved by and to move the other person (Surrey, 1987). Both (or all) participants have impact on each other and on the interaction. Each allows the other to have impact on her. Thus, from a relational perspective, power emerges from and enhances connectedness. In fact, the energy generated by movement with the other in relationship may then carry over to other arenas where each participant feels more empowered to act.

Both Miller (1986b) and Surrey (1987) have emphasized the empowering effects of interaction in mutually empathic relationships and have urged the creation and sustaining of such relational contexts for women. Clearly, women's groups provide rich opportunities for empowering connectedness as members take in the relational energy, power, and effectiveness of the group.

The leader plays a crucial part in the empowerment of the women in a group. On the one hand, women leaders must use their authority to provide as safe and emotionally validating an environment as possible. They can accomplish this by setting the general tone and the spoken, as well as the unspoken, guidelines of the group. Group therapists also model the use of power by a woman in a relationship as a mutually affirming process. This involves a firm, respectful, and empathic approach to limit-setting within the relational context of the group. To do so demands that the therapist recognize her counter-transference feelings, particularly those of sadness, anger, and helplessness. Tuning in to her emotional reactions allows a therapist to use them as clues to the clients' feelings and, thereby, to set empathic, nonblaming limits.

On the other hand, group leaders must be aware of the power differential which exists in a group simply by designating a leader or leaders. Women can attribute an enormous amount of power and influence to group leaders and, consequently, suppress their experience of their own power. Past abuses and neglect by authority figures, as well as the social context in which women have lived (Miller, 1986a), have diminished many women's capacities to feel powerful and their willingness to exercise their power. These betrayals often lead women to see authority figures as larger than life and to experience themselves as powerless.

The difficult task of the group leader involves defining, as realistically as possible, her own sense of power and the limits of that power. In a sense, leaders must be "cut down to size" — back to human dimensions. Group therapy provides a context in which members can appreciate and encourage one another's ability to be effective. Repeated support of each woman's abilities coupled with the explicit and implicit message that every woman has the right to feel powerful fosters empowerment. This process plays an essential role in healing.

Self-empathy as a healing factor

Connections which foster "self-empathy" heal. In 1984, Jordan described self-empathy as a phenomenon which occurs when the observing self makes empathic contact with the experiencing self. More recently, she described it as empathy for what is human in ourselves (1989). Self-empathy includes the ability to have compassion for oneself, or as a group member playfully said, to "do unto yourself as you would do onto others."

A number of features occur simultaneously in self-empathy. The woman feels more connected with her own affect. There is an increasing acceptance of self-representations and a lessening punitiveness toward those inner self-images. As this takes place, identifications derived from harsh, judgmental past experiences shift to incorporate the healing, empathic experiences of current relationships.

As a healing factor, the process of self-empathy may affect one's view of oneself in the past. This occurs when a part of the self steps back, observes, and understands previous emotional experiences in a new and more empathic way. Often the feelings associated with these experiences have remained unintegrated or dissociated because of a harsh or judging, observing self, which formed as a result of previous harsh or judgmental relationships. The process of healing, then, begins when the woman shares experiences in a new, nonjudgmental relationship. Here she can experience emotional resonance with another person's empathy for her. This empathic understanding for each other may become a bridge to empathy for oneself; it may allow the present self to develop compassion for the vulnerabilities of the past self. Self-empathy can also affect one's view of oneself in the present. The process is the same except that empathic contact with the experiencing self occurs as the emotions are being experienced in the present, rather than in retrospect.

How does participation in a group foster greater empathy with oneself? Opportunities for identification with an empathic and accepting group therapist can, over time, enhance self-empathy. But the often poignantly expressed empathy of peers can have even greater impact. Thus, the therapist must create an environment which facilitates the empathic connections among members. Mutual empathy among peers seems particularly effective when a group member's difficulties in trusting authority figures leave her naggingly suspicious of the leader's motivations. Moreover, fellow group members' empathic responses may have more credibility since they have often lived through similar experiences and feelings. This process of sharing with peers, in a group, provides additional and, at times, less conflictual opportunities for identification with empathic persons other than the therapist.

Further, group therapy provides a unique forum for demonstrating the contrast between members' often highly developed capacities for empathy with others and their frequently atrophied capacities for empathy with self. Any given individual may be highly attuned to and accepting of other's thoughts and feelings. Yet, at the same time she may be cut off from or harshly critical of her own thoughts and feelings. When the group explicitly recognizes the woman's empathic skills as valuable — rather than allowing them to go unnoticed as they often do in the world — her self-esteem rises. The group setting also provides an opportunity to suggest that applying some of these empathic capacities to the self would be extremely valuable. For example, the leader (or better yet, a member) can observe how much compassion and respect each woman has for the other members of the group, yet that each finds it difficult to have that same compassion or respect for herself. If well-timed, this comment generally elicits productive interaction, heightening the awareness of all to the notion of "doing unto yourself as you would do unto others."

Mutuality as a healing factor

Connections which foster mutuality heal. Jordan (1986) described mutuality as an attunement to the subjective, inner experience of another at a cognitive and an affective level. Mutuality involves an appreciation of the wholeness of the other person's experience and respect for the other person's differentness and uniqueness. It also involves an openness to the other's impact on oneself and an appreciation of one's impact on the other. Mutuality values enhancement of the other's growth and, most importantly, leaves all participants open to change. Miller (1986a) has described how mutually empathic and empowering relationships foster growth on at least five dimensions. Each participant feels more energy, becomes more able to act, knows herself and others more accurately, and feels a greater sense of self-worth and a heightened experience of connection.

Imbalances in mutuality can create significant pain. Minor disconnections are common and probably inevitable. But pervasive and/or traumatic disconnections, the antitheses of mutuality, lead to psychological wounds, especially when the relational environment is unresponsive. The immediate consequences of disconnection and violation include an inhibition of the ability to act stemming from a

sense that action within relationship leads to great trouble (Miller, 1988). There follows a loss of clarity in knowledge of self, a diminished sense of self-worth, a decrease in energy, and finally, and perhaps most importantly, a confusing sense of isolation in which the person feels locked out of the possibility of real connection. The long-term consequences include seriously distorted views of self and other, inability to express certain feelings, over-reliance on maladaptive coping mechanisms, and both isolation and/or unfulfilling attachments. Groups are particularly suited to heal these relational wounds.

Women's groups provide a place to share and validate memories of painful, nonmutual experiences. The group leader can set the stage for nonjudgmental listening and understanding. Although women often feel uncomfortable initially with self-disclosure and have difficulty allowing other people to have an emotional impact, the experience of watching other members survive, and even benefit from the process, can inspire courage to take more emotional risks.

Particularly when depressed, women may have difficulty experiencing and expressing certain feelings, leaving their capacity for mutuality impaired. Withdrawal into the self and frequent feelings of helplessness can lead to an intense need for nurturance from others. A group may tolerate the expression of neediness, connecting it to the woman's losses or other relational precipitants. In bearing the longing and in acknowledging the justification for it, the group can begin to heal the initial lack of mutuality.

A depressed woman often feels deep pain in experiencing herself as selfishly preoccupied. This self-blame then can augment the depressive feelings. Sometimes, becoming interested in another member of the group, giving of oneself, feeling and being supported for having something to offer can alleviate some of the self-blame and depression. And, as the group process continues, each woman's timing can be respected. She can see that she is not necessarily stuck in the depressive position, that re-engagement in mutual relationships can occur. This experience can revitalize her quest for connection.

The group can also provide a powerful intervention with a person who focuses on remaining self-sacrificing to the extent that her own needs are ignored. The group will tolerate this for a time, but the members will begin to see the pattern. By owning the same pattern in themselves and encouraging the self-sacrificer to ask for more for herself, they usually can make a gentle confrontation. Sometimes the group can tolerate feeling angry that a person does not participate. Encouraging her to share their experience can often replace the anger with empathic understanding, and it reinforces the possibility for more mutual connection. When the group examines outside relationships, it can support a member's feelings about her relationships, which may allow her to work them out before taking action in the relationships. Members can focus on a balance between a woman's needs and those of her lover, spouse, or friend.

As the group's relational context provides new opportunities for mutually enhancing exchanges, it can remobilize the growth-oriented relational capacities within each member. Gradually, over time, experiences of mutuality can dismantle and clear away the "scar tissue" that formed as a consequence of disconnections. The group's relational context can provide a rich and safe medium for healing in connection and the development of new patterns of relationship.

Clinical vignettes

The following examples depict the four salient healing factors —validation, empowerment, self-empathy, and mutuality — in action, in women's groups. These vignettes exemplify some of the types of exchanges that occur regularly in these groups; they portray an interactive, unfolding process, a healing interplay.

The first example: Themes of guilt and shame occur frequently in women's therapy groups. Most women have suffered alone with these terrible, painful emotions. A major healing moment occurs when a woman can tell those experiences to another, perhaps to a therapist or a friend. But something powerful and different happens when she relates her feelings of guilt and shame to a room full of other women.

In one group, a member referred to here as Karen, painfully and haltingly expressed her humiliation over an event that occurred the previous night on an inpatient unit. During the incident she had felt exposed as bad and out of control. The group gently urged her to tell what it had been like for her the previous evening, filling in pieces of information that she lacked but wanted to know. Other members gave explicit reassurance of their ongoing respect for Karen and the painful work she was doing. They validated her experience and encouraged her to stay with the feelings. It seemed as if their caring tone and persistent efforts to be with her in her pain counteracted her shame even more powerfully than their spoken reassurances. Their actions allowed Karen to connect her current shameful feelings to the pervasive sense of badness she had felt since early

childhood, when she had been sexually abused; as she expressed it, "I was born bad." Throughout this exchange mutual, empathic connections grew between Karen and other group members around her past and present pain and humiliation.

At this point a remarkable thing happened. In this atmosphere of empathic connection, another member I'll call Tina said plaintively, "But Karen, you were so little." A quiet, poignant pause ensued as everyone felt the impact of these words. Soon other members voiced both their empathic understanding of Karen's enduring guilt and shame and their connection to her innocence and goodness. This moved Karen to a more empathic position with herself. Simultaneously, prompted by the group leader, other members came to see how much easier it was for them to feel for another than for themselves. Each person came a bit closer to at least a moment of self-empathy with the memories of themselves as wounded but essentially good children. Via their connections with Karen and Tina, each member's guilt and shame diminished. In Tina's words, "It helped me absolve myself to see the little child that Karen was." An ongoing group provides opportunities for a series of such affirming experiences, gradually leading to cumulative change in the members.

This interaction was a powerful, affective moment for the group members and for the leader. The here-and-now immediacy of Tina's statement about "how little" Karen was when she was abused stimulated a swell of appreciation for "how little" and innocent they all had been during hurtful childhood experiences. Somehow the idea of the child's smallness and innocence, spoken in an atmosphere heavy with empathic connection, conveyed a powerful message: "How could you have been responsible?" Without such an empathic connection, the idea of childhood innocence, stated merely as a fact, seldom touches others in such a moving and convincing way. Indeed, in this example, the group leader felt touched and moved, momentarily, to make compassionate contact with images of herself as a child.

The second example: Issues around personal power and authority weave in and out of the material in women's psychotherapy groups. Most women seem to struggle to know their own needs and to act within their relationships to meet them. This struggle appears most prominently when the woman's relational world has been so distorted or so lacking that she becomes alienated from her needs and unable to voice them. In a women's group she can describe her experience and have her feelings and needs validated. As this process of empathic understanding proceeds, all the participants experience their mutual impact on each other leading to an increased sense of personal power and interpersonal efficacy for all.

A woman, here referred to as Lauren, came into the hospital after outpatient efforts to alleviate incapacitating depression and anorexia had failed. Growing up in a severely dysfunctional family and experiencing childhood sexual abuse had curtailed her capacity to feel empowered in relationships. Like so many women, she had never had an opportunity to relate these experiences to a receptive, responsive listener. Having had to suffer these violations alone further disempowered her.

In the group, as in the rest of her life, Lauren was attentive, even vigilant, but virtually silent. After several sessions in which she had been notably quiet, the leader checked in with her midway through one group meeting. Taking a deep breath, Lauren articulately shared some of the many thoughts and feelings that had occurred to her as she sat listening. "I've been thinking about why I can't seem to talk like all of you do. I think it's because as a child I always got the message not to say things my mother didn't want to hear. I guess, to be on the safe side, I learned not to say much of anything at all." Other members nodded and listened attentively, validating her experience of being silenced, as she continued: "I've always blamed myself for not talking. When I was little, I never told anyone the baby-sitter abused me. But now that I'm an adult I believe — no, I know — I've tried to tell my family about my husband, Jim, hitting me, and they won't listen." The therapist was awed by this flow of words and feelings. What had allowed this quiet, sad woman to speak her truth?

In a later session Lauren reflected on this group experience: "I had been watching and listening to how you all talked with each other. It was new for me to see such honesty and caring. I just decided to take a risk. And you listened — you welcomed my words." This description suggests that even as a quiet observer of group interactions, Lauren was empowered by the sense of connection within the group. Witnessing mutually validating and respectful exchanges diminished her anxiety about speaking. This anxiety stemmed in part from old experiences of being silenced. A new relational context allowed her to glimpse the possibility of a different experience. It also gave her the impetus to try out her long-unused voice and provided a forum in which to practice using it. It was mutually empowering for the group, too, to hear that their exchanges had really made a difference. One member made a point of congratulating Lauren and the group for the good work they were doing

together. The leader, too, felt proud and privileged to have helped facilitate such a curative process.

In her final group session before discharge, Lauren spoke up without prompting. She eloquently described how her interactions with the group "gave me the courage to go to my couples meeting and say what I needed to say to Jim." This clearly exemplifies how the energy and empowerment from movement in one relational setting (the group) can spread to other relational settings (the couple).

Beyond the dramatic empowering impact on Lauren, participating in these experiences significantly empowered other group members, one of whom commented that Lauren's description of her struggle had given her courage to confront a family member as well. Indeed, sometimes there seems to be almost a contagion of courage to act in and outside the group. As another group member commented in her good-byes to Lauren, "Your openness made me want to share, too."

The third example: Dysfunctional families often foster secrecy around important emotional issues. Secrecy devalues a child's experience, fosters dependency within the family, and inhibits contact with the outside world (Stiver, 1989). The family maintains its internal equilibrium at great expense to its members by reinforcing and perpetuating dysfunctional patterns. A woman's experience cannot be validated if it is denied. She cannot implement her power if it is disavowed. A women's psychotherapy group works against these influences by encouraging shared experience and by reviving a sense of connection. Members resonate with other members' feelings. This can quickly expand to include all the women in the group.

The final clinical example involves a very exciting inpatient group with two co-leaders and seven women members. Four of the members had multiple personalities; the remaining three had experienced varying amounts of abuse as children. Leadership was an extremely powerful and challenging experience because of the intensity of feelings generated in the group, the tendency for dissociation, and the occasional switching of personalities.

One of the women, referred to here as Sylvia, felt ambivalent about disclosing the fact that she had multiple personalities. During one of her initial sessions, as other members described the reasons they were in the hospital, she asked to leave the room and sat outside the door within the therapist's field of vision. She returned to the group but could not talk about her feelings. After the group, the therapist asked her how she felt. Sylvia explained that she was frightened that other members might notice that she was switching personalities or, worse, that she would return and find that one of her other personalities had done something in the group which would embarrass her. At the same time, she wanted, and felt ready, to relieve herself of the terrible burden of knowing her diagnosis in isolation. The leader assured Sylvia that it was up to her but encouraged her to discuss her feelings in the following group. The therapist added that she would help with any explanations or support that Sylvia indicated she needed. The leader also emphasized her confidence both in Sylvia's ability to work in the group and in the group's ability to work with her.

The next day, Sylvia described her feelings and her multiple personalities with great clarity. However, another member of the group, referred to here as Kathy, asked permission to leave the room, and left before the group or leader could respond. One of the co-leaders followed her down the stairs and found that she had dissociated. Kathy spoke like a frightened child, saying, "Sylvia shouldn't have said that about herself. It's a secret. You're not supposed to tell that secret because people will think you are a freak." Kathy could not return to the group at that time.

Meanwhile, the group held a lively discussion about the relief that Sylvia felt and the positive support that she had received. Sylvia expressed concern about Kathy; the leaders assured her that Kathy would be all right. Kathy was able to return to the group the next day and apologized for leaving. She claimed that it had nothing to do with what Sylvia had said. The therapists respected Kathy's silence in the hopes that group process would lead to a validating and empowering experience for Sylvia which Kathy could observe and share. In fact, Sylvia felt enormously supported and relieved to have shared this information.

Sylvia and Kathy's fear of speaking their truths illustrates the power of secrecy in the family and its extension to other relational contexts. Other group members resonated with Sylvia's disclosure and managed to discuss their own dissociation or multiple personalities. The group's capacity for shared experience proved extremely touching and powerful. The women felt empowered by the sense of connection within the group. Each woman demonstrated an openness to the other women's experiences and an appreciation of her own impact on the other women in the group. The mutuality of the group interchanges allowed many of the participants to be open to change.

Many of them went through the same frightened and ambivalent feelings, but managed to negotiate the disclosure.

Problems and impasses in the healing process

Connections which foster validation, empowerment, self-empathy, and mutuality do not always occur spontaneously in women's groups. In contrast to the examples above, group members may not connect, connections may break down, or destructive interactions may develop. At such times, the leader must actively intervene to make the relational difficulties explicit and to establish or restore connections between and among members.

One type of impasse occurs in a group when members seem walled off, each in her individual, experiential world. Clearly, this can occur situationally when, for some transient reason, members hold back. These situational impasses frequently relate to trust issues, as when membership or leadership changes, or after major emotional risks have been taken. In these instances the leader can usually identify the particular difficulty, freeing up the natural relational capacities of the members to join and interact.

A more challenging but not uncommon type of impasse occurs when the relational capacities of some or all of the members are so constricted that creating a flow of healing interactions becomes a major therapeutic task. In such instances, the leader can interpret the difficulties and try to facilitate an exchange around this shared experience of disconnection. For example, a particular group of deeply depressed women functioned with a certain degree of mutual interaction. Evelyn, a new member, joined the group. In a flat, controlled voice, she said few words; she avoided eye contact and sat rigidly erect with a stony, sad expression on her face. Gradually, other members made gentle attempts to establish empathic contact with her. The leader supported these attempts and guided their efforts by providing a metaphor of a tall, thick protective brick wall to describe Evelyn's rigid boundaries and their function. The group developed strategies to work with the image which permitted a degree of mutual sharing: removing a few bricks at a time and installing doors and windows in the wall. The leader, in effect, had guided the members in an exploration of their conflicting wishes for safety and for connection. This action freed up their strong relational wishes and capacities. Had the relational resources been more scarce, the group might have remained paralyzed for an extended period, perhaps until turnover in membership occurred.

In contrast to problems with affective constriction and overly rigid boundaries, some difficulties in groups stem from excessively permeable boundaries and affective flooding. Frequently, even members who do not have major boundary problems can find themselves so taken over by feelings with and for others that they lose touch with their own feelings and thoughts. This loss of self occurs even more dramatically for women who experience major boundary disturbances and problems in modulating affect, as in post-traumatic stress disorder. The group interaction can only lead to more genuine connection if the participants can, with the leader, work together to reattune to each other.

In one group, a member referred to here as Melissa, spoke in a very driven way about her father's extremely sadistic early abuse. With eyes averted she revealed her excitement as an adult by various sadomasochistic fantasies. The leader, after observing the overwhelmed expressions on the faces of other members, stopped Melissa. By encouraging her to pause and appreciate her impact on others, the leader allowed her to get back in synchrony with them. Melissa articulated her compulsion "to get it out" and then observed that, in the telling, she ended up feeling alienated and alone. Other members re-established contact around the wish to get rid of disturbing material and shared their own feelings of being overwhelmed. Only then could the group go on. Here the leader had helped the members to recognize their profound impact on each other and to see how the urge to expel disturbing material thwarted the ultimate need to share it in authentic connections. Only the fundamental resiliency of Melissa and the others in the group made such movement possible. Where capacities to modulate and tolerate affect are more impaired, the group can become chronically disconnected and overwhelmed until a safe level of mutually attuned sharing can again occur.

Conclusion

Though this paper has focused on psychotherapy groups, the validating and empowering connections forged by women's group interactions have wide implications for many other types of group endeavors. The process of instilling compassion for oneself and others, and engaging in mutually satisfying and empowering relationships can enrich our understanding of women's groups for work, study, support, peer supervision, friendship, business, research, activity, political action,

governance, and peace keeping. For where women gather together, there exists a potentially rich relational context to foster growth.

Discussion Summary

After each colloquium presentation a discussion is held. Selected portions of the discussion are summarized here. At this session Drs. Judith Jordan, Jean Baker Miller, Irene Stiver, and Janet Surrey joined Nicolina Fedele and Elizabeth Harrington in leading the discussion.

Comment: The healing factors that you discuss — validation, empowerment, self-empathy, and mutuality— apply to my experience attending the Stone Center colloquium series. The process of this group, although obviously much larger than a therapy group, has been very much the same. It says something about the validity of the work done at the Stone Center and its applications across a wide range of settings.

Miller: Thank you, that's very nice to hear.

Jordan: I appreciate your comments about what it feels like in the audience. I want to let you know that it is a two-way street; we also get an enormous amount from the audience. The experience of speaking here is wonderful; I feel engaged with people, very empowered, definitely heard. A women's audience is very attentive. The day after I gave a paper to this group, I presented to a group of male psychoanalysts. The difference was quite dramatic.

Question: As a man, I find myself wanting to participate in these groups. I think that most men could benefit from this kind of human process. Could you point out some of the main differences between men's groups and women's groups?

Fedele: I have no experience running men's groups. However, a psychologist who recently attended a Sam Osherson workshop on fathers and sons spoke to me about the empowerment and mutuality that he experienced in those groups. My sense is that the process we have discussed could occur in men's groups. However, therapists who have run all-men's groups indicate that it is sometimes harder to achieve. It depends on the participants' abilities to be empathic with each other and to feel empowered in a group setting, as it does in women's groups.

Question: Could you speak to the moments of disconnection, the moments of confrontation, that occur in women's groups and that can also be healing?

Harrington: Moments of confrontation have enormous potential for healing; they also have enormous potential for wounding. Women in groups have a somewhat harder time with conflict than men do. This is partly due to the fact that women are raised to avoid confrontation. We often submerge conflicts rather than deal with them directly. This interferes with the self-awareness that comes from acknowledging differences, a process which is instrumental in moving relationships to new places. Conflict resolution in a group requires a high degree of trust and safety. It is largely the leader's job to assure members that differences will be aired in a fair and reasonably sensitive way, and that there is a place for everyone in the group as long as they stay within its norms.

Question: Is the leader a critical factor?

Harrington: Yes, but the strengths and capacities the various members bring to the exchange also have a tremendous impact. Some people are reasonably comfortable dealing with confrontation; others are more threatened by it.

Fedele: Anger is definitely a difficult issue in women's groups because many women experience anger as a threat to their relationships. The leader can play an important role in tolerating and managing confrontations. If one group member is having a great deal of difficulty dealing with another's anger, the leader can sometimes deflect the anger onto herself by an interpretation or another intervention. By tolerating the anger and discussing it in a benign manner, the leader explicitly and implicitly conveys that anger is simply a feeling, not a destructive force. Further work which allows confrontations to augment the experience of relationship can provide working models for dealing with anger within relationships. Generally, a peer or supervision group can provide a forum for group leaders to discuss their own reactions to anger. This helps them understand their own issues which might be interfering with their adequate negotiation of anger in group settings.

Question: Can you speak to the effectiveness of leaderless groups and mutual-help groups and how they heal?

Stiver: Self-help groups are usually organized around a common issue, such as the various twelve-step programs. My sense is that men have an easier time when they organize around a particular issue, like fathers and sons; they have less experience and more difficulty with open-ended connections. I think a leaderless group organized around a specific focus can become enormously validating and empowering since it allows men to connect with each other.

Surrey: Some of the research on leaderless groups asserts that men tend to get into power struggles for leadership, so the meaning of leadership has different meanings for men and women. The early

models of leaderless women's groups, the consciousness-raising groups, have handed down some interesting concepts about sharing leadership and facilitating groups. They viewed the leadership role as a task that could rotate from one member to another. This facilitates a sense of mutual empowerment.

Comment: The model developed by the National Training Lab uses the idea of group functions and task functions as circulating roles. It works well for both women's and men's groups. The functions are not attached to an individual person but are rotated and considered a service for the group.

Question: Did people at the hospital think all-women's therapy groups were a good idea when you first proposed them?

Miller: No, some people were quite opposed to them. A long tradition in the field of psychotherapy says that allowing women to get together with other women leads to regression. Yet, our experience indicated that once we started women's groups, many people started asking for all-men's groups. However, no one came forward to start them. Finally, the man who was the Director of the Group Program at the time talked about his experience running groups with men. He found these groups difficult to run, at least initially, because the members tended to be defensive, competitive, silent, vague, and paranoid. But not regressed! I think women's groups have an easier time at first, but later experience difficulty dealing with conflict.

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