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The Space Between in Group Psychotherapy: Application of a Multidimensional Model of Relationship

Ruthellen Josselson[1,2]

An 8-dimensional model of interpersonal relatedness, derived from existing theories of relationship as well as a phenomenological study, is applied to understanding the "space between" people in group therapy. Relational development is conceptualized as parallel streams of growth along separate dimensions, which may involve stronger relational capacities on some dimensions and weaker and more problematic behavior on others. This model is used to reflect on the group therapy situation in terms of how people are trying to connect with one another. Examples are offered and suggestions made for how the group therapist might be alert to the manifestations of each dimension. The goal is for both patients and therapist to have an enlarged view of what people need from one another and how to go about receiving it.

KEY WORDS: **A1**

Group therapy is predicated on the notion that people have symptoms or difficulties because something is awry in their way of relating to others, and group therapy takes as its aim the understanding and improvement of relationships (Yalom, 1995). This stream of thought converges with recent developments in relational psychoanalysis that focus on the intersubjective foundations of all experience (Benjamin, 1990; Bollas, 1987; Mitchell, 1988; Ogden, 1982; Stolorow and Atwood, 1984), and regards the attainment of relationships experienced as authentic, rewarding, and meaningful as a primary criterion of mental health.

Sullivan believed that mental health—and indeed, personality itself—is a result of processes that take place between people. The other is not just a vehicle

[1]The Fielding Graduate Institute and the Hebrew University of Jerusalem.
[2]Correspondence should be directed to Ruthellen Josselson, Ph.D., 4210 Tuscany Ct., Baltimore, MD 21210; e-mail: rjosselson@towson.edu.

for managing internal reality; "interactive exchanges with and ties to the other become the fundamental psychological reality itself" (Mitchell, 1988, p. 25). But what, precisely, are these processes and interactive exchanges? And, beyond the psychoanalytic situation, what are the fundamental dimensions of intersubjectivity? If we extend our notion of mind to encompass relational configurations, with experience understood to be structured through interactions (Mitchell, 1988), then how do we parse human interaction into its elements of interconnection?

As theorists and practitioners, we still lack a comprehensive model of the interactive relatedness that characterizes adult life. In object relations theory, relational experience is crucial for the structuralization of the self, with the goal the achievement of individuation and autonomy (Mahler, Pine, & Bergman, 1975). Internalized object representations are viewed to be dynamic structures that behave autonomously, but within this theoretical framework relationships are seen as building blocks of the self (Mitchell, 1988)—rather than the foundation of future relationships. There is, of course, always a complex interaction between the expression of the self in relationships and the use of relationships to form the self; object relations theory has aimed to bring the latter into focus.

Object relations theory is primarily concerned with explicating the experience of early infancy as it may be manifested in later life (Klein, 1987). When we, as group therapists, think from object relations theory, we view the adult interactions before us in terms of their prototypes in early life. We attend to projective and introjective processes as well as to ways in which others are transferentially distorted into the figures of early experience. As Laing (1967) pointed out, psychoanalytic metapsychology has no constructs for a social system generated by more than one person at a time. The ego is part of one mental apparatus that includes internal objects. Another ego is part of a different system or structure. How these two psychic systems can relate to each other remains unexamined. "Projection and introjection do not bridge the gap between persons" (p. 50).

"The basic relational configurations have, by definition, three dimensions—the self, the other, and the space between the two. . . . Neither the self nor the object are meaningful dynamic concepts without presupposing some sense of psychic space in which they interact, in which they do things with or to each other" (Mitchell, 1988, p. 33). Theorists are just beginning to extend psychological conceptualization of what it is that people do with and to each other.

In group therapy, we observe our patient's interactions with each other and with us as therapists and we try to help them understand some of the distorted views they may hold of others in order that they might develop more satisfying and personally enriching modes of interaction (Sullivan, 1953; Yalom, 1995). But, as Jean Baker Miller (1986) has asked, "What kinds of relationships lead to the
A2 psychological development of the people in them?" (p.) While we may consider the roots of our patients' behavior in their early object experiences, we also need to enable people to learn to recognize their relational needs, their defenses against

them, and the means by which they can create relationships that are both satisfying and growth-promoting. We might be served in doing this by having in mind a complex theoretical model of the range of relational needs people have of one another and how they go about constructing relationships in which these relational needs are met.

Following Fairbairn's (1954) lead that libido is object-directed, a number **A3** of theorists have attempted to elucidate in depth aspects of interpersonal needs in the "space between," such as holding (Winnicott, 1965), attachment (Bowlby, 1969), mirroring and idealization (Kohut, 1977), mutuality (Miller, 1986) or psychosocial identity (Erikson, 1968). Each of these theories lay the foundation for understanding particular aspects of the need for connection that may define the personal universe of each participant in the intersubjective dance, but none of the relational needs explicated by one of these theorists takes account of the others. Each theorist describes a different and separate line of relational development, and these lines interact and intersect in as yet unexplicated ways.

We cannot adequately describe relatedness without the capacity to articulate the multiple facets of the experience of being with, and relational experience is so vast that language is not adequate to contain it. Even in common parlance, we have few words to describe how people intermingle with others, how we need others and need them to need us. Words like *affiliation*, *communion*, and *intimacy* are vague, all-inclusive terms that are suggestive but imprecise. *Love* is perhaps the least definable word we have—its polysemous nature has left it with little consensual meaning. Because our speech in this realm is so restricted, we end up with a cultural mythology of human intercourse that overemphasizes some aspects of interpersonal experience and ignores or distorts others.

In order to develop a model of the fundamental dimensions of interpersonal connection, I conducted intensive interviews with more than 100 people in which I used a relational mapping technique as a basis for inquiring about how others are important in people's lives. (See Josselson, 1992 for a complete description of the methodology.) Using a grounded theory approach to analysis of these interviews, the basic dimensions that emerged were then compared to concepts of interpersonal experience from the psychoanalytic literature, representing such theorists as Bowlby, Kohut, Winnicott, Miller, and others. The resulting model is thus grounded in both theory and phenomenology and attempts to parse interpersonal experience into a range of ways that people might reach across interpersonal space in order to connect to one another (Josselson, 1992). Since its publication, this model has been used to illuminate relational phenomena in the experience of work and career development (Flum, 2001), in child-abusing mothers (Price, in press), and in identity formation (Flum & Lavi-Yudelevich, 2002; Josselson, 1994).

This model, then, takes the need for relational connection as primary (following Fairbairn) and tries to elucidate the various modalities and forms through which the experience of connection is achieved. It integrates the disparate relational

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Table I.

Absence	Dimention	Excess
Falling	Holding	Suffocation
Aloneness (loss)	Attachment	Fearful clinging
Inhibition/ emotionaly deadening	Passions	Obsessive love
Annihilation/rejection	Eye to eye validation	Transparency
Disillusionment/purposelessness	Idealization/identification	Slavish devotion
Loneliness/dissonance	Mutuality/resonance	Merging
Alienation	Embeddedness	Overconformity
Indifference to others' needs	Tending/care	Compulsive caregiving

dimensions conceptualized by various theorists with phenomenological accounts of relational biographies and maps the spatial and emotional pathways of creating a sense of connection to other people.

In this paper, I propose to suggest the ways in which this 8-dimensional model of relatedness can illuminate transactions in group therapy and offer both therapists and patients a vocabulary and a framework for articulating both their interpersonal needs and the positive interactions that meet these needs.

This model proposes eight dimensions of relational experience in human life (see Table I). The first four dimensions are primary: holding, attachment, passions, and eye-to-eye validation. These are present from the beginning of life (in the case of needs to be held and needs for drive gratification) or shortly after (as in awareness of empathic response or attachment). The second four dimensions require cognitive maturation and may not develop until late childhood (although some precursors may appear earlier). Idealization and identification (which is a single dimension) and embeddedness require a concept and experience of the self and the capacity to think about how one is positioned in regard to others. Mutuality and tending/care are also very much concerned with responsiveness to others and require development out of egocentrism and into a world of others.

Each of these eight primary ways in which we transcend the space between us involves, actually or metaphorically, a way of reaching through space (or being reached) and making contact with each other. As each dimension emerges in the developmental history of the individual, each is concrete and basic. As development proceeds, each way of connecting becomes more symbolic, less physical and spatial, but no less crucial. Each dimension of relatedness has its own channel, its own origin and course, although they well may overlap and interpenetrate in a particular life history.[3]

Each dimension has an optimal range of expression but becomes pathological when suppressed or overused. Thus, one can conceptualize the pathological poles

[3]Recent research has shown that the dimensions are statistically independent and discriminable based on questionnaires derived from this model (Baram-Yanai, 2002; Katz, 2002).

for each dimension as absences or excesses. In group therapy, we witness the interplay of all of these dimensions, and it is useful for patients and therapists to name and differentiate them. Growth involves increasing one's repertoire of connections and degree of comfort in these varied modes of overcoming interpersonal space. In group therapy, the nature of the need and the kind of absence or excess each person might experience varies for each patient, and the therapeutic task is to move interpersonal experience into the more tolerable and possibly fulfilling region of the dimension.

HOLDING

The most basic of relational dimensions is that of holding, an aspect of relatedness much explored by Winnicott (1965a,b). The very earliest experience is that of feeling arms around one, supported. With development, a person who has been adequately held feels confident of survival, expects that basic needs will be met and that the world will not let one fall. A child who has been held well enough feels safe enough and protected enough to begin discovering aspects of him- or herself in the world. There is an experience of basic trust (Erikson, 1968) and support **A5** from the world, the core of an expectation that the world will not let one fall.

We know that growth only takes place within the context of adequate holding environments and an internalized representation of trustworthy objects is an important part of what is needed throughout life. In group therapy, holding is experienced through cohesiveness, the containment (Bion, 1957) and support that allows patients to feel safe enough to explore their interpersonal and internal experience. This is a basis of all therapy, but its experience can itself be therapeutic.

At the pathological poles of holding, we witness how common are people's fears that the group can not contain what they feel, that they won't be supported, that others will let go of them when they are needy or vulnerable. Until these fears are adequately worked through, people will be too afraid of falling to allow themselves much latitude for risking themselves. The experience of being held grows slowly over time, in small increments expressed as "tests" of the group's holding capacity. Often our patients speak in terms of feeling themselves going "out on a limb," a graphic metaphor for the risk of falling at times they feel most in need of secure holding.

Betrayal of trust in a moment of need upends the sense of security. The group has to be able to recognize and accept these occurrences when they inevitably occur and offer comfort. These violations of holding can be experienced as traumatic and increase the need for safety and increased vigilance. But recognizing them for what they are serves as a kind of reparative holding.

At the opposite pole, too much holding can become suffocating. In these instances, a group may become so protective of a member that they won't allow him or her to grow. One group I supervised was so eager to reassure a highly

anxious member that the member was left no room to explore the nature of her anxiety. Some members, who present as extremely fragile, may unwittingly invite the group to hold them so tightly that they become in danger of suffocating.

Good enough holding is experienced as a sense of security in the group, a feeling of being in a safe place, and many patients benefit from no more than having such an experience once a week. It behooves the group therapist to recognize its value, even when growth may go slowly for long-term patients.

ATTACHMENT

A bit later in earliest development, the baby learns to discriminate his or her mother from the other people around, making possible attachment to this one very particular other person. Bowlby (1969, 1973, 1980) considers the attachment system to be ethologically and biologically determined, necessary throughout life, and to be always distinguished from dependency. Attachment, unlike holding, requires an external object to respond to us. One cannot be attached to someone who is not there, although one can be held by an internalized object. The propensity to attach to others structures some of the most fundamental processes throughout life, including the painful vulnerability to loss that is part of our human core. When we are attached, it is as though we are clinging to someone, holding on with our limbs, keeping close. Throughout life, we continue to form attachments (if we are fortunate) and these are often at the center of our existence.

The phenomena of attachment in groups offer people who haven't experienced secure attachment an opportunity to sense that the group will "be there" for them and can be counted on to be responsive. One patient, Jim, a highly successful unmarried 35-year old business executive, was a committed and valued member of one of our therapy groups. His father had died suddenly when he was 6, and his mother was unable to care for him on her own due to her demanding career, so he grew up in a series of relatives' homes. When he was diagnosed with cancer and had to miss the group during his surgery and recuperation, the group together sent him a funny get-well card. When Jim returned to the group, he expressed his astonishment that people had done this. Not only was he surprised that people were genuinely concerned about his cancer, it was hard for him to emotionally realize that people still thought about him, talked about him, and worried about him during his absence. Internally, he had come to feel that people who were out of sight were out of mind and that that was true of how others thought of him. Jim spent many weeks in the group trying to think of himself as someone who had ongoing meaning and reality to the other group members even when he wasn't present. In Bowlby's terms, Jim was engaged in revising his internal working model of the possibilities of attachment.

But there are also difficult dilemmas of attachment in group psychotherapy. Members may work together for a long time and become intensely involved, but

they know at some level that they will not remain real figures in each other's lives. For a time, members are highly responsive to one another and may become strongly attached, but at some point this attachment must end. The painful process of saying goodbye allows the working through of loss and grief, and the patient learns to be able to value relationships that don't go on forever.

At the opposite pole, an excess of attachment need might lead to fearful clinging, manifested by people who can't leave the group. This is a difficult problem for the group therapist who begins to suspect that some patients make a career of attendance in group. But, we are likely to reason, if this is the only solid attachment experience these people have, perhaps we do them a service to let them stay as long as they need to.

PASSIONATE EXPERIENCE

In contrast to the quiet security of holding and attachment, the passions are noisy and insistent. Here, people long for intense connection to others. Patients often spend much time describing their quest for passionate connection to others. While the boundaries of group therapy prohibit the enactment of sexual involvment among members, the experience of passionate interchange can be viewed in the group not only through sexual attraction and intense fights, but also through the need for experiences of uniting and oneness among the members. When this occurs, both the antecedents (in terms of early object patterning) and consequences of passionate exchange can be witnessed and understood.

In one form or another, people seek some kind of intense connection with others. Here the nature of the connection may be less important than its strength of emotional arousal. Fairbairn (1954), who starts from the premise that libido **A6**
is object-seeking rather than pleasure-seeking, demonstrates that both pleasure and pain are channels to the object. We can feel intensely connected to each other through hurt, anxiety, or hate, as well as through pleasure. Members of the group may express passionate feelings of love or hate for one another, or set up intense interchanges that replay unconscious libidinal scripts. These feelings, because of their intensity, are always the most frightening for the group. Still, a mature group eventually gets around to them. Understanding and framing them as a need for passionate connection can sometimes mitigate the terror they arouse.

Early in one group's life, for example, Robert expressed some strongly negative feelings for Paul, and the two men began to battle with a good deal of invective. This battle, however, looked to the group therapist more like a bid for involvement than an invitation to a fight that would drive them apart, and the group therapist offered this interpretation. Both men were able to recognize their tendency to use their anger as a way of feeling emotional intensity with other people, a kind of inverted form of love.

At the pathological pole of extreme inhibition, the group can be very effective in loosening people, allowing them to approach the expression of strong affects. Good group work that engages people works against emotional deadening, and may help people contact within themselves passionate longing toward others.

The group may be somewhat less effective in states of obsessive love, although the therapeutic action in these cases can help provide a reality check and model of other kinds of relationships that have their own kind of gratification.

EYE-TO-EYE VALIDATION

In eye-to-eye validation, we overcome space through finding ourselves in the other's eyes, having a place in the other. Within psychoanalytic discourse, this dimension has been explicated most fully by Kohut (1977). In this aspect of relatedness, one finds oneself mirrored in another's eyes. The developmental history of eye-to-eye validation is learning about how we are responded to by others and how our responses to others affect them. Much of the literature on group therapy is focused on this dimension, as the group provides an interpersonal learning situation in which people can learn about their meanings for and impact on others.

What is sometimes understated in this literature, however is the way in which eye-to-eye validation operates through the processes of simply becoming known to, and therefore real to, others. The simple fact of eye contact implies that we are seen by another person and therefore exist for them. Being known, being recognized, shores up self-experience and promotes psychological health. Therefore, patients who disclose themselves to others, who take the risk of becoming known, find themselves feeling better through being accepted by the group. Often, just the interest and engagement of the group is validating, with the implication that one is worthy of others' interest and engagement.

At a deeper level of eye-to-eye validation is the experience that one's inner world is sharable and can be understood by others. Many patients have difficulty in life because their early experiences have taught them that their internal perceptions and feelings are discredited by others. They have been made to feel weird or unacceptable and have taken refuge in sharing with others only what they are certain is socially sanctioned and, therefore, safe. Such patients hesitantly approach disclosure by prefacing their statements with such phrases as "This will probably sound really crazy, but. . . ." When others react with understanding and attunement, the resulting validation is enormously relieving and makes possible the consideration that other aspects of the self that have been previously dissociated or suppressed may be similarly available for expression in relationship.

On the other hand, we can also be misapprehended by others, or we can see in the other's eyes the wish for us to be other than we are. When we look to others for validation, we become vulnerable to the emergence of the *false self*, as Winnicott

termed it, falseness residing in an identity that is not our own. The greatest danger is that of annihilation (feeling we don't even exist) or rejection, and people will often wear all kinds of masks in order to avoid these experiences.

Many, if not most, new patients enter the group painfully afraid that they will be singled out for rejection, especially if people really get to know them. Others fear invisibility, the experience of being unable to see themselves reflected in other's eyes. These fears are revisited again and again, at many levels, as the group engages the long process of recognizing that, within limits, each member will be known and taken in by others and, again within limits, accepted. It is rare in a well-functioning group for a member to stay stuck in an experience of rejection that feels to them annihilating, and this is an important site for the therapist to be continually monitoring. Patients often need a lot of therapist intervention to understand that negative feedback from others is not the same as total rejection. Often, when patients feel criticized for aspects of their behavior, such disapproval may feel to them like a kind of annihilation, a complete loss (or threat of loss) of relational connection.

More disturbed patients often enter the group near the pathological pole of eye-to-eye validation and fear transparency, the worry that others will see too much of them, that they will be known in ways that will frighten or shame them. For such patients, it is a great relief to discover that although one may be known to others in ways that one is not known to oneself, one is not transparent and that one has control over what is revealed. Evelyn, a relatively silent member of a therapy group, made a major step forward when she came to recognize the falsity of her assumption that there was no need to tell others much about herself since others would already know about her dark, secret places—that others could simply "tell" how bad she was. Once she came to appreciate that she had some control over others' knowledge of her, she became able to choose to reveal herself—and what to reveal—in the group.

IDENTIFICATION AND IDEALIZATION

Developmentally, the fifth dimension, identification and idealization, occurs somewhat later than the previous ones. Only after existing for a time in the world of others do children begin to notice that some are bigger, stronger, and more able to do things than they are. Through idealizing others and identifying with them, people become stronger internally, but idealization and identification also become ways of making a connection to others. In other words, the little boy who identifies with his father does so because he is in a relationship with his father, but the process of identification also serves to strengthen the sense of connection.

Group opportunities to connect through this dimension are often subsumed under the concept of modeling, but this conceptualization is a derivative of thinking about relationship existing for internalization possibilities, i. e., internalization

serves the development of self. Idealization and identification as relational processes serve to create and maintain a sense of connection, i. e., "I connect to you through reaching up to you."

Groups offer many possibilities to discover alternative ways of being with and responding to others. Generally, patients in groups will identify one or more other members who they admire and seek to become more like, and these are often the members who are most likely to be positively responded to by others. Beyond simply learning new ways of being, however, members find that by taking in and trying to in some ways imitate the admired other member (or therapist) they also feel an intensified sense of connection to them.

Thus, the patient who seems to be taking a "third therapist" role in the group might be viewed as someone trying to feel more connected to and closer to the therapist through becoming like them—rather than, as often happens, as someone eager to gain power or to deny the patient role. Abe, for example, in our group, was very quick to identify with my propensity to make group-as-a-whole process comments, and he enjoyed pointing out thematic linkages that might reflect underlying process. Rather than confront the competitive aspects of this or charge him with trying to be a therapist instead of a patient, I interpreted this behavior the way I experience it, as an effort to be closer to me, to join me in what interests me. Other group members were then able to talk about ways in which they, too, found themselves connecting to me through internalizing aspects of my way of thinking and looking at things.

Identification was particularly useful for Karen, a woman who initially regarded people with a critical and contemptuous eye. Not surprisingly, people stayed away from her. In the group, she was able to learn from others how to give feedback without sounding so superior and heartless. She eventually found that becoming more like others did not mean giving up her standards and values but gaining a sense of connection to them.

MUTUALITY AND RESONANCE

As the person grows through childhood, and the self matures and becomes more aware of others, the child will eventually discover the possibilities of engaging the self with others and will become able to experience companionship, which is a form of *mutuality*. In mutuality, we stand side by side with someone, moving in harmony, creating a bond that is the product of both people, an emergent "we" in the space between. Mutuality involves resonance with others (that may or may not depend on empathy) and occurs at many levels. It entails what Kohut (1977) has called an experience of "essential likeness" that is, at its deepest point, a form of twinship.

We often see that our patients begin to improve when they become able just to "be" with others, swapping stories, experiencing a communion of selves that

has no goal. Still, the group therapist often overlooks the therapeutic importance of mutuality and may wonder if a group engaged in its pursuit is truly working or instead "resisting."

The affective resonance, the simple joy of being together that accompanies mutuality, provides a necessary sense of vitality that mitigates existential aloneness (Yalom, 1980). It is this sense of "us"—a participation in the space between a you and a me that connects us in a deeper and richer sense of our existence. While in the absence of an attachment figure, people may feel alone, people can feel the loneliness of lack of mutuality even while fulfilled on the other dimensions. And because mutuality exists so completely between selves this, of all the dimensions, is the hardest to talk about. It is not given from one to the other but emerges between people, much as a symphony emerges from the interplay of all the instruments in such a way that we cannot ask if the cello is more important than the oboe in creating the music.

Too often, the simple enjoyment of human interchange goes unremarked in the group. Sometimes this takes place outside the group, in the waiting room, in the parking lot, or in the wish to meet somewhere else. The group therapist needs to recognize the pleasure group members derive from laughing together or talking about the "unserious" issues of ordinary life. This is a central form of experiencing the resonance of human communion.

Mere attendance at group meetings provides some resonance and mutuality for the lonely patient, and this is why patients often feel they get something out of the group even if they go weeks without offering much personal material about themselves. Janet, a new patient, had been silent for weeks in the group, sitting rigidly, looking frozen and perhaps too afraid to speak. The group was uncertain about how to try to engage her. At the beginning of her seventh session, one of the group members asked her what she had done the previous weekend and she recounted her experiences taking her dog to a dog show. As she warmed to the topic (and to the group's interest in it), she showed that she could be quite amusing, detailing the difficulties her dog presented in refusing to do the required steps. The group took this up by sharing stories of their own dogs, which Janet was raptly interested in. The dog stories then continued for quite some time. Rather than regarding this as resistance to the therapeutic work of the group, the therapists recognized the resonant processes occurring and that Janet was entering the group through mutuality. And for some weeks after, "How's your dog?" became the group invitation for Janet to join in. Eventually, Janet became a highly-valued and hard-working member of this group.

As mutuality deepens, the experience of being what Yalom (1980, 2002) calls "fellow travelers" becomes therapeutic in providing a sense of sharing, of being less alone with the dilemmas of life. The dimension of mutuality and resonance includes sharing the subjective space of another (Stolorow, 1994) and the experience of "I-thou" relating (Buber, 1958). Fully resonating in the "between" becomes a source of zest and vitality for living (Miller, 1986). Generally, the therapist's

affective experience of a "good group meeting" reflects the experience of deep feelings of mutuality and resonance. It thus becomes extremely important to verbally recognize these moments with patients, to note their importance and not to allow them to become secondary to a therapeutic focus on distortion and difficulty, or on drive and defense, or on eye-to-eye validation.

For patients afraid of merging (the pathological pole), the group allows opportunities to experience mutuality in a mode that maintains differentiation, but this can involve a good deal of work. Often this is an issue in highly fractious groups, especially younger groups. To be fully with another seems to carry the risk of blending into them. In an adolescent group, for example, stories told by one member may become an invitation to a "can you top this?" process. Troubled adolescents often fear that fully joining another person's experience, adding a bit, sharing emotionally in a "me, too" feeling may imply loss of the self's uniqueness, and such patients need help from therapists in recognizing that they exist individually even while allowing the loss of self that is necessary to fully take part in a space in between selves.

Louis Ormont's (1988) definition of "mature intimacy" reflects a large portion of mutuality in its focus on members making emotional space for one another, talk being unadorned and simple, open risk-taking, life existing in the moment, and "each intimate moment leading to the availability of a more intimate one" (p. 33). Mutuality then, is a communion of selves, at a variety of levels, unblemished by regressive need and self-focus.

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EMBEDDEDNESS

Being social creatures, we need to find a place within a social context, to join a culture, to entwine our individual experience with an ongoing human narrative. Learning language becomes our first act of embeddedness. How we speak, our form of communication, ever after denotes our connection to culture. We speak from our place within a society.

To be embedded within a social network is to feel included, to share characteristics, to be the same as, to give up some individuality in the service of interconnection. In a group, embeddedness is made possible by group cohesion (Yalom, 1995). While mutuality involves the sharing of experience with others, embeddedness implies a sense of belonging. (One can have mutuality/resonance without embeddedness and embeddedness without mutuality, although they might also overlap, as when we join groups because they are places where we experience mutuality.)

In long-term groups, there develops a sense of belonging, having a place, a chair, a meaning. The group may sometimes be the first real experience of reliable embeddedness for some patients. Harriet, a somewhat socially isolated

woman in midlife, tended to somatize all her distress, and had been referred to the group by her physician, who had been relatively unsuccessful in treating her many physical problems. Because her back often pained her, Harriet claimed the most comfortable chair in the group circle, and the group somewhat grudgingly ceded it to her, no matter who arrived first. Harriet was regular in her attendance, although she frequently said that she still wasn't sure what she was doing in the group or if she belonged there. Although she used the word "belong" in the sense of whether or not this was an appropriate referral and therapeutic venue for her, the therapists understood the possible unconscious other meaning of this word, that is, whether she truly had a place, fit in, was a part of. She seemed not to have any real place anywhere in her life, always on the margin in her family and her workplace, the only two sources of human interaction she seemed to have.

Harriet didn't miss a group session until she had been in the group for over five months. During this session, the group left her chair unoccupied, even though it remained the most comfortable one. The therapists commented on this and suggested that the group defer exploration of the meaning of this until the next session when Harriet would return. At this time, the group processed their reluctance to sit in this chair because it so clearly "belonged" to Harriet, and this marked the first time that Harriet seemed genuinely moved by anything that had happened to her in the group. For the first time, it seemed, it occurred to her that she might truly have a place, that she was fully a member. And this marked a turning point, after which Harriet began to talk about and work on her intense sense of disconnection in life.

Issues of embeddedness, experienced as conflicts about belonging, are legion in groups, but often overlooked. The patient who never seems to be a full member and is always on the verge of dropping out is often someone for whom embeddedness seems to feel like loss of autonomy. Theories of group dynamics recognize that groups and their members are always poised between the twin poles of isolation and merger, and this dilemma is represented in the dimension of embeddedness. Sam, a narcissistic, abrasive man in his 30s, reported to the group how astonished he was to hear himself telling a friend about something "my group" had told him. The group, who had been put off by his ungiving distance and relentless demands for validation, was also surprised that he would consider them as somehow a part of something that belonged to him. But they warmed to him after this, recognizing that in some way he did feel he belonged to them as well, and this began a slow process of his learning to more comfortably link himself to others without losing himself.

Group therapy gives all patients an opportunity to explore and bear the giving up of self that is necessary to join others. It also offers the possibilities of personal enrichment that derive from an experience of belonging. Therapists are usually attuned to this dimension when a patient is just joining the group, but it is useful also to track the experience of embeddedness when it is fully experienced by patients later in the life of the group.

Fears of merging can reflect difficulties in either mutuality or embeddedness. Where the dilemma is about mutuality, the fear is of loss of the boundaries of the self and becoming the other. Where the conflict is on the dimension of embeddedness, the fear is that the press of conformity to the group's norms and ways of being, the price of belonging, will involve loss of the prerogatives and autonomy of the self.

TENDING/CARE

We have a rudimentary idea that the ability to give to others evolves naturally from having been given enough oneself. But, as theorists, we know little about the origins of care or about its various forms of expression. We know that care is something that everyone needs, although theory is quick to assign the need for care to dependency, which is devalued and pathologized. And recently, the need to offer care has been similarly pathologized as co-dependency.

Tending to and caring for others is, however, an important way of creating a sense of connection to them. Cultures less individualistic than our own often name forms of interconnection that reflect care. The Japanese, for example, name the relational experience of *amae*, which is roughly the experience of relational meaning from being honored by others through their dependence on you (Doi, 1973). In other words, I connect to you through doing you the honor of depending on you and allowing you to do something for me. In our individualistic culture, which has spawned largely autonomy-driven theories, the role of tending in human relationships is relegated to work on motherhood and largely ignored elsewhere.

But as anyone who has been a parent, teacher, therapist, or friend knows, there are dilemmas in appropriate and meaningful care. How can we hold others without suffocating them? How do we respond to others who are in pain in ways that communicate our concern but don't place additional burdens on the sufferer? How do we remain connected to others through care without obliterating our own needs?

The therapy group becomes a forum for wrestling through (together) dilemmas of tending and care. Group members and therapists grapple together with how to be responsive to others and how to know what others need. And behind what often seems like inappropriate responsiveness in groups is frequently an effort to tend and care.

Richard, for example, a middle-aged corporate manager, responded to Anne's distress that she might be fired from her job with a long lecture about corporate politics and possible legal actions that could be undertaken, completely missing her anxiety and pain about losing what for her had been a safe haven. Several group members pointed out how unempathic and intellectualizing Richard was being towards Anne, how his long speech obliterated what she was expressing and feeling, how he hadn't noticed her sadness, etc. But the therapist was able to notice that while all this was true, Richard was, in his way, trying to offer Anne

what he felt he had to offer, something good from inside himself (his knowledge of corporate life) that might possibly help her. In other words, Richard was, however awkwardly, trying to be in connection with Anne through tending in the only way he knew.

I often become impatient with therapy groups that try to give advice to members, so firm is my belief that advice never helps. And I have often marveled at the persistence with which groups sometimes pursue advice-giving, no matter how forcefully I try to interrupt their doing so. Over time, I have come to recognize that the group also knows that advice will not be useful, but it is offered out of the impulse to give something to the troubled person. Until the group learns to rely on other means of making tending connections, it is all they have to give.

In order to connect with others through tending, one must intend (i. e., have the wish) to offer something good of oneself and also must be able to attend to what is needed. Difficulties in either of these processes can prohibit a patient from being able to connect to others through care. Sometimes patients are too self-absorbed to be interested in offering much to others and sit quietly in group awaiting their turn to claim the group's attention. Or patients, like Richard above, can wish to care for others, but have some blind spots about how to notice precisely what the other might need, or to feel confident in their ability to provide it.

One can conceptualize the forms of tending as responsiveness—the other side of some of the other relational dimensions. That is, people tend through holding, validating, and embodying ideals. Tending is usually a central dimension of work for all group members, as it is for the therapists. Yalom (1995) finds it in the therapeutic factor of altruism, connection (and growth) through giving to others.

Among patients, we witness a range from the compulsive caregiver who annihilates her- or himself in the service of others to people who appear to be indifferent to others' needs. Frequently, people are referred to group when the referral source recognizes in the patient some insensitivity or oversensitivity to others. Thus, issues of connection through tending are often central matters to our patients. One of the great powers of group therapy is to help such people learn to link to others in an appropriately responsive way.

DISCUSSION AND CONCLUSION

This model, in conceptualizing human interaction along eight dimensions of relationship, refracts interconnection into component parts that represent health and maturation, and recognizes that each dimension has a separate developmental history. Beside an understanding of their object relations history, which produces "good" and "bad" objects, we can think of people (as well as patients) as growing somewhat discontinuously on these dimensions. Thus, a particular patient may be quite advanced in her capacity to tend to others, but fear that no one will be able to hold her—or be too ready to accept from others insufficient or inaccurate

eye-to-eye validation. Another patient, desperately seeking passionate interchange, may not have learned to value the experience of mutuality—or of attachment. Being able to think of each group member as having difficulty and needing to do work along certain of these dimensions offers us a way of articulating the complexity of relationships in such a way that no one need feel like a relationally incompetent person. With this model, we can recognize areas of relational comfort and fluency even while helping the patient address what seems more foreign and conflictual. This relational scheme provides a theoretically grounded vocabulary for expressing a range of needs that people may have of one another and can help the group members to ask themselves, in a nonjudgmental way, just what form of connection they are seeking from others and with what they endeavor to fill the space between them.

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