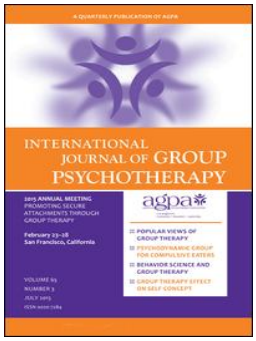

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Into the Wild: Working with Preverbal Experiences in a Group

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ABSTRACT

This article begins with a metaphor of being in the wilderness at night to demonstrate the group analyst's reliance on implicit experiences. The entrenched patterns of group members are rooted in a developmental phase before words and symbolization are available to manage distress. These group members enact in the here-and-now a relational dysfunction fixed in early attachment patterns. The defenses they induce resist interpretation and traditional analysis. The group analyst must be willing to sink into these non-verbal affective states expressed unconsciously yet communicated and to work with the member on an emotional, non-interpretative level. A brief review of affect regulation theory, attachment theory, and infant studies supports this treatment approach. Two vignettes follow to illustrate the nature of working in this visceral and intuitive manner while maintaining an observing ego.

At 8 pm in January, the sun is long gone, the air cold and thin, almost empty. I switch off the light and watch the shapes of color fade. It is pitch black, the kind of blackness that masks your outstretched hand, even if you strain to see it. No longer do the shapes and edges define where I begin and the world ends. Fear enters my body as I take my first steps away from my truck. I have learned to appreciate the unknown in the universe, as well as the unknown in my mind. Just

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the idea sends a fresh surge of life-affirming fear through my body. I could turn on a light, but that would provide me the illusion of safety. In reality, it would only help me see right in front of me, while keeping me blind to the darker surroundings.

I have walked in these woods many times, yet each step tonight feels like the first. My toes grab at the earth through my boots, and my eyes and ears struggle to make sensory sense out of any scrap of perception. My mind labors to focus on the present moment, while trying to manage my fear. Images flash in my mind. The open door of my childhood room through the wooden spokes of my crib appears and is gone.

It is amazing to experience the myriad sounds I hear without a visual map to hold them. Textures and shapes pop into my mind and organize my fear. In this moment, I feel truly alone. It is a terrifying and deeply exciting experience.

Working with preverbal experiences in group can feel like a walk in the woods at night. It is an encounter with the unknown, and to reach it we have to turn off the senses we commonly rely on for cognitive understanding.

LITERATURE

When leading groups, I try to rely on more than knowledge and technique. I must relax my analytic and cognitive mind and open myself to nonverbal and sensory information in order to guide me through the complex group dynamics. Thomas Ogden (1989) writes, "As analysts, we attempt to assist the analysand in his efforts at freeing himself from forms of organized experience (his conscious and unconscious knowledge of himself) that entrap him and prevent him from tolerating the experience of not knowing long enough to create understandings in a different way" (p. 1). This idea is helpful for the group leader as well. He, too, must tolerate not knowing while remaining available to all manners of communication in order to stay attuned to the breadth, depth, and complexity of the relationships we engage in. With this in mind, I am more likely to notice shifts in the group environment. I am most likely to be misattuned when I rely only on my conscious understanding of an exchange in group.

It is no coincidence that schools of thought regarding mutuality in therapy point to the implicit emotional and sensory experience as being paramount to the treatment. Attachment theory, infant-parent observation, affect regulation theory, and psychoanalysis focus on the power of the relationship for corrective treatment (Beebe & Lachmann, 2002; Bowlby, 1988; Fonagy, 2004; Hill, 2015; Ormont, 1989; Schore, 2011; Spotnitz, 1987; Stern, 1985; Winnicott, 1960). And a therapy group offers fertile ground for the collision of past and present relationships, in which the early sensations and emotional experiences of a life are reenacted.

Bowlby's (1988) attachment theory proposes that the earliest relationships in a person's life form a template, the internal working model, for later relationships. Daniel Stern (1985) devoted his seminal work to how the same early relationships primarily contribute to the development of the self in a person. And Fonagy (2004) offers a sophisticated contribution to this theoretical lineage with their book, *Affect Regulation, Mentalization, and the Development of the Self*. In it they expand attachment theory into an evolved intrapersonal and interpersonal theory of survival and agency. Through the process of contingent marked mirroring by the caregivers of the infant's affect states, the infant develops affect regulation and greater attachment security. Sensitive mirroring by caregivers helps the infant develop the ability to self regulate. And it is through exaggerated nonverbal displays (sad face) of marked mirroring by the caregiver that the infant is helped to have an internal state represented, yet not be overwhelmed by the genuine matched negative emotion of the parent, which may make the infant's experience seem contagious and uncontained. This latter experience can be traumatizing. According to Fonagy, this process helps the infant eventually form mental representations of the self and others, which allows for future reflective functioning. This process occurs throughout the early developmental years and relies upon the psychological maturity of the caregivers and the level of attunement and psychological reflection they can offer the burgeoning self they are raising.

Infant/parent observers have argued that knowledge of preverbal processes, including reciprocity, affect, arousal, and relational expectations will enhance our sensitivity to the dynamics with which people create and express meaning, both unconscious and interactional

(Beebe & Lachmann, 2002; Stern, 1985). The more attuned the caregiver is to the sensory and emotional world of the infant and the better able the caregiver is to metabolize the infant's distress, the less damaging are the eventual misattunements and frustrations that are inevitable in life. And the more attuned the group leader is to the sensory and emotional world of the group members, the better chance he or she has of helping them integrate these early experiences into their conscious selves. Since the affective climate is crucial to the therapeutic bond, attunement to the patient's unthought known (Bollas, 1987) is necessary to deep treatment.

Preverbal parent/infant interactions are powerful in shaping a person's self-experience (Stern, 1985). For example, if parents control interactions and a baby's bodily attempts to communicate are ignored, the baby may develop a sense of helplessness and ineffectuality (Frank & La Barre, 2011). Later, this sense of helplessness will be re-experienced in a group, and if the leader is not attuned to the preverbal communications of this member and is unable to respond in a way the patient needs, the relational trauma is repeated and the internal working model will be reinforced. Working at this level involves acknowledging sensations, intuitions, and images to make sense of the sensory/perceptual experience (Frank & La Barre, 2011). This allows for the "working through" at the preverbal level and for a new emotional experience to the repetitive dynamic, what was termed "an emotionally corrective experience." But the key is that the relational repetition, the transference, has to be alive in the room. It is not just an idea.

In his book *Affect Regulation Theory*, Daniel Hill reviews and expands on Allen Schore's research and theory. In it he focuses on what he calls the primary affect regulation system, which consists of the unconscious, implicit and automatic psychoneurobiological processes that lie at the foundation of a person's self-state system and influence the ability to self regulate and be regulated (2015). Hill proposes a theory of body-mind, which suggests that when affect is regulated, self states are integrated, and that they are dissociated when dysregulated. It is the relationships with caregivers in the early years of life that shape the primary affect-regulation system.

Allen Schore (2011) discusses the anatomical structuralizations of the brain that encode early experiences which in turn structure later experiences. It's these "later experiences" we perceive as they unfold in the

group. We just have to be patient and sink into our full experience to learn more each time we have an opportunity. By "full experience," I mean mental associations, bodily sensations, physical impulses, images, thoughts, and emotions. This is data collection and hypothesis building. For instance, each time a member in one of my groups looks out the window when she is asked about her son, I feel shame and rage, my stomach aches, my toes tingle, and I recall my elementary school and the smell of stale books. Now, some of this information is undoubtedly my own, but even so, the question is why do I experience this when she looks out the window thinking of her son. Some of it may be unconsciously communicated. So I take this data and study the symbolic scene in group (Cohen, 1996). Who is involved and what patterns are observable? Does my experience provide clues? With enough "later experience" repetitions and analysis in the group, we can start understanding the early experiences that impacted this member's life and relationship with herself and others.

All of these theoretical underpinnings suggest that the earliest, unconscious processes in the development of a person's relational expectations may reappear in a group therapy setting, given the multiplicity of transferences in the room.

INTERVENTION

When leading a group, I am working towards re-experiencing the preverbal feelings and bodily states of and with the members. I am not attempting to explain the science behind their suffering. I use the science and the analytic models to inform me, so I can be a steadier leader while in the thick of the unconscious. In order to free patients from repetitive and destructive behavioral and emotional patterns, the analyst must establish a connection with the unconscious, implicit self (Bion, 1959; Freud, 1955; Schore 2011). The implicit self involves nonverbal, nonconscious, imagistic, emotional, sensory, kinesthetic, and bodily experiences that generate in the right brain (Schore, 2011). While interpretations, solutions, and the general tendency to explain are aimed at the explicit self (verbal, conscious, and analytic components of the left brain), they often fail to provide the core shifts required for lasting change. That change is manifested through the restructuring of the preverbal, implicit self. Attachment systems of the group member are employed when someone

enters therapy, hence, the initiation of transference. Transference would then include the time before words in this person's life, since that is when the attachment system and implicit self begin shaping (Bowlby, 1988; Schore, 2011; Stern, 1985). In order to work with the infant material, we must tune into it and open ourselves beyond our initial knowledge-based ideas about the patient. Transference at the verbal level involves distortions that can be spoken and felt. Preverbal transference must be sensed and felt.

Communicating on a sensory-emotional level is an imperfect art, but it's what we have. It has evolved from the animal world. Animals have been communicating emotionally long before science developed some understanding about what is taking place interactionally (MacLean, 1990). These complex emotional communications, as witnessed in the attachment and social connection between and among the animals and their social behaviors, serve the animal's survival. For example, when two animals approach each other in the wild, it is clear there is an intense and complex emotional communication taking place that is generating meaning and the participant's eventual behavior. Studies show that mammalian mothers regulate their young through sounds, play, nursing, and feelings (Karen, 1994; MacLean, 1990). The emotional resonance of the African Grey Parrot was beautifully depicted in the 2016 *New York Times* article by Charles Siebert, "What Does a Parrot Know About PTSD?" In it, we walk with severely traumatized veterans as they are relationally selected by equally traumatized parrots, seemingly based on a deeply shared type of emotional scarring at the hands of loss and pain (Siebert, 2016).

So how do group leaders resonate with the multiple implicit selves in the room? They must study their own emotional inner world. This requires deep training and personal analysis with regard to their own transference/countertransference experiences. The leader works to differentiate between subjective feelings and the induced objective feelings (Geltner, 2013). Preverbal feeling states may be even more difficult to identify and understand simply because they originated before the leader or the patient had rationale and words to organize and contain them. It is often a sensory experience that requires thorough exploration and the willingness to lose oneself to the process. The leader is aided by curiousity concerning the complexity of the experience. Attention is paid to the physical, cognitive, associative, emotional, and sensory data in order to

gain a clearer picture about the experiences of the group and its members. An over-reliance on thinking may lead to knowing, which can foreclose access to this more primitive developmental world.

When leading a group, the induced sensations and feelings affect my emotional state and physical body (Geltner, 2013; Spotnitz, 1976). I use this experiential data to piece together what may be occurring in the room. I try to stay open and perceive myself, the group, and its members. I ask myself questions as I pay attention to my experience. Are my sensations a trace of the early relational patterns of someone in the group? What are the impulses I'm having? Do I want to engage or defend? Are these my old desires and how I was handled, or do they belong to a member or subgroup? And what do these experiences I'm having mean about the interaction occurring in group? I try to recall if I've had this experience in this group before, and if so, how did I intervene or not? I'm hoping that through internal exploration of my feelings and sensations along with my understanding of the patterns of this group and its members, I may get in touch with the inner experience of one or more of the members. It is at this point that I am often tempted to lean on an analytic understanding of what is happening in the room. And although that will be a necessary component to organizing the experience and crafting an intervention, rushing toward the comfort of knowledge usually deprives me of more fully sensing the raw experiential data in the room. If I think too much about the unconscious preverbal experience, I run the risk of disrupting its true nature and missing out on learning more about someone.

Once we sense we are in a time before words, we can begin studying our sensations, feelings, and imagination. Do we have a sudden fear rush through our bodies as if we are about to fall? Does our vision get blurry? Do we have a physiological urge to curl up? If so, we may be induced with our patient's current experience. Or we may be regressing ourselves due to the powerful emotional stimulants in the room. Still, we may be induced to scoop up our patients and nestle them in our chest. We want to rock them. The intervention begins once the affective resonance is achieved.

When working with preverbal material, group therapists focus on feelings and whatever is influencing them—the patient, the analyst, the setting, and anything else. Knowing this helps the group leader more effectively contain herself and the patients as the unknown is

encountered. When group members lose sensory control, it simulates the loss of both ego and reason, which hold us together on a daily basis. One slips to a time before words and thought; therefore, the preverbal regression in the patient must be detected by the leader through affective resonance in the countertransference as described above. Once detected, the leader can apply joining and mirroring via nonverbal emotional communication (Geltner, 2013).

Early interventions need not involve words. In such instances, the leader senses the inner experience of a group member. Here, we are primarily helping develop the preverbal self's affect regulatory system as a parent would an infant, through attuned mirroring back of the experience she is having internally (at least we hope so). Through this repetitive process, we are accomplishing two tasks. First, we help cohere the ego, or self, of the group member by mirroring their implicit experience nonverbally through gestures, voice, and facial expressions (Fonagy, 2004; Schore, 2011). Our external reflection of their internal state strengthens the affective regulatory system in the mind. Second, in our attuned, yet silent ability to contain their feelings, we are modeling for them the ability to tolerate and contain their distress (Geltner, 2013). This helps to emotionally ground the regressed group member. Through repetitive and attuned interventions, we are attempting to slow down the patterned responses that transference has brought to life in the group. In doing so, we may help form or reinforce an alternate internal working model for interaction with the self and the world (Brisch, 2002).

Daniel Hill writes about the separation of the unconscious, automatic primary affect regulation system and the secondary affect regulation system. According to Hill, the secondary affect regulation system is depicted by the conscious, cognitive, reflective, and verbal workings of mentalization theory (Fonagy, 2004; Hill, 2015). This system forms later than the primary system, and involves the left hemisphere of the brain to think intentionally and representationally about one's own mind and the minds of others. According to affect regulation theory, the psychotherapuetic treatment process may be rooted in repairing the primary affect regulating system, but the progression of the work has to involve the use of words to represent and organize the way we think about ourselves and others. The words can slowly be applied to aid in the maturation of the ego and to contain the feelings. This

process simulates the powerful early attachment resonance between caregiver and infant crucial to the development of an internal working model/ego (Bowlby, 1988; Schore, 2011; Winnicott, 1960).

It is important to note that when we are working with a regressed group member, we are not only working with the preverbal infant needs as described above. We are working with their defenses and resistances to getting these needs met. That is the preliminary task of the group leader. If all had gone well during their early years, they probably would not be in our groups. So survival meant the creation of false selves, alien selves, dissociated selves, and all manner of emotional maneuvers to protect the young ego from the pain and shame of misattunement by the parents. In 2013, Paul Geltner published a concise and complete book charting the taxonomy of emotional communications and the process by which therapists work with them in themselves and those who entrust them with this work. His openness as a writer is demonstrative of someone who has spent time in the wild.

This therapeutic process takes time. A long time. Group members who experience deep change spend years in treatment. And group leaders who work in this way spend years in treatment and training. The interventions described in this article occur over long periods and are not always clear and concise when applied. It is the shared struggle and earned attunement that heal.

VIGNETTE ONE

Ellen is an emotionally gifted violinist who was referred five years ago by her individual therapist to work in group with me. During the first of our individual sessions for group preparation, I noticed how perceptive she was. I also noted how anxious I felt sitting with her as we talked through perfunctory points about group therapy. After three meetings, we set a start date. The group Ellen was joining consisted of six members, was evenly split between men and women in their 30s and 40s, and had been running for five years. She fit right into the reflective talk that characterized the sessions. All smart members, they were astute at naming their feelings and supporting each other. But the group had a resistance to experiencing feelings they might not be able to control. There was also a powerful sense of judgment in the room that seemed to reinforce this resistance. Looking back, the group of individuals had learned to

suppress their strong feelings in order to maintain the status quo in their original families, while avoiding the criticism of perfectionistic parents.

During one of Ellen's early group sessions, Jim, a popular member, began talking about how stupid his sister had acted at Thanksgiving dinner. The group chuckled and egged him on. The more they laughed, the meaner he spoke of his sister. I recall feeling terror and shame run through my body as I listened. Then my back stiffened with rage, and I wanted to scream out at Jim to shut up! I had had this particular experience before when Jim dominated the group. He attacked insecure family members and group members in order to defend against his feelings of fear and shame. If he could get someone else to feel scared and ashamed, he would be free of his own torment. I glanced at Ellen and noticed her sitting upright with clenched fists and glassy eyes. I attempted to catch her gaze, but she averted her eyes. She seemed overwhelmed and dissociated. I immediately turned and asked Jim how he was feeling at the moment. This intervention served to interrupt the scapegoating of Jim's sister and the group members holding her experience. The emotional intensity slowly deescalated, and after a few minutes Ellen's body relaxed. I chose not to address her response, thinking the attention might make her feel ashamed. Instead, I noted that her reaction and mine had occurred when the group joined Jim's assault on his sister. I wondered about Ellen's early life and the fear she may have felt in her family when shame was used as a weapon. I noted that she did not reach out for help in the group. Instead, she was visibly distressed, silent, and seemingly dissociated. It seemed that Ellen was also holding the intense feelings of terror, shame, and rage for other members of the group, who were guarding against their own vulnerability by joining the attack. I was starting to imagine how Ellen's family had managed intense feelings.

I began paying specific attention to my feelings and sensations each time Ellen slipped into an overwhelmed state. I studied how she looked and moved when I was feeling the experience described earlier. The pattern repeated itself each time in both of us. And verbal interventions from me or from group members only made her feel more overwhelmed and unable to talk through it.

At this point, I believed the feelings and sensations I was having were Ellen's. It seemed I was tuning in to a state of her preverbal experience. When I paused my thinking and sank into these feelings, I

would get confused and "fuzzy-brained." No words came to mind, only blurry images of faces and buzzing sensations in my body. The terror charged my heart, and the shame coursed through my body.

During her regressions, I gently mirrored her experience back to her through my tone, body posture, and eye contact. When I felt terror, shame, or rage, I titrated the feelings so as to join, but not intensify them. I wanted Ellen to feel connected in these powerful emotional states, while also developing a trust that I might be able to contain them. I was hoping to send the implicit message, "I feel what you are feeling, it is really scary, and it will be all right." Other group members seemed interested and watched these nonverbal interventions. I noticed a shift in several members who shared Ellen's experience, but had not yet been in touch with it in group. I imagine that the shared emotional experience moving through these members was a powerful regulating agent for Ellen and for them. Each time shame was aroused, Ellen would regress, and I would attempt the process of attunement and mirroring described above. Most of the time, Ellen's body slowly relaxed, and after a while, she made eye contact with me and smiled as she regained her conscious ground. I started feeling affectionate towards her as a parent might feel towards a child. Although the primary work was being done with Ellen, the group was vicariously experiencing the sense of contained affect in the room. They were exchanging looks and engaging one another nonverbally during these exchanges. The group was providing itself insulation. I became less active during group regressions of this nature, and the group took over in large part.

While emotionally joined with Ellen and the group, I slowly introduced words to contain these feeling states. "This feels scary." "It's warm in here!" And once she and her group mates began repeating these, I added predictive questions when the repetitions surfaced. "Is something getting scary in here?" "Am I the only one in the room who is worried?" These questions involved the whole group in the process and insulated Ellen's ego during these challenging moments. The group and Ellen then began asking these questions and naming the shifts in the room. Members stated, "I'm tense," and "I just got really angry!" Slowly, Ellen's propensity to dissociate diminished. She stayed in the room, looked around for reassurance and grounding, and asked for help from other group members. "I need help! I'm scared and can't

think straight!" Several members would join Ellen verbally and nonverbally in her feelings. They acknowledged how helpful her emotional bravery was to the rest of the room. The group narrative slowly shifted from scapegoating the vulnerable member to empowering the group member and trusting that he or she was tuned to the defended feelings in the group. Through this supportive shift, Ellen became aware of herself and noticed when her feelings and sensations changed. She would ask, "Is anyone else having this feeling right now? I just got mad."

The work described here transpired over years and was met with group resistances to these intense and vulnerable feelings. Moving closer to the unknown and the uncontrollable takes a long time. The preverbal work we all engaged in, through the attuned mirroring of early feeling states and the slow application of words to help organize and contain them, greatly reduced the frequency and depth of Ellen's dissociative states and the defenses of the other group members. The fact that it was done in a group and that the group engaged in the work added emotional insulation and a sense of safety to a process that can be terrifying and unknown.

VIGNETTE TWO

While the first vignette involved more leader-centered intervention, the second is an example of how a working group can be a dynamic therapeutic agent for repairing preverbal dysregulation.

I had been running a group with consistent membership on Tuesdays at noon for six years. The current make-up of eight people included five women and three men, ranging in age from 28 to 65 years. The newest member had been in the group for a year, and four were original members. The group flowed between free states of emotional expression some weeks to deadened and dissociative states the next. Frank, a therapist and long-time member, frequently announced his frustration when he felt "flat" in the group and would demand to know who was squashing the anger in the room. He had been raised by a depressive mother who routinely induced him with her despair for him to hold and fix while she got drunk. In the last year, he had come alive in group and seemed able to retain a strong sense of his ego in the midst of powerful inductions from the more depressed members.

Rodney had been in the group for three years and kept everyone charmed with anecdotes from the hospital where he worked as a nurse. He was adept at keeping his sadness at bay with well-timed cracks dripping with sarcasm. He liked to follow these with, "You know I'm just joking, right?" Rodney had been raised in Fort Worth, Texas, by his mother and father who divorced when he was two. He only saw his father on weekends after that, but always spoke of him fondly in group. Rodney often stated that his father was warm and understanding and never "talked down to him." His mother was a colder disciplinarian. When Rodney was eight, his mother sat him down and informed him she was marrying a man he had not yet met who lived in Michigan and that they were moving there in a month. Rodney remembers his mom exclaiming how happy he must be! He played the good boy and learned to shelve his emotional experience. He did move to Michigan and in with the rather distant man he had never met who was now his stepfather. Two years later, his father died of AIDS, and Rodney had seen him only once since moving. The group members expressed sadness and anger for Rodney and had expected him to share grief and anger when his story was told, yet he stayed steady and said it had never bothered him. "That's just life," he said with an air of confidence. The group seemed stuck in the middle of their feelings of grief for Rodney and his lack of emotional expression.

One night, a favorite member of group named Shelly announced she was moving back to her hometown across the country. Shelly was in her mid 60s and felt it was time to be around her grandchildren more often. Shelly was a mother figure to the group. She was feisty, razor sharp, and attuned to the hidden feelings of her group mates, and she was excellent at gently checking in with them when they were having trouble talking in group. As I looked around the room that night, I saw many sad faces, but it was Rodney's sullen and flat expression that piqued my interest. I had never seen that look on his face before. Since this was a talkative and observant group, I sat back to see if any others might have noticed this shift. Frank was on it. He caringly asked Rodney whether he was all right. Other members took notice and made emotional space in the room. Shelly stayed present although she was tearful. I was struck by how still and sad the group experience became. Rodney's eyes darted around from member to member to the floor and back to Frank. Frank softly said, "Hey." He was emotionally holding Rodney with his gaze, and Rodney wasn't looking away. He slowed from the slightly panicked state he was in a

moment ago. The rest of the group remained quiet, yet engaged and seemed to sense the moment's magnitude. Rodney did not speak again for a long moment and neither did Frank. Frank's face seemed soft and solid at the same time, and I imagined he might appear to Rodney like his father had years ago. Rodney's eyes were glazed over, and the room felt both foggy and serene. And it remained that way for what felt like an hour although it was just a few minutes at most. Slowly, Rodney's eyes grew wet, and he seemed to come back into his body. Frank exhaled a deep breath, and the engaged group relaxed back into their chairs, appearing moved and exhausted. No one made a comment, including me. No words were spoken, and yet it felt as if everything had been said. I was filled with an immense sadness I could not describe—and a simultaneous joy. Rodney's experience felt foundational in the room, and yet no member offered language or thoughts to name it. After several minutes of kind expressions, the group moved away from Rodney in a way that seemed caring and attuned to how stimulating and new this experience was for him. The group was holding him as a united family might. This was an experience I do not believe Rodney had received before, either as an infant or in his early years.

It is hard to know with certainty what was transpiring in that exchange. However, as the group progressed from that session, Rodney was helped by the members to grieve over and over with the slow addition of words and interpretations. It was a painful process that radiated throughout the members, and it awakened early dysregulated affect states that served to intensify the feelings in the room and provide insulation in numbers, keeping those engaged from feeling alone. The group itself became the regulating agent in this case. Members remarked on the shift that occurred as a result of this session.

I want to stress the long-term nature of this group's work. There are moments and sessions that feel so deeply powerful that it is as if magic is at work. But it is not magic. It is the resonant experiences of the earliest affective self states in all of us coming to life and being subjectively shared and integrated through the help of the group process.

CONCLUSION

Our modern and controlled world insulates us from the environments of our early emotional states. These early states shaped the internal

models of self and relational expectations that unconsciously affect relationships and inform much of the suffering that brings a person to treatment. As clinicians, we are involved intersubjectively with everyone we work with, and that requires us to struggle in the preverbal emotional experiences with them. If not, we are denying a crucial piece of the treatment. For a group leader, the multiplicity of transference and countertransference emotional communications is considerable. Studying the preverbal experience can help us expand our chances of understanding what is happening during an interaction and how best to intervene. And by spending time in the preverbal world ourselves, we can be better equipped to work there with others.

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