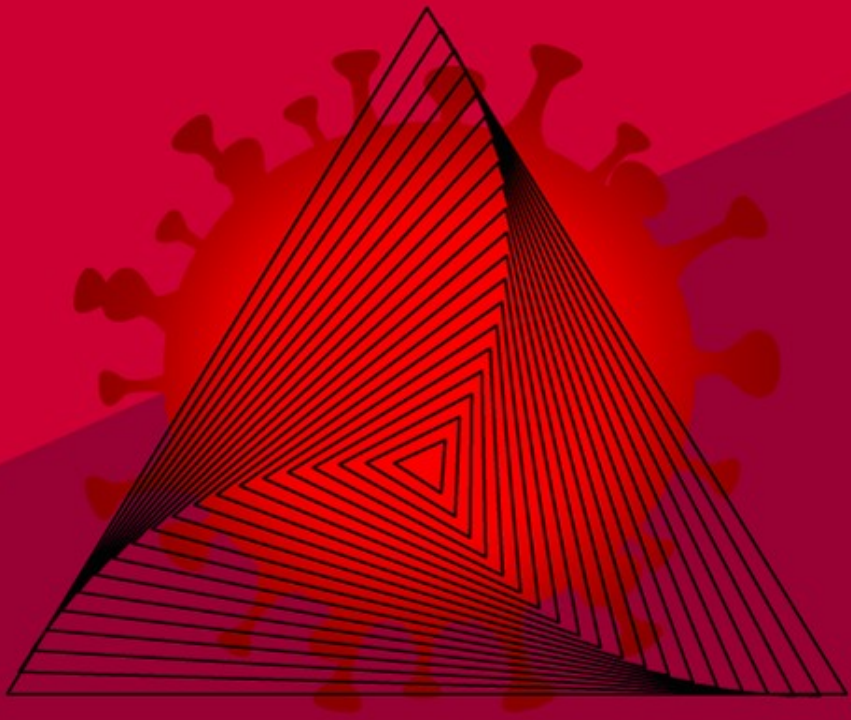
A Peer Group in the Time of COVID



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Created in the United States of America

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Overview

We constitute a peer supervision group that began to meet in 2017, long before COVID entered anyone's imagination, let alone changed our lives. But when COVID did strike, we understood that, as psychologists and psychoanalysts, we needed to be aware of its impact on our practices, our patients, ourselves, and our peer group. Accordingly, we decided to write about what we saw and what we thought about what we saw. The papers that follow are the product of our separate as well as our collective thinking.

I.

Peer Group Process in the Time of COVID

Harriette Kaley, PhD

For years I'd wanted to be in a peer supervision group. I'd always loved talking shop and hearing what my colleagues had to say. Finally, two of us decided that a way to be in one was to start one. We invited our third member after hearing her speak at the graduation ceremony of our training institute. We'd initially thought a group should be larger— and I do now think that ideally it should— but at the time the three of us generated a comfort that felt fine.

That was about five years ago. We've since met regularly every second Monday morning. Before COVID, we met in each other's offices or homes. Now we meet on Zoom. I like that much better. It saves a lot of travel time. It can feel very intimate, as I pull my iPad towards me to get literally close to the person on the screen, and in that sense, it echoes what it's like with my patients. And it eliminates a kind of hostessy, social ritual—coffee and cake or something—that had crept into our meetings, and we began instead to go straight to talking about our clinical work.

But of course, never did we talk **only** about our clinical work. And of course, paradoxically it was **all** about our work the whole time. Even when we thought we were just talking about mundane things, like an apartment renovation,

or about important things, like the deaths of a mother and a sister. And in the long run, it turned out that virtually **all** those matters converged, in the crucible of the group, into what we came to understand as questions of transference and countertransference. Those processes, as they subtly or not so subtly manifested in our work with patients—and occasionally with each other—became increasingly what we saw operating in just about everything we found problematic in our work.

For example: We'd evolved a process—which we didn't always follow religiously— of each of us having a half-hour to present. Two of us typically talked about a difficulty with particular patients. I followed a single patient intensively, presenting my most recent session with her at each meeting. In the long run, **both**

approaches worked, and worked similarly; we heard so often about the same patients that we developed in-depth understandings of the patient and the interactions between them and their analysts.

One day one of us wanted to talk particularly about feeling pressured by the parents of a teenaged patient to meet with them. Given the special COVID pressures, the analyst finally relented. But when she did, she was inundated with a detailed anguished narrative that left her little to do but silently hear the parents out. The intensity with which she conveyed that experience to us made the pressure she'd been under come alive; I felt myself thrashing around internally, looking for something helpful to say or do, and I am pretty sure that our other

member felt the same because for a while we couldn't say anything.

But then, slowly, and yet suddenly, when everything clicked into place, we realized that the analyst had induced in us the same sort of formless helplessness she'd felt in the session. We'd all been involved in an enactment that told us quite clearly, albeit in its own obscure way, about this family's inability to respect boundaries. We'd been swamped by the contagious boundarylessness of the parents' session and of our own session, and then that told us also about our **own** susceptibility to parental wishes and to parental neediness.

In the end, once that clarity dawned, we were able to offer concrete suggestions. But by then such suggestions weren't really necessary;

the treatment was no longer impeded by our misplaced responsiveness to unspoken parental pleas for rescue.

And that, fundamentally, is how we've come to work as a group. It's gotten easier as we've had more group history and we've come to see the trajectories in the patients' lives and in the ways we work with them.

What occurred in our group echoes what's been written about supervision generally. It's long been accepted that what happens in supervision often reveals in the very interplay between supervisor and presenter what's problematic in the treatment being presented. It's usually called parallel process, but it's more like an enactment, in which the supervisor and presenter themselves get engaged in a set of

dynamics that, if decoded, tell them what is happening in the treatment they are trying to grasp. And here is where we think our **peer** supervision group has been really helpful: presenting to a supervisor often implies an evaluative process embedded somehow, somewhere, in it. On the other hand, the collegial, nonhierarchical nature of the peer group facilitates the emergence of material that otherwise might be defensively suppressed. It's easier to let yourself be exposed to your supportive peers than to the superior beings who will evaluate you and make or not make referrals. We chalk that one up as a big one for peer supervision groups.

I don't mean to suggest, though, that everything in our group has been smooth sailing. One of us, for instance, is regularly unhappy

with another's willingness to educate patients with facts and detailed information; another in turn believes in a detailed history and is unhappy when we prefer to know the patient through the interactions between us. One particular engagement, though, stands out as having seriously almost derailed us before we righted ourselves.

After some vague hints, we were confronted openly and directly with one person's fierce anger about feeling left out of a group decision. That itself was bad enough. But the fallout from it was totally unexpected: being the target of such feeling completely undid another of us. She felt hollowed out, deflated, disconnected. The sheer astonishment, on all sides, at what had been unleashed was massive. We all three were reeling and, for a painful tense few hours,

recovery seemed unlikely. Salvaging the group took a determined willingness and the realization on all our parts that the toes that had been unwittingly stubbed concealed deep suppurating wounds. The angry one came to know that she'd reexperienced feeling ignored in her childhood home, and the deflated one understood why she'd not often enough grappled with patients' rage.

Now we know and it's better; it's not that we're just more careful with each other but we're more aware of the hidden vulnerabilities that in this instance made one of us overreact to a slight and another to become profoundly depressed when feeling unloved.

Ultimately, given the hothouse of interactions in which we do treatment, we are

grateful that we'd uncovered such explosive materials in the safe space our peer group had created.

II.

A Peer Group in COVID Time and the Analytic Attitude

Susannah Jacobi, PhD

The analytic attitude insists everything is grist for the mill: no assumptions, only fearless exploration. Forming a peer consultation group under conditions of that "old normal" was challenging enough. Moving to remote work during COVID has further exposed assumptions all of us risk making, especially about symmetry and power in peer relations and how the increased need for personal connection can forestall that exploration.

At first and for some time after, I had to contend with my own vulnerability and doubt: was I was up to the task of converting an established pair into a troika? There was the invitation itself: I'd been, by turns, first surprised, then flattered, then alarmed. I'd been introduced to both women at Postdoc events, but really knew them best by reputation: two respected, senior analysts, both widely published, active at Postdoc in various roles. Maybe they knew my name and something of my style from my role on the ListServ. In my graduation remarks, they had a small sample of how I present. They were offering to open what sounded like a long friendship to include a third: a baby analyst who was nominally an age mate, but otherwise a stranger with an unconventional analytic background. Sounded risky to me;

didn't they feel that same risk? Whom did they think they were getting? What could I bring to the table as a peer?

As our group took shape, we acknowledged only tacitly that many of the familiar elements of the analytic "frame" were at play. Asymmetry is built into the analyst/patient relationship, but we were aspiring to be equals. Could we keep our interactions truly symmetrical? How might asymmetry show itself in the way we worked together?

Of course, we were forging patterns of interaction and communication shaped by social forces like deference to authority, or simple politeness, rather than a rigorous analytic attitude. Still, the three of us tried to be careful to build the frame to emphasize equality. We

rotated in—person locations among our offices and homes. Each sacrificed three practice hours every other Monday morning to make the 90—minute sessions happen. We experimented with presentation formats, finally settling on half—hour segments. As we grew closer and more invested in one another, non—clinical, personal considerations came up: illnesses and even deaths of family members, our own medical scares and escapes, the horrors of renovations. We shared intimate details of how we work—financial arrangements, legal battles, and the like. Looking back, it's clear that our regular interactions, compatible outlook on life, and shared commitment to being there for one another were growing real friendship. Then COVID—19 hit.

Now we're three talking heads, periodically beset by technical glitches but at least no longer having to worry about the commute. The potential for what Todd Essig has called "kissing or kicking" has been eliminated. This has given all of us the space to consider more explicitly how we relate on more analytic levels.

Psychoanalysis has always been a potentially lonely practice. Belonging to a peer group offered the opportunity for personal connection —we had to be brave to risk rocking that boat in the best of times. As COVID put the squeeze on our social lives, we grew more reliant on one another and on video. But video has the potential to expose fault lines in any relationship. I'll mention five.

(1) Think of punctuality itself: With the excuses of travel delays eliminated, why would anybody turn up late? We had never before explicitly acknowledged resentments when one or another of us arrived minutes after time.

(2) As Harriette mentioned, over the years we had noted—and sometimes laughed about—a kind of friendly competition over hospitality. With the social cues of coffee and banana bread stripped away, we had no easy distraction from the clinical work. Circumstance invited us to look at whether and how we might have been using food as a relief from uncomfortable inquiry.

(3) Video conferencing can only approximate, not duplicate the qualities of in—person. For example, when you're all in the

same room, interrupting and talking over one another can be annoying, but read as enthusiasm rather than rudeness. At least you know someone's being drowned out and can ask for a repeat. With videoconferencing—as on speakerphone–unless you're using headphones, only one voice at a time comes through—and the parties have no idea which input the software will prioritize. This raises the issue of taking turns—a power issue on display in any video meeting with more than two people.

(4) Thinking about the frame again, I'm reminded how things change when a patient decides to transition from facing me, each of us reading and responding to the other's nonverbal expressions, to lying on the couch, looking at the ceiling. In videoconferencing, there's a novel, additional "reading" process in play: We're

tempted to monitor our own faces in a way that's impossible in the office. Seeing yourself is distracting. Light and shadow matter as never before. And outcomes can be comically undignified: Consider the dress option of what's being called "business casual above, Zoom below": woe betide who stands up without thinking!

(5) There are other video choices that are impossible in person, but meaningful analytically: We can use still photographs to represent us or close video feed while leaving audio live. Which of us chooses what? At what point? And why?

Of course, we're all adapting to technology —and interpersonal dynamics will never go away. But it's that question—Why? —that I

think has been the most interesting feature of our peer group in the time of COVID—19. We have found ourselves dealing more analytically with our immediate process, how we inhabit or shift roles and alliances. Our unique strengths and vulnerabilities are highlighted. And our developing friendship has been strengthened as we think ever more deeply as analysts.

III.

"Rupture and Repair": Patients and Therapist

Judith Warren, PhD

Three is a perilous number. Three conjures up a *menage a trois*, three is a crowd, two against one; it's so easy to split a group of three. But three is also a good base for a chair or table. Stability—instability, we as a three person peer supervision group have had both. When we came together five years ago, it was apparent from the start that we had different styles, different psychoanalytic emphases, and temperaments. The two of us who have been friends for a longer time have been the more outspoken members of the group, sometimes

wrestling over differences, while the third member has been quieter, more worried about pleasing us, more tactful, initially less forthcoming. Though that has definitely shifted over time.

Before COVID, the differences among us were exciting, though sometimes vexing, as we have never really worked out some ground rules like how a person should present, how and when the others should intervene and make suggestions. Our different styles have sometimes made me impatient since I was trained to keep the overriding issue of either the patient or the patient—therapist dyad uppermost in mind and hone in on it at a supervised setting. Others prefer to present an entire hour almost verbatim and see what emerges for discussion. Sometimes, on the other hand, I have had a hard

time when others break in too quickly with questions or their own point of view about the case being presented. Then I want to slow the interaction down and allow more space for the person presenting.

I sometimes wonder if my acceptance on one hand and impatience on the other also emerges in my work with patients, though I am more frequently requested to say more; almost never do I sense I have said too much or overridden my patients. Has that changed since working remotely? Actually, I think I have become more active lately because I feel so close to my patients—paradoxically, within a foot, of each other it feels like— due to either our ears pressed to our phones or the very close visual connection. Both methods radiate intensity. The

phrase “in your face” gains meaning especially, of course, when actually looking at one another.

Yet I am also aware that both the pace and frequency of my comments since the lockdown depend on my relationship with each patient. Some patients take the lead more now that we are not in the same room. Others seem to want and need more from me than ever before. One patient who suffered several early losses, including the violent death of her father, often seemed impervious to my comments when she was in my office, but now appears much more engaged with me. I think her current fears of death, isolation, and job insecurity have reactivated her early feelings of abandonment and terror so her need for me and my words has magnified, especially since my words are now disembodied, which I think adds to her desire to

hang on to me. And I am also abiding this awful period, during which I have lost several close friends and an ex—husband. As a result, I have felt both her struggles and strengths more keenly since the epidemic, the latest of many traumatic events in her life. And the peer group, which has also suffered losses, has been extremely empathic to my patient's early losses as we all are in this period of chaos, worry, agitation.

Since the shutdown another patient, just beginning college, has, been reporting dreams with much more frequency than ever before. I have brought some of these dreams to the supervision group though I feel a little as if I am betraying him because his telling me these dreams seems like a special act of confidence. His family lurks close by in their small apartment and he wants privacy. Yet my talking

about his dreams in our peer group also started to feel like an odd replication of his family dynamics. I go for guidance to the two in my peer group the way my patient yearns for sustenance and advice from his parents. But while he often feels misunderstood and belittled by them, I have found the peer group to be very helpful; I have become more aware of my patient's resilience and articulateness (something he's had difficulty with in the past). In one recent dream, he described climbing a precarious ladder out of a sinking ship and making it to safety on shore. In another, the "bad guy" was shot and my patient's family, which he thought had been killed by this guy, came back to life.

I have found the peer group less helpful in dealing with some of my patient's sadistic fantasies which also emerge in his dreams, as

you can see from the last dream just mentioned. I think that darker aspect is something that has been, until recently, as Harriette has said, under wraps in our group. Perhaps, as someone who has a fair amount of access to my darker side, I resonate with that aspect of my patient's unconscious, which has of late, under the strains of the pandemic and support from me, become more conscious—in both him and me. I have had parallel dreams of both despair and restitution, including one in which my apartment first collapsed and later was rebuilt with more open space and light than ever.

I think that my dream parallels not only my patient's inner life but also the life of our peer group. Both the strengths and difficulties in our group have been thrown into bolder relief by the pandemic. We too meet online, *face a face*,

which heats up our interactions. We have become increasingly important to one another as we each play our part in the saga of our group. Like most threesomes the dynamics frequently shift. Sometimes A and B are closer, sometimes A and C or B and C. As I said before, I think we need to clarify the group "rules" so we can understand and support the needs of each of us both personally and professionally. Our patient's coping skills and struggles are mirrored in ours —in splits and angers and hurts as well as our ability to work through the problems. "Rupture and repair" as Kohut said has never been clearer on so many levels. We are all currently ruptured and in great need of repair. Our group is an integral part of that process.

Conclusion

COVID threw us all a curve ball, but in the process of fielding it, our peer group was helpful. It was not always comforting and supportive—why should it have been? —but it created a space in which we could safely grapple with the new world into which we were thrust. Whether we embraced it, ignored it, distrusted it, or were simply troubled by it, the group experience required us to notice our reactions. That was an unmitigated good.