CHAPTER 3

Advances in Group Psychotherapy and Self Psychology
An Intersubjective Approach

Irene N.H. Harwood

The theory of the self as applied to group psychotherapy has had particular meaning in this age and culture wherein people strive for independence, autonomy and self-sufficiency, but all too often at the cost of alienation from others. The much-talked-about phenomenon of the 'me' culture can be viewed as a product of the times we live in, but a closer look also reveals it to be a common compensatory response to psychological factors going back to an early period of life when a child's developmental needs were misunderstood, ignored, mocked, overvalued or overwhelmed by caretakers who could not relate to the child phase-appropriately. In such a case, a foundation for good-enough object relations never emerged. Children who experienced little or no enthusiastic responsiveness from such caretakers, except perhaps by taking on a submissive, compliant false self, can hardly be expected to relate spontaneously and with mature reciprocation.

This chapter discusses clinical issues in group psychotherapy with narcissistic and borderline patients; but first a brief review of the principal concepts of self psychology will be useful, especially more recent developments. For a deeper immersion into the earlier concepts, Kohut and Wolf (1978) and Kohut (1977; 1984) are recommended.

1 This chapter was presented at the Patients with Narcissistic and Personality Disorders in Group Psychotherapy Conference in Basel, Switzerland at the Kantonsspital Basel Psychiatrische Universitatsklinik, 5 September 1989, and first published in GROUP 16, 4, 220–232 (1992).
Theoretical constructs

Self psychology views development as a continuum. The infant and child require special attunement and responsiveness to their psychobiological states—by their caretakers if psychological growth and development are to continue without major injury or derailment. Winnicott (1947; 1960a; 1960b; 1962) regarded as adequate the natural, good-enough responsiveness of a caretaker. Kohut (1966; 1971; 1972; 1977; 1984), however, perceived that adequacy was not enough—that empathic responsivity was necessary for development to proceed. In therapy, on the other hand, the empathic introspective approach consists of a mode of listening, sensing, and a temporary immersion into the feeling state of the other, only for the purpose of understanding that state, without losing one’s own boundaries. He emphasized that empathy is not the same as sympathy or just being kind.

The infant’s development needs arise very early, but not at birth, for it seems safe to assume that, strictly speaking, the neonate has not yet acquired a self (Kohut and Wolf 1978). The baby has certain needs for physical survival, and its psychological survival hinges on the presence of responsive-empathic selfobjects (persons whom we experience as part of ourself). The earlier and/or the more traumatic the insults to the developing self, the more the potential for a greater severity in the disturbance of the self exists.

At first Kohut identified two types of selfobjects: mirroring selfobjects, ‘who respond to and confirm the child’s innate sense of vigor, greatness, and perfection’; and the idealized parent image, selfobjects ‘to whom the child can look up and with whom he can merge as in image of calmness, infallibility and omnipotence.’

In 1984, Kohut reconceptualized twinship from a phase under the developmental line of the grandiose self, to another distinct developmental line. In twinship, Kohut recognized the need to experience sameness with someone seen as similar to oneself. An example of this would be appreciating with another the same cultural experiences or going through feelings of mourning. These definitions in turn imply the salutary functions of the selfobject caretaker. In the matrix of the selfobject environment, the nuclear self of the child will crystallize through a specific process of psychological structure formation that Kohut and Wolf (1978, p.416) call transmuting internalization and specify:

1. that it not occur without a previous stage in which the child’s mirroring and idealizing needs had been sufficiently responded to; (2.) that it takes place in consequence of the minor, non-traumatic failures in the responses of the...selfobjects; and (3.) that these failures lead to the gradual replacement of the selfobjects and their functions by a self and its functions. [That is,] the autonomous self is not a replica of the selfobject.
The good (not necessarily faultless) caretaker, then, exults with the child, encourages the child, and serves as a mature imago for the child, but helps lead the child to understand that reality imposes bounds on the urge toward omnipotence. It is inevitable that the caretakers themselves will sometimes frustrate the child’s wishes — but hopefully this will fall within the range of optimal frustration.

Kohut’s (1971; 1972) and Kohut and Wolf’s (1978) use of the term selfobject at times appears ambiguous, giving the impression that it can also be an external agent. They describe archaic selfobjects as objects that the infant experiences as part of the self and expects to control, much as the grown-up expects to have control over his or her mind or body. With normal unfolding and growth and phase-appropriate responsiveness, along the developmental poles of the grandiose self and idealized parent imago, the archaic selfobject becomes a mature selfobject.

The mature selfobject, on the other hand, is perceived as a separate center of initiative, with needs and wishes of his or her own, with whom one can establish an empathic, reciprocal relationship, based not on demands, but on mutuality, caring, and understanding. The achievement of mature relating takes place in what Wolf (1980) calls the empathic selfobject ambience. Shapiro (1991) reviewed how feeling safe in group is a result of experiencing empathy first.

**Advances in self psychology**

More recently, Stolorow and Brandchaft (1987) have redefined the concept of selfobject to mean not an entity or an agent, but a class of psychological functions pertaining to the maintenance, restoration, or consolidation of self-experience. In addition, a specific tie (determined by the particular nuclear self in question) is required with the subjectively experienced object in order to maintain, restore, or consolidate the organization of self-experience. Another way of putting it is that since selfobject by definition refers to the presence of a function, there is no selfobject experience without a selfobject function.

M. Tolpin (1982), Stolorow (1985) and Harwood (1986) disputed the existence of and human need for many different selfobject functions. Consequently, Harwood (1986) identified the extended selfobject function; Wolf (1988) identified the need for the adversarial and efficacy experiences; and Stolorow, Atwood and Brandchaft (1992) designated the self-delineating selfobject function to be basic to the emergence of a separate sense of self.

In the above-mentioned article (Harwood 1986), I integrated and pointed out the relevance of current developmental research to group literature and to group therapy. I especially focused on the importance of cross-modal integration (Spelke 1976). I also introduced the importance of multiple selfobject functions, or what I termed the ‘extended selfobject function’. This function is in place in the social milieu of most babies in almost all cultures, except when there is only one
...caretaker without family or friends. Otherwise, from the very beginning the baby
benefits from group membership in a larger group, the extended family.

I also emphasized the child’s ability to internalize into his or her self-structure
a multiplicity of selfobject functions from various consistently available caretakers, an
ability that then enables the child to develop a less rigid, more flexible functioning
and relating repertoire, which is the basic foundation for all human relating and
understanding. Thus, the early internalizations of extended selfobject functions are
crucial precursors for the development of empathy – the ability to understand the
many subjective experiences of people different psychologically and culturally
from oneself – a mandatory tool for the therapist.

In the group psychotherapy literature, Schwartzman (1984) has stressed how
the entity of the group can be used as an archaic selfobject, while I (Harwood
1983a; 1983b) have pointed out how a member’s obtainment of selfobject functions
from any individual in group can be shifted among different group members or to
the therapist when a misunderstanding or a subjectively experienced empathic
closure occurs. In contrast to individual treatment, Bacal (1985) states that patients
in group therapy will have less difficulty establishing the selfobject relations they
require, simply because of the multiplicity of candidate selfobjects.

Many authors agree that the entity of the group, which is often referred to as
the group self is often experienced as a provider of selfobject functions (Bacal
1983; Harwood 1983a; 1983b; 1990; Lonergan 1982; Meyers 1978; Paparo
1983; Schwartzman 1984; Stone and Whitman 1977; Weinstein 1991; Wilson
1983). As with any individual, the group as an entity can also lose its idealizing
(Weinstein 1987) and mirroring function for a member. For example, the entry of
a new member may set off a regression in a less than cohesive group (Kohut
1977). The resulting sense of fragmentation may be similar to an ill or demanding
child’s experience with a marginally functioning parent who cannot provide
soothing (Harwood 1983b; 1990). (See also the turmoil provoked by the group
member described below)

Restoration of the selfobject tie and structure building

Bion and Stolorow (1984–1985) hold that psychological structure building
occurs when the ruptured bond between the person and the one (caretaker or
therapist) providing psychological functions is restored. Restoration of the tie is
facilitated by the caretaker’s or therapist’s differentiating, synthesizing,
modulating, and cognitively articulating the emergent emotional states, thus,
helping integrate the fragmenting affect into new psychic structure. Kohut (1971,
1977) believed that psychic structure is built primarily through transmuting
internalization, whereby the child eventually takes over and internalizes some
selfobject functions that the caretakers had been performing. Stolorow (1985),
though not disagreeing with the clinical manifestations of this phenomenon,
believes — as described in his paper with Lachmann (1984—1985) — that it is the restoration and maintenance of the selfobject bond that enables and contributes to the building blocks of new psychic structure.

**Intersubjectivity**

The notion of **intersubjectivity** (Atwood and Stolorow 1984; Stolorow, Brandchaft and Atwood 1987) has emerged as a significant revision in the theoretical thinking of self psychology. It holds that all interactions occur in an intersubjective field with each participant experiencing a given situation from his or her own point of view, the latter being a product of a multiplicity of causes including genetic history and present psychic organization. In the treatment situation, both patient and psychotherapist bring their own subjective point of view, creating an intersubjective field.

The notion of intersubjectivity is not totally foreign to group therapists. On the surface, intersubjectivity may appear to be no more than Lewin’s (1947) concept of paratactic distortions in different dress. In that concept, a group member’s perceptions are viewed solely as transference manifestations based on old genetic, historical distortions, which are contraposed against an actual, correct group reality with the therapist usually acting as judge and jury. That however, differs greatly from the concept of intersubjectivity, which would accord validity to each participant’s subjective point of view. Thus, every member’s contribution (regardless of what it is) is accepted as important and valid because it brings out a particular subjective point of view which is organized around previous experience. This subjective organization of experience calls for understanding and analysis from the group therapist, not judgement. Therefore, there is no need for the therapist to intervene with pronouncements on objective reality. The group members, of course, present a collection of individual subjective realities — not objective realities. Objective reality may only exist in mathematics.

Within the group therapeutic process, one of the most important elements is the member’s efforts to understand the basis of each individual’s subjective experience. Such understanding is quite crucial after a narcissistic injury or a disconnection has occurred with another member, the therapist, or the entire group either through misunderstanding or through lack of response to a patient’s subjectively felt need. In these instances, the injured member may perceive the group as a repetition of earlier caretakers who disappointed or traumatized the young, vulnerable self. Thus, when a person’s subjective experience is not understood and held as valid, group members may become compliant, disorganized, enraged, or may flee treatment altogether. Stone, Blaze and Bozzuto (1980) cite examples of fleeing treatment.

On the other hand, when everyone’s subjective experience is understood, validated, and worked through, it allows for restoration of selfobject bonds and
for the building of new psychological structure. Depending where the initial rupture occurred, the bond needs to be restored either between individual members, the group-as-a-whole, or wherever it was ruptured.

Conflict

More recently, Stolorow and Brandchaft (1987) separated out the notion of conflict from its origin in drive theory. They believe that conflict becomes structuralized only when the child’s authentic nuclear strivings are pitted against the compliance that is required if the child is to maintain the selfobject bond with the caretakers. Though such compliance is definitely adaptive in terms of the environment, it begins a process of perverting and contorting the natural evolution of the authentic self (Harwood 1987). Conflict is seen by Stolorow and Brandchaft (1987) as becoming destructive only when caretakers (parents or therapists) are not able to adapt themselves and provide the specific functions needed by the developing child. Though not disagreeing with this notion, I (Harwood 1986) have pointed out that unusually stressful environmental circumstances also can prevent developmentally mature and good-enough responsive caretakers from reacting optimally. If the caretakers impose too great a demand for compliance, the child may surrender and give up his or her own goals. If the child has not received the affect attunement that he or she subjectively requires, the unintegrated affect states become sources of lifelong inner conflict and can manifest themselves in unresolved anger, rage, and different degrees of self-destructiveness (Stolorow and Brandchaft 1987).

In group, when there is compliance to the group’s or another member’s point of view, without recognition of understanding of a member’s wishes or subjective experience, conflict re-emerges for the individual in question. Conflict can be structuralized into inner conflict, as Stolorow and Brandchaft (1987) suggest. The less-than-cohesive individual can also take on a ‘false self based on identification’ (Harwood 1987), thus also giving up whatever nuclear strivings were beginning to emerge. Noncompliance in a group that demands agreement, on the other hand, may result in ostracism or the need to leave the group altogether.

Thus, it is a particularly important task of the group leader to safeguard and protect the individual members’ emergent goals and expressions of the authentic self from pressures to comply to suggestions from individual members or the group-as-a-whole. Only when it is a group ideal that every member has a right to his or her own direction, can the individual not only hope to attain his or her own way, but find and define his or her own self.
Transference

As previously alluded to, transference in contemporary self psychology is not viewed solely as a distortion of an objective present reality prevailing with the therapist or another group member, with the patient seen as viewing the present situation only through old historical, genetic glasses.

Kohut's significant contribution in the evolution of his reconceptualizing narcissistic disorders was his recognition of patients' pathognomonic evolution of specific selfobject transferences with the analyst. The specificity of the transference was related to a developmental phase when early selfobject functions had been deficient. These transferences might remain silent until there was an empathic failure, at which time the patient would respond with an effort to re-establish the disturbed inner equilibrium. Stolorow and Lachmann (1984–1985) expand upon and modify these original formulations focusing on specific transferences—mirroring, idealizing, or alterego (twinship) transferences—to include the contributions of both patient and analyst, or what Atwood and Stolorow (1984) and Stolorow et al. (1987) termed the intersubjective field.

Transference as defined by Stolorow and Lachman (1984–1985) is an organizing activity, which can be viewed as deriving from a microcosm of the person's total psychological world, including the person's very early conscious and unconscious configurations of self and other. Seen from this angle, transference is not merely an unconscious tendency to repeat the past, but rather the only way the person can organize experience and construct meanings about his or her internal and external world.

The patient's view of the analyst's contributions are not negated, debated or validated. Instead, the patient's view of the analyst's contributions are used to further explore the meanings and organizing principles that form the patient's psychological world. Therefore, transference can exist only in the intersubjective context, with the therapist/analyst contributing to it simply by being who he or she is and by the patient's attributing meaning to who the therapist/analyst is and what he or she does, whether these be self-expressions or countertransference manifestations. In addition, Atwood and Stolorow (1984) warn against the specific impasses that occur when therapists/analysts are not aware of the contributions of their subjective points of view, and either agree or disagree with the patient's view (actions that the authors refer to as intersubjective conjunction and disjunction).

Bipolar conception of transference

Stolorow (1988) reformulated the ebb and flow of treatment through a bipolar concept of transference (which is different from Kohut's initial bipolar formulation of the tension arc). For Stolorow, one pole is the selfobject dimension of transference. This is when the patient looks to get from the therapist the functions that were missing
during earlier development. Like Kohut, Stolorow believes that the therapist needs to understand consistently, not through sympathy or by just being nice, but through empathy (the putting oneself in the state of the patient while maintaining one's own regulated state). This type of understanding and emotional resonance, not agreement, is then experienced by the patient as the very nutrition necessary for arrested development to resume. Further, Socarides and Stolorow (1984–1985) believe that it is the therapist's acceptance of the patient's affects and needs (inherently woven into the selfobject bond) that promotes self-articulation and self-demarcation, modulation and synthesis of affective discrepant experiences, affect tolerance and the use of affects as signals, desomatization and cognitive articulation of affect, as well as other structuralizations of self-experience.

The other pole, for Stolorow (1988), is the conflictual, repetitive, and resistive dimension of transference. Ornstein (1974) has elucidated the patient's dread of repeating earlier childhood traumas in treatment. At this pole of the transference, the patient fears – perhaps expects – repeating earlier selfobject failures.

When the transference shifts from the first pole to the second, the therapist needs to be aware that the patient has shifted into the conflictual, repetitive and resistive dimension of the transference and therefore should try to identify the patient's perception of the therapist's selfobject failure without blaming the patient. Such attunement to the patient's change in feelings and reaction, Stolorow believes, mends the ruptured bond. Restoration of the bond brings back the selfobject pole of the transference, while the conflictual, resistive, repetitive dimension fades into the background.

In a group conducted from a self psychological perspective, within an inter-subjective context, selfobject and conflictual, repetitive, resistive transfersences are at play as group members intertwine past and present, both inside and outside of group experiences. Within the group process, spontaneous growth proceeds during the selfobject pole of the transference and, when needed, during the conflictual pole of the transference. The group therapist clarifies experiences and constructs intelligible meanings, thus helping to reinstate selfobject bonds between individual members and the entire group.

Group example
A group member, whom I will call Ron, announced that he had enrolled in an actualization type of group on his friend's strong recommendation. This other group — a 'don't worry, be happy' type — was supposed to be more 'upbeat', to talk more about 'doing' and how to become a 'winner', and to help people who were afraid of physical closeness learn how to hug. In our therapy group, he complained, people were not responsive physically.
As the therapist, I perceived Ron to be protesting, though provocatively and not very directly, against the lack of touching and holding he missed early in life. He seemed to require not only the mirroring selfobject function, but also the touching, holding, soothing function of Kohut’s early idealized parent imago pole. I speculated to myself whether Ron had experienced rejection and narcissistic injury toward the end of a recent group session. In that session, Nan told Ron that when he tried to hug her, she felt as if he was trying to get something from her by force, since she gave no sign that she wanted to hug him. She experienced Ron as wanting to be in total control of her reactions, treating her not as an individual but only as an object to be used. She declined to be used in such a way.

As Ron continued to praise the virtues of the ‘touch-action’ group, the members began vigorously defending the virtues of their own group. Almost all of them joined in to defend the idealized virtues of the present group against the imagined shortcomings of the other group. As the therapist, I did not feel that this group-as-a-whole reaction against one member should be considered as majority confirmation of objective reality.

I sensed that the group’s banding together against one member indicated strong feelings of potential rejection, injury and threat to the integrity of the group which the members were experiencing both individually and as a group. In the intersubjective group field, each member was reacting, in different degrees and configurations, to both prior and present fears of being rendered powerless or found deficient. With this, the group-as-a-whole was also losing its potential to function as a selfobject for Ron. While I, as the group therapist, remained quiet, sorting out the individual and group dynamics as well as my own reactions, I was not yet providing any tension-regulating functions. My silence was not subjectively experienced as containment, since it was my group that Ron was finding wanting, and it appeared that I abandoned the members to defend the group’s worth. My lack of protective intervention frightened the group further and intensified the angry standoff.

During that time, I was considering whether I agreed with Nan and disagreed with Ron, and remembered how I, like Nan, had also experienced Ron as physically demanding. I remembered how, at the beginning of treatment, he would routinely put his hand on my shoulder and tell me how he liked what I was wearing. I remembered how uncomfortable that made me, but even then, I sensed that to comment on or even ask about the meaning of this ritualistic behaviour would be an outgrowth merely of my discomfort. I feared Ron would have experienced my inquiry as a painful rejection or even condemnation of his attempt to be pleasing – or perhaps, in self psychological terms, to merge with an idealized parent imago.
I began to understand his behavior as deriving from his desperate desire for someone to notice him, to approve of him, and to touch him, as a confirmation of his goodness and desirability, thus, to mirror his authentic self. As a child, he had felt that in his parents' eyes he could do no right, while his brother could do no wrong. Though he remembered no touching or other physical comforting from his nuclear family, he recalled his paternal grandmother once standing up for him to his father, and how much it meant to him. I concluded that he indeed required the selfobject functions provided through tactile contact, which this very verbal group did not hand out automatically and had not established as a group value (under the idealized parent imago pole). Though Kohut's paradigm does not specifically include tactile functions as mirroring functions, it could be loosely adopted here. On the other hand, both Stolorow (1985) and I (Harwood 1986) believe that there are many more possible selfobject functions than those Kohut mentions.

Turning to the group, I first decided to address the group process, keeping with the notion of responding first to the shared tension of the here-and-now atmosphere. I pointed out that Ron and the group had ended up being locked in opposite positions – Ron contending that the other group was superior, and this group feeling devalued, stoutly defending its own virtues. As the therapist, I added my opinion that both groups had something to offer Ron, though what they had to offer was different. I recalled for them Ron's words about his early deficits, owing to being cared for physically while often being severely punished corporally. Perforce, Ron would feel a left-over yearning for unfulfilled needs. Although his needs may have been reawakened in this group and an attempt was being made to gain understanding of them, I added that maybe the other group had something different, but also of value, to offer Ron.

Thus, the therapist's empathic understanding of Ron's selfobject needs allowed him to call a cease-fire. He relaxed, became misty-eyed, and thanked me. Drawing an analogy with his paternal grandmother, he said he experienced the therapist as protecting him from his tyrannical, overbearing, know-it-all father, in this case the group. In turn, the rest of the group seemed to experience relief from the overheated emotional situation, with the verbal interaction it valued no longer being under threat of de-idealization. With this therapeutic intervention, I was able to diffuse the escalating intensity of unregulated affects as well as identify and integrate the fragmenting components. The restoration of the selfobject bond between the therapist and the group members, including Ron, re-established a sense of cohesion (Kohut 1978) and coherence (Pines 1986) for the group. Earlier, while I was silently reflecting, the group seemed to have experienced me as abandoning them, or possibly as being overwhelmed by Ron's attack. Thus, the therapist during this period was not experienced as the much needed powerful container of unregulated affects. But once the selfobject bond was re-established
and members no longer felt abandoned and without a conductor, they were able, little by little, to show some understanding of Ron’s needs. The process concluded with the members recalling what Ron’s attack had touched off in each of them from their own past. Ron and each member’s organization of subjective experience was brought out and understood. This accomplished, the group was able to leave the resistive, conflictual aspects of transference behind, re-established its cohesion, and resumed its work without needing the therapist’s further intervention.

Ron also was able to express his own present feelings and past associations, re-establish the ruptured bond with the group, and remain with the therapy group. In addition, he continued to participate in the actualizing group, including its advanced course, in which later he became a teacher. He did appear to gain from each group. He received the physical touching he so much needed from the actualizing group and was better able to internalize both emotional and cognitive components in the therapy group. As a result, he was able to integrate multiple or ‘extended selfobject functions’ from very different caretaking agents—in this case, two groups. He is no longer a member of either group. After getting the most out of both groups, he left his employment of 16 years to form his own company and to design and produce his own products. During the holiday season, some members of this old group (including Nan) and I receive cards with updated news.

Though Ron may be considered as borderline and with a proclivity for splitting by therapists from other theoretical points of view, I did not see him as untreatable in a psychoanalytic psychodynamically oriented group. As group therapists, it is essential to understand the subjectively needed selfobject functions of individuals who have been severely deprived early in life and not to repeat the traumas by responding rigidly.

In my experience of conducting groups from an intersubjective perspective, it is rare that a whole group will turn on one member without someone being able to empathically understand that member’s point of view, unless the whole group becomes threatened. In such a situation, it is up to the therapist to understand and bring out the intersubjective elements among the members, as well as take into account his or her own subjective contributions.

Schlachet (1985), summarizing and building on previous group psychotherapy literature, enumerated 10 criterion behaviors that are present in group process and can be used to validate the therapist’s interventions: depth of response, group participation, accessibility of feelings, anxiety reduction, decrease in acting out, greater directness of expression, development of a common language, increased acceptance of self and others, greater group cohesion, and greater autonomy and self-reliance. The above example of a group conducted from a self psychological perspective appears to meet most, and perhaps all, of Schlachet’s criteria.
Disorders of the self and borderline conditions

In his first book, Kohut (1971) viewed the narcissistic and borderline conditions as separate pathological entities. He modified that view in his second book (Kohut, 1977, p.192), in which the differences in the derailments of the self in the narcissistic and borderline disorders were characterized primarily by the degree of the experienced injury or trauma in response to the experienced narcissistic blow, as well as by the duration of the fragmentation and enfeeblement of the self.

P. Tolpin (1980), while stating that “borderliness” of patients is not to be judged from the standpoint of an observer outside the field but from the standpoint of an observer participating in a system – the self–selfobject system of the patient and therapist’ (p.312), appears to set the stage for Atwood and Stolorow’s (1984) notion of intersubjectivity. On the other hand, when Tolpin further suggests that ‘a highly vulnerable narcissistic personality disorder might be considered (incorrectly) to be a true borderline condition because of the limitations of even a competent analyst’s empathic understanding of certain constellations of severe disorders’ (p.312), he also plants the seed for Brandchaft and Stolorow’s (1984) significant paper on the iatrogenic myth.

In a groundbreaking contribution, Brandchaft and Stolorow (1984) affirm that the conception of the borderline condition as a discrete character structure is an iatrogenic myth, meaning that a borderline condition can be brought about by an unempathic therapist who does not or cannot immerse herself or himself into the subjective experience of a patient, and understand and acknowledge it as real or valid. These authors state that the borderline configuration only remains unchanged when the analyst continues to ignore the intersubjective field, through lack of attunement and understanding of the patient’s subjective experience. When the therapist/analyst further insists on interpreting reactive narcissistic rage to be a split-up projective identification of drive derivatives, the fragmenting situation only becomes further intensified and perpetuated. Supporting their premise with clinical examples, Brandchaft and Stolorow see the borderline disorders positively, as both treatable and analyzable, a view that they say Kohut also came to share in the last part of his life.

Self psychologists now generally view persons with borderline disorders as having experienced less attunement to their nuclear strivings; indeed, as having experienced traumatic blows to the basic fabric of the self at the very time when beginning strivings would start to emerge. Persons who suffer from borderline disorders experience more lengthy or permanent derailments in their self-states, while persons with narcissistic disorders seem to experience more temporary enfeeblements or fragmentations of the self. Upon the reinstatement of a selfobject bond and needed selfobject functions, the latter can more quickly restore their sense of equilibrium.
Treatability of self disorders

Others have cited the treatability of severe self disorders, or those with psychotic configurations, with a self psychological approach. Trop (1984) illustrates, through a case study, a clinical application of self psychology to the psychotherapy of a psychotic patient. Similarly, Stolorow et al. (1987) describe the analyzability and treatment of psychotic states. More recently, I (Harwood 1992) have underscored that what is labelled primary aggression in borderlines (or even psychotics) is nothing more than ongoing reactive rage to continually being misunderstood or experiencing lack of containment or retaliation from a vulnerable therapist with permeable self boundaries. When the therapist or group is subjectively experienced as forcing the self to contort, reactive rage prevails. On the other hand, when the reasons for reactive rage of those who are labelled borderline or psychotic are accurately understood, what appears to be primary aggression dissipates.

In a significant contribution to the group psychotherapy literature, Lonergan (1982), in great detail and primarily using a self psychological approach, discusses how to begin and maintain inpatient and outpatient groups with medical patients and schizophrenics. I (Harwood 1983a) have given a verbatim example describing the type of enabling group atmosphere in an outpatient setting, which is needed for persons with little or no sense of self to begin discovering their nuclear strivings.

Group psychotherapy and self psychology

Kohut did not practise group psychotherapy. Like Freud (1921) before him, Kohut was also interested in the dynamics of group phenomena and in the role of the group leader. In his paper 'Creativeness, Charisma, Group Psychology', Kohut (1978) warned that group pressure can diminish individuality, leading to primitivization of mental processes and to a lowering of resistance. The warnings take on special meaning when working in group psychotherapy with vulnerable individuals who suffer from self disorders that are considered to fall into the narcissistic and borderline diagnostic category. These individuals can be easily led from their emerging nuclear strivings by a charismatic and/or authoritarian group leader, by individual members, or by any given direction a group may take. Kohut’s theories (1971; 1977; 1984) found quick applicability to group psychotherapy, (Arensberg 1990; Bacal 1985; Harwood 1983a; 1983b; 1986; 1990; 1992; Kriegman and Solomon 1985; Lonergan 1982; Meyers 1978; Paparo 1983; Schwartzman 1984; Shapiro 1991; Stone and Gustafson 1982; Stone and Whitman 1977; 1980; Weinstein 1987; 1991; Wilson 1982; Wong 1979).

Group psychotherapy from a self psychological perspective accords with such group pioneers as Slavson (1950), Wolf and Schwartz (1962) and Yalom (1985),
who championed the concept of the individual as the focus in the group process. In addition, a group conducted from a self psychological perspective would envision, as its primary goal and purpose, the development of each person toward freedom of his or her own convictions, toward cohesion, coherence (Pines 1985; 1986), and self structure, along with the capacity for reciprocity and mutuality in personal relationships.

I have elsewhere (Harwood 1986) spelled out the importance, for a developing individual, of extended or multiple selfobject functions and experiences in the family and larger community, and how these add toward the building-up and flexibility of individual psychic structure. Multiple consistent selfobject functions are of equal importance to persons who are regressed, arrested, or at a critical point in their individual development. The self psychological group atmosphere, by its variety of potential selfobject functions and selfobject ties, offers a multitude of possibilities for Kohut’s transmuting internalizations and for the creation, restoration, and maintenance of selfobject bonds (Socarides and Stolorow 1984–1985) through which individuals can assume the building of psychic structure along with a new or renewed sense of

References


Harwood, I. (1990) 'The application of self psychology concepts to group psychotherapy.'
Psychoanalytic Association 14, 243–272.
Kohut, H. (1972) 'Thoughts on narcissism and narcissistic rage.' Psychoanalytic Study of the
Child 27, 360–400.
Kohut, H. (1978) 'Creativeness, charisma, group psychology.' In P. Ornstein (ed) The
Kohut, H. and Wolf, E.S. (1978) 'The disorders of the self and their treatment.' International
Krieman, D. and Solomon, L. (1985) 'Cult groups and the narcissistic personality: The
Lewin, K. (1947) 'Group decision and social change.' In T. Newcomb and E. Hartley (eds)
Loner gan, E.C. (1982) Group Intervention: How to Begin and Maintain Groups in Medical and
Mey ers, S.J. (1978) 'The disorders of the self: Developmental and clinical considerations.'
Group 2, 131–140.
Orstein, A. (1974) 'The dread to repeat and the new beginning.' Annual of Psychoanalysis
12/13, 195–119.
Annual Self Psychology Conference, Los Angeles.
Schlachet, P.J. (1985) 'The clinical validation of therapist interventions in group therapy.'
Psychotherapy 34, 229–241.
Psychoanalysis 12, 105–119.
Spelke, E. (1976) 'Infants' intermodal perception of events.' Cognitive Psychology 8, 553–560.