Influences from Kohutian and Contemporary Theories in the Development of a Combined Treatment Model

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Recent advances in self psychology and other contemporary theories provide a theoretical and experiential structure for combined therapy. This article explicates the use of these theories, offering clinical examples that demonstrate their effectiveness. Emphasis is placed on a treatment model in which individual treatment precedes placement in a group. Using a Kohutian selfobject, group placement is determined by the effective establishment of a selfobject transference. Other aspects of combined work, such as cotherapy, are explored.

KEYWORDS: Self psychology; selfobject; intersubjectivity; co-creation; cotherapy.

INTRODUCTION

My early work with groups, over three decades ago, took place with an inpatient population at St. Elizabeths Hospital in Washington, D.C. At that time this institution was very involved in training and teaching as well as in research. However, there was little opportunity to work using a combined treatment model. The next phase of my work took place in the psychological services of a local university before universities began to limit services. It was here that I began to explore a combined model. Also, at this time, private practice was being impacted by decreases in mental health reimbursements. Coverage for these services had been about 80% of an unlimited total. This allowed for multiple individual therapy appointments. As benefits decreased, I attempted to extend treatment for patients by placing them...
in open-ended group psychotherapy in an effort to compensate for lost individual sessions. As you can imagine, these groups were quite different from those I had conducted in institutional settings. Because they emerged gradually, initially out of necessity, the development of a treatment model arose from clinical experience.

In those early days I was generally guided by Sullivanian principles as well as by influences from the work of Bion, my own early group training. It was in 1982 that I began to incorporate ideas from the writings of Heinz Kohut, whose work I had been studying and teaching. My theory and technique were therefore influenced by an original thinker whose perspective was primarily psychoanalytic. His ideas became the main theoretical guide for my group work; that is, the primacy of the individual was inherent in my model, one in which individual therapy preceded group treatment. This is markedly different from a model, such as group analysis, that views the group as the basic relational unit. The difference in the initial treatment philosophy inevitably set the stage for very different clinical models.

Over time, I have found my own work evolving, with somewhat less emphasis on the individual to a somewhat greater emphasis on the group-as-a-whole. The balance has shifted as a result of both my experiences in the groups I lead as well as the utilization of information from attachment and neuropsychological research, particularly regarding trauma. For example, the work of Fonagy (2001), Stern (2004), Beebe et al. (2005), and others informed us about the ongoing role early attachment history has in the development of the adult capacity to succeed in forming emotional attachments. Furthermore, the work of Corboz-Warnery and Fivaz-Depeursinge (1999) elaborated on infants’ capacity to negotiate more than one relationship from birth. Their research captures the infant’s efforts at maintaining connections with both parents. This research is important for our understanding of what occurs in group therapy. As they point out, we are social animals designed to function in groups. Solomon (2003) told us that

new evidence indicates that reparative adult experiences enable those with attachment traumas to increase their ability to cope with stress and restore a sense of security. Healing through new relationships occurs frequently and makes a person who has experienced trauma increase their ability to cope with stress and negative affect. (p. 331)

Schore (2003) and others spoke of the built-in function of relational experience in descriptions of limbic to limbic system communication. The evidence from neuropsychology, with its deepening understanding of the effects of trauma and of the vast body of information from attachment research, gives support to my view that a treatment mode that appreciates our contextual embeddedness is essential.

An additional influence in my group work comes from developments within psychoanalysis, in which there is an emphasis on relational influences. Stolorow and Atwood (1992) and others focused on the inevitability of intersubjectivity. These
relational perspectives support the exploration of the person embedded in contexts with others. The group setting is such a context.

What I hope to convey with this exploration of the influences that have shaped my group work is that I regard combined treatment as a constantly evolving model, continuously informed by new information. As Donna Orange (1995) suggested in her book *Emotional Understanding*, our theories should be "held lightly," guiding our work without binding us to theoretical frames that potentially limit our personal exploration and growth in the work we do. Therefore, in my work with the combined model, I remain alert to new possibilities for enhancing the effectiveness of a combined model.

**A COMBINED TREATMENT MODEL**

An important aspect of my work that has remained constant has been the decision to work with patients in individual treatment before placing them in a group. Initially, I saw someone for several months to a year or two before placing him or her in a group. The idea was introduced as I worked slowly with the inevitable resistance. Over the last decade, group therapy has been viewed more positively, so there is no longer the resistance that I had once seen. I now, in my initial interview with potential patients, indicate that a combined treatment model is my preferred work mode. Although there is still some unwillingness to consider it, most people are at least curious, and occasionally eager, to enter a group.

As you can see, the model remains that of individual treatment preceding group. No one I treat is seen just in group. Because of my concern about early injury and unmet selfobject needs, I continue to view this initial period of individual therapy as essential. The relationship is also fully explored in light of early attachment history. I have found that the more evidence there is of disorganized attachment, the longer I will see someone individually before group placement. I remain convinced that it is the stability and strength of this period of individual work and the establishment and working through of a selfobject transference that allows patients to tolerate the inevitable disruptions of group therapy. My evidence for the success of this model rests on two points. The first is the level of improved functioning that I observe. The second is the commitment to the group evidenced by the members. I have few dropouts or precipitous terminations. Members stay for extended periods of time, developing mature selfobject experiences with each other. Their attachment to the group is demonstrated in their capacity to hear the voice of the group-self as they encounter difficult life experiences.

In this shift from individual to combined treatment, the implication for the therapist's role has to shift to consider the power of the engagement among group members. The therapist's role was initially most significant in the establishment of the developmental process of the group. In the early phases of a group the therapist interacted more actively with the members. This evolved as members struggled to
resolve wishes for the therapist to be a very active leader to gradually moving toward mutual recognition (Benjamin, 1998) among members. As part of this evolution, the role of the therapist moved from foreground to background as members began to identify and work with transfers among themselves. As part of that shift, whole-group interpretations by the therapist became more common and were accepted and worked with by the members. The narcissistic injury experienced in the early phases of group when the therapist made such interpretations no longer occurred. This move to whole-group observations and interpretations reflects a need for groupobject experiences (Segalla, 1996). Stated simply, groupobject is an extension of selfobject needs, as discussed by Kohut (1976). He spoke to the need for the group as well as to the potential dangers of the group. I view this as primary but believe that social trauma, either in the family or social group, often inhibits the ongoing development of this need. This observation reinforced my emphasis on individual treatment preceding group treatment, particularly for a population with significant narcissistic injury.

POTENTIAL PROBLEMS OF A COMBINED MODEL

Words of caution are, of course, necessary when one considers working with a combined treatment model. Steven Lipsius (1991) suggested that there are separationists and integrationists, referencing how the therapist addresses the boundary between individual and group therapy. The separationists were those who maintained a rigid boundary in both modalities. The integrationists allowed a flow of information between the two while at the same time demonstrating some discretion in that process. His observations are important and address one of the most important aspects of negotiating a combined treatment model: the interface between individual and group treatment. He discussed this boundary from the perspective of maximizing the most effective use of both treatment modes. In summary, he offered four guidelines that I have found to be very similar to my own views. In the first, he suggested analyzing "why the material was first expressed in that component modality rather than in the component modality to which it is primarily relevant" (p. 318). He saw this guideline as "consistent with the general concept of analyzing resistances where and when they arise, as opposed to waiting for the other component modality before analyzing the resistance" (p. 319). His second guideline was to "encourage material primarily relevant to a component modality to be brought back to that modality for continued analysis" (p. 320). The third guideline suggested that it is important to "use the least intrusive method necessary to help the patient bring relevant material into the component modality at hand" (p. 322). He suggested, for example, that the therapist only intervene with material from the same modality. His final guideline follows: "The therapist needs, where appropriate, to invite patients to relate individual and group session material and assist with interpretations that are helpful to the patient, with the aim of integrating disparate parts of the self" (p. 323).
Lipsius (1991) stated, and I agree, that “the general spirit of the entire combined individual and group psychotherapy process is one of integration. One does not want to engender an atmosphere in which material can only be talked about in one component modality” (p. 324). And these stipulations require that the therapist be empathically in tune with the patient. This is particularly important in the early phases of adding group to individual treatment. When they first enter groups, patients are often unable to process their affective experiences and rely on sorting out their responses in their individual therapy. It is also an opportunity to discuss new affective experiences that have not been part of the individual work. In a group session, some will welcome a reference to an individual session, while others will be unable to accept it. My own experience is that for a member who is inclined to split, we should proceed with caution, continuing to interpret and explore until he or she is able to take up the issue in the other modality. This position is informed by my emphasis on resolving empathic ruptures that inevitably occur around the boundary between the two modalities. Although we may wish to address these ruptures in the modality in which they occur, it is sometimes helpful to initiate the process, for example, in individual therapy. This can be particularly effective if the empathic exploration models for the patient are a working through process that they have not yet seen or experienced in their own individual work. Lipsius’s (1991) comments are important, but I wish to emphasize that if we view the combined model as an open system, appreciating that there is an inevitable influence from one modality to the other, we can relax more readily into a fluid relationship with our patients, appreciating the inevitability of influence in both the individual and group work.

TRANSFERENCE ACTIVATION

Transferences should be well established and partially worked through in the individual work before placement in a group; that is, the patient should have had enough experiences of working through and healing empathic ruptures in the individual therapy. The establishment of a selfobject transference will nonetheless be tested by placement in a group. Inevitably, the patient will have to shift his or her view of the patient’s relationship with the therapist. Most often, I hear about the discomfort of knowing that there are other special people in the therapist’s life. This is not unlike the experience in dyadic treatment of encountering the fact that the therapist has a significant other. Viewing the therapist in the context of the group is often profoundly disappointing. Observing the variety of relationships the therapist has with different members can activate early disappointments that occurred in the family constellation. This is exacerbated if the patient’s early attachment history is fraught with disruption. At this point in the development of the therapeutic process, it is imperative that the boundary from the group to the individual treatment be particularly permeable. I have found that if this boundary
is kept open, there is greater likelihood that the patient will remain in group despite his or her discomfort. This period of active discussion of the group in individual sessions usually lasts for several months. After that, typically, material is brought to the individual sessions only when issues discussed in the group opened the opportunity for a deeper exploration of an issue. Ultimately, I have found that people use both modalities effectively with little need to expand an issue outside the arena in which it occurred.

Another important dimension to consider is that of working with a cotherapist, as I often do. It has been my experience that the activation of an entirely new self-object transference occurs with the other therapist. This self-object transference is often related to early events that have not emerged in the individual work.

GROUP ACTION

Viewing my work through the lens of intersubjectivity suggests that co-creation is inevitable. The co-created process among members and the therapist is a useful model for considering the action of the group. Used as a guide, it encourages mutual exploration that includes all members. Using the language of co-creation and mutual influence encourages patients to consider their part in the emerging group dynamics. This approach limits scapegoating and aggressive acting out. It creates an atmosphere that is both exploratory and assertive (Lichtenberg, 1989); that is, members actively engage each other in a context in which each member is not only experiencing the group action, but is also considering his or her role in that action. This intersubjective field also characterizes the interface between group and individual treatment. We can assume that at all times the two modalities are being affected by each other. The inevitable fluidity between modalities also shapes both, so the implications for transference–countertransference work are apparent. In fact, we should assume that there will be transferential and countertransferential elements that will need attention in both modalities. For example, as therapist, I may find that I am having a particular countertransference to a group member and that this may emerge for further discussion in the individual work, or vice versa. Responses shaped by the guidelines discussed earlier are of considerable importance. An example might be my reaction to a group member who has chosen not to reveal an important piece of information to the group, leaving me, as individual therapist, holding information that should be revealed by the patient. The continued assessment of the impact of the two modes of treatment on the transferences is essential in that narcissistic injury can be particularly damaging for either patient or therapist.

CLINICAL EXAMPLE

By using a brief clinical vignette, I will attempt to demonstrate some of the points discussed. My wish is to convey the need for individual treatment where a
healthy selfobject transference sets the stage for entry into the complexity of group experience. Though my focus is primarily on one member, I could have chosen as a focus anyone from this eight-member group. Each had an equally complex history and therapeutic experience.

Rebecca entered individual treatment as a result of the breakup of a 5-year relationship. This initial period of work was characterized by her efforts to understand why she had been unable to make a commitment to Michael. Within a short period of time, however, it became clear that Rebecca was seriously depressed and actively suicidal. The precipitation of suicidal ideation coincided with a move from her mother's home into an apartment of her own. Therapy hours were increased to four times a week, and Rebecca also started taking antidepressant medication.

This 33-year-old woman's early attachment history was characterized by serious loss. Her parents, involved in a destructive relationship, sought relief in extramarital affairs. When Rebecca was 2 years old, her mother abruptly left, leaving behind Rebecca and her two siblings. The father and grandparents attempted to cope with the situation for some months. Shortly after, the father moved in with the woman he had been seeing, and a family of sorts was established. My patient, clearly upset, had a series of tantrums that were met with ridicule and banishment.

After 2 years, the mother returned and began to take her children on weekends. These visits were disruptive for Rebecca, who was adjusting to her new situation. Both before and after each weekend visit, she became agitated or depressed. By the time she was 8 years old, her father married and had three more children. It was at this time that the stepmother could no longer tolerate Rebecca and her siblings, and they were returned to their mother, who now had them full time. The mother did attempt to provide a stable home, but because she was involved in a destructive relationship that involved alcohol and physical abuse, Rebecca was often traumatized by what she saw and heard. She also suffered from the disruption with the stepmother, who had become less and less interested in her stepchildren and made little effort to continue a nurturing relationship with them.

As is apparent, the early attachment history of this young woman was extremely traumatic. I would characterize her adult attachment pattern as avoidant. She had few close connections, although she did have a rather successful career.

During the early period of treatment, Rebecca left her apartment and returned to live with her mother, who was able to provide emotional support. It was the beginning of the growth of a deeper and healthier relationship between her and her mother that has proven to be a significant part of the healing process.

Rebecca quickly established an idealizing selfobject transference with me, which was exceedingly important at that time. I was the stable, dependable, and
predictable mother she desperately needed.

After a year of individual treatment, Rebecca agreed to join a newly forming group composed of my patients as well as those of my male cotherapist. It became apparent that the group was a critically important addition to her work. She began a transformative process, changing jobs, which gave her significantly more creative outlets as well as control over her schedule. Although not financially lucrative, this career choice has been very successful. She is now recognized as a leader in her chosen field and works hard at improving her professional skills. She has also cultivated several stable friendships but is not yet involved in an intimate relationship. Where the group has been most important has been in helping her explore the relational aspects of her life. It is in the group that she does significant work on this issue.

The transition to group was an important time for Rebecca. Initially, it activated early trauma and loss issues as she became increasingly aware of her own reactions to my “other children” as well as the “children” of my cotherapist. She also reacted to the presence of the male cotherapist, seeing him as unreliable and unpredictable. He was acutely aware of her anxiety around him and steadily maintained an empathic position that ultimately allowed Rebecca to work with him on paternal issues. These issues were initially pursued only in her individual treatment. After several months, Rebecca began to discuss them in the group, where she received support from other members.

As I indicated, Rebecca entered a newly forming group composed of four men and four women. After an initial period during which a few people left and were replaced by new members, the group became a cohesive, working unit. The members proved to be highly articulate and interactive. Initially, my cotherapist and I provided guidance to the members, sometimes at the level of working with individual members or subgroups. As the group became more cohesive, we were less active and tended to make whole-group interpretations or observations rather more frequently than we had in the early phases of group development. Rebecca became a surprisingly vocal member and was active in both bringing in material about her issues and being responsive to what might be troubling others. I began to see aspects of Rebecca that were not apparent in the individual work. She was capable of instigating twinship self-object experiences and appeared much less isolated than in our sessions. She responded well to being mirrored and demonstrated a capacity to mirror others. Adversarial experiences could be explored in the group as well as in her individual sessions.

As discussed earlier, for some members it is necessary to work on issues from the group in their individual sessions in order to understand more fully the meaning of their group experiences. This was the case when Rebecca had a yelling match with Joan, a woman who was both more expressive and more willing to take time in the group. The disagreement, though enacted in the engagement between Rebecca and Joan, was reflective of a whole-group issue
around monopolizing and entitlement. Joan was most willing to take as much
time as she wished to explore particularly troubling issues. She would leave little
time or space for responses from members. Rebecca became outraged at what
she viewed as Joan's narcissistic position, and angry exchanges began. This out-
burst startled me, and I had a glimpse of the little girl who had thrown tantrums
when her father was unresponsive to her emotional needs. My cotherapist and
I remained silent in an effort to determine how well the group would be able
to negotiate this situation. The members were quickly activated and began to
intervene either to help clarify the issue or to express anxiety about the level of
intensity in the group. We were met with demands to resolve the problem, fol-
lowed by the recognition that we saw the group as capable of doing that work.
The group ended with a flurry of excited chatter that carried out into the hall. It
was clear that the members were anxious, being aware of both women's fragility
around conflictual issues. My cotherapist and I agreed that it was an important
moment for the entire group, whose members had often expressed their anxiety
about conflict. I was somewhat surprised to find that I felt quite concerned for
Rebecca. Would she be resilient enough to deal with this conflict? I also wondered
about Joan's reaction. What was so apparent in these interchanges was how both
Rebecca and Joan, through the activation of their dynamics, co-created a situa-
tion that ultimately proved useful to both women and the entire group.

Rebecca brought this issue to her next individual session, as did Joan. Through
a series of sessions Rebecca was able to understand the intensity of her reaction
to Joan, who had become, for her, the detached and occasionally rageful step-
mother. This understanding emerged slowly as I held Rebecca in the moment.
I, however, felt there were several more important connections to be made. The
stepmother was the most obvious, but the more important realization occurred
around Rebecca's exploration of the meaning of taking up space. Joan's comfort
in taking center stage was a key issue. Rebecca, with my help, gradually recon-
ected with her own early experience of being "Becky Sunshine." In this role she
received considerable attention from her father. She had learned, however, to
dampen her responses as his new children began to take center stage. Rebecca
had been unable to retain her special place with her father. Joan's monopolizing
activated early anger and loss issues for her.

Joan's behavior was an important aspect of her early development. As the
oldest child in a family of Holocaust survivors, she had learned early that lim-
ited emotional resources were not necessarily equally divided. She sought for
attention, despite the fact that the attention was often negative. She was the ideal
person for the group to use to unconsciously address their own unmet needs
for nurturing and attention.

By the following group session, Rebecca and Joan were able to address the
issue, with each working to understand the intensity of their interchanges.
Other members began to reveal their own reactions to the struggle as well as
their roles in the action. One man, who had great difficulty with conflict, was able to express his fear of anger. He had discovered in this altercation important parallels to his father's unpredictable behavior. He articulated that this was a new experience, in which people were actively struggling to understand and resolve their differences. Another woman claimed ignorance of any skill in dealing with conflict, stating that she thought that the fight might be the end of the group. Jack, quiet through these exchanges, saw Rebecca as having done his work with Joan. He sheepishly stated that he was glad to see the fight because he did not feel he could have said some of the angry things they expressed. My interpretation had to do with the clarity that had emerged out of the struggling together toward understanding. It was framed in an inclusive way, indicating that all of us were part of this struggle to find ways to express our needs and that anger was often a response to not being seen or heard by the other.

Perhaps a point to emphasize is that resolution of this conflict took place over several group sessions. Initially, Rebecca continued to discuss the group experience in her individual sessions. She would bring her insights from our work back to group, sharing new ones as they emerged. What was interesting to observe was the fact that she experienced strong affect only in her individual hours. We were unable to understand this until a session in which she recalled lying in bed at night, hearing bitter fighting from her mother's bedroom. She recognized the sounds of physical and sexual abuse. Her terror and rage erupted in her individual session as she recalled her fear and helplessness and her mother's unwillingness to understand how her behavior was impacting her daughter. What was also revealed was Rebecca's own arousal and excitement as she listened through the wall to the activity in her mother's bedroom. She began to see that her own shame at being aroused had dampened her capacity for sensual pleasure and sexual excitement. Joan's seemingly thoughtless self-preoccupation was like Rebecca's mother. She gradually understood her reluctance to really engage with Joan and the group affectively as related to these early, recurring experiences. It was not until she began to work with this important revelation that she was able truly to confront her fear of her own aggression and her desire for attention. Ultimately, she was able to continue this work with Joan and other group members. The group became a functional family for her, and remains so today. Rebecca can almost always pursue her issues freely in this setting. She has considerable devotion to the group and its members.

**CONCLUSIONS**

This clinical vignette gives us an example of the power of the combined treatment model, demonstrating the broadening and deepening of the work started in individual treatment. It also captures the multiple selfobject needs among members
that get activated in the group setting. As is perhaps apparent from the vignette, emphasis is on affective experience resulting not only from empathic ruptures, but also from the activation of deeply traumatic experiences. The interplay between individual and group work allows for containment through periods of potentially traumatic reenactments. The presence of a cotherapist deepens selfobject transference work, adding dimensions that neither individual nor group alone can achieve. The example of Rebecca is not unlike what we see on a regular basis. Her capacity to grow in this combined model has many of the elements necessary for true healing to occur.

This process of working through, though difficult because of the activation of traumatic feelings, was a significant step for Rebecca and the group. The issue of the power of traumatic experiences remains one of my primary motivations for using a combined treatment model. Without the individual work, there is little opportunity to process and understand the inevitable ruptures in the group. When these experiences are not processed, they inevitably surface in the group, often without the ties to the initial rupture. The fluid back-and-forth of individual and group therapy allows these evocative experiences to be explored as they surface. Often the individual sessions provide a kind of containment, allowing a deepening exploration of the work started in the group.

Working with a combined treatment model is an important component of the healing work of therapy. I hope my observations prove useful to you as you work with this method.

REFERENCES


