Beyond the Dyad

An Evolving Theory of Group Psychotherapy

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The long and varied history of theory development in group psychotherapy, and its clinical application, has in many ways mirrored the vicissitudes of theory development in psychoanalysis and the individual psychotherapies. It has been both applauded as a revolutionary approach to the treatment of emotional disorders and condemned as a technique that endangers the psychological health of the individual. Even a cursory survey of the vast body of literature on group psychotherapy could cause one to question the necessity of adding still another perspective. And yet in an age of rapid development of relational perspectives in psychoanalysis and psychotherapy it seems remiss not to extend the dialogue to include group psychotherapy.

Despite the recent paradigm shifts within modern psychoanalysis, group treatment remains a shadowy and somewhat disregarded mode of treatment. I have been curious about its absence from the discussions of relationalists, inter-subjectivists, and others who clearly view psychoanalysis as the study of “people’s experiences and the meaning of experiences” (Galatzer-Levy and Kohler, 1993, p. 341). These authors operating from an open system perspective state that “people seek increasingly sophisticated interdependence and use others to enhance self-affirmation at all times, but especially during times of distress and psychological growth” (p. 347). They go on to state that “the goal of psychological intervention ought to be to assist the analyzing to obtain satisfaction from reliance on others and receive greater satisfaction and comfort from a continuing use of others across the course of life” (p. 347). I suggest that group treatment is a natural extension of an individual analysis and a modality especially well suited to promote the growth necessary to cope effectively with life’s many complex endeavors. If one accepts
the basic premise that "the self cannot be understood apart from life with others" (p. 358), then we can be curious about the relative inattention that the group treatment modality has received from the psychoanalytic community, especially that part of the community that is currently so warmly embracing relational and intersubjective perspectives. Perhaps this reflects an unconscious continued emphasis on "self-reliant individual independence" and the persistence of the "unfounded assumption that separation and independence are normative" (p. 359). A group offers us vital information about the impact and necessity of essential others, information that is not fully available in the traditional psychoanalytic dyad.

In this presentation I will explore the evolution of my own theory of group psychotherapy as it has been formed by my experiences as a group therapist and by my role on the faculty of a group psychotherapy institute. The discussion will be from a perspective reflective of the selfobject, multiple selfobject, intersubjective, motivational systems, and the groupobject.

**Kohut's Influence**

Because Kohut developed his theory from clinical experiences with psychoanalytic patients, he did not expand it beyond a dyadic model of treatment. His paper, "Creativeness, Charisma, Group Psychotherapy" (1976), however captures his awareness of, and sensitivity to, group issues. He suggested that just as there is an individual "self," there is a "group self." He viewed the study of group phenomena as essential, recognizing that all aspects of group, from its formation through its "oscillations between group fragmentation and reintegration," were significant. He was abundantly clear about our continuous engagement with the other and in his final book How Does Analysis Cure (1994) he offers his view about selfobject relatedness which is basic to self psychologically oriented group work. He states, "Self psychology holds that the self-selfobject relationships form the essence of psychological life from birth to death, that a move from dependence to independence in the psychological sphere is no more possible than a corresponding move from a life dependent on oxygen to a life independent of it in the biological sphere" (p. 47).

In my early writing on group therapy (1985) I presented my ideas from a strictly Kohutian perspective. In that early paper I emphasized the selfobject experiences of the individual group members, focusing on the expansion of selfobject experiences in a cotherapy, combined treatment model. I postulated that group members had ample opportunities to have selfobject experiences that reinforced those found in the individual treatment. I further suggested that the group itself develops the need for selfobjects and that just as transferences developed in the individual, they develop in the group. I state the following:

I find clear examples of mirroring, idealizing and alter ego transferences at play in the group-as-a-whole. These group level reactions require the same process of understanding and explaining in order for the group to grow in cohesiveness and toward mature selfobject functions. So, in addition to thinking of transmuting internalizations on the level of the individual, we can consider that this happens on the group level as well. How would this be manifested and commented upon? The level of complexity of such a situation is immediately apparent. (1985, p. 8)

Expanding the selfobject to a multiple selfobject concept (Harwood, 1986; Segalla, Silvers, Wine & Pillsbury, 1988) was an obvious next step. Harwood (1986) suggests that "Those in related fields of child development, psychoanalysis and social research need to understand the positive and negative conditions and effects of multiple or extended selfobject experience upon the evolving self structure as well as the intersubjective context in which interaction takes place" (p. 291). Segalla et al., unaware of Harwood’s conclusions, came to a very similar perspective:

The multiple selfobject environment more accurately reproduces the early experiences of most of us. It dramatically recreates the move from one caretaker to several and so on to such settings as preschool, school, and jobs. By creating this complex group environment, we are creating a therapeutic environment in which these additional factors can be best addressed. One of the most significant aspects of viewing groups as multiple selfobject experiences is that it opens to sharper scrutiny relationships with other important people such as siblings, hired caretakers, school teachers, grandparents, etc. who in fact may have provided significant experiences for patients. It may also shed light on those situations in which it seems remarkable that a person has done as well as they have considering the apparently major deficits present in their primary caretaker. (1988, p. 6)

We emphasized accessing existing aspects of the self unavailable in the selfobject transferences of individual treatment and postulated that the addition of group treatment broadened and deepened our access to disturbances of the self. We likened the experience of moving from individual to group treatment as a move from considering the impact of the primary caregiver to that of the whole family system (including other caregivers and cultural institutions such as churches and schools). As a result of this thinking a multiple selfobject model was formulated in this model the cotherapists, along with group members, supply multiple selfobject functions for each other. Because of this shift, the notion of what is healing was expanded to include the rich complexity of dyadic, subgroup, and group-as-a-whole interactions operating simultaneously. The original theoretical thinking was based on a point made by Kohut in How Does Analysis Cure? He said,

In a properly conducted analysis, that is, an analysis that does not block the spontaneous unfolding of the transferences, the basic and pivotal selfobject transference that ultimately establishes itself will frequently
Thus, Kohut suggested that in the development of compensatory structures, the person has turned away from a part of the self which was not growth producing and that attempting to address this aspect of the self can result in an unnecessary regression that would ultimately not be curative.

What then becomes of these more damaged aspects of self? It was at this point that we began to speculate about why, when we placed someone in a group who had a long and rather successful individual treatment, did we see new behaviors that often appeared to be regressive throwbacks to earlier times. These were patterns that were not seen or experienced in the more empathically immersed individual treatment, but were problematic interactions that might have been described by the patient as occurring in other relationships or in other settings. We found that the sensitivity and reactivity of the patient in group highlighted aspects of the self that were sometimes referenced in individual treatment but were never manifested prior to entry into group therapy. We observed that while it was threatening for group members to experience aspects of the self that they had not explored in their individual work, it ultimately created an expanded flexibility of functioning.

In developing the multiple selfobject model, we extend Kohut's definition of the healing power of a therapeutic relationship to include not only the second therapist but also the other group members. That is, we found that the process of empathic engagement by the therapists with a group member(s), or the whole group, was gradually adopted by the members themselves and became a part of group culture. Instead of reacting primarily out of their own individual needs, they were gradually able to engage at the level of empathic inquiry and in doing so acquired the skills needed to work through empathic ruptures with each other. As the group develops, this process among members dominates the sessions, with the therapists gradually moving into a background position as the patients learn to work more effectively with each other.

The process of learning to be optimally responsive (Bacal, 1985) to each other, working through empathic ruptures and being affectively engaged promotes healthy functioning. We suggested that experiences in group therapy are most readily transferable to the larger world, providing the patient with an expanded capacity to deal with the multiple realities encountered in daily life. This leads to greater flexibility and, therefore, the possibility of having selfobject experiences as well as fostering the capacity to provide selfobject experiences to others. In leaving the protected environment in which a therapist focuses her full attention on the relationship with one person, a group provides the possibility of activating a process that allows the patient to be both affectively aware of their own wishes and needs as well as engaging in an active process of learning about how they are viewed and how they view others.

We have found that the well-established selfobject transference with the therapist, as well as the interplay between individual and group treatment, inso much as to break through potentially traumatic experiences. This is not apparent when someone is placed directly into a group without the intervening modulating experience of individual treatment. This circumstance seems to rekindle the possibility of empathic rupture and often leads to an early departure from group.

We also came to view engagement among members as selfobject transferences and saw the exploration of these transferences as a primary curative factor. This view differs from Wolf (1988) who distinguished between selfobject experiences and selfobject transferences with the latter occurring only with the therapist. We suggested that the opportunity to establish and work through selfobject transferences among group members, under the guidance of the group therapist, provides a unique opportunity to heal aspects of the self unaddressed in individual treatment. The group setting is unique in its ability to reenact experiences that have remained more or less unconscious in the dyadic treatment. A brief case example should help illustrate these points.

Larry was a high-functioning man in his late 30s who was doing an important piece of work in his individual treatment. He was a robust and warm person despite a significant depression, managed to maintain himself in a relationship and a responsible job. His idealized selfobject transference to me seemed to add unmet developmental needs. After 4 years of individual treatment, he was grappling with his disappointment in marriage and in himself for being unable to complete and publish a book. In group, I was surprised by the significant difficulty this lively man had in using his voice. He rarely spoke and when he did, it was not sufficiently engaging for the group to attend to him so the discussion would shift to other members who would do the talking. I used humor briefly, but then in a good-humored way become engaged. Larry’s self was significantly absent in his individual work prior to his entry into group therapy. When he entered group, I was unprepared for this apparent willingness to put aside his own subjective self, a self that clearly present in his twice-weekly individual sessions.

His difficulty seemed to be indicative of a family dynamic as well as a familial dyadic bond that we had discussed in individual therapy, but had not been available for us to work through transferentially. The inhibition he exhibited group was useful in supplying information as to why he was unable to advance in his chosen profession and why his voice seemed so effectively silenced in marriage. The information and emotions that emerged in the group experience allowed us to explore these issues in depth, and greatly helped him in moving forward in his life.
Intersubjectivity

Like the growth of ideas that has continued to create a lively dialogue within self psychology, group therapists have been impacted by the move within psychodynamic toward a relational perspective. Some aspects of this were foreshadowed by Kohut when he wrote about the “impact of the observer on the observed” (1979). Stolorow and Atwood (1992) state: “Self experience is always organized within a constitutive intersubjective context and is shaped at every point in development by the intersubjective system in which it crystallizes” (p. 17). They credit Beebe and Lachmann’s (1988) infant research and their conceptualization of a system of reciprocal mutual influence, stating that “the concept of an intersubjective system brings to focus both the individual’s world of inner experience and its embeddedness with other worlds in a continual flow or reciprocal mutual influence. In this vision, the gap between the intrapsychic and interpersonal realms is closed” (1992, p. 18).

One implication of the intersubjective perspective for group treatment is the change in the view of empathic ruptures. Stolorow et al. (1992) redefine them as “intractable repetitive transferences” resulting from the interface of the patient’s problems with the therapist’s issues, preventing the therapist from being optimally responsive to the patient’s affective state. This reflects their view that the individual’s selfobject needs exist alongside conflictual resistive needs. These two positions constitute a bipolar model viewed as more encompassing than simply attending to selfobject issues. This is particularly important in group treatment, where an overemphasis on either pole, selfobject or conflictual/resistive, leaves a considerable gap in understanding of group phenomena.

Indeed, group therapists have been negative about self psychology because they viewed the emphasis on selfobject functioning as ignoring much of the aggressive aspects of the self manifested in group therapy. Several other points have been made: Silvers (1998), pointing to the value inherent in expanding the experiential field, states: “Adding a group experience to an ongoing individual treatment expands the therapeutic intersubjective field, exposing patients to a wider range of selfobject and conflictual, repetitive and resistive transference phenomena. The presence of the second therapist in the cotherapy model stimulates transference material concerning the other (second) parent that does not emerge in the individual treatment or when there is a single therapist” (pp. 136–137). Shapiro (1998), emphasizing twinship selfobject experience, states: “Group therapy provides many opportunities for intersubjective exploration and to move patients from archaic to mature twinship experiences. The twinship or alterego experience is the foundation of cohesiveness in group therapy and may be more basic to the human condition than the other selfobject experience” (p. 56). Harwood (1998) points to the growth that results from a group therapist’s ability to assist the group members in clarifying experience and constructing meanings from the selfobject, as well as conflictual, repetitive, and resistive transferences at play in the group.

Paparo and Kischelt (1998) see the two dimensions of the transference proposed by Stolorow and Atwood as useful in understanding “the complex transference dimension of the group that . . . is characterized by the fact that repetitive and selfobject transferences occur simultaneously. By this we mean that while a member can experience a repetitive transference (to the analyst) he can experience a selfobject transference at the same (to the group-as-a-whole or to another member). In this last case, the group analyst should be able to handle both of the dimensions of transference that can occur at different levels” (pp. 73–74).

My own perspective (as well as that of Silvers, 1998) is that this intersubjective model is also salient when considering trauma and the potential for its escalation in a group setting. In their exploration of trauma, Stolorow and Atwood suggest that “painful or frightening affect becomes traumatic when the requisite attuned responsiveness that the child needs from the surround to assist in its tolerance, containment, modulation and alleviation is absent” (1992, p. 53). We have found that the number and complexity of interactions in a group make it unlikely that all traumatic experiences will be addressed within the group. Therefore we have continued to work from a combined individual and group treatment model. This model provides some assurance that injuries, if unaddressed or missed in the group context, will be explored in the individual therapy.

A further issue that is particularly important in considering the placement of a patient in a group is the potential for the reenactment of a core problem related to the development of the self. That is, if the patient has not resolved her own conflict around her sense of self, then:

A fundamental psychic conflict . . . becomes established between the requirement that one’s developmental course must conform to the emotional needs of caregivers and the inner imperative that its evolution be firmly rooted in a vitalizing affective core of one’s own. As one of several possible outcomes of this basic conflict, the child may be compelled to abandon or severely compromise central affective strivings in order to maintain indispensable ties. (Stolorow and Atwood, p. 79)

Brandchaft (1991, 1998) describes this as pathological accommodation. It is not difficult to think of group patients who seem only too willing to accommodate to the group culture, leaving their own needs unaddressed and thereby reactivating a pathological process from childhood. This can occur despite a good individual treatment that has reinforced self development.

A recent example of this was Jack, who was placed in a long-term group because of his difficulties in intimate relationships. In his individual sessions he was emotionally responsive and able to address his fears of the therapist’s perceived requirement—that he behave himself by agreeing with whatever she said. The therapist was also acutely aware of his sensitivity to her slightest expression and his readiness to accommodate to subtle messages she might convey. The individual sessions explored these issues and this resulted in a gradual understanding of what, in the interplay with the therapist, had led him to believe that
be organized around the less traumatic aspect of the selfobject parents. (1984, p. 206)

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His difficulty seemed to be indicative of a family dynamic as well as a father/son dyadic bond that we had discussed in individual therapy, but had never been available for us to work through transferentially. The inhibition he exhibited in group was useful in supplying information as to why he was unable to advance in his chosen profession and why his voice seemed so effectively silenced in his marriage. The information and emotions that emerged in the group experience allowed us to explore these issues in depth, and greatly aided him in moving forward in his life.
tion. The group, which had begun the session in an affiliative mode, shifted to an exploratory mode with Allen. This focus led to more and more confusion for Allen. He was unable, despite the fact that he is a very articulate person, to express his feelings. The group seemed equally frustrated by Allen’s inability to shift out of an aversive withdrawal and engage with them. The group’s frustration resulted in their own withdrawal and the group-as-a-whole was left with a sense of confusion. Although Allen was unable to move into an exploratory mode with the group he came for his individual session, with written notes about his reactions to the previous group. He spent the individual hour trying to make sense of his aversive withdrawal in reaction to the exploratory focus of the group. While the individual session calmed him, it also gave him some insights as to why he was so stymied by the group’s interest in his reaction and helped him understand how he sidestepped their interest when it felt too intrusive. His written notes capture his ability to be exploratory and they highlight the developmental importance of the individual therapy where a secure and tested attachment allows him to remain in an exploratory mode long enough to process his reactions to group. This illustrates how a patient attempts to negotiate their way through individual and group therapy, using the relatively secure and tested attachment to the individual therapist to modulate the experiences within the less secure affiliation of the group.

Model Scenes

Model scenes, a formalization of experiences that are a regular part of psychoanalytic treatment, can be usefully expanded to group treatment where affective reactions by group members are the basis of much of the group intercourse. Lichtenberg et al. (1989) state: “They (model scenes) draw on the fundamental inclination of analyst and analysand to organize experience in terms of events or episodes. Because of the clinical purpose they serve, the events selected are those amplified by an affective response triggered when the needs of a motivational system are met or more likely for the analysis, unmet” (p. 25).

The authors see model scenes as providing information about both content and process. The content is the story, or as they call it, the scene, while the process tends to the patient’s state of mind, explored in the empathic, intersubjective engagement with the therapist. The usefulness of model scenes is immediately apparent in group where the narrative flow is rich and continuous. Often a model scene will emerge when there has been a disruption of some kind, either for a member, a subgroup, or the entire group. The work on the model scene can bring a kind of cohesion to the group as it struggles to understand a particular experience. Additionally, there can be an interplay between individual and group treatment in that a model scene constructed in either setting can be readily explored in the group or individual work. The effort of the therapists is to understand the experiences of both the individual and group. An example of a model scene occurred when Ruth complained that she was experiencing the group as a dangerous place to bring her problems. Her outburst came during a group session that had in fact been quite fruitful in its exploration of another member’s experience. The group reacted with surprise to Ruth’s exclamation and wanted to know more about it. Ruth, in turn, was stunned when she realized that her experience of the session was so different from the other members and the two therapists. She stated that it was her experience that everyone was feeling unsafe. Various group members disagreed and wanted to know more about her reactions. A careful exploration of Ruth’s feelings uncovered an issue with which the group was familiar—that is, that Ruth was often scapegoated in her family for saying what was obvious but never acknowledged by other family members. Her willingness to, in her language, call a “spade a spade” endlessly got her in trouble—not just in the family, but everywhere. What emerged in the group work after considerable effort by the members was that for Ruth there was one reality and it was her painful task in life to define and name the reality that others avoided. The group member allowed her to expand her own awareness of her early experience and how it had shaped her current reality—one which, in fact, left little room for the realities of others. This model scene became an enduring one for the group and was called upon when needed in working with Ruth or other members. Unlike her experience in her family the group dealt with her subjective difference with considerable interest and curiosity, a reaction that allowed Ruth to explore her own reactivity nondefensively. Although the familial model scene had originally been verbally reconstructed in the individual therapy, its reemergence in the group caused a powerful affective experience that enabled her to effectively modify a rigidly held reactive stance that had long caused her significant interpersonal difficulties.

Model Scenes Beget Model Scenes

This example of a model scene where the attention is on one member as she worked with the whole group is only one of many other possibilities presented by group treatment. For example, a model scene can emerge in the work between one of the therapists and a group member or the group-as-a-whole. Another possibility is that the group members learn to create model scenes with each other. This can reflect historical experiences of members or it can reflect the history within the group. For example, members will return again and again to particular encounters in the group that seem to provide turning points for members or the whole group. These group model scenes when recalled provide a kind of quick access to strong affective reactions that are part of the group history. The model scene work can be particularly powerful when it occurs between the patient and the “other” therapist. This occurred in a group in which Mark, an individual patient seen by me, constructed a model scene with my cotherapist that was instructive in helping us to understanding his relationship with a withdrawn and disinterested father. The male therapist spontaneously asked Mark about his efforts at job hunting, expressing considerable interest in the possibilities that Mark outlined. Mark suddenly began to cry. As a result of this affective reaction, the two of them began an exploration of Mark’s strong emotional response. What became clear was that
my cotherapist's interest in Mark activated a painful memory of trying to engage his uninvolved father in helping him choose a college only to have him persist in reading the newspaper. As a result of this rather intensive work with Mark, and the emergence of this model scene, other group members gained access to related material, including their own experiences when they felt the group, and/or the group leaders, was not interested or engaged with them. Thus, in the group, we can say that model scenes beget model scenes, leading the group to work with increasingly more complicated situations with each other and the cotherapists.

Using a Motivational Model

How and where the therapist focuses attention can be an ongoing issue in a group of seven or eight members. This can be particularly difficult in a relatively new group where members are not clear about how they wish to occupy their group space. Working in the foreground/background the therapists can monitor both the individual's motivational dominance as well as the group motivation. A quick moment-to-moment assessment provides information that allows the therapists initially and later, as a group matures, the members themselves to focus on a particular individual or situation. As much as possible this is informed by the within-the-room process and speaks to engagement among members or members and therapists. With two therapists present, one can attend to the whole group motivational system, while the second therapist can attend to the dominant motivational system of a patient member or particular dyad. Such an engagement occurred when Mary was discussing her marriage and move to another state. One therapist was working actively with her around her anxiety that she would be unable to adjust to this new and temporary location, and that her difficulty would have a negative impact on her relationship with her boyfriend. As my cotherapist engaged with her, asking questions and creating a clearer picture of her discomfort, I stayed attuned to the group-as-a-whole and noticed the members becoming progressively more withdrawn as the session progressed. When the opportunity presented itself, I suggested that there seemed to be a mood in the group that was not being expressed. Members began to speak, stating that they felt that despite their interest and engagement earlier in the session, Mary was not responsive. They did not feel listened to and felt that they were being of no help. The group, which had begun in an affiliative engagement with Mary, had moved to an aversive position characterized by withdrawal. There were several comments that suggested that Mary was "whining." The group's flight into silence reflected an aversive withdrawal, which allowed the members to avoid an antagonistic attack, failing to see that their reactions would in fact be useful information for Mary. The first therapist began to explore with Mary what the impact of the withdrawal had been. What became clear was that she did not expect any comfort, and had in fact expected to be rejected by the group because of her departure, though it was temporary. This led to a familial model scene that surrounded her graduation from college and return home. Instead of being welcomed back, she found her large family had essentially written her off. Not feeling accepted back into the home, she moved out with little reaction from her family. The group's earlier efforts to contain and support Mary could not be taken in because, according to Mary, "I know that as soon as I'm gone I'll be forgotten and when I come back in 6 months, it will be too late and I'll never fit back in." The creation of this model scene was very useful for Mary, as well as for the group as a whole. Members found that her resistance to being helped had in fact threatened their sense of agency with each other, an important affiliative task. For her part, Mary began to grasp the extent of her injury within this rejecting family system and how the resulting expectation of disinterest had impacted her first marriage.

Groupobject—Expansion of Selfobject Theory

The conceptualization of a groupobject reflects an effort to further our understanding of group process and its meaning for individual group members, as well as for the whole group. This formulation is an extension of selfobject, multiple selfobject, intersubjectivity and motivational systems theories, which have all been significant in explicating experiences in the therapeutic encounter. In a 1996 paper, I suggested that, just as there exists in the individual the need for healthy selfobject experiences, there is also the need for healthy groupobject experiences. I stated: "The group can be said to possess a set of functions designed to maintain the integrity and cohesionness of the group self, and a set of functions which provide the group with initiative and goal direction. Along the lines of Stolorow et al., these functions might also serve to organize affective experiences." I suggested that groupobject experiences seem to exist both on the individual and group level and that just as there are selfobject transferences, there are groupobject transferences.

This emphasis on the group is an effort to understand the reality of life within a social system which, almost from birth, expands beyond the infant/caregiver dyad to ever increasing levels of complex engagements in the family, school, peer groups, and so forth of everyday life. Our ability to function within these more complex systems can be understood as being more or less successful based on the availability of healthy selfobject experiences. If, however, we extend our thinking from an individual self to a group self, it suggests the possibility that the group organism operates in many of the same ways as the individual. The groupobject concept can help us gain access to the complexity of group life. Unlike the individual, who may look to external objects to provide selfobject experiences, the group must organize itself so as to provide groupobject experiences to its members from within the group, what I call an intrasubjective experience. This is based on the idea that the human proclivity to group serves a species survival need.

For an individual to relinquish the primacy of vitalizing selfobject experiences in order to be part of a group, she must have group experiences powerful enough to motivate this somewhat dangerous surrender. But it is only by surren-
dering these needs that the individual can participate in the group’s power. The
development of the group self begins in the context of the first group, the family;
just as there are selfobject experiences that enhance and vitalize the individual,
there are groupobject experiences in the family that enhance group functioning. It
is these groupobject needs that are most significant in a group therapy and inform
us about the quality of earlier group/family/social systems.

Selfobject experiences give the individual the chance to fill missing aspects
of the self, groupobject experiences can aid in filling missing aspects of the group.
If we accept the premise; demonstrated in infant research (Beebe and Lachmann,
1988), that we are hard-wired for reciprocal mutual responsiveness on the dyadic
level, we must consider the postulate that as social animals we are also hard-
wire to operate in a mutually responsive manner in groups. And, just as we come
dyadic relationships innately prepared to engage with the other, we come to
group experiences (starting with the family) similarly prepared. Thus a primary
task of the individual is learning how to function within these larger, more com-
plex systems. The increasing complexity suggests that in learning to function in
these group contexts, we must move beyond individual needs and expectations
and learn how to function effectively in various groups. This is where the group-
object concept may help us in gaining access to the complexity of the group expe-
rience in the small as well as the large group. That is, we can assume that there is
an inherent wish to function effectively in a group and beyond the self or dyadic
intersubjective experience. I am suggesting that groupobject needs are activated
in all groups, and just as we have met with varying degrees of success in getting
selfobject needs met, we have varying degrees of success in filling groupobject
needs. Our success or failure at the earliest group level, the family, will determine
how well we traverse the unknowns of any new group experience, whether in the
therapeutic setting or the larger world.

Activating groupobject needs may be powerfully defended against for at
least two reasons: One is the fear of the loss of the individual self, and the sec-
ond is the fear of the loss of the group self. The first fear is related to a dreaded
loss of cohesion and the second is the dread of alienation. Failures or trauma at
the group self level can lead to the feelings of fragmentation at the individual
level and vice versa. Thus, as we speak of dyadic intersubjective experiences, I
would like to suggest that there is a dynamic tension between the individual’s
selfobject needs and their groupobject needs (Segalla, 1997). This tension can
be creatively transformed into a process that enhances the growth of both the
individual self and the group self. Thus to the extent that someone is successful
in having selfobject experiences, she is more available for groupobject expe-
riences. The constant negotiation between individual selfobject experiences
and groupobject experiences provides much of the texture of daily life. As we
negotiate our way dyadically, we are reassured of our capacity to cope with
another, thereby setting the stage for successful engagement on the group level.
This suggests that we can predict how well someone may respond in a therapy
group in which the emphasis shifts away from the primacy of individual needs
to becoming engaged at the group level. The capacity to make this shift is in
part the basis of healing on the group level. If the group is responsive to the
individual’s efforts to engage, we can allow an immersion in the experience.
However, if the group is not receptive, then there is a defensive withdrawal and
a return to the singleton position (Turquet, 1975). Just as a patient defensively
avoids engaging with their therapists because they fear that they will yet again
be unable to have successful selfobject experiences, engagement in the group
is defensively avoided for fear of failure in having groupobject experiences.
Returning to a motivational systems model, Lichtenberg (1989) places self-
object experiences of mirroring, idealization, and twinship within the attachment
system. I am suggesting that the groupobject experiences are primarily aspects
of affiliative motivations.

Summary
I have attempted to explore various aspects of the development of a theoretical
perspective of group therapy as it is evolved over the past 15 years. The evolu-
tion of this work has both anticipated and reflected the ongoing development of
self psychology and advances in selfobject theory. Initially, the view of group
events was primarily from a selfobject perspective, emphasizing the experiences
of meeting or disrupting selfobject needs of individual group members. The focus
was on healing empathic ruptures—a process that theoretically led to structure
building. The addition of the multiple selfobject model suggested that the group
setting makes possible selfobject experiences unavailable in individual treatment,
thereby broadening and deepening access to the disturbances of the self. It was
suggested that it was the opportunity for multiple selfobject experiences that
made group therapy uniquely helpful in healing aspects of the self unavailable
in individual therapy. This shift was soon followed by a series of enrichments
based on the work of Stolorow et al. (1992), Lichtenberg et al. (1992), and Segalla
(1995). In considering group from these additional perspectives, I find theoretical
and clinical explanation for group processes that not only emphasizes the self-
object experiences of individual members, but also considers an array of clinical
ideas that offer experience-near explanations for complex group events. These
perspectives are particularly elegant for group treatment because they clear away
many theoretical distractions and encourage work in the here and now, which is
essential to group therapy. They also offer a model of group that acknowledges
the relational experiences that are the bedrock of this form of treatment. While
the model is based on theoretical advances from a dyadic treatment model, the
ease of adaptation to a group speaks to the viability of the models explored. Self-
object theory, intersubjectivity, motivational systems, and groupobject theory all
provide useful theoretical and clinical guides to the complex system of group
therapy, and inform us about a given patient’s self and their patterns of engage-
ment with the other.
Beyond the Dyad


References


