CHAPTER 10

A Multiple Selfobject and Traumatizing Experiences Co-Therapy Model at Work

Damon L. Silvers

Several authors have written about the application of self psychology theory to group therapy (Bacal 1985a; Harwood 1983; 1986; 1992a; 1992b; 1993; 1995; Meyers 1978; Schwartzman 1984; Shapiro 1991; Stone and Whitman 1977; Weinstein 1987), but few (Harwood 1986; 1993; 1995; Segalla et al. 1988; 1989) have addressed in depth the impact of treating patients concurrently in self psychological individual and group psychotherapy. Recognizing the clinical value of combining these modalities, I and Segalla, Wine and Pillsbury (1988; 1989) reported effective treatment results with such an approach. A powerful impact on the overall treatment was noted when a group experience, co-led by the patient's individual therapist, was added to an ongoing individual treatment. Articulated as a clinically interactive model whose total impact was greater than the sum of the two modalities utilized, we also observed that members' experiences within the therapeutic group context were often catalytic in activating and deepening aspects of the transference in the individual treatment.

Combining treatment modalities deepens and enriches the overall psychotherapy experience because the addition of a co-therapy group to an ongoing individual treatment dramatically recreates the move from one caretaker to several. Segalla, Wine, Pillsbury and I made this observation in the 1988 paper stating that the individual/group co-therapy paradigm 'dramatically recreates the move from one caretaker to several and so on to such settings as preschool, school and jobs.' We observed that viewing groups as multiple selfobject experiences opened 'to sharper scrutiny relationships with other people such as siblings, hired caretakers, school teachers, grandparents, etc., who in fact may have provided significant experiences for our patients.' Also, in a related but independent contribution, Harwood (1986) made the observation that group therapy was an
effective form of treatment to help individual patients internalize a multiplicity of selfobject functions from various constantly available caretakers.

More recently, the individual/group therapy model has been understood to be effective because it expands the therapeutic intersubjective field by exposing patients to a wider range of selfobject and conflictual, repetitive and resistive transference phenomena (Stolorow 1988). Harwood (1993), drawing from this bipolar perspective of transference, states that adding a group experience to an ongoing individual treatment broadens exposure to the total caretaking and traumatizing environment. She suggests an individual/group therapy paradigm because it offers increased clinical opportunities for observing, analyzing and working through repetitions of earlier selfobject and traumatizing experiences with multiple caretakers.

While highly compatible with the work of Harwood, the model described in this chapter differs significantly in that it considers selfobject and traumatizing transference phenomena from a co-therapy paradigm, while Harwood utilizes a single therapist model. By adding a second therapist, material emerges that does not emerge in the individual treatment or when there is a single therapist. Early experiences with the co-therapist facilitate the emergence of unconscious organizing principles which have not been activated in the individual treatment. Accordingly, the model has been entitled a multiple selfobject and traumatizing experiences co-therapy model.

Clinically, much of the benefit gained from placement in the group context is that patients are provided with new opportunities to explore areas of disturbance which may remain unexamined as part of the individual treatment process. This seems to happen, in part, because early repetitive failures and disorganizing experiences which have not been activated in the individual treatment and, therefore, remain unrecognized to patient and primary therapist, begin to get triggered in the context of the expanded group intersubjective field.

In the multiple selfobject and traumatizing experiences co-therapy paradigm, affectively meaningful experiences are symbolically recreated in the evolving group context. Triggered by both the empathic and unempathic responsiveness of the other group members, as well as the co-leaders, adult patients are able to gain access to early traumatizing experiences which have been denied cognitive articulation. Also, important affect states, which may never have been validated due to the chronic absence of attunement in the child–caregiver system, are differentiated, synthesized, modulated, cognitively articulated and integrated, as Searles and Stolorow (1984–1985) suggest. From an intersubjective point of view, patients’ early developmental traumas may be understood as originating from within a formative intersubjective context. From this theoretical perspective, according to Stolorow and Atwood (1992, p.53), affect becomes traumatic when the requisite attuned or optimal responsiveness that the child needs from the
caretaker(s) is absent — leading to the child’s loss of affect-regulatory capacity and thereby to an unbearable, overwhelmed, disintegrated, disorganized state.

Considering the potential risks for retraumatization, entering a group may be viewed symbolically as indicative of a deepening level of trust between patient and individual/primary therapist. In deciding to accept the risks, Segalla et al. (1988) suggest that both patient and therapist agree that there are aspects of the work which are best addressed in a setting which more accurately reflects a potential for re-creating previous and present life situations.

Theoretical thinking about the multiple selfobject and traumatizing experiences co-therapy model has had a developmental progression over the years. This progression has been influenced by ongoing advances in self psychology and, more recently, further shaped by the new contributions to intersubjectivity theory by Stolorow, Brandchaft and Atwood (1987–present), and by psychoanalytic researchers in infant development (Beebe and Lachmann 1994; 1992; 1988a; 1988b; Emde 1988; Lichtenberg 1983; Lichtenberg et al. 1992; Stern 1985). These advances have helped in focusing closer attention on the specific affective nuances that take place in the mutually regulated dyadic interactions occurring among members in groups. Also, from their own unique vantage points, the perspectives of infant research, self psychology and intersubjectivity theory have broadened understanding of the selfobject experience. Accordingly, this chapter refocuses attention on the central importance of affects (Socarides and Solorow 1984–1985), and the selfobject experience, both developmentally and clinically.

Theoretical considerations and developmental research

Theoretically, the multiple selfobject and traumatizing experiences co-therapy model questions the validity of viewing a single, one-at-a-time transference as the sole organizer of self experience. Although it acknowledges the importance of the primary caretaker, symbolically represented in groups by the presence of the patient’s individual therapist, this model holds that the contributions of the second parent and the ‘others’ (siblings, peers, hired caretakers, grandparents, etc.) have been underplayed in classical psychoanalytic theory, and to a lesser degree in early Kohutian thinking. It parallels Segalla et al.’s (1988; 1989) and Harwood’s (1986; 1993; 1995) line of thinking that experiences with the second parent, symbolically represented in co-therapy groups in the form of the co-leader, and others (siblings, peers, etc.), symbolically represented in groups by the group members, can be just as important in contributing towards the organization of primary psychic structure. It is possible that the enduring preference of treating patients solely from an individual treatment model may be tied in part to classically trained analysts/therapists adhering to rather outdated notions of human development and motivation. This preference may need to be
reconsidered in light of more recent psychoanalytic developmental research findings pertaining to the mutuality of influence observed in infant—caregiver interactional systems.

The importance placed on patients' selfobject and traumatizing experiences in groups is consistent with the efforts in contemporary self psychology and intersubjectivity to redefine the term 'selfobject' in light of recent infant development research findings (Beebe and Lachmann 1988b; 1991; 1994; Demos 1988; Emde 1988; Lichtenberg et al. 1992; Stern 1985). According to Lichtenberg (1991), reconsiderations brought about by clinical experience within self psychology and by infant research 'tilt our focus toward intrapsychic affective experiences closely interwoven with relational and intersubjective contexts' (p.455). Contemporary theory shifts the emphasis away from the selfobject as a person and as an internalized function by placing the emphasis on the affective dimension of self experience. From this vantage point, the need for selfobject ties pertains to the need for specific, requisite responsiveness to varying affect states throughout development (Stolorow et al. 1987). Selfobject and/or traumatizing experiences are viewed primarily as affective experiences involving one's sense of self. They are triggered in the context of others' attended or misattuned responses, leading to experiences of self cohesion or fragmentation. The overwhelming evidence from infant research studies suggests that healthy child—caregiver systems involve mutual attunement, not merger. Thus, there is a theoretical shift 'away from conceptions of archaic merger states, archaic fantasies of omnipotence, and qualities of energy such as narcissistic libido' (Lichtenberg et al. 1992, p.133).

Kohut (1977), as well as Kohut and Wolf (1978), pointed in this direction by suggesting that infants do not begin life with their caretakers in a state of undifferentiation. More recently, theoreticians have found that a vital, self-differentiated person does not develop as a result of optimal frustration due to caretaker(s)’ minute, phase appropriate lapses in empathic attunement as Kohut believed. Rather, a cohesive, vital person develops within a context of optimal responsiveness (Bacal 1985b) and mutual regulation (Beebe and Lachmann 1988b), and continues to do so throughout life.

Drawing from extensive empirical research findings, Lichtenberg (1994) stated that 'a sense of self develops as a sometimes independent, sometimes interdependent center of initiation, organization and integration of experience and motivation as needs are met in the intersubjective matrix of infants and caregivers.' Stolorow and Atwood (1992) underscored the notion that the developing organization of the child’s experience, both positive and negative, must be seen as a property of the child—caregiver system of mutual regulation. Similarly, Stern (1985) stated that the formation of various senses of self come from the child’s interaction with ‘self regulating others', while Emde (1988)
concluded that personality structures develop from the internalization of infant–caregiver relationship patterns. Additionally, Beebe and Lachmann (1988) concluded that recurrent patterns of mutual influence between mother and infant provide for the development of self and object representation while determining the ways in which expectancies of social interactions are organized. Also, Demos (1988) found support for the notion that affectivity was a property of the child–caregiver system of mutual regulation.

The development of a group ambience which supports optimal responsiveness and mutual regulation in the transferential experiences taking place among members in groups is consistent with the contemporary thinking and research of Demos, Emde, Lichtenberg, Stern, and Beebe and Lachmann. Their findings point out that infants are born uniquely programmed to respond to an empathically sensitive family life that reliably provides vitalizing selfobject experiences. Also, the research strongly confirms that a vital sense of self flourishes within an optimally responsive, mutually regulated intersubjective context. Frequent observations of transformational self experiences taking place for patients within group contexts which support optimal responsiveness and mutual regulation give clinical support for the research findings cited.

By concentrating primarily on the self-organizing and/or disorganizing meanings gained through ongoing exploration of group members’ multiple transfersences, this model follows two central positions taken by contemporary self psychology and intersubjectivity theory; namely, it emphasizes clinically the central importance of affects (and affective experiences) and it strongly recognizes the intersubjective world in the therapeutic exchange.

Clinical observations

The first glimpse of the impact of the interplay between the individual and group modalities often occurs in individual treatment, where the primary therapist helps to modulate by holding (Winnicott 1960a; b) or containing (Bion 1952) some of the anxiety or fragmentation that patients experience as they enter group. Simultaneously, the therapeutic bond, established through innumerable experiences working with the patient individually from within both the selfobject and conflictual, repetitive and resistive dimensions of the transference, allows the therapist to anticipate, observe and translate the patient’s needed selfobject functions as well as impingements and traumas as they arise in group. Thus, the therapist’s awareness of the patient’s history and the therapist’s recognition of how it may interplay in the group process helps the person experience a trusting bond which eventually allows him/her to become an integral part of the group. Segalla et al. (1988) and Harwood (1995) describe the above process in placing patients into group.
As the group process unfolds, the individual's feelings about the co-therapist and the other group members begin to emerge. This phase in the developing group process is extremely significant for many patients; for while the therapeutic bond with the primary therapist continues to be strengthened as a result of ongoing contact in the individual and group contexts, it is the initiation and maintenance of ongoing intersubjective experiences with the co-therapist and the other group members that establishes the safety for deeper exploration to take place. In part, these experiences are made possible by the optimally responsive ambiance established early by the group co-therapists. This provides an atmosphere of tolerance and empathic relatedness quite early, and helps to build a foundation for group members' interactions in the future.

From the evolving relationship with the co-therapist, the patient comes to recognize patterns inherent in the mobilization of old, constricting organizing principles often developed from within the more pathological child–caregiver matrix, as Segalla et al. (1988) suggested. Frequently, the presence of the co-therapist stimulates unconscious material and affect states that may be emerging in treatment for the first time. For some group members, the unfolding of the transferential relationship with the co-therapist is relatively benign, often paralleling the experience with the primary therapist in the individual treatment. For many others, however, a significantly different transferential progression takes place.

In these cases, consistent with the theoretical underpinnings of the co-therapy paradigm, important clinical transference phenomena relating to early traumatizing experiences with the other (second) parent begin to emerge. Transferential feelings evoked by the presence of the co-therapist may be threatening and painful since they are being stimulated within the context of the less ideal caretaking experience. As the group progresses and further disruptions occur facilitating the oscillating bipolar dimensions of the transference with the co-therapist, the emergence of new, alternative organizing principles occurs as a result of working through the connections and disconnections of the selfobject bond with the co-therapist.

Typically, the development of deepening relationships with the co-therapists and other group members happens gradually in that individuals must first experience sufficient empathic attunements to their own subjective experiences. Only then are they able to fulfill reciprocal selfobject needs for others. Initially, while members may have a genuine desire to be empathically attuned to others, many come across as controlling and demanding, or passive and dismissive. It is through the connections, disruptions and restoration of connections taking place among members over the life of the group that bit by bit members develop greater capacities to fulfill selfobject needs for others.
It is difficult to capture the essence of the deepening relationships being established by group members as the group process unfolds. But in considering the developmental progression of the groups, it seems that links between members occur as a result of early negative and positive identifications and internalizations with each other. Early negative intersubjective transactions of limited usefulness are mutually reshaped and interactively integrated into deeper, self-enhancing selfobject experiences over the span of the treatment. Of course, the development of these positive experiences is different for every patient, both in pace and depth.

The depth and richness of members’ experiences may be made clearer by imagining the analytic group context at a particular moment in time. From this vantage point, one might observe a disruption being worked through between one patient and the group as a whole, followed by a transforming experience occurring between two other patients or a patient and therapist while the remaining group members participate silently. (See Segalla et al. 1988; 1989; Harwood 1992a; 1992b; for further clinical group examples.)

The emotional connections made through the intersubjective processes taking place among group members are of significant therapeutic benefit in their own right, for they offer an alternative to feelings of isolation and despair. Moreover, these connections are the building blocks of group cohesion and coherence (Pines 1981). But it is my conviction that the most important factor about the development of these connections is that they occur in a lived context that recreates the multiple selfobject and traumatizing experiences of childhood. Patients are able to have different experiences within symbolically recreated contexts that often approximate earlier lived experiences with significant others whose positive and negative contributions to the development of psychic structure continue to be instrumental in the organization of their current subjective senses of self.

Let me now share a clinical case example that illustrates a multiple selfobject and traumatizing experiences co-therapy model at work.

**Clinical example**

The case of Mark illustrates the interplay between the individual and group therapeutic modalities. It underscores how Mark’s involvement in his own curative process was enriched by the shifting back and forth between these two modalities, thus enhancing the total impact of his treatment.

Mark, a 38-year-old man, entered individual therapy depressed, disorganized and fragmented after the breakup of a year-long relationship. He was intensely frightened by his depressive affect states which he experienced as signals that he was 'going crazy'. In the early individual treatment, Mark and I came to understand the depth of his depressive episodes as being related to traumatizing
experiences of separation and abandonment by his parents. Accessing early
disavowed childhood experiences of deprivation and neglect was crucial to
understanding his extremely limited capacity to cognitively articulate,
differentiate, modulate, and integrate his depressive feelings (Socarides and

Mark experienced his mother as being chaotic, critical and self-absorbed. The
extended childhood absences of the father, whose business career kept him away
from the family for long periods of time, greatly intensified Mark’s relationship
with his mother. She seemed to require a sense of oneness (merger) with Mark,
more so than with his four younger siblings, to sustain her own sense of
self-cohesion.

Throughout his life, Mark felt continuously alienated from his parents,
siblings and peers. Life was lacking in any true genuine feeling except pervasive
emptiness and hopeless despair. He was the obedient eldest son, but typified what
Wolf (1988) has called the ‘empty self’. Mark’s self-development in the area of
self-boundary formation had been obstructed through the enmeshed relationship
with mother and the unreliable, angry and unpredictable father. Accordingly, in
treatment he was initially compliant with the therapist’s interventions continuing
the obedient ‘good boy’ role he had assumed in his family.

Early memories were rare for Mark, consistent with his massive dissociation of
affect, a product of chronic lack of attunement to his emotional state by his
parents. Because of the pervasive deprivation of self-organizing and
self-differentiating selfobject experiences, Mark was left unable to monitor,
cognitively articulate and understand his own emotions as indicators of changing
self-states (Socarides and Stolorow 1984–1985). This point was dramatically
illustrated during an early individual session in which Mark reported that, for
extended periods in his adolescent and young adult life, he was so detached from
his own internal life experience that he was unable to make the linkage between
hunger pangs and eating food as a way of alleviating his stomach pain. Thus, even
the most basic of physiological experiences in his body were not labeled and
recognized as his own.

In the treatment, Mark maintained an anxious, dependent, somewhat
emotionally withdrawn connection with me. His vulnerable sense of self did not
allow him to experience the earlier sessions as his own, much as he had been
unable to label and experience hunger pangs in his stomach as his own. The
selfobject transference which gradually emerged was an idealizing one, although
quite unrecognized by me at first, because of his highly detached, compliant style.
In his words, he experienced the therapy as ‘a series of ongoing plays’ in which I
was viewed as the director and he had a relatively small part. He would show up
religiously one hour before his regular appointment time to sit in the waiting
room. He described the time spent in the waiting room before the actual
appointment as 'fore play', which naturally then flowed into the main play, or the appointment hour. Gradually, I came to recognize that the time spent in the waiting room before sessions offered a holding environment for Mark and that it symbolized an extension of the early budding selfobject dimension of the transference. In the treatment, it was recognized by both of us as a fairly safe, 'first step' at building a selfobject tie.

Speaking from the perspective of intersubjectivity theory, Stolorow et al. (1987) has described the oscillation between the selfobject dimension and the conflictual, repetitive and resistive dimension of the transference in clinical treatment. In the selfobject dimension, the patient longs for the therapist to provide selfobject experiences that were missing or insufficient in the surround of childhood. In Mark's case, the ongoing selfobject experience of having the therapist's empathic attunement, optimal responsiveness and calming strength, coupled with the therapist's efforts to help Mark make affective sense out of his powerful negative emotions (primarily depression), were reflective of the selfobject dimension of the transference. This dimension of the transference was operative in the foreground of the individual treatment almost exclusively in our early intersubjective transactions. I see myself as having been able to establish an effective working alliance with Mark by helping him to understand, label and regulate the extreme tensions brought on by his emerging emotional reactions (Socarides and Stolorow 1984–1985).

As the treatment progressed, inquiries into any personal feelings Mark might have toward me activated the conflictual, resistive and repetitive dimension of the transference. In this dimension, the patient fears the therapist will repeat the traumatic experiences of childhood. Mark's terror would be manifested whenever the notion of a personal relationship with me was addressed. Such disruptions were immediately noticeable because Mark would experience extreme confusion, or 'fogging out' as he called it. He would then flee into a tangential, intellectual discussion.

Through ongoing exploratory work in the selfobject dimension of the transference, it became clearer that our speaking 'too personally' was traumatic for Mark because intimacy unconsciously signaled danger. Questions of a personal nature in his early history had routinely led to his mother's immediate withdrawal or irrational scolding. My misattuned directness in an effort to deepen our budding selfobject connection led to his affective disorganization, for it signalled an unconscious dictate for him to comply reciprocally in a personal manner. Feeling compelled by me to be affectively intimate, he believed the sharing of his personal feelings would precipitate my abandonment and punishment of him, much like it had with his mother.

Moreover, further exploration allowed patient and therapist to see that, in a more general way, Mark had organized his early emotional experiences according
to a conviction that affective states of vitality and aliveness needed to be disavowed to secure safety. Positive affective experiences were not only not felt as supportive, they were reorganized defensively as experiences of danger and concern.

Coming to understand this unconscious organizing principle had profound meaning for Mark, which became behaviorally evident in the individual treatment. Mark was able to tolerate disruptions more easily, enabling our interactions to have an incrementally more enlivened, fluid quality. Also, he became somewhat less wary of direct affective expression in his reactions to me, allowing us to draw links between transferential experiences and feedback he had received from the few friends with whom he was able to maintain a semblance of attachment. These friends repeatedly responded to his lack of emotion, and his discomfort at 'being close' with them. Also, it was the reported reason his girlfriend gave for the breakup of the relationship which precipitated his entering therapy.

Accordingly, over the next few months, I was able to use the strengthened selfobject tie which had developed between us as a springboard for a discussion of the possibility of his entering group therapy in conjunction with his ongoing individual work. While he needed the ongoing affirmation and bolstering provided by the idealizing selfobject dimension of the transference, I believed Mark also needed exposure to a broader base of intersubjective experiences. For while Mark was developing a more trusting relationship with me, his emotional connection with peers remained limited. It was my thinking that the group would serve as a catalyst for developing optimal (not too traumatizing) selfobject experiences that could build dimensions of self-complexity and vitality that continued to be lacking in his life, as well as help him to understand more about his impact on others.

Mark's entrance into the group toward the beginning of his third year of treatment was anxiety-provoking, but fairly uneventful for him. Although at times emotionally engaged in the process, Mark generally stayed on the periphery of the group experience. Harwood (1987) suggests that in group the less-than-cohesive individual may present a false self based on identification or compliance with the group's or therapists' norms, typically giving up whatever self-strivings are beginning to emerge. This was certainly true for Mark in the earlier phases of the group, as he chose to expose little of himself, presenting his stylistic false self (Winnicott 1960a) as the dutiful, compliant 'good boy'.

The power of the multiple selfobject and traumatizing experiences model for Mark began to emerge about six months into the group as he found himself disturbed and reacting negatively to the oppositional positions taken by two members of the group. These two male patients were experienced by Mark as critical, emotional and argumentative. One of them was particularly
contemptuous of the group in general and, at times, of Mark’s politeness and rationality in specific. For Mark, it re-created the incessant emotional struggles between his parents, and while he quietly tolerated it outwardly, he festered inside.

In his individual therapy sessions, Mark moralized about the two male group members, completely unaware of his own contempt and critical judgment of them. By clarifying for him that the intensity of his reactions to these two members might be linked to the reactivation of painful unconscious feelings associated with intense early conflict between his parents, I was able to contain and soothe Mark’s agitation to a point where he felt more open to the possibility of sharing his reactions in the group. I noted that together we had worked through significant, anxiety-provoking disruptions in earlier individual sessions, and suggested that a similar possibility existed with these two group members if he would be willing to risk raising the reactions he was having to them in the group. Also, I reminded Mark that I would be present in the group and that, although I believed him to be quite capable of handling his reactions on his own, my presence might benefit him if he became overwhelmingly anxious in the group process.

The important interplay of the sustained calming self-object experience of my presence both in the group and individual treatment settings allowed Mark to tolerate the chaos he was experiencing in the group without intolerable retraumatization to the newly evolving self-structure. Because Mark’s anxiety was modulated by the work done in the individual sessions, he was able to go back to the group and express his reactions, as well as take in feedback from the group.

Reciprocally, the group experience acted as a catalyst for some important individual transference work to take place surrounding Mark’s elusive contempt and critical judgment of me. Some of the feedback Mark received from the group when he shared his negative reactions to the two oppositional members centered on his own contemptuous capacity to ‘moralize on high’ about others. With the feedback Mark received from the group, I was able to build a bridge between group members’ reactions to him and the superior, contemptuous position Mark had taken with me in the individual work when he felt misunderstood. Unlike in several previous attempts, he was able to own his contemptuous feelings toward me because my experience in individual treatment echoed similar feedback he received from the group. Equally important, Mark and I, working together from our own subjective experiences in recalling some of our earlier individual sessions involving Mark’s contempt, were able to link his dismissive reactions of me with the myriad ways he would dismiss his father’s intellectualized lectures ‘from on high’. His father’s endless speeches would involve moralizing about what was wrong with the world, and how ‘stupid’ people were, including his children when they did not agree with his (the father’s) perceptions.
The selfobject experience of Mark having his anxious affects articulated, legitimized and modulated by me in the individual work, coupled with the group’s generally empathic stance, set the stage for Mark and the group to continue working together with an incrementally deeper level of trust. Also, it served as an opportunity to explore new, unrecognized areas of self experience in Mark’s individual treatment regarding his inability to experience himself as an effective agent in impacting others. The growing awareness from his group experience that he could be the center of his own initiative and impact others directly was a pivotal point in his treatment, and it became a powerful theme that was repeatedly explored.

Simultaneously, while Mark was establishing closer selfobject ties with the other group members, the unfolding of the bipolar transference with the group co-therapist was taking place. Mark’s initial, rather lengthy (approximately six months) avoidance of the co-therapist in the group process was reflective of the conflictual, repetitive and resistive dimension of the transference. From within Mark’s transferential perspective, the co-therapist was a female authority whom he expected to engulf and control him. Thus, in the early phases of the group process, Mark avoided eye contact with the co-therapist and never addressed her directly.

Essentially, the development of the idealizing selfobject dimension of transference with the co-therapist followed a similar pattern to the one established with me in the individual treatment. Much like he used the hour in the waiting room before his individual appointment as a less risky, first step toward developing a selfobject connection with me, Mark made his initial attempts at a connection with the co-therapist outside of the group experience. He did this by asking her for names of psychotherapists that she could recommend as referrals for a few of his friends. At first, he would speak to her by telephone; then, gradually, he spoke to her in person after group sessions.

Within the context of the actual (in the room) group process, Mark’s resistance to establishing a selfobject connection with the co-therapist was lessened significantly as a result of her taking an affectionate, devil’s advocate position with him. The co-therapist was particularly effective in reframing some of the highly intellectualized comments Mark would make about himself and others in the group. Symbolically, Mark came to experience her as a positive alternative to his mother, in that she offered him an ongoing selfobject experience with a calm female authority who could empathically buoy him up even while she was encouraging his needs for active opposition. In a sense, the co-therapist offered the emotional space Mark needed to feel more intimate with her, allowing him to experience her as safe and ‘not suffocating’.

Incrementally, over the course of the group treatment, the co-therapist became the person who was most influential in bolstering Mark’s sense of personal
autonomy and developing assertiveness. Unlike in his relationship with his mother, who demanded a sense of oneness (undifferentiation) with Mark to sustain her own sense of self-cohesion, the co-therapist symbolically represented the opportunity for intimacy without merger or engulfment. After months of not acknowledging the co-therapist’s presence in group, Mark was able to address her directly in the group process by telling her that he experienced her as ‘calm and strong’. This was a significant accomplishment for Mark, and one that signified another important benchmark in his overall treatment.

Learning from the unfolding of the selfobject dimension of the transference with the co-therapist, Mark was initiating important selfobject experiences with other members of the group. Experiencing greater flexibility and increased interpersonal options developed primarily through his identification with the co-therapist, Mark was able to initiate a selfobject experience for another female member of the group. By taking a position which was similar in manner to the one taken by the co-therapist with him, Mark was highly effective in questioning the woman’s positive attachment to her father in light of his (the father’s) ongoing lack of receptivity to her. Due to Mark’s sustained empathic use of irony, the patient was able to reconsider her emotional attachment to her father, explore its historical antecedents, and put some needed distance between her and her father.

The impact of the group members on effecting Mark’s sense of self-efficacy, power and autonomy was evidenced both within the group and in the outside world. In one instance, an articulate but emotionally intense female member of the group reacted with frustration to Mark’s relative nonchalance with respect to the ruthless way his boss had not given him a well-deserved job promotion. Having been challenged and supported by this group member, he was able to use this experience to assert himself with the boss.

Mark’s growth from his group experience was particularly noticeable in his increased capacity to maintain a supportive, engaged presence in relationships with women outside of the group. This new sense of himself as an effective agent, capable of directing his own life, freed Mark up to a point with women where he felt capable of maintaining his own sense of self autonomy, while at the same time staying connected to them in an enlivened way. Also, in part because of the selfobject experiences with the other group members, Mark grew to become effectively empathic with others at his place of work, and increasingly with his family and friends.

Hopefully, the case of Mark helps to further clarify that the model described is not merely the placement of the patient in individual and group therapy; but, rather, a model by which the individual therapy treatment can be broadened by the group co-therapy experience, and then reciprocally, how the individual’s experiences in the group can be catalytic in deepening the analytic transference work with the primary therapist in individual treatment.
Summary

Summarizing the essential aspects of the multiple selfobject and traumatizing experiences co-therapy model from the case material:

1. The bipolar transference with the primary therapist developed over three years and was firmly established prior to Mark's entering group therapy.

2. Mark's selfobject tie with the primary therapist was used to modulate his initial anxiety entering the group, and then to help him tolerate his agitation, without intolerable retraumatization, as difficulties surfaced in the intersubjective experiences with the other group members.

3. The ongoing transference work in the individual treatment was advanced and deepened due to feedback Mark received from others in the group.

4. Early maternal repetitive failures and disorganizing experiences which had not been activated in Mark's individual treatment and, therefore, remained unrecognized to patient and primary therapist, began to get triggered in the developing and deepening bipolar transference with the co-therapist.

5. Consistent with the theoretical underpinnings of the model, important clinical transference phenomena relating to early traumatizing experiences with the second parent (Mark's mother in this case) emerged as a result of utilizing the co-therapy paradigm. Stimulated by the presence of the group co-therapist, Mark transferentially expected her to engulf and control him. Paradoxically, over time, the group co-therapist became a symbolic positive alternative to Mark's mother, offering him an ongoing selfobject experience with a calm female authority that involved intimacy without merger or engulfment.

6. Essential selfobject experiences with the other group members were instrumental in helping Mark gain a sense of self-efficacy, as well as helping him to gain a better understanding of how he impacted and was impacted by others in his life.

Summarizing and identifying four representative general principles when working in the multiple selfobject and traumatizing experiences co-therapy model:

1. 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 co-therapy model stimulates transference material concerning the other (second)
parent which does not emerge in the individual treatment or when there is a single therapist.

2. Individuals placed in an optimally responsive group context can learn to interact in mutually regulating, self-vitalizing ways which in turn help them over time to broaden their capacities for self reflection and empathic responsiveness.

3. Disruption–restoration sequences, rather than being viewed as depletive, may be viewed as growth enhancing both in the individual and group contexts. These sequences may serve to strengthen group members’ connections with each other, while facilitating growth in the articulation of affects and cognitions, and in the development of enriched self structures.

4. There has been a shift away from theoretical acceptance of merger or symbiosis as an essential developmental phase. Contemporary theory and early development research suggest that person-with-others involves mutual attunement, not merger. Accordingly, intimacy in contrast to merger is viewed as essential, both from a lifelong developmental viewpoint and from the clinical perspective of effecting positive treatment outcomes.

In searching for common threads across these four principles, it can be stated that the multiple selfobject and traumatizing experiences co-therapy model is one that is built on the development of intersubjective experiences among group members and therapists characterized by optimal responsiveness and mutual regulation. Also, it is a model that has, as its overarching, unwavering goal, the development of the patient’s increased capacity for selfobject relatedness, greater capacity for tolerance of traumatizing experiences, and deepened self introspection.

References


