In our first vignette, Frank, stimulated by the sexuality embedded in the group transactions, brought forth a dream which addressed his conflict in the present over his passivity and shame. The undisguised nature of his sexual failure and his flight only to return to a place where gentle conversation was occurring all signal perceptions of the group that potentially can serve his developmental progressive thrust. The second vignette communicates Mary's sense of having increased ability to play even in the context of "serious matters." In these examples from long-term treatment, a group setting is overtly represented in one dream a specific group member is incorporated in to the second dream, both seeming to suggest that the group was experienced as a sufficiently safe setting in which growth and change could take place.

Certainly the value of any group dream is its communication both to the dreamer and others. How and in what manner the therapist and the other members respond in order to take advantage of the opportunity is multi-determined. The thrust of this paper has been to illustrate the patients' presentation of dreams in an effort to communicate about difficulties within the group setting that have interfered with their effective use of the group. And they served as a stimulus for change in a growth enhancing direction.

CHAPTER FIVE

A self psychological perspective of group development

Walter N. Stone and Gil Spielberg

Abstract: This paper examines group development from the perspective of self psychology. Members' search for particular selfobject responsiveness varies according to the particular phase of group development. In the first phase, patients' wish for safety and understanding is managed by merging with the therapist as an idealized selfobject. In the second phase, members look for mirroring selfobject functions to their assertive/aggressive self expression. In the third phase, members continue to have periods when idealizing and mirroring selfobject responsiveness assist them in maintaining inner balance. During this phase members continue to gain skills from alter-ego selfobject experiences.

In the final phase of a group, termination involves members' ability to manage the narcissistic pain of loss and separation. Members utilize their inner consolidation and the continuing selfobject experiences to stabilize themselves as they experience loss associated with leaving the group and the real relationships they have developed. Across phases, members gradually internalize the values and norms of the group, which become part of the groupself. The leader's therapeutic and countertransference responses are also examined for each phase.
A Self Psychological perspective of group development

Every individual faces substantial tasks in satisfactorily entering and maintaining membership in any group, including family, work, friendship or the special case of a psychotherapy group. Entry into a therapeutic group activates the person's internal interactional model learned within the family and subsequently modified in play, school, work, and social settings. In each situation, individuals consciously and unconsciously determine how much of themselves they will allow to participate in the group and how much they will hold back to preserve their own sense of individuality and autonomy. The balance struck between the two ends of this dichotomy is multi-determined and includes the goals of the setting, prior experience, and interactions in the present.

Members enter a therapy group with the objectives of learning about their inner worlds, finding more comfortable and successful ways of being with themselves, and of altering dysfunctional patterns of relating. Doing this brings to the fore anxieties, vulnerabilities and defenses (solutions) that may require examination in order to achieve treatment goals. As verbal and behavioural interactions among members and the leader proceed, the subjectivities of the members interact and some resolution is achieved (to the benefit or detriment of the individuals) that become embedded as “rules,” which are labelled, in group dynamic terms, values and norms. Subsequently, as a result of further transactions, norms are subject to scrutiny and to modification. These elements of group development can be observed and studied in psychotherapeutic groups.

Theory

Group developmental schemata are abstractions and only approximate the differing membership and leadership styles present in each unique group. Yet, one or more themes can often be discerned underlying any group discussion. Theories of group development compartmentalize these themes in order to describe the complexity of the group emotional environment. Contemporary theoreticians recognize that development is not linear, but may be subject to lengthy periods of working in a particular stage, and that reversals and return to earlier stages are frequent, in order to deal with particular stresses of the more advanced stage, or once more address incompletely examined issues.

Models of development arose predominantly, but not exclusively, in the context of groups organized for educational purposes (Bennis and Shepard, 1956). Early models, based on the available ego psychological and object relations theory, identified four major developmental phases labelled forming, storming, performing, and ending (Tuckman, 1965). These labels describe and categorize changes in members' behaviours and emotions across time from the vantage point of an observing other. In keeping with a self-psychological emphasis on the centrality of the self, our intent in this article is to re-examine developmental phases from a perspective that focuses on inner experiences of the members and group leader. This perspective differs from models based on object relations or ego psychological theory, which derive themes from the position of an external observer.

Self psychology, evolved within a dyadic setting from the pioneering work of Heinz Kohut (1977, 1984). In this substantial paradigm shift, the self's development and pursuit of its goals and ideals became the centre of analytic interest. Kohut conceived of the self as developing within a matrix of soothing, calming, and affirming responses. These experiences, labelled selfobject experiences, were to maintain the self's internal integrity and promote growth. At the earliest stages of development, the selfobject was felt to be under the infant's control, while the other was not recognized as a separate person. Kohut initially formulated three types of selfobject experience: idealizing, mirroring and twinship. When an environment is able to provide sufficient selfobject responsiveness, the self, to a greater degree, is gradually able to assume these functions independently. Yet it is accepted that throughout life selfobject needs are present.

Consolidation of the developing self is reflected in a shift in the nature of selfobject experiences. As noted above, beginning in infancy selfobjects are experienced as under control of the self, as if they were body parts. Gradually, with maturation of the self, the selfobject is experienced as a subject with thoughts and feelings of its own. This development implies a sufficiently maturing self so that need for immediate selfobject response is unnecessary for the self's every wish or need in order to forestall major internal disruption. In addition, the self has learned to use non-human self-objects
to serve necessary stabilizing functions. Examples of such selfobject experiences might include playing with pets, enjoying a concert, or reading an enjoyable book.

Inevitably, the child experiences failures or mis-attunements in needed selfobject response, which produce anxiety and experiences of fragmentation of the self. Repeated selfobject failures evoke powerful feelings of despair, hopelessness, loneliness and reactive rage. These emotions lead to personality malformations as adaptations protecting the self and managing affects. Such individuals are, at the least, wary of efforts to become intimately engaged, in part for fear that their selfobject needs will not be met, and in part because they fear their inner experience of unmanageable affects. Newman (2007) states: “Often, it is the absolute dread of re-experiencing the painful feelings of aloneness, the recognition of the failure of the selfobject—and above all, the frightening rage that accompanies such awareness—that keeps in place pathological ways of relating to the self or to others” (p. 1539). As we will discuss below, this perspective has important implications for therapeutic intervention.

Although Kohut was not inclined to apply his theory to group treatment (Strozier, 2001), he formulated a concept of the self that included a deeply embedded groupself (Kohut, 1976). The groupself is considered to be a portion of the self, which represents a consolidation of family, environmental, and cultural goals, and ideals that are compatible with those of the individual. It refers to an attachment to the group, and not to an individual (i.e., mother). As part of the self, the groupself requires selfobject experiences, i.e., belonging to a family in which parents are seen as successful, or to a country that is honoured and esteemed. If these experiences are aversive, the groupself (and therefore the self) may become anxious. In a therapeutic setting, if the group becomes disrupted by such actors as a departure of an important member, a newcomer, or an unmanageable conflict, the groupself may experience anxiety and fragmentation. The groupself also includes the “rules” of discourse. For example, a new member previously treated in a non-dynamic therapeutic modality has to internalize norms such as talking about one’s own feelings, not attacking others, or attending regularly on time. How people talk to one another in a group differs from how they might speak at a political meeting (Karterud and Stone, 2003).

The groupself is distinguished from the group-as-a-whole primarily based on the perspective of the observer (therapist). The group-as-a-whole is the experience of the outside observer who is positing that something central to group functioning is shared by the majority of the membership. The groupself is an organized internal experience derived from the experience of the group serving as a selfobject. It is an internal portion of the self having to do with stabilization and repair of the self. Thus the group-as-a-whole might be sharing a similar fantasy, defensive style and affective experience. The therapist intervenes with a comment that addresses the collective without regard to the internal felt experience of the participants. The groupself, which may represent group-wide emotions, is addressed from an empathic position.

In the therapeutic process, the self is exposed to experiences that illuminate (narcissistic) vulnerabilities. An injured self responds with processes, which can be understood from the patient’s perspective by a clinician’s consistent empathic stance. The interpretive process begins with the therapist articulating that understanding. Kohut (1977) emphasized the essential nature of a two-phase interpretative process: “first the analysand must realize that he has been understood; only then, as a second step, will the analyst demonstrate to the analysand the specific dynamic and genetic factors that explain the psychological content he had first empathically grasped” (p. 88). The individual, who has felt deeply understood by the therapist “comes to believe that his most profound emotional states and needs can be understood in depth. This in turn, encourages the patient to develop and expand his own capacity for self-reflection and at the same time to persist in articulating even more vulnerable and sequestered regions of his subjective life” (Stolorow, Brandchaft & Atwood, pp. 10–11).

The individual’s broad self experience, with its variety of selfobject needs, will be examined in the context of our understanding of group development. As part of this development, the group norms and values are conceptualized as becoming internalized as part of the individual’s groupself. Thus, as Brownbridge (2003) has noted, the self is in the group and group is in the self.

Developmental phases

For those engaging in any group enterprise, two overarching elements are present. From a participant’s perspective, the elements
can be framed as questions: Can I achieve my goals? Will attention be paid to my emotional needs? From these questions, an additional query emerges: What portions of my self must I forgo to belong to this group?

In psychotherapy the tasks of achieving emotional growth rest upon a foundation of patients’ concerns for emotional safety. Self psychology addresses these concerns through a therapist’s consistent efforts to understand the processes and dynamics from an empathic perspective. For the clinician, and by extension for the members, empathy includes “greater freedom to respond with deeply reverberating understanding and resonant emotionality, and the generally calmer and friendlier atmosphere of self psychological treatment ...” (Kohut, 1984, p. 82). In the context of an empathic and responsive milieu, members are more willing to take risks, thereby exposing deeper aspects of the self for understanding and modification.

Lichtenberg (2005) formulates the therapist’s stance as tuning into the subjectivities of the participants as fully as possible. This enables the clinician to maintain an empathic position and “a spirit of inquiry.” “A spirit of inquiry is the therapist’s gyroscope, helping to re-light the therapeutic endeavour when the immediacy of exploration is lost in the heat of struggles over a patient’s pressure for provisionality [i.e., answers to questions, gratification] responses” (p. xii).

Patients need to experience the therapist and others as both old and new objects (Greenberg, 1986). Opportunities to work through old experiences of trauma or failed responsiveness must be balanced with opportunities to experience the others as new objects, which will be available to provide different growth-promoting experiences. Members who have developed a deep-seated sense of hopelessness and helplessness require opportunities to learn that their previously unexpressed rage will not be destructive either to themselves or to others. The therapist, with the aid of the group, must be capable of containing strong emotions and find ways of enabling their expression. The new experience is that of the clinician who can identify tendrils of forward movement and growth (Tolpin, 2002).

The old experience is the transferential and/or the co-constructed interactions that evoked earlier selfobject failures. Greenberg (1986) has succinctly stated, “If the analyst cannot be experienced as a new object, analysis never gets under way; if he cannot be experienced as an old one, it never ends (p. 98). In groups therapist and members alike can provide these experiences.

Group developmental stages will now be discussed from the self psychological perspective of members’ and leader’s tasks. We artificially separate leader and members for heuristic purposes, recognizing that they are intimately involved and influence one another. This discussion is designed to supplement and enlarge previous conceptualizations of developmental processes.

First stage: Forming

The members: Individuals entering a psychotherapy group face the daunting and anxiety-laden tasks of revealing themselves and connecting to strangers. In the face of these tasks, they hope to be seen in the best possible light and to be appreciated, if not openly admired, for their positive attributes, indeed for the grandiose aspects of their self (Meyers, 1996). Such hopes may include being recognized as the most open, self-revealing person, even if the revelations seem to expose negative aspects of the self.

A fundamental anxiety of all members is that others will see only faults without recognizing positive attributes. This anxiety is fuelled by the common fantasy that the others are untrained and insensitive and will not mirror their strengths and abilities. Newcomers fear being traumatized and experiencing disruption or fragmentation of their sense of self. No amount of preparation will totally quell newcomers’ anxieties, although the relationship with the therapist may provide some sense of safety (Harwood, 1983; Rutan and Stone, 2001).

In the initial phase of a group, members attempt to manage their (potentially disruptive) anxiety through merging with the therapist. Their hope is that if the clinician can be experienced as all-powerful and all-knowing (idealized), they will feel safe. These processes represent a regression to archaic selfobject needs, and generally take place outside of conscious awareness. The leader is not seen as an individual but only as a function to manage the member’s anxiety.

If the leader does not seem available to idealize, members may search for other idealizable selfobjects, which can stabilize a
threatened self. In early phases of austerely led training groups and in some therapeutic groups, participants may associate to religious experiences, which Slater (1966) labelled “deification as an antidote to deprivation.” These references can be understood as the group’s search for an idealizable selfobject in the face of feelings of powerlessness and helplessness when the group leader is too remote or unavailable to serve as an idealizable selfobject. This process could be understood as firming a disrupted portion of the self, the groupself.

Idealization and/or surrender are not the only avenues for members to manage the inner disruption provoked by joining a group. Some individuals search for commonalities with others, hoping that having similar attributes or characteristics will enable them to feel more connected and less alone. These processes may be understood as search for twinned selfobject experiences. Seemingly banal inquiries such as, “Are you married?” “What kind of work do you do?” “Where do you live?” may be expressions of such a search for soothing selfobjects (Kiefer, 2001; Weinstein, 1987). These commonalities, can serve as an antidote to feelings of aloneness and powerlessness, and expand as a pathway to feeling that the group-as-a-whole can provide useful selfobject experiences (Segalla, 1996).

In this initial phase, members begin to experience the group-as-a-whole as important to them. This represents the early manifestation of a portion of the groupself derived from the treatment experience. The group may then be experienced as a facilitating or disruptive presence—that is, in the mind of a member, it may or may not be available to fulfill selfobject needs. The groupself, based on one’s perception of the group functioning, is responsive to shame, guilt, pride and pleasure.

The therapist: The primary task of the therapist is to help create a functional group where members may feel understood, respected, and safe. Therapists define the initial group structure, including boundaries between the group and the outside world, among the members, and with the leader. Without structure there can be no safety. Therapists also work to define the group norms, which define how the treatment will proceed. Therapists demonstrate (model) their capacity to reflect upon the discourse and convey (verbally and nonverbally) their efforts to understand. Understanding is based on empathy, as the clinician temporarily places him/herself in the shoes of the other. These behaviours demonstrate how leaders function in a consistent, reliable fashion that furthers members’ sense of safety and is one component in being idealized.

There are limitations to what therapists can achieve. Empathizing with the entire group is a daunting task, and often not possible. Clinicians recognize the potential for every intervention to be heard through the filter of each member’s personal psychology, and thus to have either a negative (de-idealizing) or positive impact. Therapists may diminish but not eliminate group disruption (narcissistic injury) by strengthening bonds among members and with the leader before making whole group interventions (Horwitz, 1977), but the potential remains for members to hear a whole group intervention as unempathic.

Self psychologically-informed clinicians maintain a dual focus on members’ efforts to change and grow and on their tendency to repeat old familiar patterns. Leading edge transferences represent patients’ efforts to restart growth by eliciting phase-appropriate empathic responses from the therapist or group members that will lead to new experiences. Trailling edge transferences are the patient’s expectancies that the trauma will be repeated (Stone, 2003, Tolpin, 2002). If the therapist conveys understanding that patients are trying to make changes, members may experience being safer and more deeply understood, and they may be more willing and able to explore old traumas. Without a sense of safety, patients may feel interpretations of unconscious material as shaming or guilt evoking and disruptive.

A brief example might be a member’s noting that one person invariably sits next to the therapist. Such comments are often experienced as critical of the individual or exposing a shameful “dependency.” The therapist might illuminate this situation by wondering if sitting next to him/her helps the person feel safer, perhaps in order to take more risks. Such an intervention focused on positive change may be heard throughout the group as an alternative understanding, rather than the more stereotyped dependency formulation. The intervention, in essence, may reverberate through the group-as-a-whole. Other interpretations of the same behaviour, based on a careful reading of the individual’s history, might be that the individual sitting next to the therapist is trying to address old feelings of not being a favourite child. This intervention might be accurate but is
likely to stir competitive feelings in others, to be addressed as they emerge in the process.

Alternatively, the therapist may choose not to respond to the initial comment regarding where the member was sitting. The unfolding process may turn to issues of shame, embarrassment, responses of withdrawal and safety. A therapist might convey his/her understanding that the members may have tuned in to the experience of (narcissistic) injury and subsequent emotions of the member. Such an intervention conveys the therapist’s attention to the process, helps the person feel understood, and adds to the experience of members that their emotional responses are carefully monitored. It does not preclude members’ expressions of hurt or anger.

Particular countertransferences in this opening phase tend to arise from the clinician’s discomfort with being idealized. Most dynamically-trained clinicians become accustomed to helping patients struggle with frustrations imposed by the non-directive therapeutic frame. However, clinicians may be unfamiliar with the pressure they feel when they are the object of idealization. Debunking patients’ expressions of the therapist as all-knowing or all-powerful can be traumatic for the group. A less common countertransference response arises from misunderstanding members’ efforts to find commonalities, seeing this effort as concerned with superficialities instead of as a way for members to orient and stabilize themselves.

Second stage: Storming

The storming phase is not characteristic of all groups, just as not every teenager experiences adolescent turmoil and defiance. Rather the label represents an abstraction derived from many groups and describes members’ and therapists’ experiences when members feel they have been ignored, misunderstood, depreciated or narcissistically harmed in a context of increasing group cohesion and functioning. Yet this phase provides important self experiences, as members learn that their anger, rage and rebellion can be accepted and understood without retaliation.

The members: The storming phase is described as the members’ responses to what they experience as restrictive and controlling group norms and values and to unresolved sibling rivalry remaining from the first phase. Transferences develop toward peers and the leader. A general tenor of trying to understand and create safety in the first phase may inadvertently lead to restrictive group norms that are experienced as stringent, immovable, and hurtful. In one respect, the initial process sets the stage for the possibility of members, who are frightened of the destructiveness of their anger to self or others, to begin experimenting with expressing these rageful emotions. Members must overcome these fears, which can be reinforced by group dynamic processes of contagion, which amplify emotions. In response they may search for whatever might be available to prevent fragmentation or to re-stabilize a disrupted self. At times the feelings may focus on a single individual who serves as the voice for the group (a group role). In such circumstances, the person feels emotions are amplified beyond anything previously experienced, to the detriment of the self.

The dynamics of the protest may emerge from deeply embedded self deficits arising from failures of appropriate mirroring or idealizing experiences in early childhood. In childhood the infant or toddler’s self assertion may be responded to with criticism, derision or simply ignored, creating a self that is unable to sustain pleasure in assertive activity. The older child’s efforts to enjoy experiences of school or play with others may be seen by the parents as violations of family norms, and therefore deprecated. In these individuals the joy and pleasure, which accompanies such assertion, is short-lived and replaced by a loss of vitality and a sense of dullness (Stolorow, 1984). Self-deficits acquired in childhood may not appear until adolescence and be seen dynamically as typical of teen-age years.

In this stage, members’ self-assertion is mixed with fears of rejection and condemnation. Some more traumatized persons fear the consequences to themselves of their rage. Overcoming inner restrictions and hopelessness for many individuals may reverse these emotions and create a more confident self-assertive self. The therapist’s capacity to serve a holding containing function and validation and affirmation of anger or assertiveness is a central element in the change process. More active mirroring self-object responses may be liberating. Interventions that try to understand or explain the anger can interfere with its expression, being experienced as out of touch with the person’s need to rage in a safe environment. For persons whose characteristic response is anger, a therapist’s understanding of the self-protective function of this affect may help the member to
restore an inner balance and establish improved emotional containment. This may help the member to be more effective in achieving goals and aspirations. As Ornstein & Ornstein (1993) noted, when the impediments to personal goals are removed, narcissistic rage disappears.

Persistent rage may signal previously unnoticed narcissistic vulnerability. Not all persistent rage is attributable to selfobject failure. It may be a member’s defensive strategy to protect against engagement and fears that he/she will be traumatized again.

In the storming stage members learn from others how to address conflict, be empathic, or listen carefully—abilities possessed by peers or therapist (twinship selfobjects). Some members are cautious; their protest is not loud or sharply critical, but, at times, barely perceptible, which represents a cautious new behaviour and a more cohesive self. These responses have been described as tendrils, a delicate sprouting, by Tolpin (2002). Sensitive members can mirror the emerging assertiveness. Successfully learning self-assertive skills is self-affirming. Moreover, members who provide the learning for others enhance their own sense of self by being genuinely helpful, a particular aspect of therapy groups that is not so present in dyadic treatment. Indeed, for members who develop a stable sense of self, there is some pleasure in being a selfobject for another.

As members internalize their group experiences, particularly affirming and stabilizing responses, they become more effective in expressing themselves and managing conflict. Group membership is experienced as valuable, and the self and groupself are enhanced.

The potential for negative outcome in this stage is also present. In a group filled with protest or anger, members may experience a depletion or fragmentation of the groupself portion of the self. The group is no longer experienced as a vehicle, which is concordant with the individual’s deeply felt ideals and values. As a result some members may choose to terminate their treatment.

The therapist: In this phase, therapists often feel battered and self-doubting about the value or success of the group enterprise. At times the entire project may feel on the verge of disintegration. Only a rare clinician is not beset with discouragement or fantasies of retaliation.

The clinician weathered some of the emotional storms by recognizing that anger and rebellion are members’ self-stabilizing efforts and potential growth responses. Attempts to soothe the members rather than to understand and explain the process may temporarily reduce the turmoil, but such interventions do not enable patients to learn of their self vulnerability and self-calming responses, nor do they allow patients who have been frightened by their own rage to test the limits of their inner tolerance. Soothing interventions may also be in the service of calming a distraught clinician.

Therapists’ knowledge of group dynamics adds to their ability to effectively intervene in the face of rebellion. By explaining the rebellion as a group phenomenon and not an individual process, one or more individuals will not be seen as disruptive, but as potentially voicing a group-wide concern. The non-judgmental quality of the therapist’s remarks allows members to become self-reflective and aware of previously unrecognized or disavowed aspects of themselves. Scapegoating can be understood and explained, to the potential benefit of all.

Clinical example: Three months into the life of a private practice outpatient psychotherapy group, Gloria arrived fifteen minutes late. This was the third time in recent weeks that she had been tardy. Several members irritatedly inquired about the reasons for her behaviour. Gloria provided a “reality” reason: she had experienced a car problem. This explanation was not fully accepted, and inquiries were made about the reasons for her prior lateness. Gloria became anxious and testily said that the meeting could go on when she wasn’t present. Her reply further irriitated the others and increased tension within the room.

The therapist struggled to gain perspective about the situation. He was aware that he, too, was annoyed with Gloria, and he decided that further reflection was in order. He silently thought: What was happening inside Gloria? Was she rebelling against the group norms? Was she frightened of developing intimacy? Was she enacting some sadomasochistic drama? Could others’ responses reflect Gloria’s ordinary relational experience? Were others extruding her in order to avoid feelings she was possibly expressing?

As the therapist was quietly processing these thoughts, a member suddenly wondered if Gloria was becoming a scapegoat. This only served to increase tension as Gloria angrily admonished the others for criticizing her. The therapist inquired what feelings the members might be extruding if Gloria was indeed a scapegoat; was she expressing some resentment or rebellion that she too might wish
to express. This intervention seemed to serve a mirroring selfobject experience for Gloria—the therapist had implicitly accepted her behaviour as a legitimate expression of feelings. The members felt freer to describe their own frustrations, including previously unexpressed fantasies of “taking off for a session” or quitting the group. They talked about their fears of being ostracized or of retaliation if they directly expressed dissatisfaction or anger. They, too, had felt understood by the therapist’s intervention. Subsequently, Gloria was prompt in her attendance. She also began to express dissatisfactions verbally, which we understood as an indicator of a more cohesive self, and not merely compliance.

Comment: This example illustrates commonplace expressions of acting on dissatisfaction or frustration with the group norms and/or process. The therapist’s observation implied that scapegoats are more than people bearing the blame for others; they also carry important group feelings. The intervention directly reflected the effort to understand everyone’s experience. Gloria experienced the intervention as conveying that she was doing something positive for the group, an experience of a mirroring selfobject. For the others, the notion that they were acting to scapegoat Gloria could possibly be shaming. The therapist, by inquiring about the nature of the feelings rather than criticizing members, served an idealizing function. If such formulations are accurate, they highlight the complexity of empathizing with a group. A single intervention may be experienced as serving different selfobject functions for the members. The example also highlights the members’ contribution to the therapist’s ability to make a useful intervention.

Third stage: Performing

The members: If the work has progressed satisfactorily, in the third stage of long-term dynamic groups, members have to a considerable degree internalized the values, ideals, and working methods of the group and can apply them within the group and within their daily lives. Members’ inner images of the group and of other members function as positive and enhancing selfobjects. Repeated experiences of being understood and of having their conscious and unconscious processes explained (interpreted) gradually strengthens members’ capacity to manage narcissistic injury. At this point, members have greater access to, and are more willing to identify, emotional responses in themselves and in others. They can reflect upon their feelings and can more openly express both tender and assertive emotions. They have become more fully cognizant of the power of unconscious forces and that errors or mishaps may not be due to chance. They can more successfully empathize with others and with themselves. When they have been narcissistically injured, there is usually lessened intensity of their typical responses and the duration of the reaction is shortened. With a greater sense of self and increased flexibility, members can try out unfamiliar roles (such as divergent leader) with a degree of confidence that their efforts will be appreciated and explored if their efforts are mismanaged.

In the outside world, when the inevitable frustrations occur, members learn to recognize their own self-stabilizing, self-soothing behaviours. Their “pathological” responses become muted and of briefer duration (Rubovits-Seitz, 2001). They find new self-stabilizing, self-restorative ways of soothing themselves, using both human and nonhuman selfobjects (e.g., listening to music, engaging in pleasurable activities). They may be able to pursue their goals more effectively and live within their ideals more comfortably.

This expansion of the self includes the groupself. Group values such as self-reflection, self-assertion, openness, and exploring processes of injury and repair, have been internalized in major ways, so that it is almost impossible to determine where a boundary exists between the self and the portion labelled groupself. With these additional attributes, the overall functioning of the self is enhanced.

Clinical example: Sheila, a single woman in her mid-40s, had been a member of a heterogeneous therapy group for almost three years. She had been referred to the group following several trials of brief psychotherapy and more extended medical (antidepressant) treatment for depression.

Sheila was initially reluctant to enter the group, believing that she had spent considerable time in psychotherapy over the years and knew her “issues” very well. This was true, as Sheila was able to recite, without undue anxiety, the tensions of growing up in the shadows of a brilliant brother and an abusive father. This knowledge had not lessened Sheila’s depression. Much of Sheila’s relationship history was marked by avoidance of intense emotional situations. She feared her own aggression (it might become uncontrollable) and the responses it might evoke.
In the group, Sheila at first maintained primarily affable contact with others and kept her distance from the leader. As her capacity for selfobject connectedness increased, Sheila took small steps toward more authentic contact with others by expressing moments of both warmth and minor annoyance. The members seemed quite accepting of both emotions. Sheila, likely feeling more accepted and safer, brought examples of her painting to the group. The members were surprised and pleased with her sharing this aspect of her self, disconfirming Sheila’s expected disinterest or critique. She reported that much to her surprise she had not found herself ruminating about the responses. More typically, she would wonder, “Are they just being nice? Do they really mean what they say?” She found herself enjoying the members’ responses in a new and invigorating way.

As Sheila felt more confident, she angrily confronted the leader with his announcement that a new member would be joining the group, even threatening to quit the group. She was not going to be a passive, disempowered victim of an insensitive parent.

During the week between groups, Sheila was able to reflect on the unexpected intensity of her feelings and feel pleased that she had grown to the point where she could express herself rather than nurse a grudge. Sheila felt calmed by the voices of the group members and the knowledge that any relationship disruption within the group was temporary and not permanently damaging. She found herself utilizing her painting for self soothing and was able to look forward to attending the next session without a sense of internal fragmentation and panic. The next session began quickly with members referring to Sheila’s uninhibited expression of anger at the leader. The group expressed appreciation for Sheila’s expression of what other members felt but did not say. As members noted her growth, Sheila was able to share with the group their role in her increasing capacity to risk more authentic communication, soothe herself, and stave off the familiar anxiety. In turn, members felt a sense of accomplishment in themselves and the group. Completing this process, Sheila was open to hearing that some of the members had been frightened by her aggression and had the fantasy that they wished she would leave rather than carry on as she had. Sheila was able to listen, understand the others’ experience and not “defend” herself. Rather she was rather proud of what she had said as well as her subsequent reflection on the process. She was able to add several previously undisclosed incidents in which she had been severely punished as a child for being angry.

Sheila’s behaviours impacted upon the group process to the benefit of all. As suggested above, her ability to express anger in response to the prospect of a new group member coming in and, as she saw it, intruding and upsetting the supportive functioning of the group, provided opportunities for members to address and understand their own narcissistic injuries and self-restorative responses.

Sheila’s experiences helped other members to appreciate their own emotional growth: their improved ability to manage differences, their expanded self-reflection to episodes in the group and in their extragroup life; their ability to express admiration at another’s growth; their diminished self-criticism and greater self-empathy when they mismanaged or misunderstood others. These achievements became embedded in the group process as part of the norms and values, and as part of the group self. The group was truly in the self.

The therapist: In the performing phase, therapists experience a broad spectrum of feelings. Prominent are pleasure and pride in helping to create a group atmosphere in which members can achieve and demonstrate personal growth. They hear them tell of more successful and satisfying human relationships and more effective pursuit of their personal goals. Within the meetings, clinicians observe patients assuming expanded leadership roles, being empathic with one another and themselves, and being creatively helpful to one another. Therapists can see the growth in members’ self-reflective capacity. Another pleasure is in therapists’ feeling that they have learned something new about themselves. No dynamic treatment is successful without the therapist becoming significantly emotionally engaged. Something new is bound to emerge for all parties in such an encounter.

Clinicians also experience times of confusion and uncertainty. Lichtenberg (2005) comments, “Dealing with the powerful affects generated by human desire is, and has to be, ‘messy’ at times .... They [clinicians] must appreciate retaining an open mind, the influence of context, the high probability of error, and the unpredictability of many human responses.” (p. xii). They may be unsure at which level to make an intervention—that of the group, the individual, and the present or past, either within or outside the group. Therapists worry that they might be abandoning their leadership role and
feel less important if members are making helpful interpretations or connecting empathically with one another. The setting is ripe for countertransference enactments, which may be demonstrated through increased competitiveness with members’ emerging leadership capacities or through withdrawal, as if punishing the group for making them feel less important. Therapists come to recognize these responses as attempts to stabilize their inner equilibrium and learn to monitor their responses in the service of understanding the treatment process.

Fourth stage: Ending

The members: Individuals whose treatments are deemed as successful are marked by a substantial strengthening of the self, one that no longer quickly complies or surrenders, that can reflect upon experiences and examine inner states and work to fulfill its goals and ambitions. Although possibly vulnerable to narcissistic injuries that may have emerged and been central to the therapeutic process, these individuals respond with greater resilience, less intense emotions and briefer disruptions. They have the capacity to search and utilize selfobjects throughout their life cycle.

Individuals who successfully complete their treatment have to say goodbye to colleagues, the therapist, and to their experience of the group-as-a-whole. Successful patients can justifiably feel pride in their accomplishments. They can be painfully aware that although they have learned a great deal and are better able to manage themselves and their relationships, they will still have to face the inevitable stresses and misfortunes of life. Members learn that in the future there will be circumstances when they will need soothing selfobject experiences.

Saying farewells are often bittersweet experiences. The entire group is impacted by a member’s announced departure. Previously unexpressed emotions may come to the fore and provide another opportunity to learn of self vulnerabilities and to strengthen the self. The departing person may experience others’ and their own sadness, envy, anger or intense affection. These emotions may be felt as disruptive but also provide an additional opportunity for strengthening the self. The departing person may mourn the loss of the selfobject function of the group. For those who remain, the groupself may be depleted. They may experience the group as deadened and not functioning as before the loss. In such groups, members may become familiar with their characteristic responses to loss. They will experience loss, not only of the individual, but also the selfobject provisions that person may have supplied. The members’ groupself may be depleted.

Not all departures are result of successful treatment. Abrupt departures, particularly of seasoned members, can be fragmenting to a self vulnerable to loss. Individuals who leave abruptly may be doing so as a self protective, self-stabilizing behaviour. A termination maybe foreshortened by a self that is vulnerable to the emotions of saying goodbye, and managed by making an active decision to hastily leave. The therapist may be left with the task of explaining the process to the remaining members, which can serve as a soothing selfobject function for their distress at being abandoned.

The therapist: Therapists also have the important task of saying goodbye and of continuing treatment with those who remain. When the individual has had a successful treatment, the therapist can feel pride in helping the person develop a self that is able, under ordinary circumstances and with the aid of appropriate selfobjects to pursue its goals and ideals (Kohut, 1984). Any successful therapy carries personal meaning for therapists, as does any meaningful relationship. Therapists need to appreciate that they narcissistically invest themselves into their work. Ending that endeavour with an individual patient is a very real loss, which is painful to the self. Therapists may appreciate that they, too, have changed on the basis of their encounters with the departing member. This realization may add to the sense of therapist’s satisfaction with the treatment.

In this emotionally charged period, clinicians may find themselves having participated in countertransference enactments. Many treatments are considered successful by the patient but do not meet the hopes or expectations of the clinician. In these circumstances, the clinician may not be able to engage wholeheartedly in the member’s departure. The therapist may inadvertently join the inevitable resistance to saying goodbye or misunderstand symptoms that emerge as patients reprise their difficulties by enacting their countertransference both before and after the person’s departure. Enactments are also linked to the therapist’s personal loss of a successful member and to the real loss of a portion of the group.
Difficulties in addressing and sorting out these losses may be compounded by the therapist's self vulnerabilities. Slight variations in managing the treatment frame can be clues to some of the therapist's less obvious responses. Presence of new somatic feelings or increases in prior sensations can be additional clues to the therapist's affective response to the losses. Consultation may be useful under these circumstances; the therapist, like a patient, is a vulnerable person who can profit from assistance from an empathic and thoughtful colleague.

**Concluding thoughts**

As noted in the beginning of this paper, a self psychologically informed clinician takes a fundamental position of empathy as a mode of inquiry with each patient. This presents an inherent difficulty: How can a therapist be empathic with an entire group of differing subjectivities without causing some to feel misunderstood? As with any such effort, we believe that the clinician needs to maintain an openness to his misunderstanding and misattunement. An ability to hear and appreciate patients who feel misunderstood helps create an environment of safety and a place where members can expose what they feel as less desirable or unacceptable aspects of their self.

The patient entering a group also is concerned with being listened to, understood and responded to. Patients enter with their habitual defenses, and, most importantly, subtle efforts to determine the extent of safety and the availability of necessary selfobject responses. The task is ongoing, non-linear, with forward and regressive phases.

As individuals work together, their ways of relating evolve, we suggest, in relation to an appropriate selfobject milieu. These phases have been traditionally described as group developmental phases. We have emphasized members' more prominent selfobject experiences as they become more fully engaged in the developmental phases. Concomitantly, we have noted the internalization of the group interactions as aspects of the groupself, which can deeply influence the overall sense of self. Across all group developmental levels, members acquire or strengthen portions of self that enable them to listen to others and to themselves. They have selfobject experiences with the others and with the image of the group as a whole that serve to consolidate and firm a self that can reflect upon itself and also experience and understand others as separate persons with their own needs, strengths and vulnerabilities. They can become empathic with themselves and with others.

No single theory can fully explain the observed phenomena. Self psychology emerged from a dyadic setting and has been extensively explored as applied to work with groups. We believe it enriches our understanding of group dynamics and development. We await future research that can add to our understanding of the complex relationship between the individual and the group.