Externalizing the wish for the secure base in the modern analytic group

Aaron E. Black

The author maintains that the modern psychoanalytic technique of joining to resolve resistances to progressive emotional communication can be understood with reference to attachment theory as stimulating the wish for secure attachment, which is seen as a critical maturational need. Here, the author presents a case example that illustrates how successful joining simultaneously resolves resistance—conceptualized as a symptom of insecure attachment—and arouses attachment dynamics. Aspects of attachment theory and motivation theory are reviewed to suggest that joining techniques in group treatment are especially effective when attachment-related intrapsychic conflicts are stimulated and worked through within the transference.

Practitioners of modern psychoanalysis know from clinical experience that the technique of "joining the resistance" is an effective tool when working with preoedipal conditions in group treatment. This paper suggests an additional mechanism of action that may explain the effectiveness of joining interventions with preoedipal resistances in the context of theoretical contributions from attachment theory. I propose that joining and bridging techniques of modern group analysis stimulate

the wish of a patient for a "secure base" within the transference and general treatment framework. A case example is used to demonstrate that in the context of an autonomy-supportive therapeutic relationship the repeated externalization of the inborn wish for the secure base is an important mechanism of action when joining and bridging techniques are combined.

Proponents of attachment theory and of psychoanalysis have been engaged in meaningful dialogue for a number of decades (Bowlby, 1988; Fonagy, 2001; Fonagy, Gergely, Jurist, & Target, 2002). Modern psychoanalysis, in particular, has much in common with attachment theory (Spotnitz, 1985; Meadow, 2003). Both theoretical traditions are keenly interested in the early, preverbal period of psychological development and its role in personality formation and psychopathology. Both theories recognize the critical influence of the emotional attunement of a child's caregiver on that person's later interpersonal functioning. Both modern analysis and attachment theory emphasize how barriers and resistances to emotional communication maintain the patient's psychological distress by preventing emotional development in the service of self-protection. Also, both theories emphasize the therapeutic value of recreating and reworking early, preverbal relationships within the transference-countertransference matrix. Despite these commonalities, attachment theory is a theory of emotional and interpersonal development while modern psychoanalysis is primarily a theory of analytic technique (Spotnitz, 1985). A thoughtful integration of these two perspectives might expand the available range of clinical formulations and interventions.

In practice, many therapists consider preoedipal deficits, narcissistic conditions, and disorders of attachment to be synonymous. Developmentally, the failure to form a secure attachment relationship with the primary caregiver contributes to the narcissism and preoedipal resistances with which modern psychoanalysis is centrally concerned (Spotnitz, 1985). Modern analytic methods for working with resistance are particularly potent when coupled with attachment theory, as the establishment of an internalized "secure base" is a prerequisite for functioning on an oedipal level, a treatment goal embraced by each theory. This paper examines how joining and bridging stimu-

late and interpersonally actualize the patient's unconscious wish for secure attachment. In addition, it explains how successful joining interventions support patient autonomy, which in turn, facilitates the internalization of new self- and object-representations. It is proposed that the repeated externalization of the inborn wish for secure attachment is an important mechanism of action when joining and bridging techniques are combined in the treatment of preoedipal resistances in modern group analysis.

Resistances to progressive emotional communication help to maintain adult disorders of attachment. As considered here, resistance is defined as deviations from the group agreement and goals (telling the emotionally significant story of one's life and putting thoughts and feelings toward the self and others into words as well as explaining why one has them, that is, progressive emotional communication). The group agreement generally involves the following parameters: Arrive to the group and pay on time; put feelings into words, not into action; take roughly an equal share of talking time; announce group absences in advance; refrain from eating and drinking; abstain from socializing outside of the group; maintain confidentiality; discuss major life decisions with the group in advance; talk about any feelings of wishing to end treatment as they become conscious. The group agreement and goals provide a useful framework for identifying preoedipal resistances. Brook (2001) offers this succinct description:

Modern psychoanalysts doing individual work concentrate on preoedipal conflicts and work toward helping the patient separate the self from the object-field of the mind. Modern group analysts also study resistances to oedipal-level functioning and to oedipal-level communications: "putting your thoughts and feelings toward the other person into words and explaining why you have them." Group members are more likely to put into words oedipal-level conflicts around achievement, success, rivalry, status, and competition. Yet this does not rule out treating preoedipal problems in the group. Preoedipal conflicts that interfere with oedipal-level functioning are addressed. The expectation of oedipal-level functioning sets a standard from which deviations can be studied. The study of noncompli-

ance with the group contract is the basis for resistance analysis in the group. (p. 16)

Thus, resistance in group therapy often manifests as behavioral noncompliance, which signals to the analyst that a preoedipal defensive process may be operating. Attachment-related resistances are motivated primarily out of fear of attack, abandonment, or engulfment. Within Rosenthal's (1987) taxonomy of group resistances, attachment-centered resistances generally emerge in the treatment process as ego or transference resistances. To further examine the interplay between modern analysis and attachment theory, we will explore a number of clinical examples from ongoing group treatment with a specific patient.

A case example

Allison is a 48-year-old health care professional who was seen in twice-weekly psychotherapy for five years before joining a modern analytic process group led by the author. As a child, Allison suffered severe emotional and physical abuse and neglect, including sexual abuse, perpetrated by both her mother and stepfather. The latter was a charismatic therapist (and pedophile) who forced the patient to participate in "therapy groups" that were little more than a cult of personality organized to gratify the group leader and allow him to identify female group members to seduce. The patient is the oldest of three sisters and engaged in an incestuous relationship with the stepfather partly to shield her sisters from his predatory attentions, and partly because of early attachment deprivation. This patient had enormous anxiety at the prospect of joining a therapy group and a great deal of individual work was required to prepare her for group, yet she recognized the potential benefits of facing her traumatic past as it would be re-stimulated in the group. Like most patients suffering from complex trauma, Allison displayed preoedipal deficits and resistances and disordered attachment within the transference. Symptoms of complex post-traumatic stress disorder and significant dissociation were evident when she joined the group; however, she had made much progress in the individual treatment toward their resolution. The individual therapy continued at once or twice weekly, conjoint to the

group therapy. The examples described here are drawn from different exchanges during the first year of the group.

Clinical vignette: Allison & Lisa

The following discussion took place during a group around the end of the second month. It was becoming obvious to the group that Allison was growing overwhelmingly anxious, nonverbally communicated by excessive fidgeting, almost squirming in her chair, and lack of eye contact. Seeing her regression and overstimulation, I engaged her as follows:

Analyst: [To the group as whole.] What do you imagine might be happening with Allison right now?

Lisa: I don't know, but I'm worried about her.

Analyst: What's worrying you?

Lisa: Well I noticed her seeming upset, and it made me think about how I am with my 6-year-old, how she sits in my lap, and when my attention goes to another adult or another conversation or something, my hand stays on her. She's on my lap and my hand's in her hair, sort of absentmindedly caressing her. She's nuzzled into me, so that she knows, even though I appear to be talking to someone else, with my attention elsewhere, she is still my baby. I am still with her, and she is still on my lap. And I'm guessing that's what Allison needs right now from you, Aaron [turning to Allison]. It's okay that Aaron is talking to us, the rest of the group I mean, and for us to be engaged with him, but I think you need some reassurance, just like my 6-year-old on my lap, that you're still special to him, that you have a safe, protected place with him. Is it okay that I am saying that? I'm worried that I'm being intrusive or something.

Allison: [She starts crying.] No, it's okay. I can't believe you just said all that. This is so weird. I'm afraid everybody is going to hate me for wanting too much. People here are going to think I am so crazy.

Analyst: Does anyone think Allison is crazy in this moment? [Members shake their heads.] Lisa, do you have any objections about Allison wanting that kind of connection with me in this group?

Lisa: Allison, I really want to help that little girl in you sit on Aaron's lap for as long as she needs to. I really want that for you.

I won't be mad at you at all! If I could, I would pick you up right now and put you on his lap myself!

Allison: [Visibly shocked by these comments, she starts sobbing, leaning over to hold onto her legs.] I don't understand. Why you would do that? Why would you do that for me? It doesn't make any sense. Nobody has ever done anything like that for me before. I don't understand. I don't even know what to do with that.

Lisa: Not only is it okay with me, but I need you to have it because it makes me so sad to think of you going home after group, sitting there and feeling sad and alone, not having gotten what you needed from Aaron.

Analyst: Allison, could you tell Lisa what you are feeling toward her that she wants you to have what you need?

Allison: [Still crying] I feel so close to you right now [turning toward Lisa]. My mother was so cold, so cruel. You have no idea. I don't ever remember her touching me being a good thing, you know? It always hurt somehow. I feel like such a baby right now [stated sarcastically as a self-attack]. But you are being like a mother to me, a kind one, and that feels really good, but it's scary too. I don't know if I can count on it, you know? When will all of this with you go away? How am I going to fuck up and get you to stop being so kind to me?

Analyst: But what are you feeling toward Lisa?

Allison: Oh, I am feeling so much love for her right now. So much! [I gesture for Allison to talk directly to Lisa.] I feel so much love for you, Lisa. You're being so caring with me. I don't know what to do with it but I really like how you are being with me. I bet you are such a good mother to your kids. They're so lucky. I wish I had had you as my mother!

Lisa: I feel that if you were my baby, I would take such good care of you. I really know how to do that. I would cherish you if you were my baby. What a beautiful baby, I would say to myself.

Allison: [Palpably less anxious, she starts sobbing again and slowly rocking.] Thank you. Thank you.

How can we understand what is happening in this clinical vignette? Clearly, Lisa helped Allison resolve a transference resistance (Rosenthal, 1987). Allison was afraid, because of toxic experiences in the past, of the group's recriminations if she revealed herself emotionally. Lisa's sensitive, almost uncanny, understanding about what was preventing Allison from freely

participating in the group helped to resolve a resistance by actively joining her suppressed wish for emotional contact with the group therapist. It is difficult to imagine that this touching interaction between Allison and Lisa could be fully replicated in individual treatment (particularly with a male therapist). In fact, without conscious knowledge of it, Lisa helped put into words one of Allison's self-soothing fantasies: Allison and I had agreed in advance, before she started group treatment, that she was "allowed" to imagine in her mind that a young, needy part of her could sit on my lap whenever she needed to do so in order to feel safe in the group. Resistance in group therapy carries an affective charge in the form of induced feelings (Ormont, 1974). It appeared to me that Lisa correctly interpreted her induced feelings, and she used her understanding to emotionally join with Allison's fantasy and feed it back to her in a modified form, more acceptable to Allison's mind. Allison's fear and subsequent regression disrupted access to her fantasy and its self-soothing function, just as a very young child loses her grip on object representations when threatened. It is worth noting in this example that, rather than intervening directly, I attempted to facilitate progressive emotional communication by bridging, a group analytic technique defined by Ormont (1992) as bringing into emotional contact two group members whose resistances complement one another in a clinically- significant way. Lisa, for example, was more comfortable tending to others than receiving attention herself. Had I focused my attention on Allison directly, the interaction between Lisa and Allison might well have been thwarted. In group therapy, interventions carried out by members are often the most effective, as this example illustrates. While these observations contribute to our understanding of this exchange, a more comprehensive explanation requires additional theoretical contributions from attachment theory and modern psychoanalysis.

The secure base in attachment theory:

Attachment theory (Bowlby, 1988; Ainsworth, Blehar, Waters, & Wall, 1979) was originally intended as an attempt to translate key elements of British object relations theory into observable, measurable constructs. These initial theoretical formulations

led to an explosion of empirical research that continues to this day. While space considerations preclude a thorough treatment of attachment theory, some essential elements of this developmental theory may be helpful to understanding why joining is so effective with preoedipal resistances. In attachment theory, mother and child are considered a self-regulatory dyad, the main purpose of which is to protect the child from external threats and in the process help the child manage overwhelming emotional distress. As soon as a child can physically move away from the mother and explore the world, the child must contend with an unpredictable, often frightening, environment that stimulates anxiety, fear, and rage. In this process, the mother is considered the "secure base" and the child uses her physical and emotional proximity to the mother as a way to regulate her own emotions, something her mind cannot do alone. Bowlby (1988) defined the secure base in this way:

> This brings me to a central feature of my concept of parenting—the provision by both parents of a secure base from which a child or adolescent can make sorties into the outside world and to which he can return knowing for sure that he will be welcomed when he gets there, nourished physically and emotionally, comforted if distressed, reassured if frightened. In essence this role is one of being available, ready to respond when called upon to encourage or perhaps assist, but to intervene actively only when clearly necessary. (p. 11)

For example, a toddler may leave her mother's side while visiting the park to go investigate a dog, all the while keeping an eye on the mother to locate her in case she is needed. If something startling happens, like the dog barking, the child runs back to the mother to manage the resulting surge of anxiety. The child's mind is not yet capable of regulating fear without external help. This primary attachment relationship is a dynamic emotional regulating system in which the child manages her emotions by increasing or decreasing her proximity to her mother. For this process to develop effectively, the mother must be reasonably calm and appropriately attuned and responsive in the face of the child's vacillating needs to seek connection and to explore her environment (Winnicott's "good-enough mother" [1958, p. 238]). Generally, this proceeds reasonably well and the child is considered to have a secure attachment

to her mother, the child's secure base. In fact, the secure base is eventually internalized as a both conscious and unconscious mental representation of a "good mother," which allows the child to feel relatively safe when away from the actual mother herself. The mere idea of the mother and the knowledge that she can be accessed begins to serve the child's ability to regulate her emotions. This internalization process is elaborated over time into the development of internal working models of relationships in adulthood (Crespo, 2012).

Sometimes, however, the attachment relationship does not develop adequately. When mothers are neglectful, abusive, overly narcissistic, unpredictable, or intermittently responsive, an insecure attachment develops. The classic experimental design called the "Strange Situation" (Ainsworth et al., 1979) is a method by which clinicians and researchers have been able to identify secure vs. insecure attachments in toddlers around 12 to 24 months old. This procedure creates standard scenarios, which are mildly stressful for the child, meant to activate and observe the resulting attachment dynamics. Researchers evaluate four categories of behavior including separation anxiety, willingness to explore, stranger anxiety, and reunion anxiety. When a secure attachment is stimulated, the child generally moves closer to the mother and often makes physical contact with her, lingering there until the child again becomes comfortable with her surroundings and returns to exploring the room. Thus, the securely attached child regulates her distress by making contact with the responsive mother and is soothed in the process. For our purposes, it is important to note that in secure attachment relationships more generally, the mother is able to absorb and metabolize the child's aggression, for example, hitting, biting, physical struggling, without retaliating or abandoning the child. This suggests that for securely attached children there would be less need to direct aggression against the self to preserve the relationship with the parent (Spotnitz, 1985).

The strange situation validates modern analytic knowledge: The preoedipal child's mind has not yet developed the ability to regulate emotional distress on its own. Rather, a child's self-regulation depends upon predictable, soothing participation

by the mother. When faced with stress, the insecurely attached child may respond by moving farther away from the mother, crying but remaining in place, becoming angry and hitting a toy, moving toward the mother and attempting to hit her before moving away again, ignoring the mother altogether, or relying upon dissociation and other reality-altering defenses (Ainsworth et al., 1979). Thus, the insecurely attached child must depend upon the mechanisms of her own mind in place of the mother. From an attachment theory perspective, the child's inability to access a safe, reliable secure base to soothe emotional distress leads directly to the formation of alternative self-regulatory strategies that manifest in treatment as resistance. It is useful for the modern analytic group leader to remember that attachment seeking is initially expressed through non-verbal behavior and pre-linguistic vocalization, such as crying and other sounds that signal distress and need. The use of language to seek attachment generally develops after the age of 2 years. Likewise, preoedipal resistances often manifest in group therapy via channels of communication outside of the use of language. In essence, we may think of the interaction between Allison and Lisa as the symbolic mother recognizing the child's distress through non-verbal communication and inviting emotional proximity in order to jointly metabolize the overwhelming negative emotions. In modern analytic terms, Lisa helped Allison resolve a resistance. In attachment theory, Lisa facilitated Allison's wish for, and contact with, a secure base.

Joining the resistance

Modern psychoanalysis has long recognized the value of joining, rather than attempting to confront directly, preoedipal resistances. Margolis (1986), Spotnitz (1969), Ormont (1974), Meadow (2003), Epstein (1977), and others have all written cogently and persuasively about the fact that interpretation is typically ineffective and often harmful when working with preoedipal self-states because preoedipal resistances arose as protective mechanisms before the development of language. The patient's psychological survival depended upon a very primitive defense, and attempts to alter it prematurely can lead to its intensification, malignant regression, and an increase in treat-

ment-destructive resistances. Joining interventions are attempts to relax the mind's tenacious hold on a resistance by communicating that the analyst appreciates that its function has been critical to the patient's psychological survival. Joining may thus act as an invitation to collaborate in coming to know the patient's inner world more fully by safely investigating the history, nature, and value of the resistance. Preoedipal resistances, by their nature, are often characterized by emotional discharge in the form of action rather than words. Thus, the joining intervention is thought to be successful when it facilitates a shift from feelings experienced as diffuse emotional or bodily sensations to be discharged non-verbally, to feelings as mental representations that can be discharged through language. The process of joining the resistance continues until the patient is able to discard the resistance in favor of more mature and satisfying levels of psychological functioning. Findings by Kinley and Reyno (2013) support the effectiveness of this type of joining strategy in facilitating positive changes in adult attachment style during a short-term psychodynamic group therapy intervention. In this study, the authors note the value of interventions that highlight resistance to feelings, rather than traditional interpretation, as a primary clinical tool.

The essential elements of a joining intervention involves active support, and often magnification, of a resistance and can be ego-syntonic (ego-supportive) or ego-dystonic (ego-aversive). The intervention combines an overt acknowledgement of the manifest content and a specific emotional tone that resonates with the resistance. When the content and affect are integrated effectively, a resistance can be resolved by meeting the patient's latent maturational need, as well as returning induced affect to the patient in modified form. By overtly aligning with the patient's resistance and underlying need for safety, the analyst is linking an object experience directly to a specific developmental deficit within the patient's mind. This process stimulates progressive emotional contact with the patient in the very heart of the resistance. In group therapy, such an intervention may be made with an individual group member or the group as a whole; it may also be facilitated between group members. In the previous example, Lisa recognized accurately that Allison's

mind was consumed by a resistance that was preventing her from verbally engaging in the group process. Through Allison's non-verbal cues, Lisa recognized the nature of her resistance: Allison needed contact with me in order to feel safe enough to participate in the group but expected to be punished for this very need and was trying to suppress it. In addition to helping Allison put her thoughts and feelings into words (instead of non-verbal action), Lisa co-opted Allison's need as her own, thus by-passing Allison's self-attack and legitimizing her feelings. Most importantly, Lisa conveyed a warm and loving tone in talking with Allison. This was the feeling that Allison missed from her own mother, that is, an abiding love and responsiveness to her deepest needs for emotional contact. It was the emotional tone itself that appeared to resolve this resistance, as distinguished from the actual content of what was conveyed. Allison openly identified the "foreignness" of receiving this feeling from Lisa and, while she probably only internalized one percent of the exchange, it was enough to resolve a resistance to putting her feelings into words.

As we have established, preoedipal resistances develop as a self-regulatory function, allowing for the modulation of emotional distress when a secure base is unavailable. In the modern analytic group, preoedipal resistances to the group contract and goals serve precisely the same purpose: to regulate painful negative affect and anxiety without having to rely on the verbal participation of another person. Allison initially expressed her emotional distress by engaging in action—squirming in her chair— rather than words until Lisa intervened. In this case, Lisa joined both with Allison's suppressed wish for contact and her resistance, which manifested in her non-verbal communication. It was at this point that Allison was able to discharge her fear in a way that created a new sense of agency in seeking out what she needed from the analyst (a maturational need that had been frustrated when she was a child) and also in a way that received long overdue mirroring within the group process. In early childhood, preoedipal resistances take shape in order to modify emotional distress; however, emotional self-regulation develops most effectively through engagement with a caregiver, the secure base. In other words, preoedipal resistances are the

mind's way of filling the emotional void created by the failures of the original object.

The drive to establish a secure base (object seeking) is considered an inborn, biological, genetically-based need, which contributes to the survival of species in which offspring are born helpless (Bowlby, 1988; Ainsworth et al., 1979). Since resistances emerge from insecure attachment relationships, it is the author's contention that most preoedipal resistances have embedded in them an unconscious wish for the missed secure base, and the unmet maturational needs associated with this developmental failure. Consistent with the concept of insecure attachment, preoedipal resistances can be thought of as attempts by the child's mind to fill in the gap created by unreliable caregiving. As such, the child has established a libidinal connection with aspects of her own mind as a substitute for a reliable external object. This explains, in part, the narcissism observed in preoedipal conditions, as well as a unique form of the narcissistic defense, that Spotnitz (1985) describes as the tendency of the preverbal child to direct aggression against the self and internal objects to preserve the relationship with the parent on whom her survival depends. Within insecure attachment dynamics, anger is not simply directed at the self. In addition, aggression is directed at the very needs and self-representations for emotional safety and soothing that are ideally met by a secure base. Thus, this particular form of self-attack disrupts the natural, inborn impulse to seek out a secure base which, in turn, protects the mind from the effects of additional object failures. In treatment, it also serves to maintain resistances to painful unconscious affects and memories associated with past object failures. In essence, the resistances themselves are the patient's attempt to compensate for the lack of an internalized secure base. Intrapsychic reliance on these resistances and their associated internal objects mirrors the early insecure relationship with the attachment figure. Thus, an essential interpersonal developmental process has become embedded in the person's mind as a stalled intrapsychic process because of the absence of an object responsive to a person's drive. Within the group process, this form of the narcissistic defense is evident, for example, when a member refuses to voice needs, has secret wishes

to be rescued, feels shame when receiving attention, alternates between help seeking and help rejecting, fears retaliation or attack after taking an initiative, or adopts a paranoid position in order to justify withholding participation. The treatment objective is to reverse this process by creating moments of emotional security with an object, rather than the self. As the unconscious wish for the secure base is reconstructed interpersonally in the group process, the patient is invited to grieve the original loss and resolve resistances to the progressive emotional communication central to creating secure attachment in adulthood (Mikulincer & Shaver, 2012).

Like the strange situation, emotional threat and security are each available in a therapy group. The group's inherent power creates anxiety in the members and reveals various resistances to address this anxiety. When the therapist joins with the resistance successfully, several important things take place. As other writers have noted, the therapist and patient are creating an alliance around the patient's psychological safety and survival. This alone is useful clinically. Another important element of this intervention is that it facilitates externalization of the patient's unconscious wish for a secure base, this time within the group process. Stated differently, joining the resistance can be thought of as a technique that revives a frozen, intrapsychic process, i.e., reliance on preoedipal resistances, within an interpersonal framework. In a play on Ormont's (1990) notion of bridging, one may think of joining the resistance, when working with attachment dynamics, as "bridging to the secure base." By actively aligning with a patient's resistance and corresponding need for emotional safety, ego-syntonic joining opens the mind to attachment-seeking impulses thereby stimulating the wish for the secure base. Bridging actualizes the wish interpersonally through the strategic pairing of group members or with the therapist. Through these means, a critical developmental deficit becomes accessible within the therapeutic process.

The positive effects of this externalizing process are not simply limited to helping the patient move from narcissistic self-absorption to object relatedness. When a moment of secure attachment is created within the group for the preoedipal patient, however temporarily, that member must contend with

new, unfamiliar feelings associated with having their negative emotions modified in connection with another person's mind. The patient then starts to learn that his own mind cannot provide the same emotional nutrients for itself as those created through engagement with a responsive object. Preoedipal resistances are characterized and maintained by active avoidance of exactly this type of contact. In preoedipal self-states the patient literally does not know what else is available beyond the self because as a child self-reliance was the most effective method for regulating his emotions. Thus, joining resistance (and bridging) is an effective intervention when it repeatedly externalizes and interpersonally reconstructs the wish for the secure base. This allows access to previously repressed memories, needs and affect, including grief, and a re-working of failed early attachment relationships.

Relating well to a toddler requires sensitivity to the delicate balance between supporting the child's freedom to explore the world and recognizing the need for emotional contact with a caregiver. To function as a secure base, a parent must relate successfully to the child's vacillating needs for separateness and merger, much like the concepts of "demand feeding" (Meadow, 2006) and the "contact function" (Margolis, 1983) in modern psychoanalysis. In this regard, attachment-facilitating parenting and modern analytic methods for addressing resistance share an important relational element: Both provide active support for the child's/patient's autonomy. In the context of psychotherapy, Deci & Ryan (1985) define "autonomy support" as the therapist's active support and facilitation of the patient's autonomy and autonomous self-regulation. Autonomy, in this context, should be distinguished from independence. For our purposes, autonomy describes the extent to which behavior is motivated by feelings, needs, desires, and beliefs that emanate from one's integrated self, meaning that one is wholly identified with the psychological basis of one's motivation. The motivation may be conscious or unconscious. Autonomous motivation is characterized by a sense of freedom and personal ownership. This stands in contrast to behavior motivated by external pressure—reality demands—or internal pressure, such as internalized parental demands, cultural mores, religious dogma,

etc., that are not completely endorsed by the self but operates within the mind as an introject. In contrast to autonomy, independence is defined by the relative balance of one's emotional reliance on, and psychological boundaries between, self vs. others. The distinction is important because the internalization of new object representations is maximized when joining and bridging interventions simultaneously meet patient needs for autonomy, competence, and emotional relatedness to others (Deci & Ryan, 2008a). Empirical findings, for example, have demonstrated that autonomy-supportive psychotherapy interventions are more likely to facilitate patient identification with, and integration of, emotional development in psychotherapy and to allow patients to maintain these treatment gains over time (Deci & Ryan, 2008b).

Autonomy-supportive parenting partially defines secure attachment relationships. Likewise, an autonomy-supportive therapeutic alliance is critical to effective psychotherapy. Deci and Ryan (1985, 2008b) suggest that successful psychotherapy is characterized by the therapeutic relationship facilitating patient movement from external/introjected forms of motivation to more autonomous and intrinsic forms of motivation, with concomitant reductions in the symptoms of emotional distress and the internalization of new psychological structures. In modern psychoanalysis, resistance is seen to constrict consciousness and emotional freedom, in the service of self-protection, which interferes with progressive emotional communication. Resistance can also be considered an introjected (that is controlled) form of motivation that limits curiosity and intrinsic motivation in treatment. An autonomy-supportive treatment relationship is therefore critical in facilitating changes in motivation and emotional self-regulation from less to more integrated forms (that is, integrated within the self of the patient). The modern analytic interventions of joining resistance and bridging are more likely to be effective when they are experienced by the patient as autonomy-supportive, instead of controlling, impinging, neglectful, or otherwise misattuned. This view is consistent with attachment theory as well, and suggests that autonomy-supportive joining (and bridging) is more likely to externalize the patient's wish for a secure base in the therapeutic process, and to

help the patient internalize the emotional nutrients found in this experience (Deci, Eghrari, Patrick, & Leone, 1994; Ryan & Connell, 1989; Ryan, Plant, & O'Malley, 1995). The following examples further illustrate autonomy-sensitive joining and bridging techniques in modern group analysis.

Clinical vignette: Allison & Tim

The following example takes place in the sixth month of the group. After the group's first extended discussion of sex, Allison, sitting directly to my left, is growing increasingly uncomfortable and has lost eye contact with the group while slowly slumping down in the chair as if closing in on herself. I have been deliberately ignoring this as I want to avoid making contact with her non-verbal communication directly, knowing that a group member will eventually comment on it.

Tim: Hey Allison are you OK? You look a little upset.

Allison: [Ignoring Tim and turning to me] I'm going to leave. I just need to get out of here. [She sits forward in her chair as if to get up.] I'm gonna go, OK?

Analyst: Why do you want to leave right now?

Allison: I can't take all of this talk about sex and crap. It's making me feel awful. I just need to get out of here. Would you try to stop me if I just need to get up and go? [With a defiant tone, as if setting up a confrontation] Would you do that to me?

Analyst: Well I would never physically try to stop anybody from leaving during group. But more than whether you stay or go, I'm interested in the feelings that you'd be leaving behind. Can you tell us more about the feelings you want to get rid of?

Allison: No [long pause]. I don't know. I feel terrible, just awful. If we keep talking about sex, you might want to do something sexual with me or might want me to do something sexual with somebody else in front of the whole group while everyone just watches, like I'm the entertainment. And I don't want to! I am not going to do that, do you understand? I am NOT going to do that [stated emphatically]! I know you keep saying feelings and behavior are two different things, but they feel the same to me. Exactly the same. One leads right to the other. There's no stopping feelings. Don't you get that?

Analyst: I do understand, but I also see a problem here. If we're all trying to put our thoughts and feelings into words and you

act upon your impulse to leave, doesn't that invite other people here to put their impulses into action too? If that happens, won't things ultimately be less safe here for you and everyone else?

Allison: [She dismisses my observation.] You're just trying to keep me here, and it's just making me feel worse. What do you want from me anyway?

Analyst: What am I wanting from you right now? [I do not wait for a response in an attempt to mirror her dismissal of me, and I turn back to Tim, the physically largest male member of the group to create a bridging intervention.] Tim, I have the idea that Allison is feeling very frightened of me in this moment. What would you do if I got up out of my seat and tried to touch her in some way?

Tim: I would stop you. There is no way you'd even lay a hand on her. Not in any group that I am in, anyway!

Analyst: And how would you stop me?

Tim: I'd tackle you from the side and hold you down until Allison was able to escape.

Analyst: But I'm pretty strong. I mean, what if you had a hard time holding me down? What would you do then?

Tim: I wouldn't want to, but I'd punch you if I had to. I'd do anything to keep you from hurting Allison. Anything.

Allison: Would you really do that? [She is notably calmer now.] Nobody ever stands up for me. Ever. My own father basically handed me over to my stepfather (her abuser). He never gave it a second thought.

Analyst: What are you feeling toward Tim right now?

Allison: Oh, I feel so protected and cared about. Thank you so much for that [to Tim]. I get the feeling that you really would stop him [the therapist]. That's awesome! [She laughs.]

Analyst: And how is your need to leave the room now?

Allison: Well if you promise that we are just going to be talking, I guess I can keep talking too. But can I change the subject to something else? I've had enough of the sex talk for one day.

In this example, Allison is experiencing a moment of impulsivity within group as she does in her life. She is tempted to act as a way to deal with her anger and anxiety. Like the distressed insecurely-attached child, she immediately considers unilateral action as the only solution to her emotional distress. Here, I

gently remind her of the group agreement and encourage her curiosity while using a bridging strategy—bridging to a secure base—with another group member to generate protection of, and support for, Allison's overwhelmed ego functions. Several important elements appear collectively at work in this example. First, Allison was able to put into words her sense that I was a threat by my supporting the talk about sex and "trying to keep" her in the room to hear it. Second, by indicating that I would not stop her from leaving the room and inviting her to embrace talking over acting, I implicitly supported Allison's autonomy and joined her resistance. I also let her know that if she acts on her feelings, then others might act too, and the group would become an "acting group" instead of a "talking group." Third, by bridging with Tim, I indirectly joined Allison's resistance, that is, supporting her sense that the group was unsafe and that she required protection or the ability to escape either literally or via dissociation. This intervention validated Allison's fear and need for protection, put her in contact with a responsive object, and thereby eliminated her need to protect herself through unilateral action. Perhaps most importantly, Allison was able to experience something unfamiliar: a man wanting to protect her, instead of exploit her, which allowed her emotional distress to be modified through relatedness instead of through her familiar resistances, in this case acting rather than talking. Finally, it should be noted that when I asked what she felt toward Tim, Allison responded by sharing what she was feeling inside of herself but not toward Tim. Thus, Allison was positively affected by the soothing function of the object but demonstrated little awareness of Tim as a separate person with his own subjectivity, just as a small child is soothed by the secure base but is unaware of the caregiver's subjectivity (Fonagy, 2001; Fonagy et al., 2002).

The primacy of emotional communication within modern psychoanalysis (Meadow, 2003) is consistent with the attachment theory emphasis on the attachment dyad's function as the emotional regulator for the preverbal child. Both recognize the role of the object in facilitating the child's ability to regulate and metabolize overwhelming affect. Attachment dynamics within group treatment often involve primitive induced feelings of fear

and anger in the therapist and the group members (akin to the "fight or flight" response). When insecure attachment dynamics are re-created within the transference, the therapist will often experience fear and anger as induced feelings. It is helpful to carefully study and make use of such induced feelings in crafting interventions to resolve such resistances (Zeisel, 2009). For example, when Allison suddenly expressed her desire to get out of her chair and leave, I was struck by feelings of fear and irritation. I felt afraid that if she were to act so impulsively in such a young group, the entire group might face an existential risk. At the very least, I was fearful that she would be scapegoated. In addition, I felt angered by her challenge to the group agreement and her threat of abandonment, which seemed like an indirect attack on me. She was, in essence, communicating that if the group did not "behave" by ending the conversation about sex, she would punish us with abandonment. I was able to contain and examine these feelings long enough to realize that she was probably acting out her abusive maternal introject and treating the group as a whole as she had been treated. Thus, I began to think of the induced feelings as those that Allison likely had, but could not express, as a preverbal child. By recognizing these feelings, I was able to speculate about which maturational need had been frustrated in her development (Ormont, 1984). Through the induced feelings, I understood that Allison needed to feel worthy of protection, and this was the basis of a bridging intervention, with Tim serving as the secure base. I would also consider this an indirect way of joining her resistance. Rather than confronting or challenging her wish to flee from the threat within the group, I supported her autonomy and used my awareness of the induced feelings to acknowledge that she felt afraid and threatened, which helped her to regulate her feelings through her contact with an object (Tim) instead of sole reliance on her resistances.

Clinical vignette: anger in the group

The following exchange takes place during the seventh month of the group. Allison, who typically sat immediately to my left, arrived late and sat across from me on the couch. Stephanie, sitting immediately to her left, was the one member of the group

at that time who had freely expressed negative feelings toward the group leader. A somewhat lively discussion had been taking place about anger and conflict in the group, and whether there was enough "room" to express these feelings in the group. I was being fairly active in the process, trying to stimulate as many members to participate in the discussion as possible.

Allison: [Addressing the therapist] I don't know who you are right now. I don't like this at all. You seem really full of yourself, like you are just pulling everybody's strings and getting us to dance to the tune you want us to. Why are you doing that?

Analyst: Why do you imagine I am doing that? What's going on with me?

Allison: I think you want everybody here to love you and to tell you how great you are.

Analyst: Who wouldn't want that? That sounds wonderful!

Allison: Yeah, maybe, but you aren't going to stop there.

Analyst: Where am I going to stop?

Allison: You're not going to stop at all.

Analyst: What does that mean?

Allison: You don't just want love; you want lots of other things too. You want everything from us [pausing]. I feel confused. I can't tell the difference between you and him [in reference to Sam, the stepfather, whom the group knew about]. I'm starting to feel stupid. Why did I open my stupid mouth? I'm saying way too much.

Analyst: [Turning to Joe, the man to her right] Joe, how is Allison doing right now? Does she seem stupid? Is she saying too much?

Joe: Oh my God no! [Addressing Allison] I think you are doing great. Really great. I love hearing you talk to Aaron that way. Is there anything I can do to help you keep going?

Allison: So you don't think I'm being a jerk or anything?

Joe: No no. Keep telling him what you need to say. . .

Allison: I can't remember where I was.

Analyst: You were starting to tell me about all the things I want for myself from the group.

Allison: Right. [Pause—she starts to tear-up.] I know I am confused OK? I know that. You know that, right? [I nod.] I feel like you don't just want love. You want adoration and power. From all

of us, no matter what it costs us. We even have to pay you! And you want sex. Lots of sex. You want all of the women here, all to yourself. And you would feel so good. You'd get to do whatever you want to us. And our job is just to make you feel great about you. And you get to do anything you want here. You get to feel all-powerful. We won't even be able to do anything about it. We just have to go along with you or else.

Analyst: Or else what?

Allison: Or else something bad will happen. Somebody will get hurt. I don't want anybody to get hurt.

Analyst: [Addressing Stephanie, to Allison's left] Stephanie, what do you make of all of this?

Stephanie: [Addressing Allison] Well I agree with Joe. I think you're doing an amazing job talking to Aaron. I wish I could talk to him like that.

Allison: I don't know what you mean.

Stephanie: I was just writing about Aaron in my journal last night. I was saying that he seems so nice on the surface, but I don't trust that at all. There's something threatening about him underneath all the therapist-y stuff. Like he's just using "being nice" just to set me up for the attack. I even called him an "assassin" in my journal.

Analyst: I can be very dangerous sometimes, especially when I want so much, when I am only interested in getting what I want and nothing and nobody else.

Steve: I am getting really annoyed. You [referring to Stephanie] are being so hard on him [analyst]. Don't you think calling him an assassin is a little extreme? This is ridiculous! Why are you here in the first place if he is so terrible?

Analyst: [Turning to Steve] I think Stephanie's being very courageous actually. What she's saying is hard to say. Right now, in this moment, to her, I'm an assassin. Twenty minutes from now she might feel differently, but that's how she sees me now and she's doing a fine job putting those reactions into words. Your feelings in this moment might just be different, that's all.

Allison: I think you're being awesome [addressing Stephanie]. I can't believe you called him an assassin! That's so great. Nobody ever would have talked to Sam [the stepfather] that way. Nobody was allowed to get angry. Just him. If they did, he'd go silent in the group, or he might yell and kick them out of the group. But later at home, he'd get drunk, and sometimes he'd say that he was

going to kill himself. He had guns you know. My mom would send me to him because she said I was the only one who could calm him down. That was my job, to calm him down. It was so scary.

Stephanie: Hearing that about him makes me wish he'd killed himself. I wish he'd just done it already and left you alone, the fucker.

Analyst: [Turning to Steve] Steve, what are Allison and Stephanie doing for the group right now?

Steve: I really don't know, but I can see that they're being brave to talk like this.

Analyst: Why do I have the idea that Allison and Stephanie are making the group safer for everybody?

Steve: I guess I see what you mean. Like they're making sure you don't get away with anything.

Analyst: Exactly. [Turning back to Allison and Stephanie] I wonder if the two of you would be open to something? [They each nod.] I'd like the two of you, together, to keep a close eye on me. Like a team. Whenever you see me trying to exploit somebody here, I want the two of you to bring it to the group's attention. Call me out on it. It's important that you not let me get away with anything in this group. Is that something the two of you would be willing to consider?

Stephanie: [Turning to Allison] See what I mean? He's doing it right now! This is what I'm talking about. He's seems all nice and everything, but he could be full of shit, right?

Allison: He could be. It's true. But Sam would never have said anything like that to one of his groups. [Turning to me] I like that idea, but especially because it includes Stephanie. I don't want it to be my responsibility by myself. I took care of my sisters, but they never really helped me. They were too young. [Turning to Stephanie] Can we do that, what he said? I think I can trust that you won't let him off the hook, no matter how nice he seems. I have a hard time with that, you know? I let him off the hook too easily I think.

Stephanie: Sure. I'd like having that kind of project with you. I'd be happy to be your sister here, especially if we get to gang up on him [pointing to me].

Analyst: Allison, you and Stephanie are helping us know that a group where the leader's power is unchecked can be a very dangerous place.

In the third example I utilize more direct interventions, including a combination of object-oriented questions, joining interventions, active support for (and even protection of) the negative transference, and bridging. In this case, Allison is experiencing me as she did her abusive stepfather, as an authoritarian, grandiose, sexual predator. Repeated joining interventions over many groups helped Allison finally put this transference into words during a group session (though she had done this repeatedly during individual sessions). In this case, I deliberately sought out a bridging intervention with another member of the group who had been the most comfortable expressing negative feelings toward me up to this point in the group's life. No attempt was made to correct or challenge the negative projections and assumptions of either Allison or Stephanie; rather, their perceptions and feelings were joined and investigated. In fact, my only challenge was to a group member's attempted confrontation of Stephanie for calling me an assassin. In this interchange, a secure attachment was established (and protected) between Allison and Stephanie, while I was considered a threat. The bond between Allison and Stephanie allowed for expression of their shared negative feelings and suspicions about me in a constructive, progressively emotional way. From an attachment theory perspective, Stephanie aided Allison in her ability to contain and verbally express her aggressive feelings, as is the function of the secure base. From a modern analytic perspective, Allison was able to direct aggression away from herself toward an object, which shows progress in modifying the narcissistic defense.

Clinical vignette: Allison's dream

During the ninth month of the group, Allison relayed the following dream to the group:

> **Allison:** So the dream starts right here in Aaron's office, and we are all sleeping. Even you [pointing to me]. And I wake up and see that everyone is asleep and feel really weird, like "What's going on here? Why is everyone asleep?" So I sort of get up quietly and sneak out of the room. Then, I'm standing by my car parked on a dock on a lake or something, with all of my belongings somehow stuffed into the car. The next thing I know, I'm walking on the dock toward the land, and I suddenly notice that I have no shirt

on. I feel really self-conscious and exposed all of a sudden when I realize that I am topless, but then Tim appears with a blanket and covers me up, and I felt so much better. Like I am safe. Then I woke up.

The disclosure of the dream led to the following exchange:

Tim: I'm so glad that I'm the one that covered you up. I love the idea of being able to protect you and be there for you, you know? I feel so happy that you think of me that way.

Allison: I liked that you were in my dream that way too. It's like you help me be safe in the group. Like I know you're looking out for me. It's such a good feeling for me. Nobody ever did that for me when I was little. It was always just me, all by myself, always trying to figure it all out. [She notices that Jennifer is starting to cry.]

Hey, what's the matter? Why are you getting upset?

Jennifer: I feel really bad saying this, but my feelings are hurt that I wasn't in your dream. I feel really close to you, and we have this special connection in the group—you even said so—but in your dream, it's like I don't matter to you. I'm not even there. I want to be someone you can turn to when you need to feel safe. I guess I want to feel trusted like you trust Tim. I feel so jealous that you can count on him like that. But what if I need you too sometimes? Maybe you are only going to be there for Tim, because he's the one you want protecting you? I feel like maybe I shouldn't count on you or something when I feel threatened here.

Allison: Are you sure that you want me to be the one who protects you? I mean seriously, I spend more time being frightened and anxious than anybody in this group! I'm such a baby! Who am I to protect you?

Analyst: Well that may be, but I think Jennifer is asking you if you have the desire to protect her, to be there for her? If you'd be willing to put yourself on the line for her, if she needed you, like she wants to do for you?

Allison: Oh I would want to do that for you. Of course I would. I protected my sisters from Sam for all of those years. If you needed me, Jennifer, I would do my best to be there for you. I care so much about you! I could never just sit by and let somebody hurt you.

Jennifer: That feels a lot better to me to know that. I'm really glad that you said so [pause]. I'd like to be included in your next dream please. Can you arrange that?

Allison: Absolutely!

Allison's dream is worth considering in more detail. From an attachment theory perspective several elements of clinical progress appear relevant. First, there is the initial representation of the sleeping group and group therapist. Allison's associations to this dream element helped her come to the idea that her mind "put the group to sleep" to protect her from the group's sexual and aggressive feelings that cause her so much anxiety. Her idea was that she wants to "put to sleep" certain parts of her mind that also contain these feelings. She seemed surprised that in the dream I was asleep too. I understood this, but did not say so, as a way of her telling me that, in her mind, I have become just another member of the group whereby I can "be there" for her or fail her, just like anyone else. I considered this to be evidence of progress in deconstructing a longstanding defensive idealization in her transference, that is, when in distress, she could seek contact with me only if she considered me to be infallible. Being able to seek contact with an imperfect therapist, who represents all imperfect people, was an important step in her development. Although Allison shows progress in relating to me as a more complex object with both positive and negative qualities, the group thought the "dock" in her dream supporting her car and all of her belongings represented her "doc," supporting her unconditionally. In attachment theory, this would represent at least partial internalization of the therapist as a secure base: a stable, emotionally soothing object representation. Allison strongly resonated with this idea, and then went onto say that she was standing on the "dock" when Tim put the blanket around her naked torso. This suggested that the security within the therapeutic relationship is successfully being transferred by means of the group process to another member, and the group as a whole. While one could make the argument that the interaction with Tim within the dream is simply wish fulfillment, Allison's affect communicated a sense of calm and peace that suggested deeper changes to her internal life. This appeared to be evidence that the joining and bridging interventions, over time, had been bearing fruit.

The group's overall reaction to the dream is worth discussing, as well. As representations of unconscious processes, dreams told aloud are by definition perilous and vulnerable aspects

of one's experience. The very fact that Allison disclosed this dream was a sign of an increasingly secure attachment to the group as a whole. Their sensitive treatment of her emotional process while offering their collective associations to her dream was especially touching to Allison. In addition, Jennifer's tears in response to being "excluded" from the dream invited Allison to consider her importance as an object to be sought out instead of being the attachment seeker herself. This represents an important shift from a narcissistic position of *seeking* an object for self-soothing to *being* the object that provides emotional soothing to the other. According to attachment theory, as well as psychoanalytic theory, the recognition of the object as having a separate subjectivity from one's own is a crucial developmental milestone (Bowlby, 1988; Fonagy, 2001; Fonagy et al., 2002). In insecure attachment relationships, this ability is generally impaired. Modern psychoanalysis correctly recognizes that these early developmental deficits are recreated and accessible within the narcissistic transference (Spotnitz, 1985). The interaction between Allison and Jennifer represents, in modern analytic terms, further differentiation of the self and object fields within the mind and movement toward the resolution of a narcissistic transference (Margolis, 1979).

Discussion

Several caveats are worth noting when considering the clinical material reviewed here. The clinical vignettes create an illusion of a linear progression. As Levine (2011) explains, progression and regression are inherent, critical elements of the group treatment process. Emotional gains are made, lost, and rediscovered. Also, it is important to consider that the inevitable frustration of the wish for the secure base, as with any wish, is as clinically useful as its temporary gratification. I have emphasized the utility of modern analytic joining and bridging as ways to externalize and gratify the wish for the secure base. However useful, this strategy alone is limited. First, the experience of the secure base in treatment is always temporary and transient. Allison may have had moments of emotional security that were novel, compelling, and healing; however, she was also faced with having to "lose" these attachments as well. The loss of the

secure base in group, like the loss of the good object, allows for the re-stimulation and working through of the powerful, underlying grief involving the original object (Kirman, 2004). A patient's attempt to "hold on" to the secure base often devolves into a status quo resistance. Second, the essential quality of secure attachment in childhood is the ability of the relationship to regulate the child's negative affect. Likewise in treatment, the frustration of the wish for secure attachment (which is inevitable in a group) creates negative feelings such as anxiety, shame, rage, guilt, and fear. When metabolized through progressive emotional communication, feelings associated with non-traumatic failures and frustrations within the transference may also promote the internalization of secure attachment relationships. While missed developmental milestones are rarely fully reconstructed in later life, personality maturation advances when patients experience the "right" feelings in treatment, and there are multiple pathways to that end.

The concept of autonomy-support (Deci & Ryan, 1985) is particularly important when trying to understand the process of internalization within group treatment. Preoedipal resistances, by definition, tend to be compulsive, automatic strategies for regulating psychological equilibrium. It is their rigid, compulsive nature that often causes adjustment difficulties for the preoedipal patient. Through emotional induction, resistances invite similarly compulsive, controlling responses from others, including therapists. The therapist's effective management of the induced feelings is central to creating effective interventions (Zeisel, 2009). When joining and bridging are autonomy-supportive, patient needs for autonomy and relatedness are met simultaneously and internalization is facilitated. In the clinical examples reviewed here, interventions were constructed in such a way as to allow patients to have a felt sense of choice and freedom. Pressure to conform or "behave" was minimized. All feelings and perceptions were taken seriously and engaged with meaningfully. For example, Allison's objection to the treatment frame when she had the impulse to leave the room (Clinical Vignette: Allison & Tim) was investigated rather than challenged too directly. As Allison stated so articulately in the first clinical example, patients often do not know "what to do" with unfamil-

iar emotional experiences in group therapy. Such moments can be deeply uncomfortable and disorienting. In modern analysis, we know that there is great therapeutic value in helping the patient tolerate and "say everything" (Spotnitz, 1985). New psychological insights, interpersonal experiences, and personality maturation are facilitated by placing primitive feelings and impulses into mature language. To that end, when joining and bridging interventions support patient autonomy in group therapy, the internalization of new psychological structure is further maximized (Deci et al., 1994; Ryan & Connell, 1989; Ryan, Plant, & O'Malley, 1995). For Allison, the early attachment that she felt with Lisa (Clinical Vignette: Allison & Lisa) was experienced as foreign and non-integrated within her mind. Over time, she became more personally identified with the feelings stimulated within a secure attachment relationship, leading to partial internalization of a new object representation. Since joining interventions were developed initially as a strategy to protect and support the patient's ego (Spotnitz, 1985), they tend to be autonomy-supportive by their very nature. This inherent autonomy-supportive quality directly links modern analytic joining techniques with a large empirical literature on the effectiveness of autonomy-supportive interventions in a variety of settings (Deci & Ryan, 1985, 2002, 2008a, 2008b).

Allison's progress in group treatment illustrates other developmental processes in addition to enhanced emotional self-regulation. In attachment theory, as in object relations theory (Greenberg & Mitchell, 1983), the child's ability to integrate fragmented positive and negative representations (i.e., part objects) into whole self-and object-representations is an important developmental milestone. In the Strange Situation, for example, in order to seek proximity to the caregiver, the child must assume that the caregiver is going to be responsive (a good object) and that the child is worth responding to (a good self). The threat (the bad object) is located outside of the dyad in the form of the stranger. Around age 3, the child is thought to have a beginning awareness of the mother as a center of her own subjectivity, with her own thoughts, feelings and needs outside of those of the child (Bowlby, 1988; Fonagy, 2001; Fonagy et al., 2002). Thus, the child begins to learn that the mother can be

frustrating and disappointing (a bad object) and that the child can elicit reactions from the mother that are punishing, frightening, or neglectful (a bad self). In secure attachment relationships, these emotionally charged representations of self and other become integrated into more complex representations, with conscious and unconscious elements, and form the basis of internal working models of relationships (Bowlby, 1988) and enhanced mentalization (Fonagy, 2001; Fonagy et al., 2002). Insecurely attached children fail to achieve this milestone. Positive and negative representations of self and other remain split off and un-integrated, providing a powerful basis for pre-oedipal resistances in group treatment. Joining the resistance externalizes the patient's wish for a secure attachment, within which these conflicting affects, needs, and representations can be explored, resolved, and integrated.

Allison had been treated individually with much success prior to joining a group. This treatment, however, had not adequately addressed the need to relive and work through various negative transferences. The group helped Allison contain the terror embedded in these warded-off transferences so that she could express them in language. In the individual treatment, many joining and mirroring interventions had established a secure attachment within the dyad, but not one that could tolerate the full extent of her rage, sexual feelings, and fears of acting destructively on her impulses. Direct and indirect joining interventions, along with bridging to a secure base, allowed Allison to safely recreate these feelings while temporarily maintaining a secure attachment with another group member, rather than the therapist. At the start of the group, I was the only person able to function as a symbolic secure base. Over time, by joining her resistances and through bridging interventions, this secure attachment was generalized to other members and also the group as a whole and was internalized by the patient. This process allowed Allison to actively seek out emotional contact with other members, while better containing and verbalizing her anger and fear. In modern analytic terms, she became increasingly able to confront a "bad object" and discharge the associated aggression outward, rather than at the self, thereby reducing her reliance on the narcissistic defense.

references

Ainsworth, M., Blehar, M., Waters, W., & Wall, S. (1979). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NY: Lawrence Erlbaum Associates.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routledge.

Brook, M. (2001). The evolution of modern group process: An overview. In L. B. Furgeri, (Ed.), *The technique of group treatment: The collected papers of Louis R. Ormont, Ph.D.* (pp. 11-20). Madison, CT: Psychosocial Press.

Crespo, C. (2012). Families as contexts for attachment: Reflections on theory, research, and the role of family rituals. *Journal of Family Theory & Review, 4*(4), 290-298.

Deci, E. L. & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum.

Deci, E. L., Eghrari, H., Patrick, B. C., & Leone, D. R. (1994). Facilitating internalization: The self-determination theory perspective. *Journal of Personality, 62*, 119-142.

Deci, E., & Ryan, R. (Eds.). (2002). *Handbook of self-determination research*. Rochester, NY: University of Rochester Press.

Deci, E. L. & Ryan, R. M. (2008a). Self-determination theory and the role of basic psychological needs in personality and the organization of behavior. In O. P. John, R. W. Robbins, & L. A. Pervin (Eds.), *Handbook of personality: Theory and research* (pp. 654-678). New York: The Guilford Press.

Deci, E. L. & Ryan, R. M. (2008b). A self-determination approach to psychotherapy: The motivational basis for effective change. *Canadian Psychology*, *49*, 186-193.

Epstein, L. (1977). The therapeutic use of countertransference data with borderline patients. *Contemporary Psychoanalysis Journal, 15*(1), 248-275.

Fonagy, P. (2001). *Attachment theory and psychoanalysis.* New York: Other Press.

Fonagy, P., Gergely, G., Jurist, E., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self.* New York: Other Press.

Greenberg, J. & Mitchell, S. (1983). *Object relations in psychoanalytic theory*. Cambridge, MA: Harvard University Press.

Kinley, J. L. & Reyno, S. M. (2013). Attachment style changes following intensive short- term group psychotherapy. *International Journal of Group Psychotherapy, 63*(1), 53-75.

Kirman, N. (2004). Speaking the unspeakable. *Modern Psychoanalysis, 29*(2), 215- 228.

Levine, R. (2011). Progressing while regressing in relationships. *International Journal of Group Psychotherapy, 61*(4), 621-643.

Margolis, B. (1979). Narcissistic transference: The product of overlapping self and object fields. *Modern Psychoanalysis*, *4*(2), 131-140.

Margolis, B. (1986). Joining, mirroring, psychoanalytic reflection: Terminology, definitions, theoretical considerations. *Modern Psychoanalysis, 11*(1-2), 19-35.

Margolis, B. (1983). The contact function of the ego: Its role in the narcissistic patient. *Psychoanalytic Review, 70*(1), 69-81.

Meadow, P. W. (2003). *The new psychoanalysis*. New York: Rowman & Littlefield.

Meadow, P. W. (2006). Modern psychoanalysis. In *The Edinburgh international encyclopedia of psychoanalysis* (p. 311). Edinburgh, United Kingdom: Edinburgh University Press.

Mikulincer, M. & Shaver, P. R. (2012). Adult attachment orientations and relationship processes. *Journal of Family Theory & Review, 4*(4), 259-274.

Ormont, L. (1974). The treatment of pre-oedipal resistances in the group setting. *The Psychoanalytic Review, 61*(3), 429-441.

Ormont, L. (1984). The leader's role in resolving resistance to intimacy in the group setting. *International Journal of Group Psychotherapy, 38* (1), 29-45.

Ormont, L. (1990). The craft of bridging. *International Journal of Group Psychotherapy, 40*(1), 3-17.

Ormont, L. (1992). *The group therapy experience: From theory to practice*. New York: St. Martin's Press.

Rosenthal, L. (1987). *Resolving resistances in group psychotherapy*. New York: Jason Aronson.

Ryan, R. M. & Connell, J. P. (1989). Perceived locus of causality and internalization: Examining reasons for acting in two domains. *Journal of Personality and Social Psychology*, *57*, 749-761.

Ryan, R. M., Plant, R. W., & O'Malley, S. (1995). Perceived locus of causality and internalization: Examining reasons

for acting in two domains. *Journal of Personality and Social Psychology, 57*, 749-761.

Spotnitz H. (1969). Resistance phenomena in group psychotherapy (overview). In Ruitenback, H. M. (Ed.), *Group therapy today* (pp. 203-217). New York: Atherton Press.

Spotnitz, H. (1985). *Modern psychoanalysis of the schizophrenic patient: Theory of the technique* (2nd ed.). New York: Human Sciences Press.

Winnicott, D. W. (1958). *Collected papers: Through paediatrics to psycho-analysis*. Abingdon, United Kingdom: Routledge.

Zeisel, E. M. (2009). Affect education and the development of the interpersonal ego in modern group psychoanalysis. *International Journal of Group Psychotherapy, 59*(3), 421-432.

1577 South Ave.
Rochester, NY 14620
Phone: (585) 271 1850
Email: aeblackphd@yahoo.com.