A Modern Analytic Approach to Group Resistance*

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The concept of resistance was introduced by Freud more than 100 years ago. This paper traces the development of that concept and defines the characteristics of resistance in a group setting. Many examples are provided, illustrating a wide range of resistances, and techniques used by the therapist to resolve those resistances are also described.

The topic of resistance in groups and group resistance was memorialized some years ago in a cartoon in *The New Yorker* that shows two gentleman of rather shabby leisure conversing on a park bench. The caption reads, "For heaven's sake! I'm a group therapy dropout too." That cartoon sits on my desk as a reminder of the omnipresence of resistance and also of the omnipresent inadequacy of group therapists.

I looked at the cartoon recently and realized that one of the characters bore a resemblance to a person who left one of my groups, a gentleman who had come in under considerable pressure from his wife because he had such a bad relationship with their daughter. In the initial interview he told me he had had treatment before, 10 sessions with an analyst. I introduced him to the group by saying, "This is John, and you all better get to know him pretty quickly because he's not going to be around much longer." John protested the unfairness of this comment. In his second session he told the group how he handled his daughter, and they gave him all kinds of good advice which he went home and carried out. Ten sessions later he bade a happy farewell to the group.

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Resistance was first mentioned almost 100 years ago by its discoverer, Sigmund Freud (Breuer & Freud, 1893–1895). From the publication of *Studies on Hysteria* onward, the concept evolved and was clarified. In the beginning it was seen as an action taken by the ego to protect the process of repression, and the analyst's task was to overcome it. It was "nothing other than the child's past character" that stood in the way of analytic work (Freud 1897, p. 266). Soon this understanding was broadened and Freud wrote, "Whatever interrupts the progress of the analytic work is resistance" (1900, p. 517). Still later, Freud noted that the acting out of a resistance may destroy the treatment (1905 [1901], p. 118). By 1910 Freud had located the transference relationship as the "site of the strongest resistance to cure" and "the most formidable ally of resistance. . . . Every single thought, every mental act of the patient must pay toll to the resistance, and represents a compromise between forces urging toward cure and those gathered to oppose it" (p. 101).

Freud (1913) identified some initial resistances, such as planned communications to guard against the sudden appearance of unwelcome thoughts or the dilution of treatment through leakage when patients discussed their treatment with others. The following year Freud (1914) continued his discussions of technique, highlighting the role of resistance in repeating instead of remembering, and emphasizing the importance of working-through in overcoming it.

In the *Introductory Lectures* Freud (1916–1917 [1915–1917]) wonders about the reluctance of patients to give up their suffering, but he adds that it may be understandable if we bear in mind that such reluctance is not without its analogies. "A man who has gone to the dentist with an unbearable toothache will nevertheless try to hold the dentist back when he approaches with the forceps" (p. 287). In the nineteenth lecture, however, Freud comes to see another side to transference resistances and states a view consonant with modern analytic understanding:

> They include so much of the most important material from the patient's past and bring it back in so convincing a fashion that they become some of the best supports of the analysis if a skillful technique knows how to give them the right turn. We are aware that these resistances are bound to come to light; in fact we are dissatisfied if we cannot provoke them clearly enough or are unable to demonstrate them to the patient. (p. 191)

Eventually Freud (1926 [1925]) named five basic types of resistance according to their source in the structure of the psyche. Three are ego resistances: repression, transference resistance, and secondary gain from illness. The fourth arises from the id and necessitates thorough

working through. The fifth comes from the superego and originates from the sense of guilt or the need for punishment, powerfully opposing recovery (p. 160).

Subsequently, others noted additional important resistances. Glover (1928) distinguished between acute and unobtrusive resistance—for example, the doldrum or status quo resistance; Reich (1948) described the armored quality of character resistances; and Anna Freud (1936) elaborated on the ego resistances.

Modern analytic formulations describe the need for the therapist to reinforce resistance in some instances and note how resistance may serve a protective, insulating function. Spotnitz (1969) writes that resistance encompasses more than interference with the process of analysis. Since it embraces all of the forces that prevent the patient from functioning with the analyst in an emotionally mature way, it is the main form of communication of the patient's conflicts, life history, and character structure. It reveals the reaction patterns that the patient devised in childhood in the face of psychological necessity to maintain emotional equilibrium in the swirling currents of family living. Since his resistances are designed to protect himself and those around him, they must not be overcome but are to be supported until the patient is emotionally educated and comfortable enough to drop them in favor of less destructive defenses.

The goal, then, in modern analysis is to resolve resistance rather than to overcome it. Resolving resistance means helping the patient become capable of mastering it and giving it up voluntarily. In facilitating this resolution, Spotnitz (1969) indicates that, "the analyst utilizes the most effective tools at his disposal to nullify the immediate effects of the forces that hampered the patient's emotional growth and to catalyze maturation" (pp. 111–112).

Resistances in groups are shaped and modified by the presence of others and are as diverse and farflung as those encountered in individual therapy. Group members come late, are uncooperative, rebellious, overcompliant, seductive, and abrasive. Some members monopolize, others remain silent and ignored. At times a whole group may fall into silence or may all talk at once in a Tower-of-Babel cacophony. In lieu of verbal communication, members may chew gum, smoke, exchange seats, touch each other, have surreptitious extragroup contacts. They may abruptly withdraw from treatment. They may compete for attention, seek to establish themselves as superior, or vie to be seen as the sickest or most inadequate and therefore entitled to the most attention. They may strive to drive others from the group or, like the Biblical Joseph with his provocative dreams, may induce the group to expel them.

There are those who bend all of their energies to opposing the therapist, others to pleasing him. There are those who address themselves primarily to fomenting dissension and aggression within the group; others are driven to immediately mediate and to neutralize the first hint of anger. Some Pollyanna personalities show gross intolerance to others' appropriate feelings of sadness, hurt, despair, and anger. They confront these feelings with assaultive platitudes: "Why can't you forget it? It's in the past." "Why not look at the bright side?" "Don't be angry! She only meant the best for you." "After all blood is thicker than water." "You're too sensitive." While these members feel unentitled to their aggression and seek to prevent its emergence in fellow members as well as in themselves, others have no compunction at all about spewing their anger onto the group with no regard for the consequences.

Some engage in a constant quest for the interest and admiration of the opposite sex, while others engage in a constant and savage battle of the sexes. Some enact their puritanical attitudes with harsh condemnations of any perceived moral or sexual lapse in their fellow members; others derive vicarious gratification of their own impulses by encouraging their copatients to illicit behavior. Some present themselves as hopeless and ward off any offers of help, the help-rejecting complainers. Others can only help their fellows while neglecting themselves. Some come to the group to look, to see, and to watch others emotionally undress; others use the group as a stage for their own exhibitionism. Some, like starving infants, seem to suck up every drop of attention they can squeeze from the group. Others maintain a tight-lipped silence, as if daring the group to get them to eat or to "make." Some resistances are indigenous to the group setting: subgrouping, scapegoating, and efforts to use or misuse the democratic process to subvert the purposes of the group.

Resistance in the group setting has two salient characteristics. One is that group members tend to deal with each other's individual resistances. Frequently the success or failure of the group depends on the therapist's skill in enlisting this help and cooperation from his therapeutic allies in the group. Recently a therapist described one group member who had been hospitalized for three weeks, had then called to say that he wasn't yet ready to come back, rebuked the therapist for not having called him while he was in the hospital, and commented that he assumed he would not have to pay for the missed sessions. The therapist said that it was generally his policy to charge for missed sessions. The patient said, "Well, I'll come one more time just to tell the group I'm leaving." The therapist told the group what this member had said, and when the patient returned and announced that he was thinking of

terminating, the group spoke to him and reminded him that the therapist was his analyst and not his friend. They also questioned why he had not called the analyst to let him know how he felt. The man decided to stay.

Interestingly, the therapist felt he was "weak" in having sought the help of the group. He did not understand that group therapy is based on the assumption of the inadequacy of the group therapist and the effectiveness of the members in dealing with each other. The group therapist does not do everything by himself. He seeks the help and supervision of the group members and uses them as consultants right on the spot. Generally if the right questions are asked and the therapist shows interest in their contributions, the members will do a good job.

In one of my groups a member became very disenchanted with me. She felt terribly betrayed because she found out that, unbeknown to her, I knew somebody important in her life. She came to the group to let them know she was leaving and explained the situation. They asked her why she couldn't continue coming to get help with her problems yet keep on hating me. This sounded like a great idea to her and she remained for a while until she figured out some other good reason to leave, but the group handled the first resistance in a very skillful way. Certainly I couldn't have done anything about it; she was too angry with me.

The second major characteristic of resistance in a group setting is the existence of emotional currents that influence members to act in an organized way, consciously and unconsciously, in relation to the group therapist. In other words, the group has a tendency to develop similar libidinal and aggressive strivings toward the therapist and to behave toward him on the basis of these shared feelings. The sociologist Gustave LeBon (1960) in *The Crowd* describes the contagion and suggestibility of crowds and their domination by the unconscious. Freud (1921) recognized this in his essay on group psychology.

A group resistance is the sharing of the same resistance by all or a majority of group members at any one time. Some group resistances are easily identified: silence, for example, or a group that is mired in chitchat or one that remains fixed in a single emotional area, such as constantly giving advice to each other on how to deal with a boss, a girlfriend, a wife. Perhaps the most frequently encountered group resistance is that of not sharing time democratically, e.g., shutting out certain members or monopolizing time. Another fairly common group resistance is that of members' focusing on the therapist while ignoring each other and constantly minimizing each other's contribution. The reverse is also common—consistent ignoring of the therapist.

Some groups demonstrate a total absorption by the individual members in their own personal problems with little or no interest in the concerns or difficulties of others. Again the opposite may also function as a group resistance. The group may be eager to help each other while avoiding attention to and work on their own difficulties. In some groups members derive gratification from verbally assaulting each other. Other groups banish all negative feeling and function as mutual admiration societies. In one group the expression of sexual feeling may be conspicuously absent, in another talk of sex for purposes of titillation and excitement may be rampant. Other groups develop acting-in or acting-out patterns in which feelings and impulses are enacted in lateness, outside group contact, or sexual contact or by smoking or chewing gum or eating candy in sessions.

The preceding group resistance phenomena are all readily identifiable. There are others, however, that frequently go undetected because they are camouflaged as the resistant behavior of just one or two members. These manifestations of resistance have been lucidly described by Ormont (1969). He says,

> What is more common, subtle and often unrecognized is a kind of shared, but concealed attitude which operates as a collective resistance to fulfill the terms of the therapeutic contract. Such a resistance is at work whenever the group ignores, overlooks, or tolerates a violation of the analytic contract by one or more of its members. The deviant member expresses the resistance overtly, the condoning members covertly. The deviant group member is allowed to continue on his aberrant way unchallenged because he plays out the veiled attitudes of the rest of the members. (p.147)

A treatment-destructive resistance developed swiftly in a group that changed therapists when its male therapist left the state and transferred the group to a female therapist. Initially the resistance took the form of an intent to break up the group. When any one member expressed a thought or a feeling about leaving, the group tried to persuade that person actually to leave. This resistance yielded to an interpretation of their anger at the abandoning therapist and at the "stepmother" who replaced him. However, no sooner was this resistance resolved than another appeared.

The group, having decided to remain together, apparently collectively decided that they would act as if the transfer had never taken place. They completely ignored the new therapist. Any interventions she made were regarded as inane interruptions and she was left feeling

totally excluded by the barrier of their loyalty to the original therapist. She adopted a joining strategy, in which she began to act as if Mr. H. were still in the group. She would barge into the middle of group interaction and say, "What would Mr. H. say about this?" or "How would he help a situation like this?" Some people had maintained continuing phone contact with Mr. H. She told them not only to maintain their phone contacts but to increase them so they could get further help from Mr. H. She suggested setting up a conference call so he could be present at all sessions. When a new member joined, she introduced him to "Mr. H's group." At first the group found these interventions very amusing. They would chuckle and giggle and laugh and say there she goes again. Finally, after some months, the member who most represented the group tie to Mr. H. said, "Will you cut this crap out? You're here and Mr. H. isn't. We've got to deal with you and with each other, so let's get going."

In a group of 13- to 15-year-old girls there was a lot of talk of sex, of wanting to defy their parents by having sex, not only prematurely, but with inappropriate males. One member, Yvonne, spoke excitedly of having sex with the janitor at school. Amid this ongoing discussion one member brought in a friend without discussing it with the group or the therapist. The visitor continued to come, with no comment about her presence made by anyone. The group resistance was seen as defying the mother through having an illegitimate child in the person of the visitor. Addressing Yvonne as the major spokesman for this resistance, the therapist suggested to her that she could get a beautiful baby from that janitor. Yvonne looked quite nervous at this and said, "You know, I think I better watch my step." And another girl said, "You're right." A session or two later, the visitor quietly disappeared.

In a fathers' group in a child guidance agency a severe and rather murderous treatment-destructive resistance took the form of rigorous questioning of any new member who arrived. They were like a lynch mob that challenged each father who joined the group with the question, "What did you do wrong with your kid?" Responses to this question that the group deemed denying or defensive were then met with very sharp aggression. Naturally a revolving-door situation developed. People would stay one or two sessions at the most and then run for their lives. But a nucleus of four members remained.

This was the therapist's first group and he attributed the swift demise of new members to his own faulty selection and to the lack of ego strength on the part of these new members. The process of resolving this resistance first had to overcome the considerable hurdle of helping the therapist see that a treatment-destructive resistance was operating.

When he finally became aware of its existence, he was able to ask the group, "What kind of a reception are you planning for the next member? Will that member last one session or two?" A sort of uneasy silence followed and then one of the fathers asked, "Are we that bad?" The therapist also asked what kind of a new member they thought could survive such a group. Perhaps, he suggested, he'd been picking the wrong people. The group then recommended that he select those who were "ready to have their liabilities pointed out."

As a result of the investigation of this resistance, the group's blueprint for dealing with new members emerged in sharp focus. New members had to immediately acknowledge fault and inadequacy. And if this admission were not forthcoming, then aggressive tactics were used until the victim submitted or fled. Investigation of this resistance proceeded along the lines of finding out why it was so important to have new arrivals admit to inadequacy. How did it make them feel when a newcomer did not confess? Members eventually revealed the dynamics that had been upholding this murderous pattern: identification with their own third-degreeing parents, resentment of the new siblings in their own families, and envy and fear of other males, especially "wise guys" who seem superior and confident and who thereby induced feelings of inadequacy in them. With the establishment of a more tolerant view of their own shortcomings the group was then able to assimilate new members and to deal more acceptingly with their initial defenses. The therapist also got help with his own sibling problems in his own analysis.

Another group was dominated by the implacable hatred of two members for each other. Each threatened to leave because of the other. Each maintained, "Look, there's no sense in talking to that bitch. She'll hate me no matter what I say." Finally each withdrew into hateful silence. The bitter impasse between the two members filled the sessions with tension and left the therapist feeling hopeless and in despair.

Resolution of this resistance began with the therapist asking, "What would happen if everyone here expressed their angry feelings? And if so, who would each of you be most worried about?" This resulted in other group members expressing their negative feelings toward each other and toward the therapist. Considerable anxiety was also expressed about the possibility of counterattack from the therapist. Having cleared its aggression, the group no longer had the need to channel it into the subgroup. The group resistance was permanently resolved, making way for other, more powerful resistances.

The following is an example of an oedipal-level id resistance. In an adult group Mark and Cheryl, the two youngest members, were quite

attracted to each other. When Mark mentioned wanting to sell his hi-fi set, Cheryl quickly expressed interest in buying it. The two began to negotiate and to make arrangements for Cheryl to come around to his house and see it. The group's bemused tolerance of all this suggested that a group resistance was going on. The therapist addressed this resistance by asking, "What else would you all like Mark and Cheryl to do together?" It was greeted with giggling by some, with indignation by others. One member suggested the therapist get immediate help for his sexual problems. Over the next several sessions, members got in touch with the unvoiced feelings and memories that had been upholding the resistance: primal scene memories, memories of parental seductiveness, or parental prohibition of the acknowledgment of any hint of sexuality.

In a similar situation, another group displayed a continual pattern of socializing outside the group in subgroups of two. Members called each other on the phone for comfort, met for lunch, hugged and kissed each other when they met. They all seemed on the verge of having sex. When the therapist pointed out that this was uncooperative behavior, the members argued passionately that they had no pleasure in their lives outside the group and that giving up those group contacts outside the group would be a grievous deprivation. They would be left terribly alone and in total despair. They spoke repeatedly of feeling close to each other. Each one felt an intense wish to be close to one other member. This group was showing that members preferred sex to the intense frustration endemic to analysis.

This resistance continued for so long because, in addition to the members' gratification, there was a vicarious participant. The therapist had his own wishes for closeness arising out of experiences in his own quite large family. These feelings and wishes for closeness prevented him from taking the firm stand that was indicated for resolving the resistance.

A group of senior citizens composed mostly of widows and widowers displayed a resistance that supported its members in their reluctance to reveal and understand their feelings. One member, Fred, invariably arrived with a tight, tense expression on his face. When the therapist tried to investigate what that look was saying, the other members would quickly point out, "Oh, that's his medication." There was thus a collective need to maintain emotional ignorance of their own and each other's feelings. The impression formed that the feelings that were being held in check by this resistance were anger at their departed spouses and sexual feelings that they felt were not permissible at their age.

This resistance was steadily eroded under the impact of the therapist's continuing bestowal of permission for anger and sexuality. A male

and female member whispered together in a subgroup. She observed they seemed to get along well together; had they thought of going to bed together? This was greeted with feigned shock and nervous giggles. The therapist also frequently suggested that they should be very angry at her for her intrusive questions and shocking statements. The resolution of this resistance was heralded some months later when Fred asked the therapist for a renewal of his medication for his chest pain, and another member told him, "Fred, you don't need medication. All you have to do is talk here."

A group of parents of brain-damaged children consisted of four couples. In the first two months two of the fathers left, one saying he was too tired. While the two other fathers raised questions about the departure, the mothers remained neutral. A treatment-destructive group resistance was operating. The men seemed to want to flee from their own stigmatized families out of guilt and inadequacy. The women seemed to want to get rid of the men who had given them damaged children. An exploration by the group therapist of how the advent of a damaged child affected the feelings of couples toward each other halted the exodus and enabled one of the mothers to bring her husband back into the group.

A very interesting resistance occurred in a group of adolescent girls in a parochial school who repeatedly presented themselves to the therapist as a group. Members spoke of "we" rather than "I." Each invariably presented her feelings as shared by the whole group: "We all hate this teacher." "What can we do about it?" "Our parents don't let us be alone with boys." "We don't like the school uniforms." "Teachers don't let us eat in class." This group resistance operated effectively to protect any one member from exposure and prevented the therapist from knowing them as separate individuals. The members were able to express their aggressive and sexual impulses, but only collectively, and this prevented individual blame from the therapist (mother) for any one of these unsanctioned impulses. The therapist supported this defense by responding only with collective comments: "All parents worry too much about their daughters." "All girls want to be alone with boys." "All girls want to dress nicely and sexily."

A pervasive group resistance operated in a seminar that I gave many years ago. This group manifested consistent complaints and dissatisfaction with its leader. One member remained angry because the group had seemed inhospitable when she arrived unannounced one day. A second complained that there was not enough focus on presentation of groups. A third complained that there was too much presentation of groups. A fourth was angry because yet another member was permitted

to make only a fragmentary group presentation one day. A fifth was angry because, despite the group's complaints, he felt that the group seemed to admire the leader too much. Another was unhappy because there was not enough intellectual and didactic learning going on. Yet another could not forgive the leader because he had once suggested to her that she could call an absent member—a person that hadn't shown up for group—and she felt that wasn't her job, and what right did he have to suggest such an improper task to her?

Now all this added up to a most gratifying experience for the group members of repeated and constant complaints against the therapist (mother). It was not the most gratifying experience for the group leader. Resolution of this resistance was finally achieved through repeated investigation. "Who is the most dissatisfied person today?" "How do you think I'm planning to be dissatisfying today?" I also fed back some of the induced feelings, letting them know that this was the most unsatisfying group I'd ever had but that my job wasn't to be satisfied or dissatisfied but to teach them group therapy. They finally got the idea.

One therapist had the unhappy and unsettling experience of a session beginning with one of the female members taking his chair and refusing to give it up. And she said to the group, "Why can't he sit somewhere else? See, over there. Now he's part of the group." The male group members, most of whom had had tyrannical fathers, gave quick evidence of their support for this acting-in behavior. One of them laughed excitedly and exclaimed, "Hey, this is great fun." Another disparaged the therapist's attempts to explore the feelings that the chair usurper was enacting by asking the therapist, "Why the hell are you making such a big deal about this?" At the time the therapist was too upset to explore the group's stake in this oedipal-level id resistance. I can't say I blame him.

An adolescent group was dominated for its first three months by a pervasive attitude of competition among the members as to who was in the most trouble at home or school. Who cut the most classes? Who was in the most danger of being expelled from home or school? Who was the most hung over from drugs and who was taking the greatest risks in flirting with danger? A very scary group resistance. It was finally resolved when the therapist told them that, because their parents had never taken proper protective care of them, they had never learned to take proper protective care of themselves. This explanation seemed to have quite an effect on them; they began to adopt a parental attitude toward each other. The girls advised the boys to stop racing their cars against trains at intersections. The boys told the girls that they didn't have to go to bed with anybody they met—they had a right to be selective and to protect themselves.

A rallying point for a very potent resistance in another group was the refusal of one member, Sam, to pay for two sessions missed in connection with a combined vacation and business trip. When the therapist brought to the group's attention that Sam's check did not cover the two sessions, Sam quickly expressed indignation at the therapist's expectation of payment, referred to the therapist as "pretty goddamn cheap," and expressed a growing reluctance to pay. The other members were initially silent spectators to what appeared to be a one man rebellion. However, as Sam moved from complaint to an impassioned tirade against the therapist for being selfish, acquisitive, mercenary, stonehearted, piggish, etc., the reactions of the other members indicated that they were in accord with him. Rachel applauded. Allen said, "Good going, Sam, give it to him." Ted said, "Boy, Sam's got guts." Helen said, "Sam, you really came alive." Bob said, "Boy, Sam really doesn't pull any punches." Sam, gratified and encouraged by this show of group support and emboldened by his cheering section, then announced with triumphant defiance, "He can stand on his head for his money."

With this vision of himself upended, the therapist decided that the resistance was at its height. He told the group they were all out to defeat him and added that Sam's behavior seemed to have special meaning for all of them. A silence followed. Allen, almost sadly, asked the therapist, "Are you trying to spoil our fun?" Another pause ensued and Allen continued, "I guess I always root for the underdog. When you're the runt of the litter like I was, that's how you are." Bob said, "When Sam first began to complain, I thought he was just being petty. But then I felt a sudden wave of anger at Dr. Rosenthal and I suddenly remembered how my father reneged on his promise to get me a car when I graduated college." Ted said with sadness and yet great anger, "At least he didn't break into your piggy bank like mine did. Can you imagine a grown man robbing his own kid? He never gave me a reason, never paid me back, and I guess I never forgave him." These two members then shared some of their feelings about their fathers.

After that Rachel said, "I was getting quite a kick out of Sam's belligerence and then I began to wonder if Dr. Rosenthal would punish him in some way. Maybe he'd ignore him, stop helping him in the group, or maybe even kick him out." She then recalled a pattern of how as a little girl she would egg on her younger brother to mischief and then delight in his fall from parental grace and in his punishment. Another member recalled the bleak poverty of her childhood and the deep sense of having been cheated.

The group-oriented approach to resistance illustrates that when you resolve a resistance you also get to understand each individual's unique

contribution in upholding that resistance. The group members are then freed to begin to examine each other's pervasive character attitudes exemplified and demonstrated by the resistance. In the group example just cited, after this incident the group members began to question and investigate with Sam his constant competition with the leader and also his constant conflict with employers on the job.

I'd like to thank all my supervisees and patients who gave me material for this lecture and the supervisees who stood up to the tremendous emotional bombardment stemming from these resistances and then skillfully resolved them. I will be glad to answer any questions.

Question: Are you experiencing satisfaction from this group?

Rosenthal: The answer is a resounding yes. I thought it was a very interesting group. They show a very interesting group resistance. Great hunger for socialization. They'd much rather socialize during the break than come back here and listen to some boring questions and answers.

Question: A combined compliment and criticism. Why was your delivery of case histories so engaging in contrast to your presentation of the history of resistance?

Rosenthal: That's very obvious. When you quote someone, it's boring and dull and who can stand to hear it anyway or want to follow it. When you give an emotional picture—group material, clinical material—it's always much more alive. So whoever asked this question had all the right feelings.

Question: How would you suggest dealing with a group in which the common resistance is to say, when the question of bringing new members is raised, "If you're interested in having the new member in the group, obviously you're not interested in having me. When that new member shows up, you can just count on my leaving."

Rosenthal: Now this enforcement of birth control on the therapist is a very powerful resistance. It's blackmail and it's very effective. After all, you don't want to get rid of members whom you've worked with for a while. It takes a long time to explore and to get them to really talk about it. The problem is that usually one or two members express this feeling for the group and the others are very gratified by it. So what you have to do is keep bringing up the possibility of new members until such time as everybody comes out with their feelings, especially their negative feelings about new members, and then you have a chance of finally resolving this resistance. Of course you may be sterile by the time you resolve it. That's another problem. You can always adopt.

Question: Suppose you as the leader have made a contract with the group and maintained this group over a period of time and you as the group leader tire of this contract and you'd like to break it, what do you do about that?

Rosenthal: Anybody had experience with the therapist breaking the contract with a group? The therapist resisted the contract by dying? Well, that's one way to handle the situation. If continuing with the group would mean the therapist's death or damage to his ego in any way, then I think he should forget about the contract and break up the group. If the therapist's ego integrity is threatened by a destructive group, I see no sense in continuing.

Question: What do you think about interpreting a group's resistance—a group that has worked fairly well—pointing out the resistance and asking them what it means?

Rosenthal: I use anything that works. If the group is ready to be told what they are up to, that's fine. It usually depends on the emotional age of the group. I think you're describing a group that's relatively mature. If you have a group where the emotional age is one, one-and-a-half, or six weeks, I don't recommend too much interpretation. They'll just vomit it back, get indigestion, become celiac; all kinds of problems develop with interpretation if people aren't ready for it. But if they're ready for it, that's wonderful. That's what modern psychoanalysis is all about. All we try to do is to get people to become old enough so we can use Freud's methods with them.

Question: Could you make a suggestion for dealing with the resistance of a group member's analyst. I have a group member who is in individual analysis with an analyst who refuses to talk to me yet makes snide remarks about me to this patient in individual sessions. The patient then comes in and reports these to the group. The group then gangs up against me about everything that is wrong with me.

Rosenthal: I see. So that patient is the spokesman for the group resistance.

Question: But through her analyst. She doesn't do it directly. It's her analyst's idea that I'm this, that, or the other thing.

Rosenthal: She comes in and reports things from her analyst.

Question: Right.

Rosenthal: How did you get such a friend? Who referred the case to you?

Question: She referred herself to me.

Rosenthal: Oh, with the consent of her analyst?

Question: With the consent of her analyst, she originally came for a consultation on another issue and then returned with the con-

sent of her analyst because the analyst doesn't do group. She came back with the consent of the analyst to be in group. But now there is some kind of . . .

Rosenthal: Well, you better tell her that she should follow whatever suggestion her analyst makes. That her analyst is her first and foremost therapist. You're just Johnny-Come-Lately and the mother is always most important. She comes first before the nursery school teacher and you better let her know that in any question of divided loyalty her first loyalty is to her analyst.

Question: Great idea. Thank you.

Rosenthal: And when she reports all kinds of derogatory things that she got from her analyst, tell her her analyst is very astute. My impression is that the analyst wasn't too happy about her going to group. I think the analyst wanted her all to herself.

Question: What do you think is the ideal size for a group?

Rosenthal: That's an excellent question. Some years ago at one of its conferences, the American Group Psychotherapy Association conducted a survey and asked therapists what their preferred group size was. At the time the median was from six to eight. Of course as some of you know there have been some recent developments and some size revision upwards. But there is a matter of personal feeling about this, too. Some people tell me that eight is their top limit; others say they're comfortable with twelve. Some people say if the group gets over ten they feel they're with a mob. But somewhere between eight to ten I think allows for a lot of interaction; if there are absences, you still have a considerable group membership left.

People have also reported great success with small groups. I once had a group that through attrition and people going to work was finally down to two people, who insisted on continuing. They stayed together for about a year and got a lot from each other. On another occasion, between a combination of bad weather and resistance, I found a group with only two members. One of the two, who had never talked before, talked a blue streak that day; I couldn't shut her up. I commented on how beautifully she was talking in contrast to her prior silence and asked if she could help me understand it. She said, "I guess I never told you that I was a twin." The ideal group for her would be two. For others it would be five or six. A lot of people claim the ideal size for them is one. One and a therapist.

Question: In forming a new group, how much should one be concerned about setting limits on heterogeneity—on how different the people are in the group?

Rosenthal: That's another very good question. Now you know when you

form a homogeneous group, for example, when you get together parents of handicapped children, a cohesive group is formed very swiftly. When you get together a heterogeneous group, different sexes, problems, histories, ages, that group never develops a spirit of cohesion as swiftly as the homogeneous group. However in my experience it plumbs much greater depths. Much more stimulation and much more interaction occur because of the diversity and the richer network.

Question: Are there any characteristics one should avoid bringing together?

Rosenthal: All you need to wreck a group is a compulsive talker; he will either wreck the group or wreck himself or both. The blend has something to do with the kind of group you have. If you have seven, eight, or nine withdrawn, shy, self-effacing schizoid personalities, you'll have a very effective ambulatory cemetery but you won't have a group. Similarly if you assemble nine chaotic people, a group will be full of aggression with no inhibitions, certainly no paradise regained.

Question: I would like to know if you have had any experience with only children in groups. Do they drop out more or are they more difficult to engage?

Rosenthal: That would make an excellent study. I remember Slavson saying that people who are only children should, by definition, have a group experience sometime in their lives but I have no experience with them nor am I aware of any study regarding their attendance.

REFERENCES

Breuer, J. & S. Freud (1893–1895), Studies on hysteria, *Standard Edition.* London: Hogarth Press, 2:1–369.

Freud, A. (1936), *The Ego and the Mechanisms of Defence.* New York: International Universities Press.

Freud, S. (1897), Letter 72 to Wilhelm Fliess. *Standard Edition.* London: Hogarth Press, 1:266–267.

——— (1900), *Interpretation of dreams. Standard Edition.* London: Hogarth Press, 4.

——— (1905[1901]), Fragment of an analysis of a case of hysteria. *Standard Edition.* London: Hogarth Press, 7:1–122.

——— (1910), "Wild" analysis. *Standard Edition.* London: Hogarth Press, 11:219–227.

——— (1913), On beginning the treatment. *Standard Edition.* London: Hogarth Press, 12:121–144.

——— (1914), Remembering, repeating and working-through. *Standard Edition.* London: Hogarth Press, 12:145–156.

——— (1916–1917[1915–1917]), Introductory lectures on psychoanalysis. *Standard Edition.* London: Hogarth Press, 15/16.

——— (1921), Group psychology and the analysis of the ego. *Standard Edition.* 18:67–144.

——— (1926[1925]), Inhibitions, symptoms and anxiety, *Standard Edition.* London: Hogarth Press, 20:87–175.

Glover, E. (1928), *The Technique of Psychoanalysis.* New York: International Universities Press.

Le Bon, G. (1960), *The Crowd.* New York: Viking Press. (originally published 1896)

Ormont, L. (1969), Group resistance and the therapeutic contract. *International Journal of Group Psychotherapy,* 19:420–432.

Reich, W. (1948), On character analysis. *The Psychoanalytic Reader.* R. Fliess, ed. New York: International Universities Press.

Rosenthal, L. (1976), The resolution of group-destructive resistance in modern group analysis. *Modern Psychoanalysis,* 1: 243–256.

Spotnitz. H. (1952), A psychoanalytic view of resistance in groups. *International Journal of Group Psychotherapy,* 7:155–174.

——— (1969), Resistance phenomena in group psychotherapy. *Group Therapy Today: Styles, Methods and Techniques.* H. Ruitenbeck, ed. Palo Alto, CA: Atherton Press.

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