PROGRESS TOWARD GREATER SPECIFICITY IN GROUP TREATMENT HAS BEEN RETARDED BY THE LACK OF DISTINCTION IN THE FIELD BETWEEN THE GROUP APPROACHES THAT ARE DESIGNED TO PROVIDE THE PATIENT WITH THE TYPE OF EXPERIENCE HE NEEDS TO BECOME A HEALTHY AND MATURE PERSONALITY, AND THOSE GROUP APPROACHES THAT ARE ADDRESSED TO THE NEEDS THAT HAVE ONLY AN IMMEDIATE GRATIFICATION VALUE. EVERY PROCEDURE NEEDS TO BE EVALUATED IN THESE TERMS: DOES IT PRIMARILY OFFER A GRATIFYING EXPERIENCE OR ONE THAT WILL HELP A PATIENT OUTGROW HIS EMOTIONAL IMMATURITIES?

THE FACT IS THAT MOST GROUP TREATMENT TODAY IS ANCHORED TO THE VALUES REPORTED BY THE PIONEERS IN THE FIELD. PERHAPS THEIR FIRST OUTSTANDING DISCOVERY

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1This chapter is based on material gleaned from manuscripts prepared by Hyman Spotnitz and his notes for two papers, "The Monopolizer" and "The Silent Patient."
was that the shared treatment experience facilitated socialization. Patients were observed to establish meaningful contacts in the group and, after testing out new modes of relating to others, went on from there to social groups. Contributions to ego functioning and superego relaxation were pointed out as other benefits. The family configuration of the therapy group and the reaction to the therapist as a parental figure were found to facilitate the reliving of the oedipal situation. It was observed that suffering and symptoms were alleviated more rapidly in the group than in individual treatment. The support and attention of other patients and the discovery that they had similar emotional problems were among other benefits reported.

Much group treatment today is oriented toward goals consonant with these values, being conducted by and large to reduce the symptomatology, to help socialize, to provide cathartic release, and other benefits of a superficial nature.

For the analyst who is to help people become more effectively functioning individuals, whatever their problems and stage of life, group therapy is unquestionably a powerful mode of treatment, perhaps the most powerful we possess, though not necessarily the best for all patients.

One aspect of effective group treatment that has received little recognition is the exposure of patients to feelings that catalyze growth processes. The more serious the patient's problems, the greater the need for the feelings that would facilitate desirable changes
in behavior. One major advantage of group psychoanalysis is that the need for feelings can be met in the treatment setting itself. Analytic group process equips the analyst with a powerful resistance solvent he does not have in the dyadic relationship. Beside monologue and dialogue, there is the groupalogue. The emotional impact of spontaneous reactions of the group members and the criticisms and suggestions they volunteer make group discussion a potent factor in the resolution of individual resistances.

Anyone who can arouse all the necessary feelings in his patients has little need to expose them to a therapeutic group. But it would be difficult to find an analyst who has such a broad range of feelings available. Moreover, should he confront patients with feelings that are "manufactured" for a therapeutic purpose at hand, they will be rejected as a worthless substitute. Unfortunately, much of the emotional feeding that patients engage in when left to their own devices is either damaging or, at best, unproductive in terms of personality growth.

Despite their unconscious tendency to feed one another emotionally, patients cannot be expected to obtain the precise feelings each of them needs if the analyst operates on the principle of laissez-faire. Because of the toxic elements in the feelings at the patients’ disposal, the analyst must tap the potential source of emotional nourishment in such a way as to discourage destructive emotional interchange and to facilitate the communication of emotions that are conducive to desirable changes in behavior. When
tendencies to engage in damaging interchanges are observed, the analyst may intervene appropriately to head them off.

The crucial factor in any type of psychoanalysis appears to be the unlearning of those pathogenic patterns of defense that have become part of the patient's character structure. These patterns must be freed of their charge so that more desirable defenses may come into function. When the symptomatic patterns are analyzed and dealt with effectively as resistance, they are gradually modified and outgrown. This enables the patient to respond more appropriately to the environmental pressures.

If the analyst maintains a climate that will stimulate the members of the group to contribute to the resolution of pathogenic patterns in their fellow group members, the group process will prove constructive in modifying these patterns.

Patients tend, in the group environment to call attention to the resistant attitudes and behavior of their co-patients when they differ from their own modes of functioning in the group. The tendency of group members to deal with each other's resistances is fostered by educating them to work well together as a unit and by responding appropriately to the total picture.

It is through resistance that a person undergoing psychoanalysis communicates the information that he is unable to engage consistently in spontaneous, emotionally significant verbal communication. The
notion of resistance as the absence of communication and the antithesis of self-revelation has been discarded in psychoanalysis. Resistance is now conceptualized as the primitive, inadequate, indirect form of self-revelation characteristic of a person who functions on a level of emotional immaturity.

Resistances in the group may be seen as the voluntary and involuntary methods by which group members avoid giving, or helping co-patients to give, a spontaneous and emotionally significant account of past and present psychic realities, feelings, and thoughts in the immediate situation.

The resistance pattern of a group member may operate in relation to the therapist alone, to one or more co-members, or to the group as a whole. It is the presence of common or group patterns in addition to the individual resistances which accounts in large measure for the more complex nature of analytic group process. Psychoanalysts now tend to focus on the group patterns and to intervene primarily to deal with them. The familiar conceptual tools of analytic process, transference and resistance, are used to resolve the group resistance to effective functioning. By concentrating on the group patterns that become a resistance to constructive interchange, the analyst works for the reactivation and working through of the obstacles to maturation. He controls the transference and regression as he concentrates on these group patterns of resistance. The analyst's skill in enlisting the cooperation of the group members in
dealing with each other’s resistances usually spells the success or failure of his effort to promote personality growth through a shared treatment experience. Attempts to overcome resistance forcibly are undesirable. Resistance performs a communication function, telling us something about the patient, provided, of course, that someone is present to decipher the meaning. Protracted silences or idle chatter are two patterns used when a member wants to hide, be ignored, or avoid attack. These patterns become special problems in the group when other group members cooperate in the maintenance of these resistances. Discovery of the message being concealed by the resistant behavior is the key to the resolution of these problems, but rather than attempt to abolish the resistance, the group analyst accepts it as an expression of the character of the person.

THE MONOPOLIZER

Although the compulsive talker is usually seen first in individual analysis, he can be handled by a skilled analyst in a group that has reached an advanced stage of treatment. Needless to say, the analyst should be expert in the management of mobilized aggression in the group situation. The patient may communicate that he is talking on and on because he doesn’t want to tell anything. The monopolizer often clings to one idea, or rambles on through subjects that are unrelated to his funda-
mental emotional problems. Consonant with the general theory of dealing with resistance is that though the monopolistic pattern interferes with analytic group process, its presence should initiate the silent study of why and how it was activated in the immediate situation, and also an investigation of its historical significance in the patient’s life. On the basis of analysis, the therapist decides what to do about the monopoly. Before intervening verbally in any way, he explores such questions as the following: Should the resistance be silently tolerated in the present situation? Should it be encouraged, even supported, because it serves a useful purpose? Should it be discouraged because it blocks therapeutic process?

If the monopolizer is usurping time and attention that his co-patients really want, the hostile tone of the groupalogue will make that clear. If they become destructive in their reactions, the analyst intervenes. Frequently, however, the insights inculcated through group discussion provide sufficient protection so that the monopolizer is not exposed to antitherapeutic attack. The group’s understanding or interest in influencing him in a constructive way to function cooperatively usually prevents him from becoming the target for scapegoating.

If the groupalogue indicates that the monopoly has the support of the other members of the group, the analyst deals with it, not as an individual resistance, but rather as a group resistance expressing itself in diverse but interlocking patterns of behavior. In other words, the overtalkative patient and other
members who encourage him through their prolonged silence are recognized as engaged in a combined operation. The special advantage of this approach is that no member of the group is neglected during the exploratory process. Each of the silent members may be asked why he is trying to escape being the center of attention.

But it may then become clear that the patients who have been maintaining silence really want to talk. In that case, the group analyst asks what has been blocking them from helping the monopolizer to stop talking, and from verbalizing their own desires to talk. If the obstacle to asserting themselves is a lack of understanding, the analyst may formulate his communications with a view to ascertaining what has been motivating the monopoly and their own unwilling silence. If the monopolizer responds to the various approaches that have been described, the analyst does not have to institute special interventions.

The main danger is that the monopolizer may arouse so much hostility that the group will be disrupted, or the monopolizer either eliminated or irreversibly damaged by the reaction of his co-patients to his behavior. The nature and degree of damage that can be caused by verbal hostility are variable; their assessment is a matter of careful judgment. The patient who arouses intense hostility among other group members may be temporarily traumatized through the experience of serving repeatedly as a psychological punching bag. Usually this damage is
more than compensated for by the contribution that such experiences make to the process of desensitizing him to the impact of negative emotions and helping him to become a more resilient personality. It is important, however, to bear in mind the possibility and danger of irreversible damage. While the assessment of damage from verbal hostility is a matter of judgment, no leeway can be extended to the discharge of negative feelings in motor action. Any patient who cannot adequately control his behavior in a therapy group does not belong there.

In instances in which the patient is not sufficiently influenced by the group exchange to give up the monopoly, the analyst may have to address himself to the problem more deliberately.

If the monopolizer is utilizing a relatively mild resistance of the oedipal type, this will usually respond to interpretation. For example, a group member may state, "I've been quiet here a long time. You'll have to listen to me for a change." Or the oedipal pattern may be used by more than two members; they may jointly announce that they intend to manage the group, or refuse to allow their fellow patients to take the stage during the session. Such individual and subgroup patterns would also be interpreted as much as possible in terms of the immediate configuration of total behavior. While the resisters would be helped to understand why they were trying to prevent others from talking, or usurping the parental role, the other members would be asked why they permitted themselves to be treated as children.
The monopolies just illustrated are involuntary and unconscious patterns, but not compulsive.

Preoedipal patterns of resistance are rarely responsive to interpretive procedures. Reflective techniques and emotional communications are generally employed to help the monopolizer function more cooperatively. When the behavior is joined or psychologically reflected, the patient is helped to give up a pattern outside personality control without experiencing undesirable pressures or narcissistic mortification.

For example, the analyst may say to a group member who has been talking uninterruptedly for fifteen minutes, "You have been talking for fifteen minutes today and nobody has interrupted you. Shall I ask the others if they object to your talking another fifteen minutes?" The analyst may say "Since you have talked for fifteen minutes, everyone else has the right to talk the same length of time without being interrupted. Wouldn't you like to take over, John?" More forcefully, the analyst may say to another member, "Would you like to talk for fifteen minutes and give him a taste of his own medicine?"

The analyst may respond with an emotional communication. For example, talking for the same length of time in a tone of voice similar to that of the monopolizer.

Another approach would be to inform the resistant patient that, after talking so long, he now has to remain silent for the rest of the session. Should he attempt to capture attention again, other members
will usually tell him, outright, that they don’t want to hear from him.

Usually, however, the analyst does not have to engage himself in such procedures because the group members respond emotionally to the monopolizer on their own initiative.

Another individual resistance that meets with attack and then yields to understanding is monopoly by interruption. For example, a woman who maintained silence about a variety of traumatic events going on at the time in her own life, characteristically cut in on group members who were communicating their own problems. Identifying herself with one of the problems being presented, she would say, “The same thing happened to me,” and proceed to talk at length about a more or less comparable problem she had encountered in the past. She was a brilliant woman with a sparkling sense of humor; hence, the group’s response tended to play into the resistance. Even the member who had been interrupted rarely raised an objection and, at times, the monopoly was encouraged by requests for further details or advice. The first step taken to resolve this pattern was to help the woman become aware of what she was doing. Her fellow patients asked her questions about it.

As in this case, the pattern of monopolizing by interruption often originates in sibling rivalry. This woman revealed that she had developed this pattern in childhood to cope with a sister who was the preferred child in the family. The patient had identified with her sister’s problems in order to strengthen
her marginal hold on, and to gain more securely, her mother's attention. After she discovered that she could receive the desired audience in the group by discussing her own problems, she gradually learned to control the impulse to cut in on the others in the group with a "me too."

Feedback from group members makes a tremendous contribution to the resolution of resistance patterns that interfere with the therapeutic process. Negative feedback has the effect of inhibiting the overtalkative member. Positive feedback stimulates a too silent member to function more cooperatively.

THE SILENT MEMBER

When one member of a group tends to remain silent, the analyst questions silently: Does the group consciously wish him to be silent and are the others abetting him in this behavior? If it becomes clear that the others are helping him maintain silence, there are four different types of interpretation that may be indicated. It may be pointed out that the silent member is being treated like a sacrificial lamb for the selfish purposes of the other members; that they are helping a frightened little baby escape becoming the center of attention; that they are expressing their own desire to be silent through his silence; or that they are combining with him in a sadomasochistic operation.

On the other hand, it may be decided that the
others really want the silent member to talk. In that case, it is desirable to know what blocks them from helping him to talk. If the blocking is caused by their lack of understanding, the analyst may provide it.

The group members need to be educated to the idea that there is an appropriate way to withhold information, as well as an inappropriate way. The inappropriate way is to clamp one’s mouth shut, like a baby trying to fight a bottle his mother is trying to put in his mouth. An older child can open his mouth and explain that he isn’t hungry, or is not eating carrots because he is holding out for chocolates. The group members who have something to say and can’t say it in the group at that time are expected to emulate the behavior of the older children. The appropriate way to withhold the information is to explain why it is being withheld. For example, the patient might say that he has something on his mind that is too painful to talk about, or that it might be to his disadvantage to talk about; or he may say that he cannot trust the group with this information.

This resistance may require joining before the patient is able to give it up. For example, demonstrating to the patient by explanation or illustration that he has the right to withhold information may resolve the resistance. This entails silence and respect for the group member’s privacy and for the confidential nature of his communications. When a patient learns through the group experience that an explanation (verbal) of his withholding of information is more effective and comfortable than total silence,
this is also advantageous to the group analyst because it is easier for him to deal with the more mature pattern—either to help the patient preserve it or to help him give it up if he so wishes. Therefore, one tries to determine the reason for the silence. A resistance that is supported because it makes sense may or may not be resolved later. In a therapeutic group climate, the objections to the disclosure are eventually resolved and the resistance melts away.

It is not usual procedure to apply any available technique in a routine way. Interventions will not be effective in dealing with resistance unless they are based on the recognition of the specific factors associated with the silence of the patient in a particular group setting. Any short-circuiting of the process of understanding the patient is apt to get the analyst into trouble. One always has to begin with understanding. This takes much longer than intervening by rote, but it assures the continued presence and favorable personality development of a problem patient who might otherwise have withdrawn from the group.

It would be going too far to say that "resistant" silence is never motivated by a desire, whether conscious or unconscious, to provoke hatred or resentment. There are people who are fearful of being overwhelmed by positive feelings and fight against being liked by other group members. This is notably true of schizophrenic patients who find a loving atmosphere difficult to tolerate. Nevertheless, silence stemming from a fear of being liked or an actual wish to be disliked is rarely encountered.
In one group, protracted and general silences constituted the outstanding resistance during the initial stage of the treatment. When the group members recognized that their silence was acceptable, they started, one after another, to talk about various life experiences and feelings. They recognized, eventually, that a strong wish to be liked by the others had operated as a block to meaningful communication. This wish, coupled with a fear that they would make disclosures that would be disapproved of by their co-members is a common source of resistance in the therapy group.

Some very dependent people are unable to express their negative feelings out of fear of the consequences. They resist verbalizing resentments because they do not want to run the risk of being further humiliated. They cannot tolerate a fear of loss of self-esteem. Fears of losing desirable contacts with other human beings and of being exposed to undesirable contacts appear to dominate their behavior.

Each patient tends to identify his co-patients with significant figures in his past and to relate to them with a strong emotional charge. The presence of additional transference objects endows resistance with a multidirectional character; that is, it operates not only in relation to the analyst but also toward one or more fellow patients. It may also operate toward the group as a unit. Classically, the group activates early attitudes toward the family, wherein patients tend to view the group as mother. Frequently, they relate to the analyst as a parent and to their co-
patients as siblings competing for his attention. At other times a group member may be seen as a parent.

To illustrate these processes, a middle-aged, self-absorbed spinster oscillated early in group treatment between two patterns often observed in highly narcissistic patients. She either maintained silence while the other patients conversed, or seized on their silences as a signal to plunge into a lengthy, lifeless monologue on an inconsequential topic. She talked rapidly, disjointedly, and in such a low monotone that it was difficult to hear her, let alone make sense of what she said. The verbal barrage helped her to conceal her actual thoughts and feelings.

This pattern had originated in her attempts, at the age of four, to prevent her mother from finding out that she engaged in sex play with other little girls. Her incessant chattering prevented her mother from asking questions about how she had been spending her time. Just as her mother would have censured her had she revealed the truth, this patient anticipated disapproval and criticism from the group if she disclosed her emotional problems. This was an unfortunate problem to be saddled with because it gained her the reverse of what she wanted—hostility instead of favorable attention and admiration. Her co-patients responded with impatience, annoyance, and agitation. They told her that she was dull, uninteresting, and incoherent, and was wasting their time bringing up matters about which they could not care less. She was always hurt by these comments; at times she cried. Failing to recognize that they were trying to help her function cooperatively, she would complain
that they had no feeling for her and then she would refuse to talk. Eventually the other group members recognized that her verbal barrages communicated a great need for affectionate attention.

When she retreated into silence, on the other hand, she was encouraged to join in the group dialogue. When she talked about what she really thought and felt, she was helped to continue. Her perceptive comments on problems of other patients were warmly received; she was told that she was helpful, sympathetic, and understanding. They, in turn, then demonstrated genuine interest in discussing the problems she disclosed. She thus discovered that she was better able to get the attention she craved when she did not try to conceal her need for it. Occasionally, when she felt frightened and insecure, she reverted to the original patterns, but they ceased to be compulsive operations.

CONCLUSIONS

The monopolizer is chiefly a problem because democratic sharing of time and attention is regarded as desirable in group treatment. What is sought is versatility in talking rather than time sharing on a strictly mathematical basis session after session. Sometimes the monopolizer facilitates versatility in talking, and sometimes he interferes with it. The monopolizer may interfere with the democratic sharing of time and attention; moreover, he may corner the precious psychological commodities mentioned to engage in communications that are repeti-
tive in substance and disguised in meaning. By provoking hostility among the other group members, however, the monopolizer eventually facilitates group communication. Patients who were disinclined to talk earlier join the resistance, and in so doing, they compete with the monopolizer for time and attention. Each competitor, in turn, produces others, and the monopolizer is gradually cut down to doing no more than his share of the talking.

Thanks to the presence of the monopolizer, one is rarely confronted with periods of silence in the group sessions. Group silences usually terrify the beginning analyst. More than one student has reported that he didn’t know how to get the group started until a patient began to talk and so provoked the group that the other members told him to shut up, and they took over. Even the experienced analyst is not very happy with group silences. Consequently, the monopolizer performs worthwhile services for the analyst who wants to provide patients with an emotional group experience and to eliminate protracted silences in group sessions.

The role of the modern group analyst is to resolve resistances to communication. To do this he must create the climate in which group members can experience feelings and engage in constructive emotional communication. Since we recognize that patients enter the group in different stages of emotional immaturity, it is helpful to formulate the goal of the treatment as the emergence of the emotionally mature personality, and this is the goal toward which the modern psychoanalyst works.