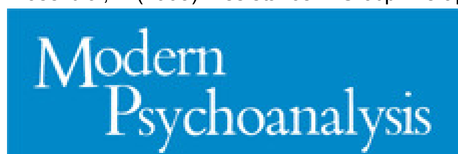
Rosenthal, L. (2005). Resistance in Group Therapy: The Interrelationship of Individual and Group... Mod. Psychoanal., 30B:7-25.



(2005). Modern Psychoanalysis, **30B**:7-25

Resistance in Group Therapy: The Interrelationship of Individual and Group Resistance*

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Freud's classification of resistance according to place of origin in the psychic structure is applied to the phenomena of resistance in group therapy. The varied forms of resistance are depicted. Special emphasis is given to group-destructive resistances, those that threaten the therapeutic viability of the group or the treatment of any of its members. The often covert relationship of the resistances of the individual to those of the group as a whole is examined. The group's tolerance of a member's uncooperative or deviant behavior is seen as prime evidence of the presence of group resistance. The therapeutic validity of a group-oriented approach to resistance is clinically illustrated.

There is consensus that the resistances that emerge in group therapy are basically similar to those that arise in individual therapy but that the group setting endows them with special qualities. Foremost among the unique dimensions that resistance takes on in the group arena is that *group members deal with each other's resistances and defenses*. Thus **Bry (1953)** reported that:

The first and most important thing in the handling of resistance in groups is that frequently resistance does not have to be handled at all, at least by

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This paper was originally published in Group and Family Therapy. L. Wolberg and M. Aronson, eds. New York: Brunner/Mazel, Inc., 1980.

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the therapist. The group itself is remarkably effective in dealing with this phenomenon. Group members gradually develop ideas as to how to deal with resistance and how to utilize it productively. In cases of protective talking about innocuous material, sooner or later a group member will complain about the "beating around the bush." (p. 112)

A statement by **Slavson (1950)** addressed this unique quality of the group:

Analytic groups facilitate the acquisition of insight because patients come to grips with resistances, especially defenses and character rigidities, much earlier and in much more telling ways due to the reactions of fellow members than do individual therapy patients. The group reacts to a patient's obvious unwillingness to accept a new point of view, to examine his feelings and values and to yield to efforts at reaching or altering them. At points in group sessions, patients may verbally attack one of their members who persists in remaining silent or proves too stubborn. This concerted pressure and disapproval affect him much more, and certainly much faster, than efforts at exploration by a therapist in individual treatment. ... There are inherent solvents of resistance in group therapy. Identification, universalization and mutual support have the effect of overcoming defensive resistances in individuals. (p. 163)

The peer engagement of resistance is illustrated in the following vignette from an adult group that had been meeting for two years. Mark, 29, had repeatedly complained about his parents, girlfriend, teachers, and employers. In the session from which this excerpt is taken, Mark had been bemoaning his inability to work on the assigned papers at school and the refusal of his professors to grant him repeated extensions of time for these assignments. Norma, a 43-year-old divorcee, addressed Mark with intensity:

Mark, I've been with you here for two years and I've usually been very sympathetic toward you, but I've just realized how you misuse this group. You came here to complain about all the injustice in the world but you're not doing anything else—you haven't got your sights set on anything higher. Your complaints are your whole life. You're just going nowhere, man. If I'm in this group two years from now, I'm afraid I'll still hear you complaining about the same old things and you'll probably be exactly where you are now.

Some additional illustrations of members' dealing with each other's resistances are offered.

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Mr. W. had consistently opposed, questioned, and disagreed with any comment or observation the group therapist had

made to others in the group. A fellow member told him, "I'm getting the feeling that you're not here to get help—you're here to fight!"

In the early sessions of a group, Mrs. A. repeatedly advised others on their revealed problems without having offered any information on her own emotional state. In the fourth session when Mrs. A. again assumed her advisory role, another member turned to her to ask, "Mrs. A. are you the Virgin Mary here? What brought you to this group?"

Mr. F. demonstrated a pattern of earnestly asking other members about their sexual adjustments. This querying persisted until a fellow member responded to one of the questions with, "I'm tired of being part of your peepshow—that's how you're using all of us here. You're the avid little boy looking through the keyhole of your parents' bedroom door!" Following this, Mr. F. was helped to put his sexual impulses into words instead of seeking to gratify them by his voyeuristic acting in in the group.

As the foregoing illustrations indicate, the therapist is not alone in his therapeutic venture. He has powerful allies if he is prepared to utilize them and if he is ready to accept that patients may be much more effective in dealing with certain resistances of other members then he could ever be. Frequently, the success or failure of the therapy will rest upon the therapist's skill in enlisting the help and cooperation of his therapeutic allies in the group in a consistent manner.

The second major characteristic of resistance in the 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.* This tendency to develop similar libidinal and aggressive strivings toward the therapist and to behave toward him on the basis of these shared feelings was recognized by **Freud (1921)** in his essay on group psychology. It is this tendency that produces *group resistance*, the sharing of the same resistance pattern by all or a majority of group members. Some group resistances are easily identified—a silent group, a group mired in chit-chat, or one that remains fixed in one emotional area, for example, a focus on members' advising each other on their reality situations. Perhaps the most frequently encountered group resistance is that of not sharing time democratically, shutting out quieter members, or permitting monopolization by individuals or subgroups. A fairly common group resistance is that of members focusing only on the therapist, ignoring each other, and consistently minimizing each other's contributions.

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The reverse—consistently ignoring the therapist—would also constitute a commonly shared resistance. Some groups demonstrate a total absorption by the members in their own personal problems, with little or no interest in the concerns and difficulties of others. Again, the opposite may also function as a resisting pattern—members being eager to help each other while avoiding attention to and work on their own problems. In some groups, members derive gratification by 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 (rather than understanding) may be rampant. Other groups develop acting-in and acting-out patterns in which feelings and impulses are enacted in lateness, extra-group social and sexual contacts, or by smoking or chewing gum and candy in sessions.

The preceding phenomena of group resistance are all readily identifiable. There are others, however, that can frequently go undetected because they are camouflaged as the resistive behavior of just one or two members. These manifestations of resistance were identified by **Ormont (1968)**:

What is more common, subtle, and often unrecognized is a genre of shared but concealed attitudes which operate as a collective reluctance to fulfill the terms of the therapeutic contract. Such a resistance is at work whenever the group ignores, overlooks, encourages, 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 nakedly plays out the veiled attitudes of the rest of the members. (pp. 1-2)

Ormont (1968) offers as an example the group's prolonged use of a witty actor whose jokes and flippant remarks provided a shield against painful examination of their feelings. Other examples of this less obvious form of group resistance would be group tolerance, acceptance, or encouragement of a member's lateness, absence, non-fee payment, monopolization, or silence.

It should be noted that the group contract provides the setting and backdrop for the resistance and the field within which it functions. The contract in analytic group therapy usually embraces the following:

1. Group members will talk about important life areas, including their past, present, and future and their feelings toward each other, the therapist, and the group; in addition, they will help each other to do the same.

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2. Group members will refrain from acting out, such as engaging in physical rather than verbal communication with fellow group members, breaching the confidentiality of the group, eating, smoking, or chewing during sessions, or engaging in extra-group relations with other members.

The knowledgeable group therapist does not expect members to be able to live up to the terms of the contract and he expects and is prepared for deviations. He is alert to the inevitability of individual, subgroup, and group resistance and to the probability of a deviant member being the instrument of and spokesman for the resistance of the group when his or her deviation goes unchallenged or unquestioned. As **Ormont (1968)** so aptly phrased it, “The deviant member expresses the resistance overtly, the condoning members covertly. The deviant member is allowed to continue his aberrant way unchallenged because he nakedly plays out the veiled attitudes of the rest of the members” (p. 148).

If unaware of the factor of group gratification and sibling support for the nonconforming member, the group therapist may find himself engaged in a generally futile attempt to deal with seemingly individual resistance when actually a potent group resistance is operating.

In a fathers group in a child guidance clinic, Ralph, a flamboyant private detective, consistently regaled his fellow members with lurid tales of crimes, adultery, and violence. His son had been brought to the clinic because of his school conduct problems, primarily hyperactivity and incitement of other students to misconduct. The therapist sought to deal with Ralph's group behavior as an individual resistance by asking the group members whether they saw any connection between Ralph's functioning in the group and his son's excited and instigative school behavior. This question seemed to fall on emotionally deaf ears. Instead, the therapist met a barrage of support for Ralph.

“Look, his job is the most important part of his life—why shouldn't he talk about it here?”

“Lay off him, Doc, what's the matter—you had a hard day at the office?” (laughter from group)

“Come on, Doc, we're all interested in each other here and we show it by our interest in each other's families, our problems, our jobs. So what's all the fuss about?”

“Can't you take it if we're not talking about our kids every single minute? What's your problem?”

“We're here to learn, aren't we? Well, I learn a lot from Ralph about the seamy side of the world that our kids are going into, things that are important for us as fathers to know.”

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Feeling helpless and defeated, the therapist retreated into passivity and the resistance continued unabated as Ralph resumed enlivening the group with his stories. The process of resolving this resistance was set into motion at a subsequent session when the therapist, armed with the recognition that a full-blown common resistance was operating, opened the meeting by asking, “How would you all like Ralph to excite you today?” Repeated interventions over several sessions addressed to the whole group's gratification in Ralph's stimulating behavior led to dissolution of the resistance.

Another group tolerantly witnessed a male member's kissing a female member at the end of each session, a departure from the contract that emphasized that feelings were to be expressed in words only. The situation led to a sexual relationship outside the group and the breaking off of treatment by the two lovers. Subsequent investigation of the group's reluctance to scrutinize this subgroup resistance revealed that the members had been attaining vicarious sexual gratification from the budding relationship. Thus, group resistance had been operating.

Classification of Resistances

The preceding section described how the group setting endows resistance with unique dimension. However, resistance in group therapy is still intrinsically similar to resistance in individual therapy. Freud at various times sought to differentiate among the various types of resistance, and in “Inhibitions, Symptoms and Anxiety” **(1926 [1925])** he distinguished five kinds and classified them according to their point of origin in the psychic structure. This classification can be usefully applied to the understanding of resistance in the group.

Repression Resistance

Repression resistance, the resistance of the ego's defenses, appears prominently in the early stage of group treatment and is frequently manifested by conscious objections to disclosure of information about some area of life experience. A member may refuse to talk about sex, claiming that it is too personal and is no one else's business. He thus circumscribes and limits his communications and may even seek to

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limit and control the communications of others, i.e., “I'll talk about anything here except my sex life—if sex comes up again, I'm leaving.” A member may show a pattern of participation only when a topic of special personal significance is being discussed. This type of subject specialization was demonstrated by one member who would participate only when the subject of mothers came up, at which time she would immediately talk about her own mother. The moment the subject changed, she would disengage again. Some individuals and groups in effect censor their own and others' communications by a focus on reality. They seek to banish fantasies,

wishes, and dreams by demanding "What has that got to do with reality?"

At times a member, several members, or the whole group may insist on doing something which runs counter to the group agreement, or they may demonstrate a negative attitude to the therapist's wishes to have the group function cooperatively. Members may insist on having a picnic session in the park; others may refuse to talk to the therapist.

The ego resistances provide valuable information about the kind of early training members received from parents. These resistances respond favorably to noncritical investigation and joining rather than to correction.

A group of 15-year-old boys displayed strong reluctance to discussing their feelings and problems, preferred to talk about sports, and repeatedly complained that group sessions were boring and uninteresting. When asked what would make sessions more interesting for them, the boys clamored for the addition of girls to the group and couches to replace the chairs. The group therapist indicated that the suggestion was worthy of consideration. For the next several sessions the therapist elicited discussion about the possibility of girls' joining the group: What kind of girls did they want? What would happen if two group members liked the same girl? What if the girls did not like sports? What would happen to the group therapist's reputation and job if he permitted the group to be turned into a "sex club"? What would happen if Joe, who had boasted of taking away his friends' girls, took the girlfriend of another group member? After thorough discussion of the possible consequences of making the group coed, the boys concluded that bringing in girls at this time would cause more dissension than satisfaction and would probably lead to the breakup of the group. Following this, their craving for excitement subsided, and the boys were enabled to seriously express their feelings about girls, their sisters, and mothers.

Ego resistances originate in the ego's early developmental stages and operate as initial defenses against the anxieties aroused by the group experience and exposure to the impact of its familial significance.

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Resolution of the ego resistances has the significant effect of smoothing the road toward cooperative group functioning.

Superego Resistance

The most frequently encountered resistance in group treatment, superego resistance, presents attitudes developed in relation to parents in the oedipal period. It involves feelings of shame, guilt, and humiliation around disclosing information. It should be borne in mind that some patients may have engaged in illegal or highly stigmatized behavior and the group member's reluctance to reveal information may be realistic. It thus behooves the therapist to protect any member from pressure to disclose such information.

Superego resistance may also manifest itself in harsh judgmental and punitive attitudes by some toward nonconforming members as a defense against their own noncooperative wishes. Others may react with persistently moralistic and critical attitudes toward the sexual and aggressive feelings of fellow members.

Another form of superego resistance, harsh and punitive self-judgment, may lead some members to feel unworthy of the ameliorative effects of treatment. One woman, rejected by her lover, told the group, "I don't deserve him or you." Such a pattern, in extreme form, will operate as a treatment-destructive resistance and the therapist needs to be alert to the tolerance levels of such patients to acceptance, support, praise, and success.

ID Resistance

Id resistance originates in the unconscious tendencies to repetitively seek some previously experienced gratification—the repetition compulsion. The difficulty encountered in dealing with this resistance resides in the potent charge of libidinal or aggressive energy that powers it. Such gratification, where it becomes a major component of the treatment situation for the individual member, subgroup, or group, is a full-blown id resistance.

Id resistance can express gratifications associated with each of the levels of development and can be charged predominantly by either aggression or libido. An oral id resistance might manifest itself in a pervasive

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libidinal wish to be constantly fed, nurtured, and suckled by the therapist. Behaviorally this could be expressed in waiting for the therapist to talk, asking for help, advice, suggestions, and understanding, and the general adoption of the passive, dependent attitude of the hungry infant. An aggressive id resistance on this level is encountered in the pleasure of making "cutting remarks" with a "biting tongue."

On the anal level, the behavioral equivalents of diarrhea and constipation can be observed in patients who spew out an uncontrolled stream of words or who stingily and spitefully retain their verbal productions or eke them out only with reluctance and strain. One member would let loose a series of unrelated thoughts and ideas and then sit back with an expression of contentment while the group sought to make sense and order out of his "mess." Having defecated, he was enjoying being cleaned up and diapered by the group. A delinquent group used several sessions to deluge its therapist with scatological expressions, which were accompanied by gales of group-wide laughter. The therapist was left with a clear feeling of being defecated upon.

On the urethral level, a group of young men constantly competed with each other in dress, seeking to outdo each other in style and in trendiness. They also competitively compared the size of their biceps and one member claimed superiority over his group rivals in penile dimensions.

On the genital level, these resistances are manifested in attempts to break up any interacting couple in the group and in attempts to entice other members or the therapist into love relationships. The powerful charge of sexuality from the oedipal period can lead to sexual acting out among group members. **Freud (1921)** noted that the enactment of "directly sexual impulsions" among members has a disintegrative effect on groups, and experience has borne out the validity of this warning. Id resistances are frequently the cover for hatred and murderous feeling disguised in seductive behavior. One man's constantly charming behavior to the women in the group cloaked his wish to destroy the male therapist and have the female members to himself.

The basic approach to the id resistance is the constant emphasis by the therapist on educating the group from the very start that group psychotherapy involves *talking* and not action. The statement that "this is a talking group only" bears frequent repetition. The therapist will also investigate and bring under analytic scrutiny those feelings that impel patients to want to smoke in sessions, those feelings that cause them to make fists, touch each other, bring food to sessions, chew gum, take off their shoes, cry instead of talk, run out of the meeting room, and seek extra-group contact with each other. When the group members accept

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this basic principle of talk rather than action, they will then recognize acting-in and acting-out behavior as uncooperative behavior.

Secondary-Gain Resistance

In secondary-gain resistance, concealed pleasure or some special benefit or advantage is obtained from one's illness and its continuation or from some exploitation of the treatment situation. This resistance is often clearly observed in the terminal stages of treatment when members seek to maintain any perceived emotional benefits accruing to them from their illnesses. They will seek to retard, defer, impede, and delay cure and improvement, and it is at this time in treatment that old symptoms reappear in an effort to fend off termination. A whole group may remain helpless and demonstrate powerful status quo resistance so that its members may continue to have the gratifications of group membership. This resistance may show itself in concealed exhibitionistic pleasure in talking about sexual matters in seemingly cooperative fashion. Conversely, a member's seemingly sincere interest in the sexual feelings of fellow members may conceal the gratification of voyeurism. Some members remain silent in order to derive the secondary gain of being courted to participate. This variety of resistance is also visible in patients whose recovery from illness would result in eligibility for military service. Another form of secondary-gain resistance is operative when patients avoid disclosing some gratifying activity such as a perversion or extramarital affair because of fear that group disapproval might lead to pressure to give up the activity. Secondary-gain resistance is often puzzling to the therapist because the members do not talk about it but rather act surreptitiously to extract pleasure or gain from the therapeutic situation. Its resolution involves bringing this underlying stratum of pleasure into view in the group, transforming it by recognition, investigation, and exploration from a hidden benefit to an overt and analyzable gratification.

Transference Resistance

Transference resistance is the fifth and most fundamental resistance. The key to the group's cure is held by these resistances, of which Fenichel (**1945**, p. 29) stated, "The repetition of previously acquired

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attitudes toward the analyst is but one example of this most significant category of resistance." Freud (1912, **1914**) formulated that transference phenomena are the source of the greatest resistances, as well as the most potent instrument for psychoanalytic therapy. Greenson (**1967**, p. 182) described transference reactions as "a repetition of the past, a reliving without memory," which is invariably associated with resistance. "On the other hand, the reactions to the analyst provide the most important bridges to the patient's inaccessible past. Transference is a detour on the road to memory and of insight, but it is a pathway where hardly any other exists" (p. 182).

Transference develops in both individual and group psychotherapy. In intensive individual psychotherapy, transference manifestations focus on the analyst as the object of an intense regressive transference so as to expose for analysis the patient's underlying unconscious childhood conflicts. In contrast to the intense focusing of transference solely upon the therapist in individual analytic treatment, it is generally agreed that the conditions extant in group psychotherapy significantly alter the manner in which transference is manifested. There is more or less general agreement that these modifications occur in two ways: (1) The intensity of the transference toward the therapist is to some degree lessened or diluted, and (2) transference is also directed toward other members of the group and to the group as a whole as well as toward the therapist. The existence of intense transference in the group setting is substantiated by the development and emergence of the powerful and varied forms of resistance arising out of the transference.

Transference resistance in group psychotherapy directed toward the therapist is as manifold in variety in the group setting as in individual analysis. It is frequently enacted through the medium of positive transference resistance. **Mann (1951)** described this form of

transference resistance:

Positive transference may grow to almost unique proportions. It may be positive to the point where the group meeting becomes something of an inspirational experience. The flood of warm feelings for the central figure brings us to speculate about the phenomenon of intoxication of the group ego which seems to involve elements of magical donations from the omnipotent parent-therapist. This kind of group transference may serve to critically dampen the critical aspects of the group ego and thus be in the service of resistance to change and further understanding. (p. 142)T

The same group transference resistance is also described by **Yalom (1970)**:

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The group grants the leader superhuman powers. His words are given more weight and imbued with more wisdom than they possess. Equally astute observations made by other members are ignored or minimized. All faux pas, latenesses, or errors of the therapist are seen as deliberate attempts to provoke the group for its own good. All progress in the group is attributed to him and the members believe that there are great calculated depths to each of his interventions and that he predicts and controls all events in the group. Even where he confesses puzzlement or ignorance, that too is regarded as part of his technique deliberately intended to have a particular constructive effect on the group. (pp. 198-199)

Yalom (1970) describes one member who brought a list of issues that troubled him to session after session, waiting for the therapist to divine its existence and to ask him to read it. Obviously, if he had really wanted to work on the problems, he would have taken the initiative himself to present the list to the group. What was of overriding importance to this patient was the need to have the therapist be his all-knowing parent. His transference was such that he had incompletely differentiated himself from the therapist; if he knew something, then that was tantamount to the therapist's knowing and feeling it. The transference resistance operated to prevent him from properly communicating his wishes to the therapist and to the group.

An example of group negative transference resistance follows. The members of one group repeatedly conveyed feelings that the group was not the right one for them. They complained that it reminded them of their own unhappy families, that other group members were unlikable, unhelpful, unconcerned and uninterested. Members frequently spoke glumly of not wanting to come to sessions or said that they had been thinking of dropping out. Resolution of this resistance was achieved through investigation, understanding, and analysis of what made the members feel it was a "rotten" group and by getting the whole group to participate in this investigation (which countered this group's tendency to eliminate one or two members by ignoring them). Interventions were directed toward the group, such as: "You all sound gloomy." "You all look morose." "Why are you all ignoring Helen?" At times the group's attention was called to the resistive behavior of one or several of its members.

Investigation elicited what caused each individual member's negative feelings about the group. Paula thought the group was "rotten" because it wasn't run the way she wanted it to be run. Sol's disenchantment with the group was a response to Paula's controlling and interruptive behavior, which he found intensely aggravating. Orin, the one non-therapist in the group, felt that he wasn't respected by the others. Iris was resentful

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on the basis of feeling that no one in the group cared for her, especially the other women. This represented for her a recapitulation of her family configuration in which she was excluded by the intense involvement between her mother and sister. Irving relived in the group his elementary school experience when he took drugs and felt "out of it." Gabriel felt criticized and unliked as a reenactment of his family experience. Lionel enacted his isolated preoccupation with waiting for the father who had abandoned him. When the other members did not come looking for him by paying attention to him, he felt the group was not right for him.

As noted earlier in this chapter, group members tend to deal with each other's resistances, and this phenomenon is also observed in transference resistance. While a majority of the members may be locked into a pattern of transference resistance, i.e., seeing the therapist as a revered or as a despicable figure, there are usually several members whose emotional vision is clearer in that they are not caught up in a particular transference stage. These less conflicted members can be utilized by the therapist to present a more realistic perception of the therapist, which can counter the distortions of transference; gradually other members may join this more objective subgroup.

An added feature of this most crucial of the resistances is that it may, and frequently does, encompass components of other forms of resistance. A group transference resistance with id- and ego-resistive elements is illustrated in the following exchange:

Therapist: You were all talking in the waiting room, and now that you are in this room with me, you are all silent. What's going on?

Member A: To hell with you!

Therapist: Why the hell with me?

Member A: Just because you want us to talk, we won't do it.

Member B: Right on!

Member C: You're always so smart; figure it out for yourself.

Member D: (Grinning with excitement) Don't tell him a damn thing.

The preceding vignettes and examples have been presented to illustrate the emergence, development, and resolution of a number of transference resistances on varying developmental levels and in varying gradations of emotional intensity. The group's capacity to elicit, evoke, heighten, and eventually resolve intense transference feelings and the resistances that arise from them validate the status of group psychotherapy as an effective form of analytic psychotherapy. The modern analytic group psychotherapist works with the cornerstone processes of

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resistance and transference and looks toward dealing with their manifestations on a group-wide level as the resistances and transferences of individual members converge and coalesce into group resistance and group transference. In this framework and in following the principles of resolution of resistance, the therapist can help to free a group of human beings from the tyranny of unconscious and compulsive impulse patterns that they do not comprehend.

Group-Destructive Resistance

The group analyst accepts responsibility for maintaining the integrity of the group and preserving it as a therapeutic entity. The group, by its evocation of familial configuration (multiple transferences), elicits patterns of accommodation to group living that emerge in the therapy group as resistances. Some surface gradually and can be studied unhurriedly by the group therapist until they develop fully as transferences. Other resistances, such as the need to conceal one's own inadequacy by concentrating on helpfulness to others or serving as "doctor's assistant," pose no danger to group functioning and can await handling by the other group members. However, certain forms of resistance may endanger the integrity of the group or expose a member to potentially damaging contact. This point is clearly illustrated by **Spotnitz and Meadow (1976)** in their discussion of special resistances in group analysis. They closely examine the monopolizing resistance and note the danger of damage to the monopolizer if he is permitted to arouse excessive hostility in the group. If a group were bent on such wishes, then protecting the integrity of the individual would take priority over preservation of the group. Dissolution of such a destructive group would be indicated.

Spotnitz (1969) has suggested a sequence for dealing with resistive patterns that group members may enact. First priority is accorded to group-destructive and treatment-destructive resistance, which Spotnitz defines as "any form of noncooperative behavior which, if permitted to continue, would seriously disrupt the total functioning of the group 'family' or lead to the elimination of one of its members" (p. 212). This category of resistance would include absence without notice, chronic lateness, destructive manifestations of acting out, such as striking another member, refusing to talk, or preventing others from talking, running out of the room, and unexplained and protracted delays in payment of fees.

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The need for alertness to these resistances is also noted by **Yalom (1970)**:

The therapist must recognize and negotiate any factors which foster or portend group dissolution. Continued tardiness, absences, subgrouping. disruptive extragroup socialization, scapegoating—all threaten the integrity of the group and command the intervention of the therapist. (p. 84)

The extent of one prevalent form of group-destructive resistance, premature termination, is reflected by Yalom. He observes that in the normal course of events, 10 to 35 percent of members drop out in the first 12 to 20 sessions and that a similar percentage of new additions drop out in the first dozen or so sessions. **Johnson (1963)** paid particular attention to this problem. He estimated that group losses average between one-third and one-half of the original members, citing a statistical study of eight groups of eight members each, in which total losses during one year were 26 patients, or 40.6 percent.

The forms and varieties of destructive resistance are multiple and may occur as individual, subgroup, or total group phenomena. A blatantly destructive behavioral pattern is reported by **Kadis et al. (1963)** in their description of Stanley, an individual who drove three successive new members out of a group. Upon the arrival of a new member Stanley would immediately interrogate him about his reasons for wanting group therapy and would offer evidence to indicate that the group and the therapist could not help him. This barrage created such anxiety that new members fled. When other members tried to stop his behavior, Stanley maintained that he was only exercising the privilege of expressing his feelings. This illustrates in extreme form a resistance in which freedom of expression is misused to gratify murderous impulses.

An example of a whole group enacting a treatment-destructive resistance was that of a natural group of predelinquent early adolescent girls who were referred as a unit by their school to a child guidance clinic. The group was seen on an exploratory basis by an experienced group therapist. These early sessions were marked by vivid descriptions of perverse sexual acts and of acts of sadistic aggression in an atmosphere of excitement. It was then discovered that the group members met before the group sessions to plan a

contrived sexual and aggressive agenda designed to shock the therapist. When exploration of the girls' attitude toward the contact with the clinic revealed that they had little interest in attaining understanding of themselves and also had continuing strong wishes to defeat authority, group sessions

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were terminated. Several girls were later able to use individual treatment constructively.

In a group of mothers of disturbed children, two members developed strong reciprocal negative transferences, each perceiving the other as her critical and rejecting mother. Their bitter exchanges dominated the group and kept it in a state of tension. Each bitterly accused the therapist and other members of favoring the other. Each of the combatants tried to blackmail the analyst into eliminating the other, by saying, for example, “I'm not talking or listening as long as she's here.” After unsuccessful attempts to deal with them as individuals, the analyst addressed the two belligerents as a resistive subgroup, telling them that they were both acting in a blatantly uncooperative manner without regard for the treatment needs of the other members. Reflecting their blackmail, the therapist warned that if they could not behave more cooperatively, he'd have to ask both to leave. With their acting in curbed by the therapist's intervention, the two rivals were able to remember their intense struggles with their mothers and siblings for the attention of their fathers.

In his essay on group psychology, **Freud (1921)** observed that sexual love relationships were inimical to the formation and development of groups. This is true for group analysis where sexual acting out among members can seriously endanger group integrity. **Yalom (1970)** says,

> *Clinical experience has taught us that members of a therapy group who establish a sexual relationship will come to value their dyadie relationship more than their therapeutic group. They cease to be helpful to one another; they refuse to betray confidences; in their efforts to be charming to one another they affect poses in the group; they live for one another, blurring out the therapist and other members, and, most importantly, their primary goals in therapy. The effects on the other members are equally antitherapeutic. They resent being left out, they resent the amount of energy consumed by the dyad; they are restricted by the sexualization of the group process. It has been my experience that, with extreme effort, the therapist can turn such an event into therapeutic profit. However, the process is risky and exacts a high toll from the rest of the group. The therapist does well to heed Freud's warning to discourage sexual love between members of his group. (pp. 79-80)*

Alertness by the group analyst can forestall action by mutually attracted pairs by eliciting verbalization of their feelings for each other in the group sessions. As the therapist becomes aware of two members

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looking at each other with interest and excitement or addressing their remarks primarily to each other, he may bring their relationship under group scrutiny and subject it to prophylactic exploration and analysis. He might ask why John and Mary are more interested in each other than in anyone else in the group.

Monopolization of the group session by an individual or subgroup can effectively deny treatment to other members. Ed, a member of a newly formed adult group, would talk on and on about his own feelings and experiences with no awareness of the obvious restlessness, boredom, and frustration of his fellow members. Whenever the therapist intervened to ask Ed how he thought the group was reacting to him or how much time he thought each member should have in a session, Ed would shrug and slump into hurt isolation. His marked early deprivation had rendered him unready for the frustration of group living. In individual treatment after his removal from the group, Ed recalled constantly stealing food from his siblings at mealtimes.

Group analysts have no immunity from destructive wishes toward their groups, and the enactment of these impulses may include any of the following: forming blatantly ill-suited groups that are bound to disintegrate; permitting destructive behavior; avoiding setting a group agreement that defines what constitutes desirable and cooperative behavior; permitting the group to dwindle without replenishing it with new members; bringing in new members without adequately preparing the group; being abruptly and repeatedly absent; seducing members into individual contacts; rejecting every potential group member in the screening process. The cumulative impact of the great amount of emotional stimulation to which the group therapist is exposed—the feelings of each member toward him and toward each other and his own countertransference toward each member and toward the group as a whole— all combine to seriously test his disciplined capacity to feel those feelings and then act in appropriate therapeutic fashion.

The presence of destructive resistances appears to be related to destructive experiences in the life histories of the individuals who use them. They seem to need both to repeat those experiences in the group as victim and to victimize others through identification with the original aggressor. Understanding of the toxic experiences of the individual in his crucial developmental years alerts the group analyst to predictable patterns of destructive resistance. Knowledge of the life histories of prospective group members is essential to developing a group with the potential for cooperative functioning so that the therapeutic process will operate for the emotional benefit of all the members.

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Rosenthal, L. (2005). Resistance in Group Therapy: The Interrelationship of Individual and Group Resistance*. *Mod. Psychoanal.*, 30B:7-25

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