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Resistance of the Non-Communicating Patient in the Group*

Hyman Spotnitz

The term "non-communicating patient" is useful for discussion purposes, but we recognize that it is not strictly accurate. When two or more persons assemble in the same place, some type of communication goes on between them provided that at least one of them has the capacity to recognize it. Even though they do not communicate voluntarily and intentionally in words, they convey information about themselves through whatever else they do as they maintain silence. A momentous message may be transmitted involuntarily and unintentionally through an action, such as the first kick by which the unborn child notifies the mother of its presence. As Emerson remarked, "Actions are a kind of words."

Resistance too is a "kind of words." Through resistance, a person undergoing psychotherapy 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 analytic psychotherapy. Resistance is now conceptualized as the primitive, inadequate, indirect form of self-revelation which is characteristic of a person who functions on a level of emotional immaturity. In a letter to Wilhelm Fliess in 1897, Freud referred to resistance as an "objectively tangible thing," and "in the last resort the thing that stands in the way of the work" of the psychoanalyst. He also registered agreement

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with this modern concept in the following words: "Resistance … is nothing but the child's character."

While silence is usually technically classified as resistance, we distinguish such immature forms of communication from those silences that, in psychotherapy as in real-life situations, are an appropriate expression of an emotional state. In other words, silence does not invariably operate as an obstacle to progress even in individual therapy; and in the shared psychotherapeutic experience progress would be impossible if each group member did not intersperse his verbal communications with intervals of attentive listening. A democratic sharing of time and attention is desirable, not mathematically allotted among the participants per session, but averaging out more or less on a long-term basis.

As I have just suggested, a person who grossly *underparticipates* in the group's verbal interchanges does communicate information about himself even when he is not functioning cooperatively. Therefore, instead of describing him as a non-communicator, I prefer to deal with him as an *immature* communicator. He has encountered obstacles to personality maturation that make him incapable of engaging consistently in mature verbal communication. The goal of his treatment is to help him resolve these obstacles. If treatment provides the growth ingredients he requires, he will voluntarily give up his infantile modes of communication and will progressively engage in communication on more advanced levels. In brief, treatment is oriented toward personality maturation in terms of communication function.

The various forms of immature communication, which are dealt with as resistance patterns, are fundamentally the same in both treatment settings. The group therapist observes the operation of five different types of resistance phenomena, utilizing at least twice that number of personality defense mechanisms. One of the five forces that block cooperative communication is designated as *ego* resistance, which signifies an objection—a conscious objection though the patient may not be aware of the reason for it—to disclosing information about a specific area of his experience. *Superego* resistance denotes an unwillingness to endure the shame, embarrassment, or other unpleasant feelings entailed in the process of disclosure or expected to ensue from it. *Transference* resistance motivates the withholding of information that might lead to a disturbance of the

therapeutic relationship itself. *Id* resistance is associated with an unwillingness to lose some form of instinctual gratification which is important to the patient. Finally,

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there is *secondary gain* resistance. This springs from the anticipation that he will be required to give up some pleasurable experience if he reveals it or, eventually, that some special consideration accorded him because of his difficulties will have to be forfeited when he resolves them.

Naturally, the group setting endows these resistance phenomena with dimensions they do not possess in the individual relationship. The resistance pattern of the group member may operate in relation to the therapist alone, to one or more co-members, or to the group as a whole. For example, a person with a strong stake in continuing group membership who withholds a disclosure he believes will lead to expulsion, manifests transference resistance to the group as a whole. Another entirely new dimension is created when the same resistance pattern operates simultaneously in all or most members of the group.

The presence of common or group patterns in addition to the individual resistance patterns accounts in large measure for the more complex nature of analytic group process, and for the greater demands it imposes on the therapist. His skill in enlisting the cooperation of the group members in dealing with each other's resistances usually determines the success or failure of his efforts to promote personality growth through a shared treatment experience.

Fortunately, each patient tends to call attention to the resistant attitudes and behavior of his co-patients that differ from his own modes of functioning in the group. The therapist fosters this tendency of the group members to deal with each other's resistances by educating them to work well together as a unit and by responding appropriately to the total picture.

It is my policy to focus on this group pattern and to intervene primarily to deal with it. For example, the protracted silence of one member is usually a facet of a group resistance which can best be dealt with as a combined operation. The added advantage of this approach is that no member is neglected as the pattern is investigated.

Therefore, when one member remains silent, I begin my study of the situation by investigating whether the group consciously wishes him to be silent and is abetting this behavior. If it becomes clear that the others are helping him maintain silence, this is a combined operation; the whole group is engaged in this resistance pattern. Four types of interpretation may be indicated in this situation; it may be pointed out (1) that the silent member is being

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treated like a sacrificial lamb for the selfish purposes of the other members; (2) that they are helping a frightened baby escape becoming the center of attention; (3) that they are expressing their own desire to be silent through his silence; or (4) that they are combining with him in a sadomasochistic operation.

On the other hand, I may decide that the others really want the silent member to talk. In that case, I try to find out what blocks them from helping him talk. If the blocking is caused by their lack of understanding, I try to augment their knowledge of the situation.

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 fighting a nipple his mother is trying to put into his mouth. An older child can explain that he isn't hungry or isn't eating carrots because he is holding out for chocolates. The group members who have something to say and can't say it are expected to emulate the behavior of the older child. The appropriate way to withhold information is to explain *why*. For example, the patient may say that he has something on his mind too painful to talk about, or it is to his disadvantage to talk; he may also say that he cannot trust the group with the information.

Repeated interpretation and working through of an oedipal-type resistance to talking usually helps the group member to talk. On the other hand, preoedipal resistances may not be resolved by interpretation. They frequently require joining before the patient is able to give them up. For example, demonstrating by explanation or illustration that he has the right to withhold information may resolve the resistance. This entails discussion, understanding, respect for each other's privacy, and educating the group to the need to keep communications confidential.

When a patient learns through the group experience that a verbal explanation of the reason for withholding information is more effective and comfortable than total silence, the therapist benefits; he can then deal more easily with the maturer pattern, whether to help the patient preserve it or to help him give it up if he wishes to. Therefore, it is important to discover the reason for the apparent non-communication. A resistance which is supported because its use at the time makes sense may or may not be resolved later. In a therapeutic group climate, the objections to the disclosure are usually resolved eventually and the resistance melts away.

Special techniques for dealing with the habitual under-participator

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are employed by some group therapists, and some of them are reported in the literature. It is not my usual procedure to attempt to override resistance or to apply any available technique in a routine way. Interventions will not be effective in dealing with this problem unless they are based on the recognition of the specific factors associated with the silence of that patient in a particular group situation. Any short-circuiting of the process of understanding the patient is likely to get the therapist into trouble. One always has to begin with understanding. This takes much longer than intervening by rote, but by and large it assures the continued presence and favorable personality development of a problem patient who might otherwise have to withdraw 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. In my experience 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 of my groups, protracted and general silences constituted the outstanding resistance pattern during the initial stage of the treatment. When the members recognized that their silence was acceptable, they started, one after another, to talk about it. They recognized eventually that a strong wish to be liked by the others had operated as a block to meaningful communication. That wish, coupled with a fear of making disclosures that co-members would disapprove, is a common source of resistance in the therapy group.

In seeking to understand the under-participator, we must recognize that some of the thoughts, feelings, impulses, and memories he tends to hold back are, in essence, the product of a particular orientation to life. Organic disfigurements and physical disabilities often warp the psyche. In this patient population there are some exceedingly disappointed and frustrated individuals, full of rage for what life has done to them. Their psychological problems pretty much cover the spectrum of mental illness. Many of them suffer from depression, especially the reactive form, body image disturbances, strong feelings of ignominy, inferiority, isolation, and other painful emotions associated with the handicapping effects of their condition. These feelings are experienced not

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only in relation to society in general but also to the person in the helping role.

One usually finds that the greater the disability, the greater the dependency. 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 an even greater loss of self-esteem. Fear of losing desirable contact with other human beings and of being exposed to undesirable contact appear to dominate their behavior.

Let us consider the type of information that a physically disabled group member may be withholding, consciously or unconsciously, through the different types of resistance patterns that I have referred to. An ego resistance may conceal this message: I hate you for being whole while I am so crippled. Superego resistance may communicate shame over saying what one really thinks and feels in the presence of a person who is trying to be helpful. Transference resistance directed to the group may conceal the thought that expressing a lack of interest in helping the others with their problems would be like biting the hand that feeds one. Id resistance may indicate that the patient is not participating because he does not want to lose spotlight gratification—even if it is hostile. Finally, secondary gain resistance may indicate a fear of loss of privilege, such as low-cost treatment, if a fantasy is divulged of extracting revenge for his condition by disturbing other people.

Some of these feelings and thoughts are common reactions to bodily and environmental difficulties; others are not. But whether the reactions are appropriate or inappropriate, a therapeutic group experience does afford

patients opportunities to verbalize whatever they really think and feel, and to accept similar communications from others. Often patients are not aware of their negative feelings, especially for those who want to help them, and they may not be aware of their lack of self-approval. In a group climate that communicates the idea that they have the right to experience all of their feelings freely, to hate and to love and to verbalize everything, they discover that others feel and think as they do.

Some therapists have a need to be especially sympathetic to handicapped people and to assuage such patients' negative feelings. This approach, in my view, may serve to intensify the patients' resentments and compound their objections to verbalizing their true emotional state. On the other hand, the group setting

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facilitates the solution of the problem, because patients are much less inhibited in expressing anger in this setting than when alone with the therapist. Some patients who have never felt justified in coming out with their rage have been startled at the ease with which they explode at co-members of their group. If the therapist succeeds in creating a group climate in which they feel free to say whatever they think and feel, obstacles to the verbalization of feelings will be resolved relatively quickly, and the group members will be able to deal more constructively with their life problems.

To summarize briefly: resistances are handicapping and immature modes of communication which the group therapist works to transform into progressively more mature and comprehensible communications. By intervening effectively to deal with resistance, he accomplishes the dual purpose of the group therapeutic experience, which is to make the communications of the members more understandable and their understanding more readily communicable.

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