resistances until he is capable of mastering and outgrowing them lessens significantly the danger of a psychotic regression. Resistance is seen as a counterforce that is activated at the beginning of treatment, when the patient is directed to talk. "As this counterforce waxes and wanes, it gives rise to countless manifestations which the analyst recognizes and deals with as resistance. Attempts to overcome the resistance of an extremely narcissistic patient serve to intensify the counterforce. In order to diminish it, the pressure for progress is carefully controlled" (p. 144). The patient's patterns of resistance are also viewed as holding operations that the patient resorts to to maintain his psychological equilibrium in other life situations, as well as in treatment. Accordingly, their survival function is recognized and respected.

Additionally, resistance is seen as performing a communication function by conveying the behaviors that the patient had to utilize in preserving his ego in his crucial early years.

The modifications of the standard approach to resistance were organized by Spotnitz (1969b) in an approach he termed "modern psychoanalysis." In his book, Spotnitz notes the standard procedures for dealing with resistance: confrontation, clarification, interpretation, and working-through, with primary reliance on interpretation and the attendant achievement of insight by the patient. He describes his method as "a distillation of the classical approach that is in evidence from the opening of the case when "the therapist demonstrates the attitude that the patient has the right to resist" (p. 111).
Before we review the development of the concept of resistance in group therapy, an outline of the history of the group-treatment approach is appropriate.

The pioneer period of group therapy is generally considered to extend from 1907 to the early 1930s, and those most frequently associated with this period include Pratt, Lazell, Marsh, Burrow, Adler, and Moreno.

In 1905, Dr. Joseph Pratt, a Boston internist, organized the "home sanitorium" treatment of consumption at the outpatient clinic of Massachusetts General Hospital. His weekly meeting with indigent patients was admittedly a timesaving device; his brief inspirational talks were given to help patients maintain the hygienic regimen he prescribed. Pratt's awareness of some of the psychological dividends of group membership—feelings of belonging, mutual support, and identification with fellow members—is reflected in his description of the weekly meeting (Pratt 1907): "The Class Meeting is a pleasant social hour for the members. One confided that the meeting was her weekly picnic. Made up as our membership is of different races and
sects, they have a common bond in a common disease and a fine spirit of comradery has been developed" (p. 14).

Psychiatrists in mental hospitals were stimulated by the possibilities of Pratt's approach. About 1910, Lazell and Marsh began to apply group methods to the treatment of psychiatric patients, hoping to positively influence poor morale and counteract their isolation and emotional withdrawal. In 1918 Lazell gave a series of lectures to groups of schizophrenic war veterans. He spoke to them in simple language about their war experiences and the causes and symptoms of their illness.

In a 1921 article, Lazell listed the advantages of the group method:

1. The patient's fear of death and of his sexual problems were universalized, with resultant alleviation of feelings of damage and stigma.
2. The patient's fear of the analyst was diminished in the presence of the group.
3. The patient who seemed totally inaccessible was found to have heard and retained much of the lecture.
4. The patient developed positive transference to the speaker and sought individual contact with him.
5. The patient was emotionally activated.

Lazell also noted another distinct advantage of the group method: The patient's problems were reactivated thus unsettling his passive adjustment to the security of the institution.

Marsh, a minister and morale officer in World War I before entering the field of psychiatry, employed techniques he described as the "psychological equivalents of the revival." Working with patient groups that averaged fewer than twenty people, Marsh sought to emotionally stimulate his patients through lectures, discussions, singing, and dancing. The development of a group bond through crowd psychology, morale boosting, and salesmanship made it easier, he stated, to "sell sanity" to members of a group than to a solitary patient in his office. He experimented with the idea of a therapeutic community in which all the personnel would be involved in a common
effort to fully develop themselves. He organized lecture series for social workers, occupational therapists, chaplains, medical and nursing personnel, and ward attendants, which focused on helping them to attain self-understanding as a prerequisite to understanding their patients. Each participant was asked to make a personality chart that traced his own emotional development. At Worcester State Hospital, Marsh utilized the hospital radio equipment to deliver mental-hygiene courses and lectures to the patients. Stressing the social and environmental aspects of mental illness, he adopted the credo: "By the crowd have they been broken; by the crowd shall they be healed" (Marsh 1931, p. 349).

Another pioneering effort was that of Alfred Adler, who, in 1921 in the Vienna School Guidance Clinics, began to counsel children before groups that included social workers, teachers, and physicians studying his procedures. Although Adler's initial purpose was instructional, it was subsequently observed that the group procedure was producing emotional effects among the spectators and favorable effects in the therapist-patient relationship.

Trigant Burrow (1927) is recognized as the first American psychoanalyst to practice group therapy. A pupil of Freud who later developed a social theory of behavior called phyloanalysis, Burrow began his private practice of group analysis in 1918. He and his students analyzed one another in experimental laboratory groups of from four to twenty members. In general, Burrow felt that the Freudian emphasis on the individual and his phenomenology was wrong. Burrow felt there were no individuals in society, only members of groups. Since his group activities were primarily oriented to social research, rather than to therapy, and because he gave up his groups to devote himself to the development of his social theories, Burrow did not heavily influence events in group therapy.

Moreno is considered to have played a role in propagating the more recent phase of group therapy. His name is most identified with the application of role-playing in the framework of group psychotherapy and psychodrama, an approach he developed in experiments with groups in Vienna before World
War I. (While a medical student, he attempted to help prostitutes rehabilitate themselves through group procedures.) In 1932, Moreno introduced the term *group therapy* to describe a method of grouping prisoners so their interactions would be mutually beneficial.

Louis Wender is considered to be one of the first to conduct psychoanalytically oriented groups, having done so in a hospital setting in 1930. Like Pratt, Lazell, and Marsh before him, Wender (1936) utilized lectures and theoretical discussion. He described his approach as being based on the following assumption:

The application of some of the hypotheses and methods of psychoanalysis, when applied to a group for the purposes of treatment, will lead to the release of certain emotional conflicts and a partial reorganization of the personality and ultimately to an increased capacity for social amalgamation. [p. 54]

Wender's group sessions were begun with lectures on instinctual drives, conscious and unconscious elements of the mind, the significance of dreams, early infantile traumatism, and the varying defense mechanisms. Wender reported that "a sense of intimacy within the group develops, greater freedom from inhibition is observed in theoretical discussions and is followed by a spontaneous readiness on the part of some patients to discuss their own problems" (p. 55). Along with insight, patient-to-patient transference, and reality checking through group interaction, Wender listed "catharsis-in-the-family" as a basic dynamic of his group approach (referring to the patient experiencing a significant degree of acceptance, respect, and love within a symbolic family setting provided by the group).

Paul Schilder, a prominent psychiatrist, began work with therapeutic groups in 1935 at Bellevue Hospital in New York. Each patient was seen individually before joining the group, and individual sessions continued in conjunction with group sessions. Schilder also began group sessions in a structured way, with studies of case histories of group members. These histories were based on an elaborate set of questions that elicited information about the patient's life history, including early infantile material, fantasies, familial relationships, and sexual development. After review and study of a member's case history, a freer type of discussion ensued, which Schilder described as a form of free association. Dream interpretation was also a standard feature of Schilder's group treatment. He specifically advocated the use of group therapy in alleviating the patient's feelings of being isolated. He reported that a group member's recall of sexual feelings toward his sister evoked similar memories in other members, and stated: "The relief patients experience when they no longer feel excluded from the community because of their urges and desires that society does not openly tolerate is remarkable" (p. 90).

Schilder noted that many of the cases treated in the groups could not have achieved as good results in individual analysis. He suggested group psychotherapy in cases of "social neuroses" characterized by marked discomfort in the presence of others, a reluctance to be observed, and accompanying physical symptoms such as abdominal discomfort, excessive sweating, and blushing.

In 1934, Slavson began applying the concepts of individual psychoanalysis to children's groups at the Jewish Board of Guardians in New York. He developed activity group therapy, a group-treatment modality widely used today with children in the 8–12 age range. This approach (1943) utilizes a highly permissive setting in which the children express and discharge their pent-up feelings in the presence of an unconditionally loving therapist. In this method Slavson stressed the corrective impact of the dynamics of regression, the positive transference toward and identification with the therapist, the cathartic expression of feelings of anger toward sibling figures in the group, and the strengthening of the self-image through acceptance by the group "family." As he extended his work to adolescents and adults, Slavson (1950) termed his approach "analytic group psychotherapy," which he defined as directly descended from psychoanalysis.
Analytic group psychotherapy employs transference, catharsis, interpretation of latent content of the patients' communication; it deals with infantile sexuality, the unconscious, the basic hostility of man's nature and accepts the inherent intrapsychic conflict between the id and superego and its effect in determining of character, personality and pathology. [p. 18]

Alexander Wolf, a New York psychoanalyst, began working with groups in his private practice in 1938. He described his work as “psychoanalysis in groups,” based on the four pillars of Freudian psychoanalysis: dream interpretation, free association, the analysis of transference, and resistance. He assumed that the patient’s repressed memories were as accessible in a group situation as in individual psychoanalysis, and that they were exploratory through the techniques of free association and dream analysis.

The slow but steady development of group therapy in institutional and community settings was tremendously catalyzed by World War II, when military psychiatrists were faced with huge caseloads. Psychotherapists improvised, tested, and developed a wide array of group approaches to deal with the streams of patients suffering from battle fatigue, acute anxiety states, hysteria, and other disturbances. On returning to civilian life, many therapists who had worked with groups in a military setting began to use group therapy in their private practices or became affiliated with similar treatment programs in hospitals and social agencies. Extensive research in group treatment, conducted by Powdernaker and Frank in Veterans' Administration hospitals, stimulated the awareness and growth of group therapy in this country.

POST-WAR CONTRIBUTIONS

The first published contribution dealing specifically with resistance in group therapy was made by Fritz Redl. In his paper, Redl offered observations on resistances demonstrated by individual members of groups of delinquent adolescents. He indicated there are “group psychological defenses against change and treatment reaching far beyond the scope of individual behavior” (Redl 1948, p. 307). He identified several of these group resistances, including “escape into love,” whereby the group lures the therapist into a loving relationship while maintaining their delinquent behavior outside the group. Also cited was “protective provocation,” whereby the group courts rejection by the therapist to avoid treatment and growing up.

In his comprehensive paper “The Psychoanalysis of Groups” Wolf (1949–1950) saw the analysis of resistance as one of the basic stages in his method. Wolf observed that the group setting provides a special environment lending itself to the elaboration of resistive forms peculiar to it, and he identified some of the most commonly encountered ones. “Fickle transference love,” where a patient claims to be in love with the analyst but soon becomes emotionally attached to another group member, is confronted in the group as a compulsive pattern. Another manifestation of resistance is the “compulsive missionary spirit who persists in looking after group members in a supportive parental way, using this device to subtly dominate and to repress more basic feelings. The group always resents this false charity and demands and evokes more spontaneous participation from the messianic” (Wolf 1949–1950, p. 38). Voyeurism, a resistance unique to the group setting, is utilized by those patients who try to escape personal examination and engagement by taking grandstand seats which give them a gratifying view of what may be the equivalent of the primal scene. They seem willing and even eager to allow others full interaction, while they assign to themselves a tremulous watchfulness. [p. 39].

Hiding behind the analysis of others is portrayed as a common resistance in a group situation, which provides a convenient setting for its exercise. This is characterized by a concentration on the neurotic behavior of other patients, with
an accompanying evasion of analysis directed toward oneself. The use of history as resistance is seen in patients who produce long, irrelevant biographies as a form of evasion. Reluctance to discuss sexuality is also listed.

Wolf notes that resistances are as manifold and distinct as human beings themselves. Some try to hide in the group; some seek to escape into a group from individual treatment. Some exhibit contempt and a supercilious avoidance of members they regard as inferior. Some seek to overwhelm the group “with endless outpourings of irrelevant talk” (Wolf 1949–1950, p. 43).

Wolf also observed that the catalytic atmosphere of mutual revelation in the group setting exerted a significant influence in dissolving resistance.

Wolf and colleagues (1954) later addressed the resistance of sexual acting out among group members. Although they recognized its resistive and destructive aspects, they suggested such behavior had constructive potential for the working through of conflicts.

From 1948 to 1951, W. R. Bion, a British psychiatrist, wrote a series of influential articles in which he postulated concepts of unconscious basic assumptions underlying the behavior of groups. Every group was seen as having two aspects, or two different modes of behavior: the “work group” and the “basic-assumption group.” The work group is that aspect of group functioning that has to do with the real, stated task of the group and therefore attempts to be organized, rational, purposeful, and constructive. Beneath this overt, conscious level, Bion sees the life of the group as entirely different. On this latent level, group members come and stay together because of strong needs that are embodied in their basic assumptions. Bion (1948–1951) suggested that these emotional forces fall into three distinct categories: dependency, fight-flight, and pairing.

The essential aim of the basic-assumption dependency group is to attain security through the leader. Members act in an inadequate and immature manner, as if to imply that the leader, by contrast, is omnipotent. Benefit is not felt to come from other members, but from the leader alone, with the result that members feel they are being treated only when talking to the leader. The leader is thus idealized and made into a godlike parent who will care for his little children.

The second assumption is that the group has met to preserve itself and this can only be done by fighting (someone or something) or fleeing. Such a group is, in Bion’s view, dominated by the need for action, and tends to be anti-intellectual and opposed to the idea of self-examination. The leader is expected to mobilize the group for attack or lead it in flight.

In pairing, the assumption is that the group has met for purposes of reproduction and to bring forth someone who will act as a savior. To achieve this end, two members are selected to symbolically “get together” and carry out the pairing task; thus, the group may tolerate and encourage a strong emotional tie between two of its members. A group dominated by this assumption is pervaded by an atmosphere of eager helpfulness and optimism. The group climate is one of pleasant agreeableness beneath which, Bion suggests, is considerable aggression.

These basic assumptions represent obstacles to the fulfillment of the group’s stated goals and can be seen as major sources of resistance in the group setting. The basic-assumption phenomena appear to be conceptualizations of similar forces discussed by Spotnitz in his formulations of the inadequacy (dependency), reproductive (pairing), and negative-reproductive (fight-flight) constellations.

Spotnitz and Gabriel (1950) described how emotional currents operate as resistances to the therapeutic process. One type, the “reproductive constellation,” comprised those forces in adolescent girls and mothers that are present in the desire for sexual gratification, pregnancy, and the wish for a healthy child. The “inadequacy constellation” concerned the emotional and physical inadequacies that deterred individuals from fulfilling the goals of the reproductive constellation. These inadequacies were evidenced in pervasive feelings of inadequacy, inability to cope with the demands of school and work, and feelings that legitimate sexual satisfaction was unattainable.

In resistances based on the inadequacy constellation, the
Groups reacted with inadequacy when confronted with the therapist's request that they tell their life stories. The reproductive constellation operated as resistance when group members sought gratification by talking about sex and seeking immediate satisfaction for genital and related pleasures, rather than trying to understand themselves and one another. As Redl had done, the authors identified resistances of individuals and of the group as a whole.

A third category of resistances, one induced in the therapist by the group, was also identified. The idea was introduced that group members tend to deal with one another's individual resistances "so that eventually they could unite in dealing with the therapist who was not gratifying them" (Spotnitz and Gabril 1950, p. 77). It was noted that the resistances served a significant function: Their maintenance helped the members to adjust to the forces stimulated by the immediate stresses due to the operation of the inadequacy and reproductive constellation. The utilization of resistances served to preserve the status quo and to maintain the existing relationships (p. 84).

Spotnitz's next paper (1952a) represented a seminal contribution on several levels. First, it clarified the nature of resistance in the group setting. Second, it brought the new field of group psychotherapy under the umbrella of long-established Freudian concepts, while simultaneously explaining some of the basic dynamics of resistance as molded by the group setting. The same types of resistances delineated by Freud in individual analysis also appear in the course of group therapy. Spotnitz suggested that the individual resistances of group members may unite to become a group resistance, which is defined as the same form of resistance being used by all or a majority of group members at the same time. In this paper, Spotnitz offered an understanding of resistance as an effort—on the part of an individual or a group—to hold a feeling in check. It was also suggested that the resistance could not be effectively dealt with until the emotional forces behind it were understood.

In another contribution, Spotnitz (1952b) offered the following definition of resistance: "When individuals are gathered in a group for therapeutic purposes and are directed to give an account of their life histories, feelings, and thoughts in a spontaneous, emotional, significant way, it is natural that they will find it difficult to do so, and the voluntary and involuntary methods they use to avoid presenting the desired material are considered the resistances" (p. 95). He also observed that the resistances of the individual patient are strengthened in a group setting through the presence of diverse personalities. The need for increased use of regression as a defense is therefore significantly lessened. Instead, less dangerous defenses are adequate for the individual, and the therapist can study these at a more leisurely pace, with less danger to the emotional stability of the individual patient. The main task of the therapist is defined as "how to deal with the resistances that are common to all members of the group in their relationship to him" (p. 92).

Spotnitz presented two fundamental differences in the operation and handling of resistance in group and individual therapy. First, group members tend to deal with one another's resistances. This may be done constructively or destructively, and it is the therapist's task to enlist cooperation among group members in dealing constructively with one another's resistances. Second, group members tend to develop a common (group) resistance.

Spotnitz also applied Glover's concept of counterresistance to the position of the group therapist: "The common resistances of the group tend to stimulate in the group therapist counter-resistances" (p. 85).

FURTHER CONTRIBUTIONS: 1950–1955

In the early 1950s, other clinicians began to identify varied resistances in the group setting.

Prados (1951) found that the adjunctive use of films was effective in overcoming resistance in group therapy, especially in loosening the barriers of repression. He emphasized the
value of group therapy in helping patients achieve insight into their defense mechanisms. The dynamic processes in the group setting broke down narcissistic barriers, thus rendering it easier to deal with many resistances that would be difficult to recognize and handle in individual therapy.

Prados (1953) also focused on the reactions of patients in individual therapy to the invitation to join a group as a fruitful opportunity for the uncovering of a series of resistances that extended into the patient's early group sessions. He observed that the feeling of being supported by the group makes the patient more capable of withstanding his impulses. This reduces the danger of regression more than individual therapy.

A group of clinicians at Johns Hopkins Hospital (Frank et al. 1952), identified several consistent behavioral patterns of resistance that they observed in early sessions of therapy groups. These behavioral types are termed the "help-rejecting complainer" and the "doctor's assistant." The first continually clamors for attention to his problem and simultaneously rejects any advice offered, maintaining the helplessness of his situation. The second pattern reveals itself in a patronizing, helpful-offering attitude toward other patients: the giving of repressive, trite advice and the stimulation of others to express their difficulties. When pressed to reveal themselves, these "assistants" tend to withdraw from treatment.

In a subsequent paper from this group, Rosenthal and colleagues (1954) described the "self-righteous moralist," whose major characterological pattern is the need to be right and to prove others wrong, particularly in regard to moral issues such as justice, sacrifice, responsibility, and gratitude. Such an individual manages to become the central figure by indefinitely restating his position. He shows no ability to concede, compromise, or admit error, and demonstrates no awareness of his effect upon other group members. In the area of therapeutic management, the authors emphasize that this type of patient needs early support for his need for status, while other members may simultaneously need protection from him.

In a discussion of transference in group therapy, Glatzer (1952) noted that the presence of others admitting to difficulties has a significant loosening effect on previously suspicious and highly resistive patients. The inclusion of diverse personalities in groups is recommended as productive of intragroup transference and the erosion of resistance.

Glatzer (1953) also observed that positive transference seems to be facilitated by the group, which is helpful in overcoming initial resistances. However, she cautioned alertness to the resistances of negative feelings underlying the positive transference, and deemed it an error for therapists to encourage the prolongation of the positive aspect. She warned that "unless individual resistance is penetrated, there is danger it may spill over and turn the whole group against the therapist" (p. 41).

A focus on transference resistances was presented by Taylor (1952). Resistances discussed included patients displacing aggression against one another, scapegoating, leakage from group discussions, silence, formation of conspiratorial friendships outside the group, and turning of group discussion into mere symptom description. One form of transference resistance, erotic contact outside the group, was effectively handled by the issuance of "prophylactic predictions" (p. 133) of such behavior by the therapist. It was noted that certain patients—who occupy dominant positions in the group but are unpopular—show high incidence of premature termination. This resistance of the "flight of the deputy leader" is handled by predicting his withdrawal and initiating discussion of the feelings he induces in the group.

In their comprehensive research project on group therapy in Veterans' Administration hospital settings, Powdemaker and Frank (1953) pointed to resistance of the whole group as "one of the greatest challenges to the therapist's skill" (p. 384). They accepted the necessity of dealing with it and suggested some techniques. They also reported that the resolution of resistance in a patient was often facilitated by other group members. A resistant member might begin to participate as the protégé of another patient with whom he identifies. He may follow the leader of another patient who expressed feelings similar to his own and was accepted by the group. The group itself may
convince the reluctant patient that his underlying feelings are more acceptable than his defense.

Shea (1954) compared resistance reactions in individual and group psychotherapy, noting that: (1) group therapy makes possible for some patients the dissolution of resistances that are intractable in individual therapy; and (2) in still other patients, whose resistances would eventually succumb to individual treatment, the group setting markedly catalyzes the process.

Durkin (1954), in a book on the group therapy of mothers, saw the nature and management of resistance in group therapy basically the same as in individual therapy. However, she noted some special conditions of group therapy affecting resistance. These refer to group members sometimes reinforcing one another’s resistances, sometimes helping to fight them. Additionally, certain resistances are easily hidden in the group setting. For example, the patient with strong voyeuristic tendencies who appears eager to help another member by questioning her about her feelings and various aspects of her life. The exhibitionistic patient may enact her unconscious impulse through the giving of seemingly valuable material of a sexual nature. The defense of living by proxy may also be concealed within the group fabric. In the same way, in sexually homogenous groups, homosexual feelings can be unconsciously gratified by talking about otherwise forbidden subjects. Intense transference feelings among members may be acted out between sessions and lead to withdrawal from group participation, a situation to be forestalled, the author indicates, by early interpretation of growing transferences.

Durkin observed that patients with similar defenses tend to have blind spots for one another’s resistances. Durkin gave special attention to character resistance, noting that groups act as a magnifying glass for the examination of character. Members connect on one another’s ingrained attitudes and patterns: “You’re always so dignified,” or “You always have that smile.” The unified weight of group opinion can exert a powerful impact on even rigid character traits.

In their remarks on the special features of group therapy and their implications for the selection of patients, Freedman and Sweet (1954) noted a special aspect of resistance they termed “sibling support.” In this situation, some or all of the members cooperate with a defensive member in warding off a threat of therapeutic participation. Such concerted group activity serves to support individual resistance by obscuring its true significance as resistance. The group setting is seen as offering opportunities for the freer play of resistances, permitting patients to refrain from participation and emotional involvement, which allows more prolonged periods of resistance than individual treatment. The presence of other forces in the group that work to dissolve resistance, such as the mutual stimulation of members, is acknowledged.

Fried (1955) described the therapeutic benefit of combined individual and group therapy for passive-narcissistic patients. The monotonously friendly, seemingly cooperative, submissive behavior demonstrated by these patients in individual therapy is seen as evidence of “the intense resistance to any reorganization of the personality.” This resistance and the resistive barrier of narcissism are breached in the group setting, where such patients are enabled to experience their hostility.

Mann (1955) presented the thesis of a powerful group-destructive resistance: “Any group tends to mobilize very quickly its disruptive forces in an attempt to provoke dissolution of the group so as to avoid tender, constructive, self-sacrificing libidinal investments in the therapist and in each other. The chief weapon in the service of the need is hostility” (p. 237). Fear of terrible retaliation for sexual and aggressive fantasies is viewed as giving rise to the “enormous resistances against the kind of close participation that is offered to the members” (p. 237).

Morse and colleagues (1955) presented a case illustration of the effect of group therapy in diminishing resistance to individual treatment. The patient, highly guarded and suspicious, adhered rigidly to the stand that he had been perfectly well until his military service and any discussions of childhood events and familial relations were therefore irrelevant. Any attempt to guide therapeutic discussion in those directions during individual therapy was met with strong resistance.
the group setting, the patient was exposed to peers who revealed the early childhood bases for their current illnesses. The patient soon became more productive and spontaneous in individual therapy; his identification with other group members was seen as the chief tool in the resolution of his resistance.

The resistances of orally dependent patients in group therapy were examined by Beukenkamp (1955). Such patients seek an exclusive relationship with the therapist and enter the group with no investment in any of its members. When the therapist does not respond to their demands for dependency, the resultant frustration can activate oral-sadistic behavior. Some sit defiantly on the periphery of the group; others ask repeatedly, "What are we to do here?" and "What is expected of me?" Some take it upon themselves to be the "teachers" or "junior therapists" as a denial of their own wishes to be cared for and fed. Dissolution of these resistances is accomplished through the group becoming the "protective parent" and by the therapist gratifying the oral hunger by paraphrasing what these patients have said, rather than by interpreting the material.

Cameron and Stewart (1955) reported on resistances encountered in group therapy with chronically neurotic patients in a hospital setting. One such resistance, termed "failure of theme development," involved casual social conversation about unconnected subjects, which ultimately took the form of silence that was a chronic group resistance. Acting out, irregular attendance, and intense hostility to new members (which effectively closed the group to new patients) were also resistances in evidence.

CONTRIBUTIONS: 1956-1959

In 1956, Cameron and Freeman discussed the resistances they encountered in group therapy with inpatients suffering from depressive reactions. Resistances were classified as either belonging to the group as a whole or to individuals. Group resistances were expressed in silences, in permitting one member to deliver prolonged monologues, or by a majority of the group engaging one member in discussion of innocuous material. Quarreling by subgroups was reported as another expression of group resistance. Withholding of information, deflection, absenteeism, and avoidance of discussion of one's own sexuality were mentioned as individual resistances. In dealing with the resistances, the writers utilized interpretation addressed and limited to the immediate group situation and in the context of the group as a whole. The interpretation of negative transference allusions, in which the group would discuss how various doctors had erred in treating them, resulted in their becoming aware of this latent hostility against the therapists. After awhile, the patients learned to anticipate these negative-transference interpretations, and this was employed as a group resistance. The therapist observed that groupwide interpretations were then not personal enough to allow the patients to react to them emotionally; subsequently, individual interpretations of resistance and transference were made.

In their description of an adolescent group-therapy program, Becker and colleagues (1956) paid special attention to the individual member's resistances. Among those reported were the expansive, narcissistic youth who overwhelms the group with his charm; the critical attitudes of the perfectionistic youngster who may withdraw into silence or scornful aloofness; the self-effacing and ingratiating youth; and the resigned member who needs constant encouragement to participate.

Bross (1966) evaluated some of the factors involved in premature termination of patients in group therapy. The dynamics reported included: feelings of rejection by the group "family"; strong dependency needs that promote repetitious testing of the therapist and group; intense anxiety generated by group interactions; fear of the unknown—"a frightening awareness of disorganized and destructive unconscious impulses which force abandoning the group to forestall a breakdown of ego defenses" (p. 392).

Slavson (1956) examined the nature and treatment of acting-out resistance in group therapy and noted that the ego finds, in