acting out, “a shorter, easier and more primitively direct route to discharge anxiety, guilt and aggression than working it through by the prolonged and arduous road to verbalization and insight” (p. 11). Acting out is defined as the “transmutation of emotional tension into physical expression that may stem from temperamental dispositions or psychogenic stress and from inadequate ego controls of general or specific impulses” (p. 9). The author describes a variety of acting-out resistances. Acting out through aggression, withdrawal, or silence may appear: as a reaction to fear and anxiety in the group situation; as provocation based on masochistic need or latent homosexuality; as striving for status through exhibitionism, domination, and rivalry; as “emotional hypochondriasis” based on the yearning to be pitied and to receive sympathy. Slavson observes that acting out can be contagious and thus become a group phenomenon of resistance. The acting-out syndrome of compulsive talking is focused on as a resistance that has a very adverse effect on groups. The transference nature of acting out is stressed.

Durkin (1956) reviewed group psychotherapy with mothers and presented two forms of resistance to which mothers’ groups are especially prone. First, after the initial phase of the group, they revert to talking about children, usually as a defense against repressed aggression or sexuality that is displaced onto the child. Second, they talk of sexual material, which seems valuable, but is essentially a disguised enactment of their homosexual feelings toward one another or the female therapist.

In a review of group therapy with patients suffering from psychosomatic disorders, Stein (1956) recognized in these patients a powerful resistance to the idea that their somatic complaints had psychogenic causes. This resistance strongly united the group in aggressive attitudes toward the therapist.

In an evaluation of the dynamic factors involved in the treatment of borderline schizophrenics in group therapy, Spott-nitz (1957b) noted that resistances are not overcome, but outgrown. The resistances exhibited by this type of patient are identified as resistance to spontaneous emotional communica-

The concept of resistance in group psychotherapy was articulated by Zifferstein and Grotjahn (1957): (1) Acting out is more common in group therapy, because tendencies to act out are stimulated by the unconscious impulses and anxieties of other members. (2) Acting out is therapeutically useful only as a transition to understanding. Essentially it is a resistance—at times a dangerous one—and it should be treated as such. (3) Interpretation, consistently applied, results in the recovery of the memories and associations that are being enacted rather than remembered.

In studying the emergence of common forms of resistance in group therapy, Kotkov (1957a) presented the categories of control and avoidance of feeling, denial of emotion and anxiety, and belligerence and antagonism. These reactions that permeate resistance are manifested through difficulties in speaking, antagonistic reactions, mobilization of symptoms, and queries about the efficacy of treatment.

Kotkov discusses silence as a protection against the discovery of weakness, a defense against revelation of hostile fantasies, a defense against punishment and rejection, and as an expression of ambivalence toward treatment. Antagonistic reactions are viewed as a hostile defense against treatment and the emotional acceptance of illness. They are also seen as: a reaction to fear; displacement from traumatic experiences of the past; a defense against guilt from gratification (i.e., the acceptance and attention they receive from the group, to which they feel unentitled); and defense against developing positive feelings toward others in the group. In the category of mobilization of symptoms, the author cites Obstinate attempts to blame psychological symptoms on physical causes: “They have a desperate desire to retreat into the organic in order to escape talking about their thoughts. They flee into their symptoms when threatened by situations which recall infantile fears of inadequacy” (Kotkov 1957a, p. 94). Obsessions, the author states, “are used as an escape from subjectively exaggerated
responsibility and the conviction of failure with attendant anxiety” (p. 95). The author suggests that group therapy should centralize its efforts on resistances, rather than place pressure on the recollection of experiences. “The clearance of resistance promotes the birth of insight” (p. 88). It is also noted that “resistances of the individual become mobilized as resistances of the group” (p. 88).

In another paper, Kotkov (1957b) examined the resistance to discussing sex in group therapy and emphasized that members need encouragement to face their sexual thoughts. He presented frequently encountered sexual fantasies and anxieties.

In remarks on group therapy with antisocial adolescents, Schulman (1957) stated that the resistance encountered is basically the delinquent’s character resistance to conformity and cooperative behavior. It is noted that interpretation of group silence seems to create added anxiety that could lead to physical acting out.

The resistances of institutionalized delinquents in group therapy were enumerated by Shellow and colleagues (1958). The initial resistances against relating are manifested by irrelevant gossip that serves as a smoke screen between the group and the therapist. The verbally facile members lead the flight into trivia, while others reveal their anxiety by sleeping or answering the therapist’s direct questions with noncommittal, monosyllabic responses. The role of the con man—the skillful manipulator of others—in leading this resistance is recognized. The next stage of resistance takes the form of the projection of the group’s defensive hostility toward the therapist into the surrounding institutional life. A following resistance involves making demands upon the therapist, in order to validate their belief that he is just another hateful, depriving adult. A final group resistance, apparently similar to Redl’s “protective provocation,” is a direct attack upon the therapist, to keep him at a distance.

Bowers and co-authors (1958) discussed the resistances presented by religious personnel in group therapy. Their verbal proficiency, facility for dialectic thinking, and tendencies to monopolize could be used in the service of powerful resistances to cooperative group functioning. A destructive resistance manifested was the expression of severe condemnatory attitudes employed to drive weaker members out of the group. The management of these resistances was based on the emotional reactions of other group members, “in having sufficient people in the group who are not impressed, who demand that the language of the group be nonprofessional, who become quite angry when ‘churchy’ language is used, who are quite capable of fighting back when attacked” (p. 247).

Jackson and Grotjahn (1958) evaluated the treatment of an oral dependent and demanding character neurosis in a woman patient in individual and group-therapy settings. Individual settings offered excessive oral gratification to the patient. “She accepted interpretations like mother’s milk by incorporating them like mother’s milk and not by integrating them at a mature level of functioning” (p. 375). Her main resistance in the group was a refusal to participate, being unwilling to emotionally join the group and share the therapist as a mother. She remained in the group only because of the positive transference to her therapist in individual therapy. When the group pointed out her nonparticipation, she parried by replying that since she had individual sessions and other members did not, she would feel guilty taking the group’s time for herself. Under constant group pressure, she would participate, but only in a reversal of roles, where she would feed advice and interpretation to other dependent members. Threats to leave the group were also employed. The shift of her transference neurosis from the individual to the group setting removed the therapist as the exclusive focus of her neurosis and permitted the group to effectively intervene; this led to the emergence into consciousness of her oral need for sole possession of the therapist.

Moses and Schwartz (1958) explain the defense mechanisms utilized by prisoners to allay the anxiety aroused in them by group therapy. The most frequently used mechanism was the “party line” that presents the inmate as having been perpetually “bum-rapped.” In this view, the administration is pictured as exclusively concerned with keeping prisons filled to capacity
and with holding prisoners longer than is reasonable or necessary. The prisoner, in this view, is characterized as reasonable, wronged, and responsible. When the “party line” defense failed, group members employed the resistance of seeking to force the therapists “to declare themselves either as the representatives of an angry, primitive, rejecting society, or as the messianic emissaries of the bum-rapped, maltreated and misunderstood inmate population in their crusade for justice” (p. 455).

In a far-ranging review of the field of group therapy, Slavson (1959) described the essential dynamics of the various forms of group therapy according to the types of transference, catharsis, insight, reality testing, sublimation, and resistance that emerged. Individual resistances listed as appearing in analytic group therapy are: displacement, deflection, distraction, planned communication, irrelevancy, silence, absence, lateness, and acting out.

CONTRIBUTIONS: 1959–1980

In his book *The Couch and the Circle*, Spotnitz (1961b) presented his approach to resistance in the group setting. He recognizes that patients are incapable of consistently engaging in the kind of verbal communication demanded of them at the beginning of treatment. Patients frequently need to resist talking about themselves in order to monitor their emotional balance in the group. Accordingly, Spotnitz often supports members’ needs to resist talking, so he can study the origins and purpose of the resistance.

Goodman and colleagues (1964) offer cross sections of therapist–group interaction in which the therapist enhanced or induced group resistance. The authors posit: “The phenomenon of a therapy group in a state of resistance, which the therapist recognizes but is unable to deal with, is likely to be related integrally to a counter-transference distortion of the therapist” (p. 343). They suggest that many premature terminations of treatment are based on the therapist’s inability, because of his own conflicts, to act constructively in the face of resistance.

Mally and Ogston (1964) summarized a group-therapy experience with patients with chronic physical complaints and functional symptoms. A primary resistance they displayed was competition for the position of being the “sickest,” in hopes of winning the sole concern of the co-leaders. On the other hand, they supported one another’s resistances to understanding themselves and the maintaining of their status as being ill. Their life histories were recounted to obtain pity rather than understanding.

Ormont (1964) described the resolution of tenacious individual resistances through a combination of individual and group therapy settings employing two analysts, plus an optional setting of group sessions without the group analyst. The therapeutically useful parameters observed are presented as:

1. Multiple transferences: The patient’s intense transference in the individual setting is dealt with by establishing, via the group, other, less intense transferences in which he is more accessible.
2. Multiple interpreters: The group setting adds “multiple interpreters who validate the patient’s attitudes and actions.”
3. Multiple countertransference reactions: The patient is better understood, and his reactions better dealt with, as both therapists use and compare their induced feelings.
4. Multiple settings: The patient’s selective functioning in the different settings is utilized in working through special resistances.

Ormont continued his interest in the study of resistance phenomena and the identification of groupwide manifestations of resistance. In the first of a series of papers, Ormont (1968) defined group resistance 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.
ates a violation of the analytic contract by one or more of its members” (p. 147). Illustrations of groupwide resistance and its management are presented.

In his next paper, Ormont (1969) discussed “acting in resistances where instead of relating the emotionally significant story of his life in words, the patient may communicate it in action, dramatizing the story through his behavior in the group” (p. 420). Verbal and physical acting out are differentiated.

Ormont (1970–1971) developed Spotnitz’s notion that the feelings induced in the therapist by his patients could be developed into a defined instrument for resolving patients’ resistances:

Like the individual analyst, the group analyst, if he is in empathic resonance with the group’s emotional vibrations, will experience powerful feelings as a natural product of the total group interaction. They are vital, if primitive messages he is receiving from the members’ shared unconscious emotions. [p. 96]

Next Ormont (1974) presented techniques involving emotional, symbolic, and joining interventions for the resolution of resistances originating in the preoedipal period of emotional development.

Slavson (1964) elucidated the dynamics of the frequently encountered resistance of silence in group therapy and discerned four types: general and selective individual silences and general and selective silences of the group. Selective individual silence, when it contains negative attitudes of anger, spite, and resentment, is seen as caused by a variety of dynamic factors that may at times signify a “resistive phalanx to the ongoing therapeutic process mobilized by predominant negative transference toward the therapist or prevalent general hostility on the part of group members at a given time” (p. 398). Slavson also notes that group silence may often represent reflection upon a significant group event or feeling. Interpretation of the transference is recommended in the face of resistive phalanx silence.

Aronson (1967) offered criteria for resistance in individual and group therapy. He defined individual resistance as “any diminution in the efficiency of the patient’s task behavior during therapy sessions” (p. 87). The author suggests that the most difficult technical problem confronting the group therapist is the recognition and resolution of the simultaneous resistances of most or all of the patients. This group resistance is defined as “a decrease in the operating efficiency of a therapy group manifested by a heightening of the transferential projections, defenses and defensive maneuvers of most or all patients and a joining together of their individual resistances into a common resistive pattern” (p. 94).

Aronson attributes the presence of group resistance to therapeutic error, in that it “presupposes that the therapist has failed to deal adequately with the individual resistances of group patients in his prior contact with them in individual therapy or in the group” (Aronson 1967, p. 92). Among such errors, the author mentions premature placement of patients into group therapy, delay in intervening to analyze and work through individual resistances, and, most crucial, failure to analyze and work through the reactions of group members to some common stimulus impinging strongly on all or most of them. In this last category of factors, countertransference attitudes and actions are the most likely contributors.

Two contributions by Spotnitz embrace his formulations, techniques, and general approach to resistance in the group setting. In a 1968 paper, Spotnitz charted a sequence of resistance patterns that shows the urgency of recognizing and intervening in these “characteristic modes of uncooperative behavior” (p. 16). First priority is accorded to treatment-destructive resistance—“any type of behavior which if permitted to continue would imperil the group’s existence or seriously damage any one of its members” (p. 13).

The next stage, status quo (inertia) resistance, usually appears after the first six months, when the members’ presenting problems have been somewhat alleviated. This resistance re-
flects the group's feeling that maintenance of the present state of functioning is all that can be asked of them. This is demonstrated by their wish to drift along aimlessly and have a good time together. Resistance to analytic progress contains more anxiety than status quo patterns and represents fear of change and apprehension about moving ahead into unknown emotional areas.

Fourth priority is accorded to resistance to teamwork, which involves self-preoccupation, desires for undivided attention, and an unwillingness to listen to or learn from others. A fifth level in this system of priorities is reached in resistance to termination, which features a return to patterns of resistive and uncooperative behavior that had seemingly been outgrown but reappear during the final months of treatment and before the vacation break.

In another paper, Spotnitz (1969a) gave an overview of resistance phenomena in group therapy. Freud's concept of resistance and his categorization of it are reviewed and placed into the perspective of the group setting. The suggestion is made that the group be involved in a concurrence of opinion as to what constitutes resistive behavior. The author states that "the total ideal situation for recognizing and analyzing irrational and inappropriate behavior obtained when the group members have consciously accepted it as a resistance pattern" (p. 212).

Gadpaille (1959) studied resistance in groups of delinquent adolescents, and observed that the very existence of the group as a therapeutic milieu permits types of resistance that vary from those seen in individual therapy. The presence of other patients allows for side conversations, mutual support by avoidance, and deflection of feelings. In a reference to group resistance, the author noted "there is often a contagiousness, a totality of response in which the individuality of the patients is submerged by a total group attitude" (p. 277).

The earliest resistances of these groups were organized against projected external dangers. These organized resistances followed a predictable sequence. First, overt defiance was expressed, verbally and behaviorally, through absence and bodily postures. At times, sizeable numbers would stay away or walk out. The next level of resistance was via testing to provoke the therapist into retaliatory anger, a pattern also recognized by Redl and Shell. The threat of group silence was the next level of resistance; but members' needs to defy, complain, and provoke verbally overrode any tendencies of the group as a whole to defend itself with total silence. All of the defenses against projected external dangers were also directed against other members by individuals or subgroups.

Gadpaille concluded that delinquent groups are capable of employing a host of highly organized resistances against external dangers, with great versatility. When the internal conflicts are exposed, a member is prey to anxieties against which he has no prepared defense. "However, the achievement of this stage in therapy is a major step forward" (p. 284).

Leopold (1959) addressed the process of working through conflicts and resistances in group therapy. He saw the availability of multiple channels of communication—patient with therapist, patient with another group member, patient with the group as a whole, and the group with the therapist—as paramount. The patient's constant involvement in and exposure to these levels of interaction enrich and intensify therapy and, when properly utilized, facilitate the process of working through. "They confront the patient with all the bipolar attitudes of his conflict—past and present, fantasy and reality, hate and love" (p. 292).

Mann (1962) gave a theoretical formulation of the group resistance of conformity on different developmental levels. In conformity with what they believe is expected behavior in group therapy, members initially display verbal (oral) aggression toward one another. This is followed by a stage of identification with the leader, in the guise of exceedingly adult behavior that gives a superficial appearance of group cohesion and cooperation. In essence, at this stage passivity is a defense against underlying rebellion. In the next stage, members become occupied with questions of democracy, which represents a maturational advance from the position of conformity. The members engage in a pseudodemocracy, but an underlying
sabotage of the group's efforts is in progress. On the next level, the group's hostility toward the leader and their previously disguised rebellious feelings emerge openly. "When the leader's dreaded retaliation fails to materialize, the members realize and express not only their earlier expectations of the group but also begin to recognize the unreality of those expectations" (Mann 1962, p. 10). Following this resolution, resistance is replaced by identification with the constructive aspects of the leader.

In his remarks on the function of the group therapist, Berger (1962) featured dealing with resistance. Citing the analysis of resistance as the hallmark of success in individual and group therapy, he emphasized its centrality. He observed that resistances are chameleonic in character, capable of assuming new colors and forms in the course of treatment. "Resistance can express itself through action or inaction, silence or works, feeling or non-feeling, overtly or covertly. The resistances of the therapist, individual patients and of the group itself may occur simultaneously, consecutively or intermittently. Each may influence the development of the other" (p. 559).

Group resistances cited by Berger are: silences, absenteeism, lateness, "tea party" discussions of events outside the group, nonpayment of fees by a large segment of the group, decrease in the group's interactional patterns, and withholding of dreams and fantasies.

In his book on the theory, dynamics, and technique of group therapy, Johnson (1963) defined resistance in relationship to the group's working contract: "As soon as the patient begins to react to the stress of the group, he wants to change the contract. Then by drawing attention to the patient's incessant violations of the contract, the therapist can show him how he wants to twist the reality of the contract to suit his own maladaptive patterns" (p. 63). Johnson pays particular attention to silence and acting out as the most troublesome resistances facing the therapist.

In a comprehensive text on group therapy, Slavson (1964) differentiated between those resistances that are common to both individual and group therapy and those that are indigenous to therapy groups. In the former category he listed absenteeism, lateness, deflection, planned communication, irrelevancy, distraction, silence, passivity, and acting out. It was noted that groups afford opportunities for escape from participation that are not available in individual treatment. Slavson also referred to the presence of "inherent solvents of resistance" in groups, such as identification, universalization, and mutual support, which overcome defensive resistances in individuals.

Rosenthal (1968), in a paper on interpretation in group therapy, illustrated the significant impact of members' interpretations to one another in bringing attention to and resolving one another's resistances. The rationale for reflecting back to group members their attitudes and feelings, rather than employing the classical interpretative approach, is clarified and illustrated.

In a series of papers, Rosenthal studied patterns of resistance in a variety of group settings. His paper on adolescent group therapy (1971) clinically illustrated resistances frequently encountered in these groups: craving for excitement, extragroup subgrouping, testing, and denial of inadequacy and damage. The importance of converting negative feeling into language as soon as possible, in order to effectively deter premature termination, was emphasized in a paper (1976) on group-destructive resistance in group therapy. The maturational effect upon a group of the resolution of its major resistances was delineated and illustrated (1979). A sixth paper (1980) depicted the ways in which resistances of individual members are used by the majority of the group to represent its own hidden resistance to the therapist. In a seventh paper (1985) Rosenthal presented a comprehensive approach to the phenomenon of resistance in group psychotherapy.