As long as it is not threatening, the therapist can encourage the patient to bring his remaining objections about the group into the meeting itself. For, above all, the therapist should convert the group itself into an arena where each member’s reluctances undergo continuous reciprocal examination by the other members.

**SUMMARY AND CONCLUSION**

Preparing the patient for group psychotherapy requires several approaches. A fruitful approach that has not as yet been stressed in the literature is resistance exploration. Though we cannot predict whether or not a patient will leave the group prematurely, working through initial reluctances appears to cut down the rate of withdrawal.

**REFERENCES**


---

**Establishing the Analytic Contract in a Newly Formed Therapeutic Group**

It is a well-established fact in individual therapy that the less the patient knows what is expected of him, the greater the loss of time and energy for both the analyst and the patient. Yet this axiom is not accorded the same recognition in group therapy. In fact, putting aside some descriptions of the opening session (Ormont, 1959) and a few discussions of the initial phase, there is little in the literature that specifically deals with instructing the patients and structuring the therapeutic process in the early stages of a group’s development. Group patients tend to flounder about for months before they learn what is expected of them, and it frequently takes a year or more for a group to develop a modus operandi, particularly with a beginning therapist.

No doubt this lag in the emergence of structuring is due to the novelty of the therapy. Being of comparatively recent origin, group analysis and group therapy have yet to formulate their therapeutic procedures into a systematic approach. Probably the most glaring lack
of rigor is seen in this absence of discussion of what group patients are expected to do. To answer the pressing need for detailed treatment of this subject, a delineation of the steps the therapist takes to establish the analytic environment might be of considerable value (Spielneit, 1961).

In the initial group sessions patients are understandably uncertain and confused about their tasks. A question often heard is “What are we supposed to do here? What do you talk about?” At that point, the analyst can inform his patients that the preferred activity in the group is for each member to tell the meaningful story of his life and seek to understand the other members.

Subsequently, other incidents arise which call for an elaboration and expansion of this initial instruction. For example, the patients may ask just what is meant by the “story of your life.” The analyst can explain that he does not mean repetitious clichés such as, “My mother was always picking on me.” Nor does he mean transference accusations such as, “You remind me of my father.” But he does mean such emotionally pertinent facts of the developmental history as, “I can recall the musty smell of the parlour in which my grandmother was laid out after her death. I didn’t want to walk into that room...” Here the listeners are getting the charged minutiae, the inner biography, the essence of the formative experience.

Nor does the analyst mean by “story of your life” a concentration solely on the past or present; the life story also encompasses the future. When members, for example, begin to make plans without airing them in the group, like suddenly announcing a two-week trip only a few days in the offering, the phenomenon must be heeded and dealt with. Such behavior, more often than not, is being used to undermine the group analysis. When this stratagem is encountered on the part of patients, analysts will do well to inform the group at that point that “the life story includes future plans. No decision affecting your life or the group’s life is supposed to be made without discussing it with us beforehand.”

Unless the analytic position is clarified at the earliest appropriate opportunity, the members may tend to glide over significant re-arrangements of their external environment. A member may, for instance, indulge in job-hopping, presenting it to the group as a fait accompli. This unnecessarily hinders the therapeutic inquiry and progress. The member may be the type of patient who skips from analyst to analyst, and if the pattern is resolved in terms of his job-hopping, its resolution will also serve to keep him in group treatment.

When a member of the group appears to be withholding or reticent, the analyst can point out to the group that it is helpful for each of them to express his total talking time. One trainee, asked whether all the members of his group were verbally participating, recalled that one of his female patients would lapse into long silences. Instructed to discuss this withdrawal with her, he discovered that she was experiencing severe frustration whenever she was interrupted by another member. She was terrified by the violent feelings of rage produced by these interruptions. To protect other members, and herself, she withdrew from verbal communication. In silence, she smoldered helplessly, and was consequently suffered to be stifled by the group as actively nodding, smiling, and assuming sympathetic expressions of concern. No one knew that she was weighing various means of dropping out of group treatment without incurring the imagined wrath of the analyst.

The analyst must be equally concerned about the member who significantly avoids talking about any one of a number of key topics, including his job, marital relations, sex life, dreams, or the group itself. Such evasions, if traced to their roots, reveal the meaningful history and motivations of the member, often the very core of his character structure.

Ernie, a brilliant 32-year-old engineer, came to analysis with a checked employment history. Though engineers were in great demand, he had difficulty holding a position for more than a year. He attributed his difficulties to jealous coworkers or insufferable superiors. In the group he appeared genuinely interested in the cooperative examination of his problems.

Soon after his arrival he began to complain about his girl friend’s inadequacies. He was critical of her ineptness at meeting his needs, expressed and unexpressed, and complained in particular that she was insensitive to how he felt or what was on his mind at any specific moment. The members took a sympathetic interest in the problem, but pointed out that his picture of the woman was probably distorted because he tended to air the same unsubstantiated grievances against
female members of the group. They encouraged him to continue seeing the woman, whom he was preparing to drop in the same manner as he had disposed of 12 other women over a period of 10 years. Meanwhile, the members explored the possibility that his complaints were based on his identification with his overcritical mother. After some working through, Ernie’s complaints about the female group members diminished. He also ceased discussing his “inexplicable” girlfriend, and for weeks made no mention of her. If anything, he appeared to have withdrawn to a detached attitude toward the group proceedings.

The group analyst, while questioning himself whether the members were covering all significant aspects of their lives, paused on Ernie. What had been happening to his relations with his girlfriend? Investigation revealed that Ernie had proposed to her and was planning to marry within the month. The members reacted with surprise and irritation. They had explored his difficulties with him in good faith, but subsequently he had ignored them, not even mentioning his intentions. Ernie denied they had helped him, denouncing their contributions, thereby adding to their anger. At one point Ernie was asked if he was accustomed to consult colleagues with his job problems, and then once he got what he wanted, drop those who had helped him. Under prodding, Ernie revealed a number of incidents in which he had “brain-picked” or “milked” coworkers for ideas and solutions, and then, ignoring their aid, took undeserved credit for the work accomplished. Several members indicated that their reactions must be like the reactions he evoked on his job. It became apparent that it was this type of conduct that caused his numerous difficulties and dismissals. Ernie confirmed their observations. Now alerted to his exploitative behavior, the members pointed it out at every occasion. When his callus use of others could no longer be concealed even from himself, Ernie reacted with prolonged depression. Upon further analysis, the aggression hidden beneath it was released at the group members. When his pent-up fury dissipated, he relaxed and became more accessible to a cooperative exploration of this pattern. He also began to take an active interest in the historical antecedents of this activity. Had the analyst not alerted the group to the avoidance of sharing a most important part of his life—his social relations—with the group, Ernie’s evasive operations might have long eluded detection.
As each piece of acting out materializes, it must be promptly identified, and appropriately labeled; and members must be reminded that they are expected to refrain from such behavior. Once the aberrant pattern is thus labeled and the group understands the expected behavior, the first step is completed. If the pattern is repeated, it then becomes a subject for investigation. If appropriately educated, the group members will consensually understand and accept what they are supposed to do and be able to weigh any activity against this ideal. If a member forgets any preferred activity, a member will be quick to point it out to him. As a whole, the group will spot and describe deviations from the recommended norm with considerable acuity.

Thus, through the use of spontaneous incidents in the group, the analyst sets up a contract of preferred activities. When the group has comprehended and tacitly agreed to the preferred activities as a desirable modus operandi, the preanalytic phase can be said to be terminated, even though the group, throughout its existence, will have to be reminded from time to time of its contract.

But what of the person who enters the group and never becomes a member, that is, never indicates his acceptance of the terms of the therapeutic contract? One trainee reported continual harassment by a man whose mode of attack was to spew forth obscenities. The man had come for group therapy at the insistence of his wife who had threatened to divorce him. As long as the group uncritically accepted his horrendous descriptions of his wife’s conduct, all went well; but as soon as the members began to make him aware of his provocative behavior both in his marriage and in the group, his behavior underwent a metamorphosis. He became defiant, denying any statement, no matter how sensitively proffered, turning aside any explanation for his contrary conduct, and contenting himself with cursing anyone who addressed him. When the trainee pointed out to the man that he was preventing any mutual exploration of his behavior, the trainee became the butt of his irrational attacks. From then on there was no stopping him. On meeting nights, he gleefully reported that he would announce to his wife that he was going to the group “to dump his weekly dose of dynamite.” Though his activity was motivated by the fear that he would have to face his role in the marriage, he also received hidden gratifications from his name-calling. These were interpreted to him to no avail.

The trainee was instructed to indicate that, “We are interested in mature verbal communication. Name-calling tells us nothing about mature verbal communication. If you feel you cannot cooperate in our common each other or you. If you feel you cannot cooperate in our common vent, then we have to ask why you are coming here.” When the patient persisted in his heckling, the supervising analyst advised the patient to terminate the analytic contract. It was apparent that the man recognized his activity as a deviation from a desired norm, but was unwilling—ever though able—to examine it. His unwillingness to cooperate indicated a preanalytic resistance. To become a member of the group, the prospective patient must decide, at least a psychoanalytic group, the prospective patient must decide, at least the conscious ego level, to adhere to the therapeutic agreement. If he is able to, but refuses, he cannot be considered a fit subject for treatment.

Another trainee expressed concern about a patient’s apparent inability to desist from passing on material to business associates and friends, although it had been clearly established that all communications in the group were to be treated as confidential. At one point, it was clear that he was on the verge of passing along damaging information about the homosexuality of a fellow member. The trainee was instructed to repeat the group contract and to explain the futility of continuing the treatment in the face of such noncooperation. After some hesitancy the patient decided the treatment was too important to him to flout the group’s agreement. He inhibited his exhibitionism and became an active participant in its analytic exploration. His considered decision to cooperate resolved the preanalytic ego resistance. At this point his other resistances around exhibitionistic gratification—unconscious ego, secondary gain, superego, transference, and id—were at last opened up to investigation.

These examples should not obscure the fact that the analyst is less interested in getting a group member to obey any psychoanalytic dictum than he is in studying why the members either will not or cannot cooperate with the agreed-upon terms of group-analytic conduct. These terms can be recapitulated as follows:
The members are expected to tell the emotionally meaningful stories of their lives—past, present, and future plans. They are expected to understand each other. They are to take an equal share of the total talking time, communicating in mature verbal language. They are to arrive punctually to all meetings, to pay their bills on time, and to keep the group’s confidences. They are expected to desist from acting out, including such behavior as baby talk, cursing, shouting, physical contact, and socializing outside the sessions.

The analyst knows, however, that the members will find it difficult to adhere to this contract to the letter. In fact, he does not expect them sedulously to abide by it, their best efforts notwithstanding. He accepts the fact that they will use many subterfuges, manipulations, and evasions to avoid presenting the desired material. But once he has their conscious assent to the analytic agreement, he welcomes these avoidances. Then as he spots a deviation from the contract, he can study (observe), investigate (ask why), and trace the origin of the aberrant activity (reconstruct), bringing its form and meaning to the group’s attention and eliciting the members’ reactions (see chapter 3).

Furthermore, each deviation may be operationally defined as a resistance, and, as Freud indicated, the analysis of resistances is at the heart of our work, requiring the greatest time and the greatest effort. Establishing a specific set of criteria and studying deviations from them expedites the analyst’s work; to the extent that a member’s deviations are analyzed and resolved, he should be able to obtain mastery over what was previously uncontrollable. Once he has accomplished this, the member has taken a long step toward effective functioning in many areas of his life.

REFERENCES


Acting In and the Therapeutic Contract in Group Psychoanalysis

There are many ways a patient may break his contract. Instead of relating the emotionally significant story of his life in words, he may communicate it in action, dramatizing the story through his behavior in the group. Such behavior has been called acting in. Both Eidelberg (1968) and Zeligs (1967) claim to have introduced the term. Since 1957, Kohut (Panel, 1957), Tarachow (1963), Greenson (1967), and others have refined it.

By now, the term has come to mean the reenactment by the patient of his life history, albeit in a disguised fashion, within the therapeutic setting. Such reenactments are compulsive and repetitive. The patient cannot recall the antecedent events giving rise to his behavior. And because his acting in gratifies a hidden wish, he is apt to defend it fiercely or rationalize it even though it appears patently inappropriate to other group members.