

EXPRESSION OF HOSTILITY: ITS VALUE IN THE PSYCHOTHERAPY GROUP¹

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What, if anything, is therapeutic in group members verbally attacking each other or the therapist? The Freudian answer to this would be:

Something happened in the patient's life which has crippled his devices for handling his own instinctual pressures; he could (can) only control his raging aggressiveness by devices which cost him too much and make him sick (1, p. 69). Hence, the release for better direction of long repressed rage is, in a narrow sense, an *immediate* object of treatment (1, p. 54).

This viewpoint has been also applied to group psychotherapy:

Acting out always connotes either a regression or a fixation. . . . The pattern that he re-enacts and to which he reverts is one that had been employed earlier in his development, especially during childhood (3, p. 20). Therapeutic regression occurs in a transference relation to a therapist as a parent substitute and, in the case of group psychotherapy, to fellow patients as replicas of siblings and other important persons in the patients' lives (3, p. 6).

The members of the Workshop on Group Therapy at the Alfred Adler Mental Hygiene Clinic,² responding to the challenge of this specific problem, reported incidents of overtly expressed hostility which occurred in their groups. They then tried to determine whether the results of these interactions were harmful or constructive to individual patients and to the group. I shall try to recount these incidents briefly.

INCIDENTS

Group A. Jane, an attractive single woman of 30, reported how happy she felt after a successful experience with a desirable man during and after a dance. Mary violently criticized her for being flirtatious and false in dress, speech, and manner, shouting, ". . . things I never could be." Jane counteracted with the charge that Mary's inadequate social and marital fulfillments were probably

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²The eight therapists who, besides myself, actively participated in the Workshop were: Danica Deutsch, Robert Ellenbogen, Maria Gitter, Harry Lerner, Warner Lowe, Luna Reich, Hattie Rosenthal, and Isaac Ziman.

making her hypercritical of others (the "sour grapes" interpretation, which frequently is a correct one). Naomi, who also could not endure some of Jane's affected mannerisms, came to the support of Mary. As it is much easier to respond rationally to an attack if one has at least one person (the "buddy") on one's side, Mary was then able to examine her feelings of being mistreated and hurt, by asking all the group members for their original reactions to her. This enabled the group to become more united in the effort to work on a common problem. Members were able to offer criticisms, as well as commendations of Mary, in a spirit of helpfulness which was reassuring to all, and which contributed to valuable insights for the three women involved in this incident.

The technique used in this case, that is, a patient or the therapist soliciting opinions of every group member, is called "going around" and is a very useful device to uncover differences of opinions and feelings, and, thereby, to help everybody in gaining a better, more realistic understanding of the others and of himself.

Group B offered an example of how "going around" can backfire. The group consisted of four men, one of them a psychologist, and four women, two of them actresses. Prompted by an outside incident, the psychologist-patient broke loose with a tongue-lashing against the actresses as being egotistical, demanding, and domineering, and finally attacked their professional work as being cheap and over-rated.

Here the therapist stopped the aggressor by suggesting a "going around," hoping that the victims would get some support from the others. But this sudden outbreak had an unexpected effect on the other members of the group. Each seconded one or the other of the attacker's negative statements. This change of atmosphere left the two actresses dumbfounded; one started to cry, the other became speechless.

What had happened can be explained as "contagion" or a free-for-all mood, where everybody jumps on the bandwagon of the attacker. The therapist now felt that an intervention was imperative, in order to prevent permanent damage to the group cohesion. The interpretation focussed on the attacker's prejudice against actresses and whatever meaning this had in his life style. Then an effort was made to have the other group members understand why they had joined in the exaggerated attack. In the following sessions, the incident was digested and constructively worked out, until a better in-

sight into the individual motivation and group reactions was produced.

Thus the therapist protected the two victims of the attack by shifting attention to the attacker and those patients whose hostility had been triggered off. The group had become more "cohesive" in a neurotic satisfaction, through a common attack on two members, the scapegoats. This is a group-dynamic principle which may occur in all kinds of groups. When it was observed in Group C, it was halted differently by the therapist.

Group C. Mrs. O., in a mothers' group, presented a summary of all her complaints against her family in a violent and hostile manner. She demanded full consideration of her plight for a whole hour, disregarding the needs of other group members. They vehemently disapproved of her behavior and criticized her for her unreasonable demands.

Mrs. O. had provoked the whole group without being aware of it, and the provocateur had become the scapegoat. The interaction between a provoking member and a hostile group can become automatic, stereotyped and destructive, apparently giving a great deal of neurotic satisfaction to everybody involved. Here the therapist intervened by asking Mrs. O. whether she merely wanted the group to be on her side, or whether she wanted to understand her own motivations. The therapist, by thus indirectly disapproving of Mrs. O.'s behavior, at the same time pointed out that only slow progress could be expected with such a deeply ingrained pattern of living and reacting. This cleared the air and re-established a cooperative atmosphere in which Mrs. O.'s attitudes could be explored further.

Group D. Here an incident describes vividly that a hostile attack on one co-patient can have a destructive effect on the whole group, unless a resolution of the anger and relief of the consecutive tension occur, and group unity is re-established. Stanley, a 39-year-old gambler, was a group member whose life style included a constant feeling of being rejected and of provoking rejection. In his bitterness he could not stand happiness in others. When Stella, a 46-year-old single woman, happily reported, on her birthday, that she was functioning much better, the group members responded positively to her optimistic mood — all but Stanley. Silent until then, Stanley retorted: "She really doesn't have any problem. What she needs is to have sex with a guy. There's nothing great about sex. Every woman

uses it as a weapon — my wife does it too. She thinks she will force me to give up gambling. Stella thinks that she's great, a lady; this is all trash!" Stella stifled her tears and was just able to say, "Shut up!" The mood of the group changed from friendliness and elation to confusion and anger. The therapist suggested a general discussion on motives for disparaging others. Stanley became aware that he had attacked Stella because of the fight he had had the day before with his mother and his wife, and understood that such displaced anger hurts and confuses.

Group E. If a patient directs his hostility or rage not against a co-patient, but against the therapist, the impact on the group is even stronger. David, 44 years old, suffered from flatulence. This symptom prevented any close relationship and made it difficult for him to keep a job. He had been in treatment on and off for many years. During a group session, a member expressed satisfaction with the results of the therapy for her. This provoked David and triggered off a verbal attack against the "species" of psychologists. He ended his tirade with yelling at the therapist: "You are not a bit better than the others. You are selfish, disinterested; you talk like an automaton." The group members sat silently.

After two or three minutes of this painful silence, a young woman risked saying: "I always trusted the therapists. I thought they all understood their business. Maybe I was wrong, and he is right." Then a man said: "Who can say that they all are wrong or right? Maybe there are differences in these therapists too." Another silence set in, but everyone now seemed more comfortable. The therapist still kept out of the conversation. Finally a third member said: "God knows, maybe he is just angry at his (dead) parents and lets it out on the therapists." The attacker was impressed by this interpretation and after thinking it over, asked the therapist in a friendly way: "Have I hurt you badly?"

After this event, the members of the group expressed themselves with more courage and honesty. David was more open to sincere discussions of his problems; his flatulence slowly disappeared after the purpose of this symptom — to keep people at a distance — had lost its importance.

DISCUSSION

Our examples are similar. All have a "happy ending." Anger is followed by tension and anxiety, and these in turn are resolved by

therapeutic intervention. Through such incidents therapeutic movement occurs. Verbalized hostility helps the therapist to understand the complexity of the patients' life styles. It helps the attacker to understand his motivations. He learns to appreciate the consequences of his behavior. He realizes that sometimes he wants to hurt, whom and why he wants to hurt, and he may discover that he really does not want to hurt at all. Or, the victim may gain insight into why and how he provokes, why he does not get from others the appreciation and acceptance he desperately needs, how relationships and social feeling are destroyed by repetitive expressions of anger based on distortions and misunderstandings. The opportunity to challenge the therapist even by attacking him, will give others more courage, will tend to shake the dependency patterns of some, will help to give a more rounded picture of the therapist as a human being and thus provide a clearer model of human complexity.

Anger expressed in the group is therapeutic and constructive if it results in a learning experience and contributes to the strengthening of the patients' social feeling. None of the incidents we quoted showed open or hidden damage done to a group member. But it may also happen that either attacker or victim drop out, believing that everybody, including the therapist, rejects him — the attacker because he was not stopped from becoming violent or vicious, the victim because nobody helped or protected him.

Expression of hostility can have hidden antitherapeutic effects which, if not recognized, may become lasting and, therefore, more dangerous than sudden overt damage. Expression of anger and rage may mean lack of concern for others, and have such purposes as getting attention, feeling powerful by provoking, or finding relief of chronic dissatisfaction and tenseness, and so on. The therapist should recognize these patterns. Otherwise, in the free atmosphere of the group, showing anger may become a goal in itself. A patient may come to feel justified in being unpleasant because he has neglected expressing negative emotions in the past. "I have learned how to be angry in therapy" becomes a consequence of the (in our opinion erroneous) assumption that there is repressed emotion to be liberated.

We do not hold with this view, but believe the goal is to learn to express and experience one's self in new positive ways, not merely to release bottled-up emotions. We agree with the Sullivanian viewpoint:

Perceptual distortions that arouse hostility prevent communication between feuding patients, with the result that the negative affect is further exaggerated. When the distortions are understood, not only may this insight be therapeutic, but usually the discovery of a common background or common problems makes for a good working relationship after the difficulty is resolved. Other patients with similar problems or mechanisms may become involved in the discussion in a way useful to them, although sometimes a considerable interval elapses before they participate actively (2, p. 252).

Confusion on the subject of mental health may lead to psychotherapeutic techniques which are detrimental to individual patients and to groups. The concept of social feeling must be included in any definition of the term mental health; otherwise this term loses meaning and becomes inapplicable to behavior. The group situation is conducive to the therapeutic goal only if the patients learn to interact cooperatively and in a friendly way, if positive feelings outbalance negative ones. To be therapeutic, crises of hostility and anger have to result, sooner or later, in solutions of "happy ending," simply because human beings are happier, healthier, and more fulfilled in love than in hate.

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