Aspects of Transference in Group Analysis

By MARIO MARRONE

The Concept of Transference

In classical psychoanalytic theory 'transference' is viewed as a form of displacement since it refers to a process whereby feelings, wishes or expectations are deflected from one person to another. The term was initially used by Freud (1895) in his 'Studies on Hysteria' and conceived as a 'false connection', because feelings originally associated with parental figures are disconnected from their early context and object and revived elsewhere with somebody else.

The term 'transference' has been used in many different ways, often to denote all sorts of feelings, ideas and impulses that the patient experiences in the course of his analytic treatment. However, strictly speaking, transference has been conceptualized as a displacement of wishes, affects or expectations from one 'object image' to another (Glover, 1949; Menninger, 1958; Jacobson, 1964; Searles, 1965; Malan, 1979). Transference is basically a mental relationship that involves three persons, normally called the 'subject', the 'object of the past' and the 'object of the present'.

Bowlby (1973, 1980) sees transference in terms of misattributions that the individual unconsciously makes under the influence of representational models of himself and others. He says: 'Seen in the perspective of Piaget's theorizing, the concept of transference implies, first, that the analyst in his caretaking relationship to the patient is being assimilated to some pre-existing (and perhaps unconscious) model that the patient has of how any caretaker might be expected to relate to him, and, second, that the patient's pre-existing model of caretakers has not been accommodated – namely, is not yet modified – to take account of how the analyst has actually behaved and is still behaving in relation to him'.

The concept of transference that I use is based on a number of propositions compatible with attachment theory (Bowlby, 1973, 1982). Some of these propositions are controversial and concern very complex issues. It is beyond the scope of this paper to attempt a comprehensive review of these

MARIO MARRONE is a psychiatrist and psychotherapist. He is currently chairman of the Scientific Programme Committee of the Institute of Group Analysis (London).

fundamental questions. As a clinician I confine myself to giving an account of empirical work and mentioning the theoretical models which I use to interpret and process my observations.

The first set of propositions concerns the notion that transference phenomena manifest the structure of representational models that everyone builds on the basis of his perceptions and experiences. Representational constellations exist, each one of which is composed of a model of oneself, a model of the world and a model of the relationship between the one and the other. Multiple representational constellations coexist, as they have been formed in the course of different scenes and at different stages of psychic development and are kept by complex psychic mechanisms. These constellations can operate simultaneously despite being mutually incompatible. A particular constellation can be dominant at one time or another, even if its existence and dominance remain outside the individual's consciousness. In these constellations the two key features are models of how available, reliable and emphatic the attachment figures are and how lovable and acceptable the individual himself is in the eyes of his attachment figures. On the basis of these representational models an individual assesses himself, perceives people, interprets events, shapes his social rôles, responds with certain types of feelings, forecasts outcomes and organizes his behavioural reactions.

The second set of propositions concerns aetiology. If representational models are integrated under the dominance of good self-esteem and trusting images of the world, the individual will be less prone to either intense or chronic anxiety and its derivatives than will a person who has not achieved this type of representational organization.

The third set of propositions concerns therapy. It contains the notion that the analysis of transference goes hand-in-hand with the discovery of representational models, their symbolic elements and derivatives, associated anxieties and defences.

Some authors seem to believe that transference is a by-product of analysis, that is to say that it is exclusively elicited by and occurs only in the therapeutic situation. For example, Waelder (1956) says:- 'Transference may be said to be an attempt of the patient to revive and re-enact, in the analytic situation and in relation to the analyst, situations and phantasies of his childhood. Hence, transference is a regressive process. Transference develops in consequence of the conditions of the analytic experiment, *viz*, of the analytic situation and the analytic technique'.

However, as Szasz (1963) rightly points out, to define transference in terms of the analytic situation is like defining microbes as little objects appearing under a microscope. As the occurrence of bacteria is not confined to labora-

tories, so the occurrence of transference is not confined to the analytic situation. Transference arises spontaneously in different contexts and in all human relationships simply because, as we have seen, it is a manifestation of representational models.

Since Freud's famous about-turn of 1897 regarding the aetiology of hysteria (he said that some apparent memories recalled by his patients turned out to be phantasies) and under the influences of the Kleinian school (Klein. 1952) which maintains that the transference process is by-and-large one of projective identification with the aid of splitting, analysts have tended to mistrust patients' memories. Moreover, people can never remember episodes that occurred during the first and second years of life – a period which is regarded by many as the most sensitive in determining personality structure.

Nevertheless, clinical experience shows that a significant number of patients who suffer from anxiety and its derivatives have representational models which appear to have been built either as a consequence of traumatic episodes which occurred at any time between the second birthday and mid-teens (for example, loss of a parent through divorce or death, admission of the child into hospital and so on) or through long-standing recurrence of anxiety-provoking communications among members of the family. These patients are often able – if assisted – to recall plausible and painful episodes of their childhood and adolescence.

A patient of mine, whom I shall call Lucy*, has been very sensitive to the slightest sign of irritation that people may show towards her. In the group session Lucy recognizes that she is always afraid of being reprimanded and told that she interferes with other people's lives. For instance, when she is at the check-out in the supermarket her hand trembles while she is writing her cheque as she fears that the cashier and other people in the queue may become impatient. In fact, she is always expecting a sudden attack. Upon questioning, she recalls that her father used to be very impatient and intolerant with her and her brother. She pictures father as a chronically dissatisfied, impulsive and irritable man who often hit her for reasons she could not understand. Mother – instead of protecting her – sided with father and complained that Lucy was interfering with her own life by making father so unhappy.

Transference in the Group-Analytic Context

Foulkes (1964, 1968, 1975) recognizes the fact that members can take one another as well as the conductor as transference figures. Whereas in psycho-

*In order to preserve confidentiality I have changed patients' names and other details which are irrelevant from the clinical point of view.

analysis the analyst is the sole focus of the patients' transference phenomena (mother, father, siblings, and so on), in group analysis there are more people present and members are free, as it were, to make all sorts of misattributions among themselves. Even so, members tend to make strong and durable transference reactions to the group analyst, who is seen as a parental figure and a normative authority and who is expected to provide care and comfort and to give rewards and punishments. Other group members are often seen as siblings.

Durkin (1964) and Agazarian and Peters (1981) agree that in the group the various infantile figures and the many ideas and affects attached to them need not be forced onto the therapist: there are several people to choose among. In many cases, another member's personality or physical appearance is more conducive to the development of a particular aspect of transference than is the therapist's. Moreover, transference to the group-as-a-whole also occurs, since the entire group may stand for mother, father, both parents or the total family. For example, Grotjahn (1977) recognizes a transference to the group as mother-symbol and a transference to the group as a family.

I have observed in my clinical practice that newcomers usually expect to be treated by the whole group as they were treated by their parents. Vivien is 26 years old. In the group she feels inferior, isolated and unable to express her feelings. She recognizes that when she was a child her parents used to compare her unfavourably with her siblings. Whenever she showed any sensitivity to their attitude they called her a cry-baby.

One interesting asset of group analysis is that it permits observation of a particular type of transference phenomenon which consists of an emotional state evoked by the interaction between other people, which the patient witnesses and which resembles an episode of past family life. In a group session Caroline becomes very upset because two other members are engaged in a noisy quarrel. She is reminded of the storms and fights her parents had with each other in her presence.

Transference and Transference Neurosis

In the literature there is a considerable degree of ambiguity about the concept of 'transference neurosis'. As Szasz (1963) says, the difference between transference and transference neurosis is one of degree and remains arbitrary and impressionistic; analysts generally speak of 'transferences' when referring to isolated ideas, affects or incidents and use the term 'transference neurosis' when referring to a more extensive and coherent set of transference. I believe that many analysts call 'transference neurosis' the anxious attachment that some of their patients tend to establish with the therapist or the group.

Transference and the Non-Transference Relationship

There is always a real or non-transference relationship which goes alongside and beyond the transference relationship (Mackie, 1981). We should not say 'transference' when we refer to the patient's total relationship to the therapist. Instead, we should say 'the therapeutic relationship'.

Since by definition the term 'transference' implies distortion, we must leave room for the patient's valid and non-distorted functioning and perceptions. Foulkes is aware of the need to make this distinction and in his 1964 and 1975 books he establishes the difference between 'Transference' (spelt with a capital T) and 'transference' (spelt with a small t). Transference with a small t (or 't-relationship') is the name that designates all complex interpersonal reactions which take place in the group and which do not correspond to 'transference' in the strict sense of the term. Foulkes' recognition of these two dimensions is accurate but his language is confusing.

Moreno (1954) gives a better description when he differentiates 'tele' from 'transference'. 'Tele' is the quality of a human encounter which is not interfered with by misattributions and perceptual distortions. Moreno views transference as something that needs to be resolved in order to develop 'tele'. In the group, the 'tele' relationship strengthens the secure base from which the patient can further explore and reorganize his out-look (cognitive and affective) of himself and others.

Transference and Regression

The theory of regression assumes that infantile phases of development (libidinal or otherwise) are not entirely outgrown, so that in certain circumstances early patterns of psychic functioning become reactivated. Descriptions and formulations of this kind have explanatory significance for many direct observations of clinical states and transference reactions but they leave out something that is important to recognize. In many cases transference reflects life-long patterns of relatedness between the person and members of his family. Analytic exploration reveals in such cases that the way in which the patient's parents have behaved towards him (not only in his early childhood but during the whole of his growing years — sometimes right up to the present day as well) has had a pervasive and continuous influence on his feelings, thoughts and actions. When the analytic situation provokes and elicits these types of response one can hardly say that the patient is regressing to a particular phase of his development.

Sheila, a patient of mine, who tends to feel inferior and inadequate in many situations, tells us how her parents repeatedly undermined her self-con-

fidence. When she was a child she was hardly ever praised for her achievements and often told that she was not good at anything. At times, father used to do the school homework on her behalf. His basic attitude towards her has been manifested in many ways over the years. At the age of twenty-eight, after painstaking analytic work, Sheila was able to leave her parental home and purchase a flat to live on her own. She worked very hard at making her flat nice and comfortable. When her father visited her newly-painted home he commented: 'It looks so nice in appearance but I'm sure you forgot to give it the undercoat'. This was, of course, only one incident among many others of a similar kind in her family life.

Mother was a very irritable woman who instead of tolerating and soothing Sheila's anxieties would escalate them out of all proportions. Again, this type of response occurred when Sheila was five, ten, fifteen, twenty and twenty-five years old. One of these typical reactions took place when Sheila was already a young woman, working as a clerk in a big company. Sheila told her mother that she was upset because she had done something wrong at work and her supervisor was not pleased. Mother (with insufficient knowledge of the actual event) quickly responded: 'My God, I'm sure you'll get the sack'.

At the beginning of her therapy, this patient frequently assumed that she was always held to be in the wrong; she showed a marked lack of self-assertiveness; she could not have opinions of her own; she did not believe that others (including her therapist) could tolerate her anxieties, and she acted upon a complicated set of defensive formations. In this case, any reference to 'regression in the transference' would only obscure the understanding of the patients' problems.

Testing Hypothesis in the Group-Analytic Session

Patients come to the group session with stories that often consist of accounts of their recent or present circumstances. Moreover, the group session itself becomes a story, that is to say an articulate sequence of scenes. Excessive anxiety can be detected in some of these situations. A patient may show that he felt unduly anxious in the course of a particular event. Or he may be very anxious in reporting such episode. Or he may become the over-anxious protagonist of a group scene. But even when the patient says: 'I was anxious (or fearful, or guilty, or tense, or embarrassed) there and then,' one must assume that the anxiety and its source are still present so far as they have not been worked-through in the analysis.

On the other hand, defence against anxiety may be detected. The defence may take different forms (denial, projection, and so on) and the experienced therapist may have no difficulty in eliciting the defensive nature of the patient's behaviour and discovering the underlying anxiety. One common form of defence is to treat others as one has been treated (Anna Freud calls it 'identification with the aggressor'). Another form of defence against fear of being disappointed by the attachment figure is to become compulsively self-reliant, a mechanism that often forms the core of a character disorder (Parkes, 1973). A variation of the compulsive self-reliant character is that of the compulsive care-giver.

In watching out for signs of anxiety and defence the group analyst can indeed formulate a hypothesis regarding (a) the nature of the anxiety; (b) the transference situation which reactivates that anxiety and (c) the pattern of parent-child relationships that may have given rise to this type of transference reaction.

If the group analyst believes that the timing of his intervention is appropriate, he proceeds as follows: Firstly, he assists the patient to recognize the presence of excessive anxiety (or anxiety-ridden feelings) and — if pertinent — the operation of defence mechanisms. Secondly, he draws the patient's attention to the fact that the present or recent interpersonal situation he is describing, or is involved in, does not warrant such an amount of anxiety. Thirdly, he explains that, in fact, the present or recent situation only reactivates an anxiety that — that because of its intensity — is likely to belong to the past. From that, the analyst may suggest that this anxiety may have been induced by a particular type of early parent-child interaction and can indeed formulate a hypothesis as to what may have happened.

In this way, the patient may recall episodes of his childhood and adolescence that illustrate traumas, bereavements or specific patterns of family interaction. At times, once the anxiety or anxiety-ridden feeling has been recognized in the here-and-now, the analyst need do no more than ask: 'Is this feeling familiar to you? Have you experienced it before?' to elicit a relevant response.

In my group I occasionally use psychodramatic techniques in order to facilitate the revival of past scenes and their associated affects. The effect can be very powerful. In any case, one should be able to guide the patient in his search, while at the same time allowing him to follow the association path that is most evocative.

> Joseph is very distressed in the group and says that since his baby was born his wife has lost her sexual drive. He feels deprived of sex. I ex-

plain to him that, given the intensity of his anguish, he may be expressing a feeling of deprivation that may have deeper roots. Another group member says to him: 'Once you told us that when you were little your mother used to go shopping with your baby sister leaving you locked in your room'. However, the patient does not respond to this intervention and says that he now remembers a dream. In this dream he was embracing his wife and baby while a war was going on and his house was under bombardment. The ensuing associations indicate that he is afraid of destroying himself and the people he is attached to (including the group-as-a-whole) with his inner rage. I interpret this and his anxiety decreases.

In the following session Joseph says: 'I've been thinking about our previous session and I began to wonder how can I possibly be normal with the sort of childhood I had'. He tells us that his mother was a single parent and neglected him in many ways. He also says: 'I've remembered that once my mother left me locked up in my room for hours. I must have been six or seven. I was angry and out of rage cut my bedclothes with a pair of scissors. When my mother returned and found out what I did she struck me with her shoe and told me she was going to get rid of me.'

When a group member is able to recall painful episodes of his life together with the associated affects, other group members – by resonance – recapture similar experiences of their own lives and/or develop insight into the nature of their anxieties and defences.

Paul is a 37-year-old married man. He is doing well in business and is active in a voluntary service organization. He is a compulsive care-giver and suffers from a psychosomatic illness. He is the first of four siblings and there is a five-year age gap between himself and the next child. His father spent long periods of time working hard. His mother was a lonely and emotionally unstable woman who often turned to Paul for support and asked him to supervise his younger siblings.

Once Paul brought the group to the pub after the session (against an explicit group norm) and paid the total bill in an apparent act of generosity. Yet, he delays paying my fees even if, as he often says, he is doing well in business and can afford to pay me much more than I request. In this session he angrily refuses to examine the nature of his acting-out. Nevertheless, in response to an interpretation, he breaks down in tears and tells us how restless he feels inside. I explain to him that he does not

pay me in time in order not to recognize his dependence on me and that it is apparently easier for him to give than to receive. At this point he recalls an episode of his childhood, when he was envious of his younger siblings who were allowed to play in the courtyard while he was forced to help his mother with the domestic chores and meticulously clean the windows.

Philip — another group member — exclaims: 'I now understand what I've been doing. I usually volunteer to be helpful no matter how much I resent doing so. I've been putting myself in the position of Cinderella all the time'.

A Clinical Illustration from a Group Session

This is a once-a-week group-analytic group in its fifth year of life. Tracey has been in the group for four years and so has Peter. Tracey is twenty-six years old and originally joined the group because of long-standing unhappiness, inability to stick to one boy friend and tension leading to overdoses and wrist-cutting. She has improved remarkably since she started therapy; she took a University degree and at present works as a junior art adviser to an educational organization. Peter is single, thirty-two years old, and came to the group with complex and florid personal problems (including episodic transvestite behaviour and a compulsion to collect pictures of naked women).

Today Tracey is late. She is anxious and tells us a story. A senior art adviser at work has retired. The Head of the Art Department has offered her the vacant post. He has told her that in spite of the fact that she is relatively inexperienced he believes she is a promising candidate. Tracey felt proud and honoured but also panicky as she is so unsure about her abilities to live up to her boss's expectations. Nevertheless, she hesitantly accepted this offer. Later in the day she went to talk to the personnel officer, who bluntly and openly regretted the decision made by the Head of the Art Department on the ground that Tracey is too young and inexperienced for such degree of seniority.

While talking, Tracey becomes increasing fidgety. Although commonsense dictates that she may have felt deeply hurt by the personnel officer's remarks we know that they mirror Tracey's self-representation as someone worthless. Objectively, the Head of the Art Department is best suited to evaluate his staff and in this sense Tracey has done very well. Since she highly values this man, she should have been sufficiently rewarded and reassured by him. It becomes clear that the incident with the personnel officer in itself cannot account for such an over-anxious reaction.

At this point I am initially tempted to interpret the material according to a stereotyped theoretical approach. In this triangular situation formed by

Tracey, an accepting authority and a rejecting authority one can easily find indications of splitting between the good and the bad. This situation can only be seen in terms of an Oedipal constellation. However, I only say to Tracey: 'Look, in this situation there are three persons: you, one who accepts you, another one who rejects you. Lets see what sort of feelings, ideas or memories you can associate with a triangle of this kind'.

Tracey responds by saying: 'Well, what comes to my mind is the image of my mother. She was a good, comforting mother. When I was little she was strong and friendly. She was strict but never patronizing. My father was more erratic but great fun. Mummy looked after me, Daddy played with me . . .'

At this point, Tracey stops but the group invites her to proceed. She adds: 'My father developed a game and the game was that if I was naughty I would be sent to the Rock school. The Rock school was placed in a remote Scottish island. There were no holidays; the only food was porridge; one would be beaten constantly; it was cold. Escape was futile: the island was surrounded by voracious sharks'.

This account provokes a number of different feelings and comments in the group. She continues: 'I think I was frightened. Maybe my father was jealous of me and my mother, and whenever he saw us together he came and said something sarcastic and threatening in order to separate us. I recognize how fond of my father I am. That is why I don't want to talk about him. I feel I need to protect his image. Nowadays I get on reasonably well with him.'

A group member sympathizes with Tracey's reluctance to consider negative aspects of her father. Another group member invites Tracey to illustrate her assertion that father was jealous. Tracey tries to recapture a scene of her childhood. Early, on a Sunday morning, she went to her parents' bed and embraced mother. Father got angry, pushed her out of bed and threatened to send her to the Rock school. Tracey felt upset and as mother tried to protect her, father became grisly and frantic. While recalling this episode, Tracey becomes tearful and shaky. She makes further associations while trying to smile and talk in a composed way but breaks into tears again.

Then she says: 'My mother died on Christmas Day in 1965. I was eight years old. She had been ill all through the summer and went into hospital in September. She knew, somewhere, that she was dying and I knew too. Long before talk of her getting better she finally died away. I missed her terribly and I still do. Losing someone you love is not something you get over. You live with it. The last time I saw her she was in hospital. She had a second major operation and she was thin and weak. I and my two elder half-brothers visited her. Because there were so many of us we were moved to a little office in the hospital. She found it very difficult to walk there and once settled, the

conversation faltered. Talk about schools, activities and so on. I sat close to her and said little. I resented my brothers being there. I couldn't explain to her that my new life without her was simply an adjustment to survive without her. I felt guilty that I was existing separately, that I could get up and walk and go to school. I couldn't tell her how miserable I felt and how much I loved her. When I said goodbye to her I was very cold and formal. I just couldn't express anything. I began to cry in my father's car and desperately wanted to go back to the hospital and replay the scene and be different and embrace her. I asked my father to stop and go back. He dismissed my feelings and drove away. That was the last time I saw her. When she died my father did not let me get anywhere near her body. I did not attend her funeral and I was taken away to live with relatives for a while.'

The group is moved. Now Peter sobs and tells us that he can recall memories of when he was about three years old and had gone into hospital with an infectious disease and was placed in an isolation cubicle. He could see mother through a glazed window and could not reach her. A nurse told him to stop screaming; no way was he going to touch his mother!

Final Comments

Repeated experiences of this kind induce a climate of group cohesiveness and mutual understanding. Group members – and especially those who have been in the group for a good length of time – become effective aids of the analyst in using a number of therapeutic strategies, namely to interpret group scenes through models of childhood events, to be able temporarily to tune into each other's inner and insightful experiences, to bear in mind the continuous existence of different levels of emotional and cognitive organization, to pay attention to and scan for signs of significant transference phenomena through detailed inquiry and co-operative dialogue and to tolerate and use productively the revival of painful feelings.

References

AGAZARIAN, Y. and PETERS, R. (1981) The Visible and Invisible Group. London: Routledge and Kegan Paul.

BOWLBY, J. (1973) Separation Anxiety and Anger. London: The Hogarth Press.

BOWLBY, J. (1979) On Knowing What You are Not Supposed to Know and Feeling What You are Not Supposed to Feel. Canadian Journal of Psychiatry, Vol. 24, 403.

BOWLBY, J. (1980) Loss, Sadness and Depression. London: The Hogarth Press.

BOWLBY, J. (1982) Attachment and Loss: Retrospect and Prospect. American Journal of Orthopsychiatry. 52(4), 664.

DURKIN, H. E. (1964) The Group in Depth. New York: International University Press.

FOULKES, S. H. (1964) Therapeutic Group Analysis. London: George Allen and Unwin, Ltd.

FOULKES, S. H. (1968) On Interpretation in Group Analysis. International Journal of Group Psychiatry. Vol. 18, 432.

FOULKES, S. H. (1975) Group Analytic Psychotherapy. London: Interface (Gordon and Breach Science Publishers Ltd.).

FREUD, S. (1895) Studies on Hysteria. Standard Edition, Vol. 2.

FREUD, S. (1909) Five Lectures on Psycho-Analysis. Standard Edition, Vol. 2.

GLOVER, E. (1949) Psycho-Analysis. A Handbook for Medical Practitioners and Students of Comparative Psychology. London: Staples.

GROTJAHN, M. (1977) The Art and Technique of Analytic Group Therapy, New York: Jason Aronson.

JACOBSON, E. (1964) The Self and the Object World. New York: International University Press.

KLEIN, M. (1952) The Origins of Transference. In: Envy and Gratitude and Other Works 1946-1963. London: The Hogarth Press.

MACKIE, A. J. (1981) Attachment Theory: Its Relevance to the Therapeutic Alliance. British Journal of Medical Psychology, 54, 203.

MALAN, D. H. (1979) Individual Psychotherapy and the Science of Psychodynamics. London: Butterworth.

MENNINGER, K. (1958) The Theory of Psychoanalytic Technique. New York: Basic Books.

MORENO, J. (1954). Transference, Countertransference and Tele. In: Psychodrama. New York: Beacon House.

PARKES, C. M. (1973) Factors Determining the Persistence of Phantom Pain in the Amputee. Journal of Psychosomatic Research, 17, 97-108.

SEARLES, H. F. (1965) Collected Papers on Schizophrenia and Related Subjects. New York: International University Press.

SZASZ, T. S. (1963) The Concept of Transference. International Journal of Psycho-Analysis, 44, 432.

WAELDER, P. (1956) Introduction to the Discussion on Problems of Transference. International Journal of Psycho-Analysis, 37.

4 Somerton Road
London NW2 1SA

Discussion on Paper by Mario Marrone

JOHN BOWLBY:

Dr Marrone has given a vivid account of a psychotherapeutic technique in part derived from and wholly in keeping with attachment theory (Bowlby, 1979). In this approach to the understanding of personality development and psychopathology emphasis is put on the crucial part to be played by parents in ensuring their child's mental health by providing him (or her) with a secure base from which to explore and to which to return, giving him comfort and reassurance when he is distressed or anxious, and encouraging him with understanding and assistance when he is eager for activity.

Emotional disturbance in an individual is regarded as being usually the result of his parents' having been unable to provide these conditions during his childhood and adolescence, for whatever reasons. In consequence socio-emotional development deviates from the norm in one of two principal directions. On the one hand are individuals who have become anxious about the security of their base and who therefore tend to cling apprehensively and to be subject to panic or despair should they experience separation or loss. On the other hand are those who having striven to maintain affectionate relations with parents during their childhood and having repeatedly failed to do so have decided to avoid making further attempts and to become instead emotionally self-sufficient. The aim of therapy is then to help the person recognize the nature of his current problems and also the extent to which his ways of construing current relationships, and in consequence the ways he feels and behaves towards significant others, are influenced by the representational models of others and of himself that he has built as a consequence of childhood and adolescent experiences.

The patient's task is then to reappraise the relevance of these models in the light both of his present-day experiences and the experiences he had earlier in life. The therapist's tasks are so far as possible to provide the patient with a secure base from which he can explore his thoughts and feelings about both current and earlier experiences, and to recognize that the descriptions a patient gives of the events and situations of his childhood and adolescence are not only likely to be reasonably accurate, but are far more likely to omit distressing experiences than to invent episodes that never occurred.

In attributing the origin of a person's emotional problems to events and

situations that he has encouraged in real life, the approach advocated runs counter to the long tradition that maintains that a patient's memories are not to be trusted, that they are either grave distortions of whatever may have occurred or else wholly imagined. In that tradition of psychopathology and therapy the rôle of phantasy is dominant and scorn is poured on those who give credence to the patient's accounts of his childhood and adolescence. Although no resolution of this sharp conflict can be expected in the near future, those who attribute aetiology to actual events and situations point to the steadily increasing weight of evidence that supports their position. This evidence comes from many sources. Among the richest are the research projects of developmental psychologists working in the tradition initiated by Mary Ainsworth (1982) and now carried on by many others (for example, Bretherton and Waters). Another important source is the series of projects into the conditions leading to depressive disorder in women initiated by George Brown (Brown and Harris, 1978; Brown, 1982). Furthermore, earlier findings regarding the serious risk to mental health of maternal deprivation are now confirmed, and accepted even by the initially critical (Rutter, 1981).

During the past decade or so clinicians of several disciplines have become painfully aware that abuse of children and adolescents (both physical abuse and sexual) is a great deal commoner than earlier generations have liked to believe. Yet although it is now apparent that many of these individuals become psychiatric casualties, it would be possible to read a multitude of analytically-oriented books and journals without meeting any reference whatever to such events, or to their being a material cause of a patient's condition. For all too long there has been a policy of head-in-sand.

A difficulty sometimes raised to a therapeutic technique which gives prominence to recollections of childhood is that a patient may refer to these memories again and again without it helping him in any way. Certainly this can happen, but it is usually due, I believe, to the therapist's failing to help the patient express the emotions that had been evoked by the situations he was in in earlier life, and which are still likely to be evoked by memories of them, but only if given the right conditions. In such patients an absence of emotional response is probably always due to the patient's having as a child experienced from his parents not only a total lack of sympathy but also a hostile and rejecting reaction. More often than not the parent, having ill-treated the child, pours contempt on the child's distress and tears. To help such a patient a therapist must not only accept the patient's account of his experiences as basically true but also indicate that he realizes how deeply distressed, frightened and angry the patient must have been in the childhood situations described. The work of Selma Fraiburg's group with neglecting and abusive

mothers provides an excellent illustration of an effective therapeutic approach (Fraiburg *et al*, 1976).

To this technique the traditional approach stands in stark contrast. Instead of accepting the patient's account, scepticism and disbelief in the reality of the experiences are expressed or at least implied. Instead of understanding and sympathy for the patient's plight, interpretations proposing projection of the patient's own hostile impulses are offered. Small wonder therefore if the patient responds by retreating even further into his shell.

In the account he gives of the technique of group therapy he favours, Dr Marrone describes what he believes to be some of the typical responses to his interventions. Often, though not always, a patient responds to the therapist by recalling, with strong emotion, some incident from his childhood or adolescence that has clear implications for understanding the problems of feeling and behaving he is having today. Often, too, there is resonance in others in the group who recall, also with a strong emotion, events and situations of a similar kind in their own childhood or adolescence. To those who favour the technique such reverberations are impressive, especially as they appear to be followed by therapeutic improvement. Nevertheless, caution is necessary. Throughout medicine the enthusiastic therapist is inevitably an unreliable judge of his own methods. Only when the consequences of applying a technique have been observed and recorded by independent witnesses can there be confidence in the results.

Meanwhile, I warmly welcome the technique and hope it will be subjected to the most rigorous investigation. Since it is clearly in keeping with so much that is now known about psychological and psychopathological development, it must be regarded as being better-based than most other psychotherapeutic techniques and for that reason one that promises unusually well.

References

AINSWORTH, M. D. S. (1982) Attachment: Retrospect and Prospect In: The Place of Attachment in Human Behaviour. Ed. C. M. Parkes and J. Stevenson-Hinde, London: Tavistock Publications. New York: Basic Books.

BOWLBY, J. (1979) The Making and Breaking of Affectional Bonds. London: Tavistock Publications.

BRETHERTON, I. and WATERS, E. (Ed.) (In Press) Growing Points in Attachment: Theory and Research. Monograph of the Society for Research in Child Development.

BROWN, G. W. (1982) Early Loss and Depression. In: The Place of Attachment in Human Behaviour. Ed. C. M. Parkes and J. Stevenson-Hinde. London: Tavistock Publications. New York: Basic Books.

BROWN, G., and HARRIS, T. (1978) The Social Origins of Depression: A Study of Psychiatric Disorder in Women. London: Tavistock Publications.

FRAIBURG, S., ADELSON, E., and SHAPIRO, V. (1975) Ghosts in the Nursery; a Psychoanalytic Approach to the Problems of Impaired Infant-Mother Relationships. Journal of the American Academy of Child Psychiatry, 14, pp. 387-421.

RUTTER, M. (1981) Maternal Deprivation Reassessed. 2nd Edition. Harmondsworth, Middlesex: Penguin Books.

The Tavistock Clinic
Department for Children and Parents
120 Belsize Lane
London NW3 5BA