always get into trouble in particular circumstances, or that they cannot stand up for themselves, or cannot get promotion when they should, or have severe panic attacks. There are patients who complain of blushing or fear of blushing, of crippling shyness, of various social inhibitions, of morbid phantasy which they know to be groundless, of feeling despised, or that people secretly laugh at them, watch them, talk about them, or disparage them.

All these symptoms are, at least, clearly psychological and consequently the psychiatrist will find it easier initially to approach this type of patient. Such people very much desire an opportunity to talk about their symptoms, find relief in doing so, and want the psychiatrist to reassure them that they are not going mad – that they can be helped and are going to recover. But it is very rare to meet an individual who feels that the worries which really underlie his complaint are hidden from his knowledge and probably remote from those that apparently drive him to seek help. In other words this type of patient, notwithstanding the psychological character of his complaint, is not necessarily a better subject for psychotherapy than the type with physical symptoms. Both are equally on the defence and both, in a sense, would prefer to be ill rather than know the true nature of their problem which is likely in any case to be mainly below the level of consciousness.

For this reason, part of our work with patients of either of these types, and with many others, is in the nature of a 'translation'. It was Freud who showed us not only that distortion does take place, but how and why it does so and also the methods by which we may hope – in collaboration with the patient – to retranslate these distortions back into original meaning. As is well known, Freud did this in connexion with dreams, and in his classic work *The Interpretation of Dreams* (1900) gave us the basic knowledge and technique which we use in this task.

Just because our patients are so unaware of the meaning of their symptoms, they have a long way to go from the state in which we find them to an elucidation of their problems. Indeed even to awake in them a realization that what they suffer from is due to unresolved mental conflict, a conflict in their own minds, is quite a big step. It is in fact very rare for these patients to come and complain of problems, but if they do they will almost certainly complain about the 'wrong' ones.

4. PSYCHOLOGICAL AND PHYSICAL ILLNESS

What we have said so far has perhaps given us an idea of the sort of difficulties with which we have to grapple. These difficulties are encountered in treating any problem which psychiatrists call psychogenetic, that is originating in the mind, and are not peculiar to group psychotherapy. We have been dealing in the foregoing pages with psychological illnesses and psychosomatic illnesses, by which we mean physical illnesses whose origins lie wholly or partly in a state of mental conflict.

We must begin by emphasizing that when we call a condition psychological we do not imply that it is either more real or less real than a physical one. Nor do we maintain that there is anything which we meet and deal with in human life which has not got its physical, material side – even in the case of phenomena which are called by such high-sounding names as 'spiritual'. On the contrary, we believe that everything which happens in the human organism can be looked upon from both aspects: the physiological as well as the psychological or mental. We may fairly ask in the face of any given illness where is the best point to apply a therapeutic lever, and in this respect imagine the various processes on a scale, ranging from the physical at one end to the psychological at the other. This is a practical problem and we may have to apply our therapy simultaneously at several points, but usually we find there is one optimal point.

In a similar way we can also ask where on this same scale the illness or disturbance lies. Ideally and theoretically treatment should correspond in kind to the nature of the illness: physical illness to be treated by physical means, psychological disturbance by psychotherapy. In the foregoing we have indicated why this is often not so in practice. Let us once more illustrate the point.

A patient may be infected by certain bacilli as a consequence of which his heart has, perhaps, been affected. It is now already too late to combat the infection as such (this may in any case have been mastered by the organism), and all we can now do is to treat and support the heart-muscle or the circulation. By now the best treatment may be entirely psychological in an endeavour to bring about greater peace of mind, better capacity for enjoyment and relaxation, and so forth. Or to take a crude example from the

field of nervous illness, a patient may have had an accident which we can see on closer examination was in fact an unconscious attempt at suicide. However, at the moment he has a broken leg and concussion of the brain. Obviously we must first treat the fracture and concussion, which will demand the application of surgical techniques, and only later shall we be able to approach the depressive factors in the patient's personality which caused him to involve himself in a serious accident. Conversely we sometimes come across illnesses which start as a *bona fide* physical disease but continue as a complaint which best lends itself to a psychological approach.

5. THE BASIS OF PSYCHOANALYSIS AND GROUP-ANALYSIS

Such differentiations as we have just been making can only be made on a psychological level of thought. The psychological level is the highest because it is the only one which can take into account the patient's whole personality and circumstances. On this level we can determine even early stages of organic disturbance, and sometimes can determine them earlier and with greater precision than by physical means. On this level we can also assess how far the processes of an illness can be reversed by psychological means.

Unconscious conflict in early childhood development is always at the root of psychogenetic disturbances and manifests itself in the patient's reaction to the therapist in the so-called transference situation, where past and present meet. In individual treatment we rely mainly on the transference relationship between therapist and patient to bring about necessary changes. It also manifests itself within his total field of interaction with others. For the study of this wider field and of the location and constellation of his disturbance within its complex network of human relationships the group situation provides an indispensable means of bringing essential patterns into focus. Within the group-analytic situation we have, instead of the individual transference relationship between patient and therapist, a whole spectrum of relationships in active operation before our eyes.

When we come to study the individual origins of a psychogenetic disturbance we are drawn far back into the patient's past; and so it may be worth while to recapitulate once more the

characteristics of this relationship between past and present. Psychoanalysis is occupied at one and the same time with the task of what we have called 'translation' – that is, the translation and interpretation of the raw material presented by the patient in the form of free association – and with the relationship which develops in analysis between therapist and patient. This relationship is called a 'transference relationship' because it contains in essence the relationship which the patient formed in early childhood with the most important persons in his environment (usually the parents or their substitutes). These relationships persist below consciousness in the patient's mind and continue to construct the pattern of his relationships to other people in adult life. They are unconscious partly because they have never been conscious, in the sense of accessible to memory, partly because they include deeply repressed feelings of desire, hope, and fear towards the parents, and partly because they have become established by a complicated process of internalization, at the very core of the patient's ego and super-ego. These deep, inner, relationships established in early childhood, become alive again in the so-called transference relationship. Psychoanalysis has shown both that neurotic people suffer from unconscious conflict, and that this conflict is, at its core, a conflict with internalized parental figures.

The phenomena of neurotic illness, which psychoanalysis has studied in the individual therapeutic situation, must of course also appear in the group situation. We shall therefore have to show how they appear in the group and to note similarities and differences between the operation of individual analysis and group-analysis (see Table overleaf).

We shall be dealing with these questions throughout this book but we can note at once certain essential points. The group situation also revives and brings to light the deep and central forces underlying mental conflict. They appear in the way in which members of a group-analytic group relate to the conductor on the one hand and to their fellow patients individually and as a group on the other. But the transference situation in the group is on a much broader front. The individual patient's transference relationship to the conductor or to any other member of the group cannot develop to anything like the same extent as in psychoanalysis and be analysed *vertically* (as we call it) to anything like the same degree. Instead, transference in depth and in its regressive

	Psychoanalysis	*Group-analysis*
Raw material as to subject matter	Verbal communication, relaxed control	
	'Free association' of patient	Spontaneous contributions of members 'Free floating discussion' 'Free group association'
Translation From symptom to meaning From complaint to problem (conflict)	Making repressed unconscious conscious	
	Interpretation by psychoanalyst	Interpretation by group-analyst with the active participation of all members Group-as-a-whole as background of interpretation
Resistances, defences	Made conscious	Made conscious, including collective and interactional modes
	Behaviour and expressive (non-verbal) communication	
Raw material as to relationship	Two-personal situation	Multipersonal situation
	Transference, regressive, infantile	Multiple transference relationships
	Counter transference	
	Relations to other people are *outside* the T-situation	*Within* T-situation
Nature of therapeutic (transference) relationship	Regression encouraged by situation	Regression not encouraged by situation
	Relative anonymity and passivity of psychoanalyst	Relatively realistic role by group-analyst and interaction with others
	Transference neurosis fully established	Transference neurosis not fully established
	Problem of dependence and fixation on psychoanalyst	Less dependency problem
	No manipulation of transference situation	
Therapeutic processes and principles	Emphasis on insight and on contrast between past and present	In addition: emphasis on reaction and experience in the present situation ('here-and-now')
		Corrective experience 'Ego-training in action'

character is more in the background, and the *horizontal*, contemporary plane presents itself for relational operations.

This fact has certain consequences and imposes certain limitations on the value of group treatment in cases which require a complete, detailed, and systematic revision of childhood experiences and childhood neurosis. There are a number of people for whom this is not absolutely necessary even though it might be desirable. These often show that when the greatly amplified and intensified horizontal analysis is taken into consideration, enough vertical analysis of their problems can be done in a group to enable them to make decisive personal readjustment. We shall return to this point when we come to speak of the practical application of group-analysis where such considerations are of particular importance.

Our conclusion at this stage is then, that while some conditions are more suitable for psychoanalytic treatment, other very important ones yield more readily to the horizontal group approach, and for the moment we shall leave the matter there.

6. THE HUMAN ENVIRONMENT

We come now to another point in connexion with that transference relationship which stands particularly and specifically in the foreground of psychoanalytic treatment. However great the importance of transference in all human relationships – and therefore also in our groups – it is equally important to observe and to operate with other relationships which belong to the existing life situation of the patient and which manifest themselves much more fully in the therapeutic group. It is only by observing both the transference characteristics and the reality characteristics of a relationship and by noting how they contrast, overlap, and interact that we can do full justice to the facts before us.

What we wish to underline is that all the disturbances we have touched on so far are essentially and integrally bound up with human relationships. Our experience with groups and especially with analytic groups in recent years has brought this out much more clearly than ever before. These disturbances affect first the patient's relationships with those nearest to him, and any dislocation in these relationships is the first indication we get of mental illness, be it light or severe. Furthermore, the best approach to the

treatment of these disturbances lies through the analysis, correction, and deeper understanding of human relationships. Herein lies the essence of therapy and it is best applied in a human group – a group of a particular kind.

We can go still further and say that in our observation none of the disturbances we have mentioned is really confined to the person who comes to us as a patient. They are not simply a function of his individual personality, not even in their symptomatic aspect, but are functions of a whole nexus of relationships between many people. For example, a marital disturbance is always a matter between at least two people and, as soon as we study the conflict between this couple, we find it involves other people, perhaps a mother-in-law towards whom each partner feels differently, and this in turn involves each partner's earlier relationships to his or her parents and brothers and sisters. Again we may find that the irritating mother-in-law only reacts to the original couple in the way she does because her own father, brother, or son is involved, and so the expanding network of implicated relationship grows. Even to describe adequately and accurately the simplest case, we could almost say even to describe a single symptom, we have to refer to an interacting network of human relationships from which it grows.

All this leads us to the general formulation that the disturbance which we see in front of us, embodied in a particular patient, is in fact the expression of a disturbed balance in a total field of interaction which involves a number of different people as participants. The patient who comes to us is more or less unaware of all this and, being a wholehearted participant who plays his full part in this network of forces, he wants to be helped without being forced to cooperate in any really basic changes. That is, he wants to leave the situation as a whole just as it is, but to be enabled to do so without paying the price for this in terms of illness, without cost to himself. He may even want our help to do harm or to put someone else within his field of relationships in the wrong. It is rare that a patient comes with the wish to take responsibility for his problems, or to be put in a position to tackle his problems himself and settle outstanding issues. Usually he comes with the unconscious wish to change his conflict into some form of suffering or symptom, for which he can pretend to want treatment, and in this way lay the onus of his problems on his doctor. In the face of this situation,

we, unlike the patient, know that a real change is needed. Where the patient really wants to make no fundamental change we want to achieve a fundamental change in him and, as a necessary result, in the relations between him and the other people involved. We can now see better perhaps that there are, apart from the defensive forces in the person himself, also defences opposing changes in the total field.

These often come out quite dramatically in the course of treatment, when the other people involved in the patient's illness and who in a way drive him to seek help, begin to react, unconsciously and indirectly but very obviously, against any change in the patient. This reaction is generally expressed as opposition to a development which would make the patient less dependent on them and more able to stand up for himself and against their claims on him. These interactions between the patient and his human environment are strongly and deeply felt. We are watching here the play of passionate emotional feelings and we conclude from this that the changes we have initiated are taking place on fundamental levels of the patient's personality. This should not really surprise us, if we remember that neurotic suffering of any kind is the result of conflict – conflict between interacting personalities and within the interacting personalities – and represents a tentative solution of that conflict, a compromise which involves much suffering but at the same time much satisfaction and the avoidance of something judged more formidable than the suffering. It is therefore inevitable that any treatment which touches the deeper conflict and seeks a new resolution of it will also entail suffering.

7. THE CONSTRUCTION OF THE GROUP SITUATION

After this brief survey of the field, we can now proceed to develop our ideas, firstly on how to construct a situation in which the many considerations we have raised can be met, and secondly on how that therapy can be adapted to the needs of the patients.

The situation which we want must make it possible to achieve the following:

(*a*) What we have called *translation*. For this we need the communication of material that would normally be censored, so that we can arrive, with the help of this material by steps and stages,