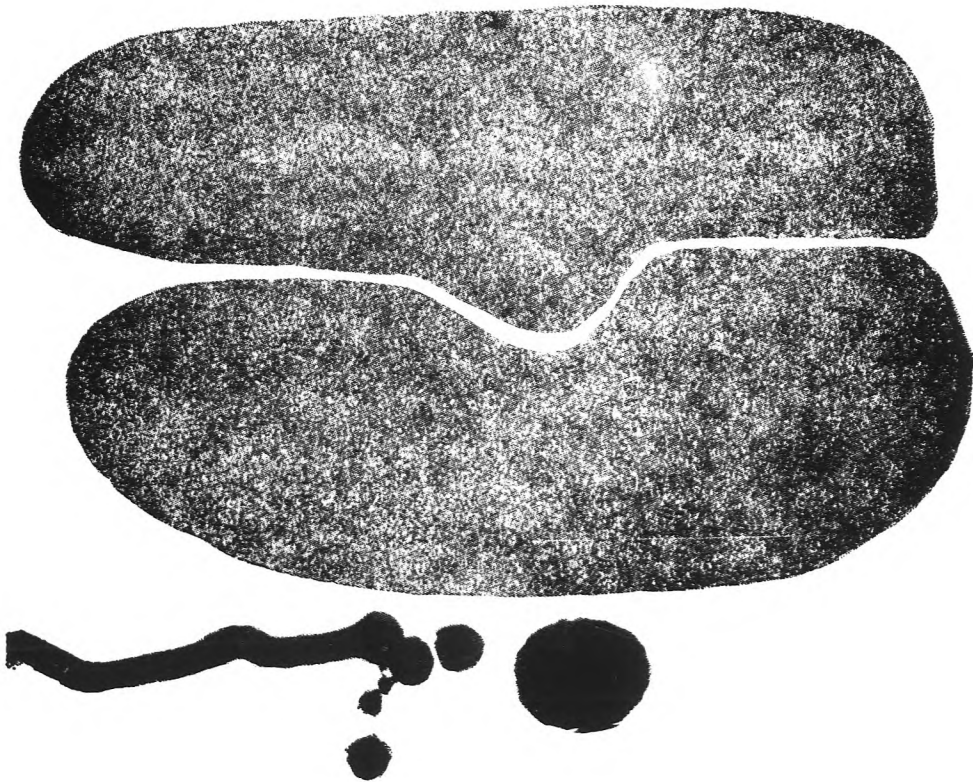


**JOURNAL  
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THE BALINT SOCIETY  
1983**



**Vol. 11**

# JOURNAL OF THE BALINT SOCIETY

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**Editor:** Philip Hopkins

# Editorial

The Michael Balint Memorial Lecturer for 1983, Dr. J. J. van Bork, chose the title, *Pills and the Unconscious*, himself. The title for the Balint Society Prize Essay, *The Doctor as 'Drug'*, won by Dr. Stanley Levenstein, was announced nearly three years ago. Their appearance together in this issue of our *Journal* is entirely fortuitous.

Both van Bork and Levenstein are to be congratulated, not only for their efforts, but also for making their contributions in print so aptly complementary to each other. Although they both refer to the use of drugs, and particularly to the doctor, 'doctor', the nature of their work is quite different.

This might well be an indication that this topic is more important now than ever before when the ever increasing availability of so many, and more potent drugs, is considered.

It is fascinating to see how van Bork experienced the same sense of guilt that so many general practitioners have felt, when faced with patients who could not accept his psychoanalytic approach, and for whom he felt the only way in which he could help them was to prescribe drugs. He relates how a general practitioner in one of his Balint-groups accused him of changing over to this form of treatment. He describes how he learned something of the new developments in the understanding of brain mechanisms and in psychopharmacology.

He found that he could produce changes in the REM-sleep of his patient, so that new material became available in their dreams for analysis and he could now make progress with them. This, of course, is quite different from the use of potent drugs to smother and hide patients' feelings and needs.

Levenstein also reminds us of how, during Balint-training, there is a tendency to develop a sense of guilt when we respond to our patients who block our psychotherapeutic approach, by prescribing drugs of

one sort or another. He could have reminded us also that this was none of Balint's doing, since he also had considered this situation. Indeed, Balint wrote that there is a ' . . . great variety of possible relationships at a general practitioner's command . . .', and that in the event of the patient blocking the doctor's psychotherapeutic approach, he could ' . . . continue by prescribing some "sensible" medicine such as hypnotic, a vitamin, a cough mixture, something against headache, . . . '.

Levenstein refers to the concern about prescribing 'numerous unnecessary drugs' — and goes further with his concept of the doctor acting as a *catalyst*, ' . . . facilitating the inherent growth potentials which exist within each patient and his family, and helping *them* to find healthy solutions to their problems instead of illness.'

Again, Levenstein refers to the 'synergistic' use of the drug, 'doctor', ' . . . with other drugs, such as psychotropics, or social workers and other paramedical personnel . . .' Different indeed from the wide use of drugs without first relating and exploring with the patient his *real* needs; quite impossible where patients are able, on demand, to obtain 'repeat prescriptions', a practice that seems to be spreading and obtaining general acceptance. There have even been papers published in journals such as that of the Royal College of General Practitioners, in which newer and more efficient methods for issuing 'repeat prescriptions' are advocated. Indeed, it is now possible to arrange for 'repeat prescriptions' to be printed by the receptionist's finger applied to the keyboard of a computer.

In Michael Balint's words, ' . . . general practice is seriously ill, but the illness is benign and, provided the right therapy is applied, the prognosis is good . . .' But these words were written over a quarter of a century ago — would Michael Balint still consider the illness to be benign, and the prognosis good?

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# Pills and the Unconscious

*Michael Balint Memorial Lecture given by J. J. van Bork, M.D.*

*on 15th February 1983*

In the first chapter of *The Doctor, his Patient and the Illness* Michael Balint stated, 'that by far the most frequently used drug in general practice is the doctor himself'. The first seminar discovered that no pharmacology of this important 'drug' existed.

Michael Balint scrutinized the application of the drug 'doctor' in the doctor/patient relationship. One of the merits of his work was that he applied the ideas of Sigmund Freud on the reciprocal relationship between patient and doctor on both the conscious and the unconscious level.

Balint started his first seminar in 1951. That was a famous year for neuropsychiatry. In that year three major discoveries were made. First, the vital functions of the brain-stem were discovered by Moruzzi and Magoun; that is they defined the function of the so called reticular system, the wake-sleep mechanisms and all the vital functions of respiration, blood-pressure and so on. In that same year Delay and Deniker discovered chlorpromazine, the first antipsychotic drug. This was the first drug to have a direct chemical influence on mental life. The third development in that year was the discovery that this drug, chlorpromazine, works directly on the reticular formation. The solution to the mind-body problem came somewhat nearer.

It was my good luck that in that same year, 1951, I started my marriage and my training in neuropsychiatry. So at the start of my professional life those lines of work, the ideas about brain mechanisms, psychopharmacology, and the conscious and unconscious were present, and in my personal life the relationship between two people played a rôle in the background of my life.

In order to explain why I chose this topic: *Pills and the Unconscious*, I should like to introduce myself in somewhat greater detail by describing my medical career, so that you know a bit about the doctor whom you invited and what kind of people his patients are.

In 1951 I started the four years training in neuropsychiatry with an internship in electroencephalography and neurology. Thereafter followed two years of psychiatric training in the same university clinic in Groningen.

In 1956 I started my personal psychoanalysis and started my first job as a specialist in a mental hospital. I had about 230 patients under my personal care. Some time later something happened that still strikes me as quite unusual. It is not customary for general practitioners to come to a mental hospital to

pay their patients a visit. However this is precisely what did happen in the case of Dr. van Lidth de Jeude, who took the opportunity to pay me a visit as well, in order to become acquainted with the psychiatrist in charge. He co-founded the Dutch Society of General Practitioners. He asked me some questions, he mentioned the name of Michael Balint and when it became clear that I was familiar with Balint's work, he told me that he was in the process of translating Balint's book into Dutch. He then invited me to coach a discussion group of general practitioners already in existence. One of the four that began Balint-work in Holland. The year was 1956.

In 1964 I finished my thesis titled: *Prognosis and Benefit. A katamnestic research concerning my own patients.*

In 1962 I established myself as an independent psychoanalyst in addition to a variety of functions in adolescent and adult psychiatry. However, aware of my desire to become personally acquainted with the people whose case histories were discussed in my two Balint groups, I decided to open an outpatients' department at the mental hospital where my career began. Since 1972 I see approximately 300 new patients a year who are sent to me by their family doctors for a modified kind of mental health consultation. 'Modified' because in the context of true mental health consultation the psychiatrist does not meet the patient. His only direct contact is with the patient's physician. I, on the other hand, have several personal interviews with patients. Thereafter I have a talk with the family doctor and I give him some kind of supervision. Principally their patients remain their responsibility. There are some exceptions. It became clear to me that severely traumatised people give their confidence to a therapist only once. In this category I consider to be those people who are victimised by World War II in Holland during the occupation, in the German concentration camps and many of them in Indonesia in the Japanese camps. Presently we feel that approximately 50,000 people in Holland belong to this category. Many of them do not present themselves in the surgery of the family doctor. They cannot bear to speak of their horrors, their sleep disturbances, their nightmares. They are depressed and too incapacitated to work. In Utrecht these people are referred to me and I stay in an ongoing psychotherapeutic contact with them in my outpatients' department.

During my work with psychotic patients I had become quite familiar with the use of potent anti-

psychotic drugs. But now that I entered the new field in the outpatients' department I was confronted with the question what kind of medication, if any, to prescribe. It was obvious that I had to decide on some course of action, but as a psychoanalyst I had my doubts about pills and psychotherapy. However the fact remained that there were anxiety-ridden and depressed patients who sought and often desperately needed my advice.

A general practitioner, an old hand in one of my two Balint-groups, said, 'Years ago we felt guilty when we gave our patients a tranquillizer. You have changed, since you are no longer only at work in your psychoanalytic consultation room, but also in an outpatients' department. You give prescriptions yourself and you discuss our prescription of pills in the Balint-group.' I was aware of his guilt feelings for I had a vivid recollection of the first case that this family doctor presented in the Balint-group. At that particular time he had succeeded his father in his practice and his first case was a repeat-prescription case, a patient who was on amphetamine. The patient was clearly addicted. The young general practitioner had his doubts about his predecessor.

The authors of *Treatment or Diagnosis: a Study of Repeat Prescriptions in General Practice*<sup>3</sup> are very familiar with those doubts. Michael Balint pointed out the intensity of the resistance against recognising that the repeat-prescription is a problem. With respect to this resistance against recognizing the problem, I have wondered, 'Could it be that part of this stubborn resistance relates to our lack of true insight into precisely what we are doing when we give a prescription in our field?' Certainly we have an enormous amount of psychopharmacological and neurochemical literature at our disposal and the therapeutic results of antidepressive agents and anti-psychotic drugs are miraculous. But perhaps deep inside ourselves we are aware of ignoring part of the interaction between those drugs and the minds of our patients.

During the treatment of the survivors of the Holocaust I was struck by their current sleep disturbances and by their horrible anxiety dreams. Those nightmares disappeared under the influence of an antidepressive agent. As I was interested in the psychodynamic aspects of this phenomenon I began to scrutinize the dreams of those people. Only a few articles are available on this topic in the medical literature. I became aware of an enormous problem. That is, that when giving antidepressive agents to depressed patients, we do not know what we are doing. We do not realize the impact those pills have on the unconscious. I felt obliged to further this research. It is evident that we can help them much better if we know what we are doing, which is normal in life.

Freud discovered the unconscious and you have heard his well-known dictum that the dream is the royal road to the unconscious. Freud's *Interpretation of Dreams*,<sup>5</sup> published in 1900, is the only medical textbook 83 years old that is as up-to-date as ever.

Now that I have told you something about my patients and myself, you will not be surprised that studying the unconscious of my patients I took the royal road. So let me tell you about the dreams of my patients. But don't forget the influence of pills on dreams is not a psychoanalyst's hobby. It is the doctor's everyday responsibility to be aware of the influence of pills on the doctor/patient relationship. In this context I might mention that 25% of all the prescriptions at the chemist's are for tranquillizers, sleeping-pills and antidepressive agents.

### Importance of dreams

In the new *Introductory Lectures on Psychoanalysis*<sup>5</sup> there is a chapter titled: Revision of Dream Theory (1933). Freud gives a summary of the work that was done since the publication in 1900. Freud makes the fundamental distinction between the manifest content of dreams and the latent dream-thoughts. It is impossible to make an interpretation of a manifest dream unless one has the dreamer's associations to it at one's disposal. I must say that this is a reason that we can do so little with the bulk of facts that comes from the hard working and dedicated colleagues in dream laboratories, because it is true that the best of them do tell us something about manifest dreams, but you never hear what kind of human beings the volunteers or the patients are. In a few cases you get the story, the dream-story, and the manifest dream, but I have found only two or three articles in which there was a hint at associations and day-residues. Day-residues are very important. When a patient presents you with a dream you ask for the associations and you direct the dreamer's attention to look out for the day-residues in the dream. 'If we follow the connections, we often arrive with one blow at the transition from the apparently far remote dreamworld to the real life of the patient'. The censorship of the dream between latent and manifest dream is not an institution peculiar to dream-life. The dream-censorship is nothing other than the resistance due to repression in our whole mental life. A final quotation: 'There is no doubt about it; the unconscious impulse is the true creator of the dream; it is what produces the physical energy for the dream's construction'.

Following these comments on Freudian concepts of dreams, let us put theory to practice and try our hand at the interpretation of an actual dream. I know it well because of my own dream which I had shortly before I woke up on the morning of 18th February 1982. The evening before, I had received a letter from Dr. Graham. The manifest dream content was as follows. 'I feel content because I made it possible for my father to carry out his practice in a room under us. We live in a flat and there under us is a room'. End of the dream.

Associations and day-residues: it is February 18th. The evening before I had received the letter from the Secretary of the Balint Society. I intended writing down all my work of that day. My father was a psychiatrist. Michael Balint has some fatherly aspects for me. I am directly aware of one of my

favourite interpretations: a house is the blue print of the personality structure. The personality structure has three layers. The upper floor is the residence of the super-ego (next to heaven). On the ground floor the ego is at work and in the cellar you will find the Id, aggression and sexuality. In fact I have my psychoanalytic consultation room on the ground floor of my own house and we live on the first floor. As I was in a hurry and rather content with the dream, I did not realize other implications. But now after re-reading the dream a year later, I ask myself about the wish fulfillment aspect in the dream. Then I realized that the meaning of the dream for me is: let my father or Balint do the job, let them write their own lectures and let me live in my home. This was my wish and that wish was fulfilled in my dream, where another psychiatrist did the work in my consultation room. As to the dream work you can see that there was practically no distortion, but nevertheless I managed to deny the wish fulfillment aspect of my dream.

Now that we know something about dreaming and dream work, we should like to be informed what the literature has to say about the combination of five items: the unconscious, dreams, antidepressive agents, anxiolytics, and psychopharmacology. Jessica Hoogendijk did literature research on those items. The literature computer by Hoffman la Roche (Dr Woud) gave me seventy references on the same items. Only four articles were really helpful, as the other articles do not mention the latent dream content. When one registers an electroencephalogram during sleep you find periods of Rapid Eye Movements (REM), during which people dream.

Fisher, an American psychiatrist trained in psychoanalysis, has worked more than twenty years in a dream laboratory, says, 'There is good reason to believe that during REM-sleep there is a release from inhibition of the drive centres and circuits within the limbic system. The removal during the REM-state of the normal inhibitory and modulating influences of the hippocampus and amygdala on the hypothalamic drive areas are probably of prime importance. The functions regulated by the limbic system have in the broadest sense to do with self and species preservation, what neurophysiologists refer to as the four F's, namely: fight, flight, feeding and fornication, functions which Freud included in his all-encompassing dual instinctual drive theory of sex and aggression'.<sup>6</sup>

Fisher says, 'It may be suggested that REM-periods represent one of the purest drive states we know of. Seminal emission in the male and orgasm in the female in association with an hallucinatory REM-dream is a fact of singular importance'. And: 'There does not appear to exist a one to one correlation between dream content and physiological fluctuations'.

As recently as 1978 Fisher concludes, 'I want to conclude by suggesting that Freud's wish fulfillment theory of dreaming has been given a premature burial. I believe it is still a viable hypothesis that the

unconscious wish (the cognitive format of the drive) is activated during REM-sleep and is raised to hallucinatory intensity in the form of a wish-fulfilling dream during a special organismic state that includes ongoing drive activity. In most recent theories, the concept of dreaming has become pallid and watered down in comparison to Freud's formulation in terms of the dream as an attempt to deal with those indestructible, especially repressed, unconscious infantile wishes, the mental representations of the great human passions, the instinctual drives. REM-sleep and sleep generally become more mysterious the more we learn about them.

#### Neurochemical aspects

I give my patients bromazepam as an anxiolytic agent and maprotiline hydrochloride as an antidepressive agent. The psychopharmacology of anxiety has not yet been elucidated. A first breakthrough in the understanding of these drugs has been the finding that they affect in a highly selective manner one type of chemical synapse in the central nervous system, so called GABA neurotransmission. Anxiolytics diminish the REM-sleep periods and nightmares are abolished by for example, diazepam. The nightmare occurs in stage four of sleep. A nightmare is a totally different phenomenon from anxiety dream. I have not found data on bromazepam and REM-sleep. Volunteers under nitrazepam were having quite pleasant dreams, whereas under flunitrazepam outbursts of anxiety dreams have been reported. As regards the psychopharmacology of antidepressants: The bulk of this work is focussed on the neurotransmitters; catecholamines (dopamine and norepinephrine) and the indolemine serotonin. A wealth of evidence indicates that these amines function as neurotransmitters in the central nervous system, particularly in critical integrative neuropathways. In the synapse you find noradrenalin, serotonin, and dopamine. The re-uptake of these amines in the nerve cell is blocked by antidepressive agents. Imipramine diminishes the length of the REM-period, whereas maprotiline hydrochloride hardly diminishes the REM-sleep period.

As an introduction to the presentation of my case material of people using antidepressives and anxiolytics, I feel that I can do no better than to start with some of my thoughts and ideas. We learned from Freud that the unconscious impulse is the true creator of the dream, and that what is essential in dream is the process of the dream work. Now we come to the heart of the problem — do those drugs have a direct influence on the impulses or do they influence the dream work, the censorship of the dream, that is the resistance? I shall present to you the manifest dreams and as we discuss the dream content I will try to touch the latent dream content. In some cases we will have the opportunity to examine the censorship. It is important to know that the censorship, that was lately called the mechanisms of defences, as Anna Freud said, is the surest sign of conflict between the unconscious impulses, trying to

overcome resistance, the dream censorship, in order to become manifest dream content.

### Case histories

I shall start with patients with profound disturbances such as the victims of the Holocaust. These are people suffering from nightmares, rather than mere anxiety dreams.

The first case history concerns a man who is not only a patient but also a friend of mine. His nightmares disappeared years ago with the use of an antidepressant. At the Burma road he was left to die in a make-shift bamboo structure amid those near death. For three months he was semi-comatose. Someone must have helped him. Many patients feel that they can express their dream content much better under maprotiline hydrochloride. My friend cannot do this, because he had no recollections of those three months, possibly due to cerebral damage during the time of semi-coma.

Another war-victim patient had horrible anxiety dreams. I do not know when they first started. He was arrested by the Gestapo, who were called 'the greens', because of their green uniform. Some of his dream events were coloured green. After a year on maprotiline hydrochloride, he told me that some terrifying events still surfaced in his dreams, but that they no longer felt as horrible as they did before, and that the events occurring in those dreams had lost their green colour. It is crucial that the patient himself indicated that his actual emotions while dreaming had changed. In itself this is quite common. However this case is exceptional because the altered emotional quality of his dreams is symbolised by the disappearance of the colour green. Another factor of importance in this case must be taken into consideration. We directly established a good working alliance, because the earliest part of his life was linked to the immediate present. It is a well known fact that the more basic trust acquired during infancy, the greater is the patient's ability to withstand the hardships of war and disaster. When he entered my room for the first time he pointed at my desk and said, 'I was born here on this very spot'. Our mental hospital dates from the fourteenth century and a new hospital has been added to the old building, so that the narrow street and the house where this man was born no longer exist. I presume that visiting me on the spot where he was born gave him immediately a feeling of safety and comfort, which may well have been an additional plus.

Now from man-made disaster to everyday life. The following case-history concerns a 26-year-old housewife. She became depressed after the birth of her first child. When I saw her, four months after her daughter was born, she was very unhappy. Listening to her, I began to feel sad myself. This is a sure sign that a patient is severely depressed. Depression is directly related to introverted aggressive impulses. With the use of maprotiline hydrochloride, her depressive mood appeared to

clear considerably, and she could now allow herself to externalise her angry feelings. We could discuss how angry she was with her child who did not want to eat as well as her mother expected her to. After three months she was practically her old self and I discontinued the drug treatment. Then she became depressed again after the sudden death of a friend, and her anxiety dreams reappeared. Back on maprotiline hydrochloride it became evident what was troubling her at the unconscious level. One night after a seemingly dreamless six hours of sleep she awakened at 5.30 a.m. She went to the bathroom, smoked a cigarette and then went back to sleep. She had an awful super-ego dream. I have to relate what happened the preceding evening in order to demonstrate the importance of the day-residue concept. As the honorary secretary of the society of dog-lovers she had attended a council meeting, which was disrupted by a terrible quarrel. Some of the council members had deliberately provoked a dispute, and she had felt quite unhappy. I asked for her associations. She told me that she had felt quite powerless in settling the conflict. She was actually angry with herself for failing to reconcile these people. I pointed out that she disliked her council members for provoking a row. She admitted that this might be true, but her inner resistance against admitting these feelings of aggression was still too strong. I also explained to her that this anxiety dream marked the transition from depression to aggression and that in my opinion she was on her way to recovery.

This case history concerns a nurse, 26 years old. One night she suddenly became ill. She ran a high fever and dragged herself to the hospital where she worked. Being one of the nurses she was seen by senior consultants, including the chief specialists of internal medicine, surgery and gynaecology. An operation for acute appendicitis was performed, but this proved to be the wrong diagnosis. She remained feverish and daily suffered over 20 attacks of severe pain in the groin. Puzzled by his patient's condition and dissatisfied with the whole procedure, her family doctor asked for my opinion. I had a lengthy talk with her. In a letter to all colleagues involved, I denied in rather strong words any psycho-pathology. Still suffering from these curious attacks of pain, she could work on a fifty percent basis only. She felt miserable.

Finally a family member, an orthopaedic surgeon, came to her aid and she was hospitalised elsewhere. A colleague of his removed two somewhat enlarged glands in the groin region and a cutaneous nerve was severed. I am not sure that there was any real inflammation, because I did not see the pathologist's report. But it is a fact that she no longer suffered from either fever or pain. She returned to her nursing job full-time.

Gradually she began voicing new complaints and a different picture emerged. She slept very poorly, three to four hours nightly at the most. She came back to see me and entered psychotherapy on a weekly basis. I tried to talk with her about her

process of mourning after the loss of her mother, who had died ten years previously, having spent the last ten years of her life confined to a wheelchair. I could not really get in touch with her emotions, her sorrow, which I sensed to be there. The psychotherapy did not go well. Having my own ideas about maprotiline hydrochloride, I discussed with her that I would try the influence of an antidepressive agent on her sleep disturbances. She agreed and I prescribed 75 mg. of maprotiline hydrochloride at night. I usually ask my patients to telephone me after three nights on this drug to inform me about their experiences. My patient had a vivid dream during the third night. Seated on the toilet she was having an abortion. She was absolutely astonished about this happening to her because she could not possibly be pregnant. She was a virgin.

Associations to this dream: as part of her work in a gynaecological ward, she accompanied women to the bathroom whenever there was danger of abortion. 'It is not the abortion', she said, 'but my sense of utter astonishment at my own pregnancy that forms the central feeling in my dream.' I was aware of an incident that happened a year ago. An assistant-surgeon made a rude remark. She had heard that when her case was under discussion, this particular doctor had said: 'In my opinion all this girl needs is a good fucy'. My patient was enraged about this rude contemptuous remark. How should I go about the interpretation about this abortion-dream?

I did not make far reaching interpretation about hidden wishes to become pregnant. That would have been wild analysis indeed. All I did was to tell her that her dream about a possible pregnancy suggested to me that she felt very angry with the physician in question. She then exploded and expressed her fury about the incident. No one in the hospital wanted to believe that she had a somatic disease. It took several months on maprotiline hydrochloride before other dreams occurred, but her sleep-schedule became more and more regular. After approximately three months she slept six to seven hours nightly. After six months in psychotherapy I saw her first tears. At that point she became really depressed about her mother's death.

In retrospect I believe that the cause of sleeplessness was her deep-seated anger. In her unconscious there was an ongoing turbulent conflict of aggressive impulses. This makes one anxious. I am convinced that maprotiline hydrochloride affects the dream work, the censorship of the dream. I feel that it lowers the anxiety level. It seems as if under its influence the aggressive impulses get a chance to come to the surface and change from primary process impulses into a manifest dream. That is why my patient after introduction of maprotiline hydrochloride could allow herself a dream that was associated with deep seated anger. This conflict more or less resolved, she became depressed, and the loss of her mother became a central theme. In the

future I expect some indications of aggressive feelings in relation to her invalid mother.

In this context it seems useful to point out that antidepressive agents may cause a depression, contradictory as it may appear to be.

The following case illustrates the influence of maprotiline hydrochloride in combination with bromazepam.

A 25-year-old patient with strong phobic complaints benefitted from this combination of an anxiolytic agent and an antidepressant in so far that his anxiety dreams disappeared. After discontinuation of bromazepam, dreams did occur which were clearly related to the reappearance of chronic hyperventilation during sleep. The bodily complaints resulting from chronic hyperventilation triggered an anxiety dream in which he was suffocating. Bromazepam has a direct anxiolytic influence on limbic structures whereas maprotiline hydrochloride interferes with the drive centres and with serotonin. When speaking with patients on the latter there are far more opportunities to make inner contact with them to tune in, than in patients on an anxiolytic agent. I presume that the explanation is the same. Maprotiline hydrochloride influences the drives, where as bromazepam diminishes secondary anxiety.

During my work in the outpatients' department I came to realise that prescribing antidepressants influences the unconscious of patients. From my experience with severely traumatised people I learned how intensely anxious they are. I felt compelled to do something to help them, to alleviate their fears and at least to let them sleep better. In the case histories it came out how 'normal patients' handle their anxieties and their aggressive impulses when depressed. What did I do with these new experiences? As a Balint-leader I had a problem, the well known problem of teaching and/or training in a Balint-group. I had no set policy in mind. Now and then I just told them something about my experiences with maprotiline hydrochloride and about the importance of the dream on the third day. Now it looks like those bits of information fell on fertile soil. In my group there is a general practitioner whose father took his own life. As a consequence he has had great difficulties handling suicidal patients. We were aware of this in the group. Two weeks ago he presented the case of a suicidal woman. He gave her maprotiline hydrochloride. After three nights she had a dream: she saw her father as one of the pall-bearers at his own funeral. Her father smiled at her.

The doctor did not know anything about her father. But in spite of his special sensitivity in relation to suicidal problems, he felt quite at ease with the situation. He did not try to make an interpretation. I am not sure that he realised the significance of the relationship between her suicidal wishes and the funeral of her smiling father. That would have been the terrain of a psychotherapist. Our colleague accepted her dream as a matter of fact. He discussed

with his patient the loss of her father, which seemed to be important to her and he made a nice remark about the smile of her father. Without so-called deep interpretations he developed an excellent contact with his patient. In the group he told us about his satisfaction with his own development, that now he could handle such a severe case without being overwhelmed by his own anxieties. Both doctor and patient seem to have benefitted from this experience.

In the doctor/patient relationship the patient allows himself to open gradually, thereby giving his doctor more or less reluctantly an insight into his mind. The patient allows the doctor to sympathise with him and simultaneously he defends himself against that intimacy.

Since 1951 new intruders upon the mind of people have appeared on the scene. Highly potent pills. These pills do their work in the brain. They have a chemical influence. I have raised the question as to what the influence of some of these pills might be on mental life, especially on the unconscious. I feel that this is a very important question that is largely neglected. The doctor decides whether or not he will prescribe psychopharmacological medication and the patient decides whether or not he will take these drugs. For the sake of my argument I presume that both parties are free to make their decision at the conscious level. However, these drugs interfere with the freedom of mental life at the unconscious level as I have demonstrated.

When we give these drugs to our patients it is our responsibility to scrutinize what we are doing.<sup>7</sup>

My final story is a beautiful illustration of just how the patient experiences this intrusion of the given medication upon his unconscious. It also illustrates nicely the influence of maprotiline hydrochloride on dreaming and the rôle of the doctor as the actual intruder.

When I first met this severely depressed 38-year-old scientist, I realised that he badly needed analytically orientated psychotherapy, but that this could only be effective after prolonged psychopharmacological treatment. Thus far he had no recollection dreaming at all. I prescribed 25 mg. of maprotiline hydrochloride. In view of my previous experience I hoped for a significant dream after the first few nights. What happened? He came back instead with a mass of irrelevant, often even happy manifest dream material directly relating to his current everyday life. 'What happened to his depression?', I wondered. But lo and behold, after three weeks on maprotiline hydrochloride he presented me with two meaningful dreams.

In the first dream he was seated on the toilet. Through the tiny window the face of his neighbour appeared, acting like a peeping Tom. His neighbour, a respected man in his fifties, wrestled himself through its small opening. He declared himself to be attracted to my patient, who became furious and threw a cup of tea at the man.

In the second dream there was a car accident and a young boy was badly hurt. My patient carried the wounded boy into his home. He felt deeply moved. He did not actually wake up in tears, but in his dream it was as if he were weeping. This was the first time that I felt that I came in touch with his deep seated depressive personality conflicts. I offered my interpretation that in the first dream I, his psychiatrist, am his neighbour. 'By giving you a drug and asking you to relate your dreams to me', I said, 'I act like a peeping Tom, trying to look into your most private feelings.' When I said that, he smiled and remarked: 'Hence my aggression, I see what you mean!' I agreed with him that in the first dream he could ventilate his aggression against me. His aggression partially expressed made it possible in the same session to touch upon the subject of his depressive feelings associated with the severely wounded little boy. I waited until the next session before suggesting my interpretation that he himself was that little boy.

New findings signify a challenge to test old hypotheses. This lecture was a challenge to me. I hope that you will agree with me that the study of the doctor/patient relationship is essential when we try to evaluate the influence of pills on the unconscious.

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# The Doctor as 'Drug'\*

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How are we to assess the doctor as 'drug'? We can do no double-blind trials, controlled for age, sex, nationality, religion etc. and we would have difficulty in finding a group of patients willing to act as volunteers for such a project. Even if we could, we would be beset with enormous problems with 'drug interaction'. After all, when we consider the drug 'doctor', the receptor-site is the patient himself, and much competition for this site exists from his genetic make-up, his family of origin, his spouse and children, friends, neighbours, employers, and the society in which he lives.

On more than one occasion after seeing a patient for the first time in several months and hearing that he felt much better than when I last saw him, I have enquired hopefully, 'do you think our chat helped?'. Almost invariably they have magnanimously refrained from saying, 'What chat?' and have usually said, 'yes' or at least, 'I think so'. However, I have had to ask myself whether the patient really felt he could say otherwise, and then when reflecting on my initial excitement on being thus complimented had to admire the effectiveness of the drug 'patient'!

Another major obstacle to any study of the doctor as 'drug' would be *observer bias*. Doctors, in considering their own therapeutic effectiveness, tend to err by considering themselves either omnipotent or impotent. Either extreme mitigates against a realistic evaluation of our role. When I first entered practice I believed it was my duty, and well within my scope, to cure all my patients of all their ailments.

The fact that Mrs Jones was married to an unemployed alcoholic who beat her and the children regularly, and who used what little money there was available for drink, did not deter me in the slightest. She was to come and talk to me regularly and I would *cure* her tension headaches, her insomnia, her husband's alcoholism, and her child's enuresis. Before long they would be a perfectly happy family with all their trials and tribulations a thing of the past. It never occurred to me to ask Mrs Jones why she was putting up with such maltreatment, or to try to get her to look at *her* role in her husband's drinking pattern. That would have meant that *she*

had some control over her situation, which would mean that my own importance was thereby relatively diminished. I was not even keen to involve the Social Welfare and other agencies as if that would be an admission that I could not solve the problem single-handed.

When, as invariably occurred, Mrs Jones remained depressed and her husband continued to drink in spite of my heroic interventions, I felt disappointed, hurt and angry. Added to my list of failures were couples who divorced in spite of my conviction that I could and would save their marriage, obese children who got fatter, chronic bronchitics who continued to smoke heavily and so on. Not to mention those who I drove away because I insisted on 'psychologising' them against their will. I also became depressed, as I still am, about our profession's ineffectiveness against socio-political problems like poverty, malnutrition, illiteracy, overcrowded living conditions and even overcrowded waiting-rooms.

Before long I moved from the impotent to the impotent position. All attempts to help patients, especially with their psychological problems were a waste of time. I was helpless against their lack of motivation to change and against the alienating society in which they lived, but I remained quite unaware of the fact that I was contributing to their depersonalisation by implying that it was only I who could solve their problems.

By prescribing numerous unnecessary drugs, especially psychotropics, and ordering as many unnecessary investigations daily, most doctors are effectively saying that it would be quite useless just to prescribe themselves. Yet because they have claimed the sole right to write prescriptions and fill in pathology request forms, they feel they must be very important people. With his widespread lack on insight, it is not surprising that we are not much further advanced in our understanding of the pharmacology of the drug 'doctor' than when Balint first suggested it as a topic meriting close study.<sup>1</sup>

Could we risk a hypothetical study of the drug 'doctor' without fearing that it would prove an embarrassment and a humiliation to us? Truax and Carkhuff<sup>2</sup> found that the most important factor influencing the outcome of *psychotherapy* was the therapist/patient *relationship*, and *not* the theoretical orientation or 'school' of the therapist. It is worth noting that studies on *compliance* with

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\*The Balint Society Prize Essay, 1982

doctors' treatment-regimes by patients have shown that the most important variable is also the quality of the doctor/patient relationship. If this finding is true for psychotherapy, why should it not hold good for general practice? In principle there seems to be no reason why it should not, but there are important differences between the two situations.

Firstly, the general practitioner is in a position to practice continuing care, sometimes over a whole life-time, with his patients and their families in a variety of situations such as childbirth, life-threatening emergencies and other crises, terminal care and bereavement. However, he is rarely able to have the *regular and sustained* influence on his patient that his analyst or psychotherapist colleague may have. To use the pharmacological analogy again, the general practitioner is less able to displace competitive antagonists from the receptor-site. The interventions a general practitioner may make might be meaningful and even dramatic, but can they compete with the one to five hours a week spent with a therapist? Secondly, even if they could, have general practitioners had the *training* to make their relationships with their patients therapeutically effective?

This brings us to the next question, 'are Balint-trained general practitioners more effective as the drug 'doctor' than those who have not received this training?' Looking back on my own early Balint-training I remember that one of the first things taught was to abandon messianic fervour, the 'knight-in-shining-armor' attitude, as one group member called it. I also learned some useful psychotherapeutic principles, such as the futility of reassurance and the giving of advice, the importance of 'listening', trying to ascertain a patient's *actual* reason for consultation and the importance of being aware of one's own reaction to patients. I developed a more realistic view of what I could and could not expect to achieve with my patients. Interestingly, in assessing the progress of members of Balint-groups, Bacal<sup>3</sup> uses as his main criterion the decreasing extent to which members presented 'impossible' cases as time went on.

It should be remembered that an effective drug is usually also a potentially harmful one. I attended a family-therapy workshop recently where the family-therapist who was leading it, said that reports had appeared that in certain instances, family-therapy had actually been *harmful*. This pleased him because it implied that family-therapy was an effective form of treatment which could *therefore* be injurious if injudiciously applied!

Bergin<sup>4</sup> has reported similar findings about individual psychotherapy. So if we are to claim that a doctor can be effective as a 'drug' we also have to admit we can *harm* our patients. How many of us are prepared to do that, or furnish examples of it, even if it is to strengthen our case?! I feel uncomfortable about attempting to do this, but I will try.

I remember in my early years of practice I had a patient, Mrs A, who had become very dependent on me, telephoning me repeatedly for various apparently 'trivial' reasons, and asking me to call at inconvenient times. I sensed that there must be underlying emotional problems to which she was trying to draw my attention, but I feared I might antagonise her if I broached them, so I kept doing her bidding to try to please her. One day on calling me to see her sick child she said, 'the trouble with my relationship with you is that sickness has become rewarding!' In retrospect I thank goodness that the patient had more insight than I had! The drug 'doctor' had become habituating and more and more drastic measures had to be resorted to, to acquire it. Who knows what might have happened had she not forced me to see this? Who knows what has already happened to many of our patients, because we did not recognise their distress calls, so that they had to develop a 'real sickness' like a heart attack or a bleeding ulcer before we took notice of them? I therefore make no apology for stressing the importance of not doing harm as a beneficial effect of Balint-training.

I am reminded of the words on the front page of a pharmacology text book: *primum non nocere*. A colleague recently told me that he has just been a locum in a practice where one of the patients, an 11-year old boy, had been given prescriptions for Valium continuously for the past 3 years! I hope I will not sound chauvinistic when I say that the general practitioner could not have been Balint-trained!

Having completed the masochistic exercise of proving that I have harmed some patients, I feel entitled to indulge in claims that I have actually helped others. Moreover, I take comfort from the fact that those who minimise my claims to have done some patients good, will at least by implication be exonerating me from having done others much harm, i.e. I am too weak an instrument to have had much influence either way.

Mrs B, a 50-year-old divorcee came to see me with a complaint that the callosities on her feet had become very troublesome. I thought she looked sad and asked if there was anything else she would like to talk about. She dissolved into tears, saying that her only son who lived with her, had left home to start his army-training the previous day. He was her whole life as she didn't 'bother with friends' and had no close relatives in the same city. I said I could see she must be feeling very isolated. She replied 'yes, at a time like this it's nice to know there's one genuine person you can talk to.'

Mr C, aged 55, a shop owner, had recently moved into the area after emigrating from a neighbouring country. He said he wanted his blood pressure checked, but he clearly looked tired and depressed. When I asked how life was treating him, he said, 'no use complaining, is there? I asked, 'why not?' He told me he had left school at the age of 12 and had

always had to fend for himself. He found that if he confided in others about his lack of education, they would throw it back in his face or he would be demoted in his job. He added, 'I've always been a loner'. I suggested maybe he had paid the price for having to bottle up his feelings so much. His face lit up and he replied, 'maybe I should speak my heart a bit more'. I invited him to do so whenever he felt like it.

When I saw his wife a week later, she said he was 'much less tired'. This was rewarding for me, although one may well ask how much the drug 'doctor' could achieve with such a patient, given the competitive inhibition of parents, employers, peers, and loss of his money and familiar environment in his country of origin.

Mrs D, a 43-year-old housewife presented with tension-headaches. She said her nerves were bad, but she could not think why, because, 'I've got a wonderful marriage'. She added that the only thing wrong with it was the sexual relationship, which she found an ordeal. Further exploration revealed that she had a great fear of pregnancy. She was on the pill, which made her anxious because she had heard of the risks associated with it at her age. She had found this difficult to discuss with her husband for fear of upsetting him. I suggested he should come to see me, which he did. After some discussion, he suggested that he should have a vasectomy, and added that he wished his wife had told him of her feelings long ago.

Mr E, aged 40, a hard-working, heavy-smoking, business executive with border-line hypertension presented with epigastric pain. After some discussion, it emerged that he was over-working in order to gain promotion in his company. I told him I thought he was heading for a coronary thrombosis. He was shocked but pursued the idea with keen interest. I suggested that he was faced with a choice, which was to try to become managing director, and possibly killing himself in the process, or to modify his life-style and relinquish his ambition. He said he would think about it.

When I saw him a month later, he had made his choice. He had cut down his working hours, was going to take more holidays, and intended spending more time with his family. That was seven years ago. He has not had a coronary thrombosis, and I believe I saved him from it, although I can never prove it. I believe that what happened was that an authority figure (in his perception) had given him *permission* to work less hard and enjoy life more. I believe that I have saved several patients in this way, although I know that in claiming this I have to accept responsibility for several others who I did not save.

Finally, Mrs F, aged 25, brought in her 3-months old baby, complaining that he did not take his feeds properly, slept badly, was irritable, and cried constantly. Physical examination of the baby was non-contributory. I enquired how she felt about having to look after this, her first child. Her eyes filled with tears which told the whole story. She felt

hopelessly inadequate as a mother. When asked whether she was getting any help from her husband, she shook her head angrily. I told her I wanted to see him with her the next day. It soon emerged that he felt excluded from the relationship between his wife and the baby, and hurt by his wife's sexual non-responsiveness since they had resumed having sexual intercourse. We discussed the wife's feelings of inadequacy and ways in which her husband could help her.

I saw them weekly for the next six weeks. At the end of this time, her depression had markedly diminished, the sexual relationship had improved, and the baby was much more contented. This is one situation in which I believe the drug 'doctor' has to be prescribed in high doses and at short intervals. I regard the neonatal period as a crisis for every family, and I have been particularly struck by how often the onset of sexual dysfunction in a marriage can be traced back to this time.

Inevitably, the examples of myself as a beneficial 'drug' have been more numerous and more spectacular than those demonstrating the opposite effect. However, even looking at the favourable examples, I know there will be those who will question how much good I actually did the patients, and for how long. There will also be those who will point out that whatever benefit the patients derived was largely due to their mobilising their own emotional resources and the latent potentials in their relationships with spouses and others. I am very happy to accept the validity of this latter view. In fact, my concept of the rôle of the drug 'doctor' is that he should act as a *catalyst*, facilitating the inherent growth potentials which exist within each patient and family, and helping them to find healthy solutions to their problems instead of illness.

The drug 'doctor' may sometimes achieve this by working synergistically with other drugs, such as psychotropics, or social workers and other paramedical personnel, consultants and improved social circumstances. Where these growth potentials are minimal or absent, or too strongly counter-balanced by negative or destructive forces within and without the patient, it is sheer arrogance on the part of the doctor to claim that he can achieve very much. I think it is reasonable to attribute to ourselves an enzymatic action. Once we regard ourselves as cytostatic agents we have fallen to our own narcissism! It is important to realise that the drug 'doctor' needs to be *aware* of limitations and dangers because this is a 'drug' which has needs of its own, which can sometimes be detrimental to the patient, e.g. the need for power, control, approval and adulation. When this awareness is absent the 'drug' is at its *most* dangerous. The advantage of this situation however is that *this* 'drug' can be modified by Balint-training or even by psychotherapy if necessary, provided that the doctor recognises the need for it.

The patient-centred approach has the advantage, among other things, that if correctly practised we do not have to worry unduly about the variability of the

'drug' doctor. The emphasis is on the patient, so we need concern ourselves relatively less with whether a particular doctor's personality is 'suited' to a particular patient and his problems. This holds true in spite of the fact that certain patients may expect and even demand that the 'drug' be administered differently, such as by assuming responsibility for the patient's life, decisions, and engaging in social relationships.

At this point it should be mentioned that the 'drug company' manufacturing the drug 'doctor,' i.e. the medical school, seems to be producing a very poor product and one which could never fulfill the requirements of a 'medicines control council' such as, say the 'British Balint Council'! Granted that they sometimes received the raw material in bad shape due to parental and societal factors, the fact is that they do little to improve it and often make it worse; an end-product filled with its own importance, but not necessarily effectiveness.

We arrive at a paradox: to be maximally effective, that is to practice patient-centred medicine, we have to play down our own importance and stress that of our patients. This seems especially necessary in an age where people have been led to believe that any decision they may take is necessarily inferior to one which might have appeared on a computer print-out. We need to avoid reinforcing the idea that patients submit to our machinations as the medical representatives of the Technology God.

The patient-centred approach may not achieve miracles, but it has value nonetheless: when I ask a man what is troubling him, and his wife replies, 'he's got a sore back', I may not be achieving anything earth-shattering when I politely request that he be allowed to answer the question himself, but I am indicating to him that *somebody* accords him the right to speak for himself. When he replies, 'maybe if she gets off my back I'll be O.K.' I may also not achieve much when I do not laugh at the 'joke', but I will at least be giving both of them a chance to get some help with their troubled relationship. When a patient discovers that he is not only permitted to express anger towards me, but that he is actually encouraged to do so when he feels it, it may not bring about a fundamental change in his attitude towards authority figures but it might at least cause him to think about it. When a patient is encouraged to express his real fear behind his abdominal pain, e.g. cancer or appendicitis he may not be less troubled, but he will feel less alone with his anxieties.

We need to bear in mind that we are living in rapidly changing times, and modern medicine is currently under severe attack from many sources, and is being branded as not only useless, but as actually being harmful. Illich<sup>5</sup> protests against the enormous cost, both in financial and health terms of what he regards as our 'iatrogenic' practices. Hopkins<sup>6</sup> has claimed that the Balint-trained general practitioner could save his country a great deal of money through less indiscriminate drug prescribing. I think it is reasonable to attribute much of the

current epidemic of over-prescribing to lack of insight into the doctor/patient relationship on the part of the general practitioner i.e. he very often fails to discover why it is that the patient has *actually* come to see him. On this note I am reminded of the fascinating autobiography of the famous plant-healer, Maurice Mességué<sup>7</sup>. He points out that he soon discovered the importance of listening to the patient, and of the effect of the psyche on the soma. Small wonder that he achieved the results he did with greater celandine and hawthorn blossoms! The same could be said of the results achieved by the traditional healers or 'witch doctors' in Africa and elsewhere. We must realise that an awareness of our patients' cultural backgrounds is of the utmost importance, and that the more different it is from our own, the more difficult it is for us to relate to them effectively.

All in all, I believe the drug 'doctor' could emerge from a hypothetical trial with an efficacy statistically significantly greater than placebo, psychotropic drugs, and other agents, such as friends. If it is argued that this does not say much, I would reply that if we as doctors are dispensing just a few drops of beneficial elixir into the huge cauldron of sorrow and joy, love and hate, pain and pleasure, and fear and conflict that is our patients' lives, we are doing our jobs well. It was Michael Balint who said, 'It happens so rarely in life that you have a person who understands what you are up to and openly faces it with you. This is what we can do for our patients, and it is an enormous thing'. It was typical of him (as it still is of Enid Balint) not to over-state his case, but to encourage an open-minded and dispassionate search for the truth. A great challenge still awaits us. Can we minimise our own importance in an attempt to help our patients restore their faith in themselves? Can we do this when all around us our scientific colleagues are screaming their achievements into our ears, and our specialist colleagues are boasting that they can replace diseased human organs by taking healthy ones from the bodies of other people? Can we fly the banner of patient-centred medicine and not succumb to the power motives so often underlying banner-flying? I deeply hope so.

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# Some Observations on Dress during Psychotherapy\*

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In their book 'The Doctor-Patient Relationship' Browne and Freeling state, 'It is not merely the words that the patient uses which are the substance of the information; every nuance of expression and action is relevant. Nothing in the content of the consultation is accidental, although it may be unintentional.'<sup>1</sup>

It is with this concept in mind that I venture to present observations I made during the course of psychotherapy with one of my female patients. This patient has been under my care since she was 16 years old.

When she was 19 she became pregnant by a boy in Germany. She became very distressed at the idea of continuing the pregnancy and I had no difficulty in obtaining from a senior woman psychoanalyst the opinion that she should have a termination. The analyst considered that the patient was repeating the pattern of her mother who was also German and who had conceived the patient before her own marriage. Her parents had a bad relationship and separated when the patient was 15. Father was twenty years older than mother and died of a stroke two years after their separation. Five years after the termination at an annual check-up for the contraceptive pill she expressed some ambivalence about taking the Pill and about what work she wanted to do in the future. At this stage I saw her for a few psychotherapy sessions at intervals of about a month. It transpired that her mother had turned her out of the home after the patient said that she felt like going away to stay with one of her mother's friends, though mother was continuing to pay her an allowance. So she had nowhere to live and also was without a job or a boy-friend. As a result of this she was quite depressed.

A year later she came to see me because she was worried about her mother who was depressed and drinking. She told me that she now had a boy-friend and was taking her Pill again after having stopped it for some time. About this time regular psychotherapy was started.

Almost at once she began to present her feelings in terms of dress: for example, she spoke of being

impatient with herself for holding back and being timid, and then went on to describe a fantasy in which she would be able to be aggressive in a short blue dress with white clumpy shoes. This then led her on to a long black dress and thence to a long shining velvet dress in which she would be remote and a man would be dependent. The presentation of this kind of material over several sessions caused me to begin noting the kind of clothes she actually wore at each session to see how they might relate to the material presented, and it is these observations which form the basis of this paper.

In this connection it was interesting that during the fifth session she spoke of a man in the house in which she was living who had said he changed clothes for different occasions and she related this to a problem of identity. In this same session she said she thought she had lost the chance to have a family by having the abortion and spoke of her envy of the two mothers who were living in the same house. Not long after this she spoke of fantasies of being wicked and upsetting the men in her office by wearing a bare midriff to such a degree that they would be unable to concentrate on their work. We were able to see that as a result of this wish she stressed her own lack of attractiveness in order not to provoke them.

Some months later at the office party one of the men had wanted to go to bed with her. This led in turn to her feeling on one hand she was the office 'Screw' or that she could have any man that she wanted, which in turn led to her feeling quite unable to bear the idea of wearing the red culotte dress she had worn at the party.

Nevertheless two weeks later she came dressed in trousers and boots, and said she had bought and used contraceptive foam though she had felt awkward about it and not been very successful. She said that the boots made her feel more aggressive, dominant and attractive, but this then led on to ideas of destroying the man as she felt her mother had destroyed her father. Shortly after this session she moved away from mother again.

She then came to a session feeling tired after looking for a flat for three days. She was dressed in co-ordinated clothes which she said made her feel more efficient. She then, however, went on to express her fear of being older and not being able to run which she felt was being like mother. She related

\*Paper read to the Society on 26th October, 1982.

her anxiety about promotion but said she could not believe that she was considering it.

About five months later she came and told me that her boy-friend had criticised her for not making the most of herself, e.g. with regard to her make-up, glasses and excess of hair on her upper lip. She said she thought she would ask her mother about it.

A month later she came wearing make-up and platform soles with all the appearance of a young woman and clearly not a girl or a boy. She said she felt her appearance was phoney but that she was doing it successfully.

At the following session she expressed embarrassment about my remarks on her clothes, though she was aware of the necessity of my doing so. She said she was split about the idea of dressing up and felt she was being a dolly-bird, a sexual object for the male, but was then able to talk about the sexual satisfaction of her relationship. At the next session she spoke of her conflict of identity and that she and her mother both felt that she had inherited father's weakness.

At the next session she told me that she and her boy-friend were getting involved though they had not intended to do so. She felt aware of his being dominant and of herself being feminine, soft and giving but equated this to being like father which in turn gave her a feeling of unreality.

Three months later, at the beginning of December, she was clearly depressed. Her clothes were not matched and her hair had not been washed for a week. This all seemed to be related to the imminence of Christmas and the inevitable break in the sessions as well as memories of going to stay with her father for Christmas at the age of 14.

Two weeks later she spoke about contact-lenses which she said she wore when feeling energetic but she also felt that her face was not definite without glasses.

Two months later she came looking smart and at the outset of the sessions cancelled the following two weeks' sessions as she was going on holiday. I remarked that she looked different and she volunteered that she was wearing contact lenses, had had her hair cut and was wearing clean clothes. She said though she felt smarter she was feeling pompous and not attractive. She was feeling fatter and therefore more like her mother. She expressed a fear of not being liked because she was no longer scatty. It then transpired that this session was at the anniversary of her previous termination and she wept at the sudden realisation of the loss of her baby. She also wept because she was going to stay with the aunt with whom she had stayed before father's death and funeral.

A few weeks later mother remarried. The day before the wedding the patient wept about it and expressed feelings of losing her, as well as envy and guilt about these feelings. The day after the wedding she developed a cough and laryngitis. She came to see me two days later wearing a red cardigan over a dark green shirt and jeans. We related this to putting

a bright face on over her depression which seemed to be related to mother's marriage as well as the forthcoming break in the therapy for the Easter holiday.

A couple of weeks after the break she talked about trying on rainhats to go with a raincoat that mother had bought her. She described it as having a Gestapo air, but said it might also appear light and frivolous. She then went on to say that her work was becoming more responsible and that she was doing it well, but she feared her friends would not like her for being more efficient and less scatty. She related the coat to an awareness of feeling aggressive sexually with her ex-boy-friend with whom she had intercourse but this led her on to feelings of uncertainty as to whether she was male or female. She then said that a West Indian man in her office wanted her coat and this led her to doubts about its femininity.

A month later she came and told me that she had been away with her boy-friend, but sex had not been satisfactory. She felt she was very demanding. She had driven the car. At the session she was wearing a dirty sweater which she equated with not being attractive and at the same time being imperious as she would have felt if she had got him to drive the car.

A month after this she came to see me wearing a jean jacket with trousers and a pink shirt, complaining of feeling weary and dreary, confused and tense. She reported a dream from which it was clear that she was feeling ambivalent about the coming holiday break and confusion about her dependence on me. Her parting words were: 'It is not completely negative is it, to want to be independent?'

Two weeks later she expressed the idea that not wearing glasses was related to independence and described it as, 'Throwing away a prop' but she had not properly insured her contact-lenses, and later in the session expressed anxiety about her dependence on her boy-friend and on me.

At the next session she came without glasses, wearing a pretty necklet. She was in touch with, and even able to express her more aggressive feelings with her boy-friend. He in turn had shown his dependence upon her.

Two weeks later she came dressed in a singlet which was quite revealing and recounted a dream with associations of ambivalence about sexuality and at the following sessions she had her annual check-up for the Pill. Two weeks later, in the session before the holiday break she came wearing her glasses again and reported a dream in which her boy-friend had rolled down a cliff but had come up laughing, which obviously means that people who go away come back.

A month later she returned to the sessions wearing glasses and told me she had lenses in until that morning when her eyes became so irritable that she had to take them out and put her glasses back on again.

A week later she came wearing a striped shirt with cardigan and jeans and expressed a great deal of concern about her mother who was ill and having a most unsatisfactory relationship with her husband. The clothes seemed to be those of a daughter but were also the clothes for working at home. There was mention of a recurring dream of food that she does not take which came up after mention of the fact that she was not having sex with her boy-friend.

The following week she wore jeans with a blue and green sweater over a blue and green shirt all matching well, and said she was feeling better at the idea of expressing anger. She also said she was completing her thesis. A week later she was dressed in a blue and purple shirt, purple sweater and blue jeans, with a gold brooch and wearing her glasses. She had just handed in her thesis.

She spoke of her conflict of being overbearing and diffident at the same time. She had missed her Pill one night and then had sex with her boy-friend which was making her anxious. This led to conflicting thoughts about having a baby, and again to anxieties about her mother, who was now in hospital.

In the following session we discussed the idea of her being referred for psychoanalysis for the first time.

Two weeks later she came and expressed ideas of being upset about rape and abortion. We were able to relate this to her wearing glasses and a roll-collar sweater from which she expressed a fear of being used. She recalled seeing a poster on the tube of a model in a raincoat and wearing pants and bra, lying on a beach which she described as being horrible and erotic with ambivalent disturbing feelings about the fact that the model is going to be, and wants to be used.

She associated the model with her mother and a memory of hearing her giggling with a male neighbour which made her leave the house. The following week she reported a dream in which she went to a party with a lot of people she did not know from the neighbouring borough. She was treated as one of them and not afraid of being asked questions. There was a lot of nice food but she was not hungry. Then at the end she ate three helpings of sweet made of apples, blackcurrant fool and sausage. It became clear that this was related to sexual feelings towards me, which recalled her embarrassment at arousing father when he was sentimental.

The following week she came with an episode of bronchitis which necessitated her being examined. She then reported a frightening dream in which someone came up the stairs to get her, at which she woke up and she was able to associate this to the idea of her next therapist coming to get her.

She wore a choc-bar brooch with a bit bitten off and when I suggested that this might be related to the dream about food in the previous session she told me that she wore it because it matched her shoes. She was aware that matching her clothes

made her more prepared. Two weeks later she came wearing a brown and grey striped jacket over a brown sweater and grey trousers, and talked of being worried about not having heard from her mother and her fear of rejection by mother which was related to a feeling of rejection by me. She was angry with me as she was with father for sending away someone that I care for. She returned to the question of mother and her fears about mother's death. She was trying to come to terms with that and referral, she was feeling sorry for the next therapist.

The next week she came with ambivalent feelings about referral, and the following week she began with a wish to talk about her reluctance to have a woman therapist who she felt would be too like mother and affected by moods. She also expressed fears about brainwashing and dependence and this seemed to be related to the fact that she was wearing a gold necklace under her blouse with only the top button undone, that meant that she was not properly showing it off and I suggested that she had a wish to be exposed and a wish not to be.

Two weeks later she came having arranged an appointment to see the psychoanalyst. She was wearing black which she associated to being in mourning but also to being an undertaker, in which case she would be the child asserting herself. She reported a dream of being among beautifully dressed adults sitting down for a meal but she sat down with the children. I suggested that the food was representing the therapy and she said that she was looking, and was dressed like an adult but did not feel like one. It later transpired that she was taking an examination the following day which she also related to becoming an adult.

In her last session before seeing the psychoanalyst she reported a dream about making a choice. She was in a clothes shop trying to choose. She found two dresses very similar, one with stripes and a pattern and one with a gold stripe. The assistant who looked like my secretary said have both.

### Discussion

It must be asked how these observations came to be made in the first place. The answer clearly lies in the counter-transference where I feel sure I responded to her need for the absent father. This was reinforced by the fact that she had lived very close to the surgery in the earlier days of her attendance when I had seen her through the termination. J. C. Flugel<sup>2</sup> has classified individuals in the way that they dress, e.g., the rebellious type, the resigned type, the unemotional type, etc.

I think this patient shows very clearly that it is possible for a person to move from one type to another in relation to their emotional state at a particular time; for example, on one occasion she could be described as Phallic Type in trousers and boots. The sublimed type suggested by Flugel<sup>2, 3</sup> when she was wearing co-ordinated matching clothes, feeling more efficient and looking for a flat.

She could be said to be presenting herself as the Protected Type when she came wearing glasses and a roll-collar sweater, with anxieties about being used. In general she shows a repeated problem about the masculinity/femininity of her own identity — like the man she told me about early on in the therapy.

However, though the counter-transference might have triggered off the observations, it was clearly the patient herself who maintained the presentation of her disturbance in terms of her clothes. This mode of presentation continued in what she actually wore as well as dreams and fantasy material presented despite the obvious improvements she had made in her life.

She had started therapy while still living with mother, without a job or a close relationship. She now had a flat of her own, a job she enjoyed and a regular boy-friend, but all was not well inside her, as she kept showing me and the rest of the world by her dress. It began clear that something more was

needed and she was referred for psychoanalysis — which is still continuing.

### Conclusion

I think this patient shows that what is worn by the patient may be an integral part of what he or she is communicating, and needs as much respect and interpretation as what is said.

### References

1. Browne, K. W., and Freeling, P. (1967) *The Doctor-Patient Relationship*. Edinburgh, E. and S. Livingstone.
2. Flugel, J. C. (1929). Clothes Symbolism and Clothes Ambivalence. *Internat J. Psychoanalysis*. 10, 205.
3. Flugel, J. C. (1930). *The Psychology of Clothes*. London, Hogarth Press.

### Comment by Dr. M. H. Friedman:

This patient has been in analysis with me since 1976:— initially three times a week, then working up to five times a week. Before commenting on her dress, I think it is important to note that whereas in the transference/counter-transference situation with Dr. Kalina his rôle was predominantly that of the absent father in her analysis with me, I undoubtedly stood for the dominant, threatening and overpowering mother.

This is not based entirely on fantasy; there is much evidence to support the fact that, *in reality*, Miss A was controlled by a mother who was not only profoundly depressed through much of her childhood but who used Miss A as a prop for herself. On a deeper and much more serious level, it is clear that the mother cannot perceive her daughter as an individual, but only as an extension of herself.

The state of affairs has not changed; even now, whenever mother telephones Miss A it is always to load her with her own problems; she practically never inquires about her daughter's welfare, and has never visited her in London; but whenever the need arises, she will expect her daughter to drop everything and go to Surrey to visit her.

Thus, a rather difficult analytic situation arises, the mother-transference, as previously mentioned, gets continual re-inforcement from reality. It is therefore not surprising that in the transference situation with me, she has for a long period perceived me as the threatening mother who must be pleased, thus she presents as the 'good' patient/'good'

child. It has taken a long period of analysis to work through this, and only in the last few months has her aggression towards me begun to find expression, initially by displacement on to her boy-friend and work colleagues and, more recently, by long periods of silence in the sessions, interspersed by mild complaining and above all, questioning the extent to which I am really concerned about her. She compares this with the benevolent concern Dr. Kalina had for her; it is fascinating to compare the very different qualities involved in the transference with him, and with me.

Naturally, I welcome the eventual emergence of the negative mother-transference, and I have little doubt that the next period in the analysis is going to become stormy, to say the least, now that she is at last becoming courageous enough to discard her 'good' patient mantle.

To come now to the matter of her dress: it is true that there was a period in the analysis where dressing in a particular way did indicate the meanings referred to viz. masculine, feminine — and what sort of femininity, e.g. dolly-bird, seductive, or proper and prim, etc.

But beyond all this we have reached the stage where her greatest anxiety is not to dress as her mother dresses, as this symbolizes the loss of her own identity, and fears or merging with or being engulfed by the mother. Again one detects the re-inforcement from reality, in that for years mother has been in the habit of buying 'good' clothes for Miss A, without any consultation or discussion.

Miss A has spent many hours contemplating all the mother-chosen garments in her wardrobe. There was a time, earlier in the analysis, when she would feel compelled to wear these clothes, but she has now reached the stage of absolute refusal to wear them, and more recently, the wish to give them away.

It is not only in the area of dress that Miss A experiences these unsolicited intrusions by the mother. Birthday and Christmas presents, etc. come into the same category; mother chooses what she herself would want, and dumps them on her daughter.

Miss A has begun to realize that, in spite of all the material benefits bestowed on her by mother, it

never happened in the context of mother displaying a genuine concern for her daughter's emotional needs.

As I have indicated, this is now making its appearance in the transference; I have every hope that we will be able to work through this, so that Miss A will eventually free herself from her mother, and emerge with her own identity more strongly consolidated, because there is no doubt that she has an identity of her own; I can compare those sessions when she is really herself — bright, lively, confident, full of inventive ideas — and those sessions when she feels depressed, overweight, i.e. overtaken with her mother's identity.

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## The Balint Society Prize Essay, 1984

The Council of the Balint Society will award a prize of £250 for the best essay submitted on the theme 'Six Minutes . . .' Essays should be based on the writer's personal experience, and should not have been published previously.

Essays should be typed on one side only, with two copies, preferably on A4 size paper, with double spacing, and margins of at least 25mm. Length of essay is not critical. Entry is open to all (except members of the Balint Society Council). Where case histories are included, the identity of the patients should be suitably concealed.

All references should conform to the usual practice in this journal. Essays should be signed with a *nom de plume*, and should be accompanied by a sealed envelope containing the writer's identity. The judges will be members of the Balint Society Council, and their decision is final. All entries will be considered for publication in the Journal of the Balint Society and the prize-winner will be announced at the 14th Annual General Meeting in June, 1984.

Entries must be submitted by 15th April, 1984, to:

Dr. Peter Graham,  
149 Altmore Avenue,  
London E.6.

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## THE SIXTH INTERNATIONAL BALINT CONFERENCE

will be held by the

Swiss Society of Psychosomatic Medicine

at the

Convention and Exhibition Centre at

MONTREUX, SWITZERLAND

4-6 October 1984

The theme of the conference will be the Development and Change in Doctors during Balint-group Training. Current Research and Research in the future.

Those who are interested either in reading a paper, or in attending are invited to write for full details to:

Geme Congres International Balint,  
P.O. Box 97,  
CH — 1820 MONTREUX,  
Switzerland.

# From the Annual General Meeting held on 8th June, 1983

## President's Report

This Annual General Meeting and dinner is overshadowed by Mrs Enid Balint-Edmonds' current illness. She is undergoing surgery this week. The president will convey to her the Society's fervent wish for a speedy recovery.

The Group Leaders' Workshop is continuing its activity and most of the leaders are still concerned with trainee groups. However, there are groups for established general practitioners, notably those run by Andrew Elder, and Enid Balint-Edmonds herself. There is also a new group starting in the West Country, led by Dr. Gosling. This has evolved from attenders at the Oxford meetings. Dr. Geoffrey Smerdon is also advertising for a new group to start in the Cornwall area.

At the next Oxford weekend we propose to include an extra day (Thursday) for any English speaking visitors from overseas who may wish to join us before the main group meets. This is in accordance with the ideas of the International Federation meeting at Cologne, where small international groups were to be encouraged before the next large conference at Switzerland.

The retiring president expressed his thanks to the secretary for the hard work which he is undertaking on our behalf, and presented him with a briefcase to contain the many documents of the Society.

CYRIL GILL

## Secretary's Report

I am very pleased to report another successful and active year for the Society. Although membership has remained static at home, the number of overseas associates is increasing. Probably this will culminate in the formation of a North American Balint Society.

Our weekend at Exeter College was a success with nearly 100 doctors attending. Their comments were all favourable. It is unfortunate that Mr Salter, the steward, had already booked the same weekend this year, so we have transferred to Pembroke College.

We have altered the programme slightly this year to make a preliminary introductory day on the Thursday evening and Friday morning, and it is hoped all our group leaders will come to this and we will arrange a workshop. The main conference pattern which was so successful before will start from Friday evening. We have had thirty confirmed bookings so far.

We have had some excellent lecture discussions at our evening meetings at the Royal College of General Practitioners. Starting last October with Ted Hatfield and *The Balint Approach to Family Therapy*, a subject which we still need to clarify our own ideas. Then Dr. Heinz Wolff of University College Hospital stimulated us with his ideas of *Teaching Psychotherapy to Medical Students*. In January, Mrs Ruth Cohen and Mrs Val Hatswell showed us what can be achieved by *A Counsellor in General Practice*.

In March, Sandy Bourne of the Tavistock Clinic discussed how he came to write his first book about a seminar for physiotherapists entitled *Under The Doctor*. In April, Dr Jack Norell distilled his experience as Dean of Studies at the Royal College of General Practitioners and talked about *Making People Better*.

Next years programme is ready to be printed. We are pleased to announce that Dr. J. J. Van Bork of Utrecht will be giving the Michael Balint Memorial Lecture at the Royal Society of Medicine on 15th February, 1983. Also we are planning a residential weekend at Bristol University in April with the Student Medical Health Service. In addition there will be a full programme of lectures.

I would like to record my thanks to the committees for their hard work, particularly to Cyril Gill, and also to Andrew Elder, Philip Hopkins and Paddy Monk. I am so glad that John Salinsky has agreed to be treasurer. I am sure he will do an excellent job. I am sorry to lose David Cohen and Paul Julian.

PETER GRAHAM

# Joint Meeting of The British Student Health Association and The Balint Society

After making several visits to the Balint weekends at Oxford, Dr. Derek Sylvester the Honorary Secretary of the British Student Health Association decided that he enjoyed their format so much that he would organise a similar weekend as a joint venture. With the result that on Friday, 8th April 1983 six intrepid members\* of the Balint Society, some with their wives, drove west down the M4. On the far side of Bristol in the clear air of the Downs near the Clifton Gorge we found the residential campus. Wills Hall is a transplanted replica of an Oxbridge College built this century by the Wills cigarette family complete with quadrangle and medieval plumbing.

On the first evening we all wound down with a general interest lecture by Dr. Robert Sellin of the Department of Civil Engineering of the University of Bristol, on Tidal Energy and the Severn Barrage, fully illustrated with aerial slides and models. The seminars proper began on Saturday morning when we divided into four small groups for case discussion. We had three sessions during that day and a final one on Sunday with a concluding plenary session before lunch.

Most of the B.S.H.A. members were ex-general practitioners who had some previous group experience and were used to dealing with counselling situations. There was also a physiotherapist, a nurse-counsellor and a psychiatrist from widely different parts of the country as one might expect from the University-based group of doctors. Many of them were keen to extend their practices to the families of students and lecturers in the University, even to take on ordinary patients who lived nearby. We were surprised to learn about their difficulties in dealing with anorexia in its different forms, and the hot-house intellectual atmosphere that can develop in the ivory tower. Also they seemed to have a much closer social relationship with their patients than is common in general practice. We managed to record one session on tape to transcribe for discussion at the Group Leaders' Workshop.

Our group spent a long time discussing a case of anorexia where the doctor found it difficult to let go of the patient who wanted time to settle down with a new boy-friend rather than depend on long weekly consultations at the Health Centre. Another case of interest was presented where the student had developed a crush on the doctor, who then referred her to a 'counsellor' who was unable to help. The group pushed the doctor to take the patient back, but he was very reluctant and demurred. They both found the discussion helpful.

Saturday afternoon was free and as the weather cleared some of us wandered around the gardens nearby, while others visited some of the many attractions of Bristol, including its Cathedral, Zoo, Brunel's Clifton Suspension Bridge and the S.S. Great Britain, at present being restored.

Overall it was a highly successful weekend and we ended by having a general discussion at the plenary session on the value of short weekend meetings as an introduction to working in Balint-Groups.

\* CYRIL GILL, PETER GRAHAM, ROGER GREEN, PHILIP HOPKINS, SALLY HULL, OLIVER SAMUELS.

PETER GRAHAM

## Residential Balint Weekend at Pembroke College, Oxford

From 6 p.m. Friday, September 23rd to 1 p.m. Sunday,  
September 25th, 1983

General practitioners, both principals and trainees, are invited to sample the experience of attending a Balint-group for a weekend. There will be opportunities to discuss the experience, and the problems of learning and teaching in small groups.

The cost of the weekend, together with travelling expenses, will be reclaimable under Section 63 (four sessions).

Further details are available from the Secretary:

Dr Peter Graham,  
149 Altmore Avenue,  
London. E.6

# Report from the International Balint Federation, Ascona, 1983

Every year at the end of March, an International Balint Meeting is held at Ascona on Lake Maggiore in Switzerland. The meeting is held in German and French. During this weekend, the International Council of the Balint Federation also meets. As representatives of the Balint Society in Britain, I attended the Council Meeting as well as the International Balint Weekend. It was a most interesting experience.

It was comforting, after a somewhat trying journey involving two aeroplanes, two trains and a bus, to arrive in this beautiful resort and see a notice pointing up the hill saying 'Balint'. Nothing else, just 'Balint'. The meeting was held at the Hotel Monteverte, once a naturist community where many artists and writers of the 1920s came. The library in Ascona has put aside a room for all Balint books and documents, and the Hotel Monteverte has a large room named The Balint Room.

The main meetings were held in the Balint Room although it was not large enough to contain the very large number of participants, who spread into the coffee lounge and into the bar, but were able to participate with the help of Television cameras. Group-meetings were held all over the hotel, and also in rooms of other hotels scattered up and down the mountain.

The theme of the conference was 'Anxiety in the Patient and Anxiety in the Doctor'. After the opening remarks, we had a series of lectures. Professor Plodinger spoke on 'Therapeutic Prospectives in Anxiety', in German. Dr Roger Van Laethem spoke in French on 'Anxiety in my Practice'; Dr Cavelli spoke in French on 'The Tumour Patient', a particularly interesting paper. Professor Dr. Staehelin read a paper entitled 'The Patient between Fear and Hope'. The last paper of the first afternoon was by Professor Dr. Heigl Evers who spoke about 'Anxiety in the Group'.

There was somewhat haphazard translation backwards and forwards into French and German. The round-table discussion that followed was not really a success. Perhaps it was too early in the conference, and too many people were not in the main hall.

On the second day, we were divided into groups, and there were spontaneous and experimental groups in any odd corner of the hotel that could be found, divided only by language into French and German. The leaders of the group I was in had not met before, and had very different styles of leadership. We sat on the floor, the windowsill, with a few chairs for the older members, but by a combination of goodwill and enthusiasm, something happened.

In the afternoon, large group-discussions took place for qualified doctors on Balint-work in general medicine; and for the students, a discussion on the use of Balint-work in the study of medicine. An expedition to the local museums was planned in the afternoon. I was delighted to be invited by some of my colleagues who were old Asconian hands to join them for a short trip into Italy.

At 8.30 p.m. that evening, we all gathered in the Balint Room for a formal lecture by Professor Dr. Hans Strotzka of Vienna, on 'Anxiety and Destiny'. He felt that anxiety was increasing all around us, a realistic anxiety, considering its world-wide spread, but that there is an increase in irrational anxiety. He went on to say how psychoanalytic theory explained this development. He invited us to consider Kierkegaard as a way of handling this confusing complexity and the many methods and systems of schools of thought. He felt that leaders of Balint-groups have an important contribution to make towards the development of hope and trust.

The last two days were like out Balint Weekends at Oxford, but we were divided into groups speaking French or German. Each group had two leaders, with about twenty members to each. The group I was in had nine general practitioners, four psychiatrists, seven university medical students and a medical student tutor. Our leaders were both psychiatrists, one German, the other Austrian. All the medical students with us had had quite a lot of group-experience, more than many of the general practitioners, and they made a very useful contribution to the group. It was interesting to see the way in which this very diverse group was able to function so well, and that practising doctors, psychiatrists and medical students are not necessarily a disadvantage to group activities when mixed together.

In between all this, I attended the meeting of the Council of the Administration of the International Balint Federation. Some time was spent discussing proposed changes in the Constitution. These had been sent out to all the constituents' member Societies, and had been returned, some with comments. The Federation will now consist of:

1. *Full members*: Representatives of National Societies, or of affiliated Societies, and only they will be allowed to vote.
2. *Associate members*: Individuals who work for the same aims, using the same methods.
3. *Corresponding members*: Where as yet there is no National Balint Society.

There was much discussion about the forthcoming Sixth International Congress in Montreux in 1984. The theme will be *Development and Change in Doctors during Balint-Group Training: Current Research and Research for the Future*. (See page 17).

We also had some interesting news items. A Balint-group has started in Athens, and a representative from Athens was present. Professor Plodinger led a Balint-group in Chang Tou in the Chinese People's Republic of China. There was a report from a Balint-group in Rumania. Dr Luchina of Argentina, who will be remembered by many who met him at the Fourth International Balint Conference which was held in London, has written a book, *El Group Balint*, and hopes to send his Society's subscriptions as soon as restrictions on sending money out of Argentina are lifted. As discussion in the Council meetings takes place in several languages simultaneously, it makes for a very stimulating afternoon!

After our last Group-meeting on the fourth and final morning, there was a plenary meeting with a surprisingly lively general discussion about the many aspects of Balint-work, Group-work, and the way in which the Conference had been run.

ERICA JONES

*Journal of Balint Society*

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