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Psycho-Analysis and Medical Practice[1]

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Introduction

In recent years, the training of general practitioners and non-psychiatric specialists in psychiatry and psychotherapeutic methods has become a public problem of some importance. The reason for this change has been the realization that a substantial number of people asking for surgical and medical assistance are in fact suffering from emotional problems. To offer them surgical or medical treatment has proved inefficient and unhelpful, a waste of time, money, and energy, and has often amounted to gross neglect, or even cruelty.

Freud was one of the very first to foresee this development: in his Budapest Congress paper in 1918 he predicted that the time would come when society must accept that the individual has the same right for help in his neurotic or emotional suffering as in his organic illnesses. At present, all over the Western world, and in particular in the United States, large sums of public money are spent either in the form of grants to non-psychiatrists, especially general practitioners, to induce them to change over to psychiatry, or for organizing courses to teach those who want to remain in their branch of the profession some kind of psychotherapy.

An important question faces us here: Shall we analysts accept any responsibility in this field? If so, what sort of responsibility? Or shall we keep out of it? As the answer to this question is rather complex and bristles with difficulty, it is worth remembering that we were faced on two previous occasions with similar problems, and on the two occasions the psycho-analytic movement gave two diametrically opposite answers.

The first occasion arose in the early twenties, when the question was: Should we psycho-analysts accept responsibility for developing techniques for child psychotherapy? The answer was an unqualified 'Yes', and the result of this decision was the development of child analysis, a real pride for us, and a great impetus for the development of both our theories and techniques.

The second occasion faced us in the second half of the forties when the question was: Should we psycho-analysts accept responsibility for the development of techniques to be used in grouppsychotherapy? The answer was a hesitating 'No', with the result that group therapy and psycho-analysis developed largely independently of each other to the great detriment of both.

It is perhaps worth pointing out that in spite of the diametrically opposite answers there was a good deal of similarity in the two situations Child analysis could be considered as following the trail laid down by Freud in his 'Three Essays' and 'Little Hans', first validating his findings and then extending and developing them. It could be argued that the situation was similar with group therapy, which could be considered as following the trail laid down by Freud's 'Mourning and Melancholia' and especially *Group Psychology and the Analysis of the Ego* with the aim of first validating the ideas expressed in them and then extending and developing them. It would be an interesting historical and psychological study to find out why in the first case the answer was 'Yes' and in the second 'No'.

Now in the sixties—I really do not know whether these twenty-year cycles have any deeper meaning or are mere coincidences—a similar question faces us: Should we analysts accept responsibility for developing psycho-therapeutic techniques to be used in medical practice? I hasten

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to add that this too could be conceived as following the trial laid down by Freud, for instance by his often-quoted dictum that 'the ego is above all a body ego' in order first to validate this idea and then to extend and develop it.

Surveying the present day psycho-analytic public opinion as it is expressed in papers read to the various societies, on the one hand, and published in our periodicals, on the other, it is impossible to predict what the answer will be. True, conversion—that 'mysterious leap into the organic'—is one of the oldest, and still a most attractive, concept in psycho-analysis. On the other hand, the new ego psychologies have been more concerned with the normal and distorted connexions between the ego and its various functions, more or less neglecting the processes which may lead to a pathological functioning of the body. It is true that ideas about psychosomatic connexions ever since the great pioneers in this field—Ferenczi, Jelliffe and Groddeck—have always aroused sympathetic interest in our ranks; but these interests have remained restricted to selected cases, and psychosomatic thinking has never become an integral part of psycho-analytic theory as, for instance, child analysis has.

As this short survey shows, the decision whether or not to take part in developing specific psychotherapeutic techniques for use in medical practice will be a difficult one. Moreover, it will involve a decision about the future of our mildly interested but uncommitted attitude towards pathological conditions of the body, which will not be an easy one. There are many more, both internal and external problems that have to be recognized before any decision can be made. I cannot even attempt to disentangle them in this short paper. The only thing I can do here is to pick out one of these problems and submit it to readers. The one I have chosen is the question of which roles are open to us psycho-analysts in this new field of training, and what it would mean to accept one role or the other.

As far as I know the situation, two rather different roles are offered to us. The first role is involved in the type of training schemes described by phrases like 'Post-graduate education for general practitioners and non-psychiatric specialists in psychiatry or psychotherapy'. If we enter the field under this banner our role will be that of *educators*. This type of training is very widely used in the United States and has been tried with varying success also in the United Kingdom. The other type of training, that developed by me in London, has been described by a phrase used right from the beginning: 'Discussion seminars on psychological problems in medical practice'. Our role in this setting is that of a leader of a research team.

These two roles are fundamentally different, and in what follows I will try to discuss the consequences of adopting the one role or the other.

Educator or Research Group Leader?

Let us start by examining the first of these two propositions. I have to preface my discussion by admitting that I have no first-hand knowledge of this sort of training because what I saw of it made me rather critical. In consequence, all that I shall say about it rests on other people's work, partly observed by me directly but partly only gained from the literature. The discussion will be under two headings: (i) What in fact do analysts do when 'educating' non-psycho-analysts? and (ii) What is the justification for the particular role adopted by them?

It is fair to say that every analyst engaged in this sort of education is sincerely concerned to avoid the danger of teaching 'wild analysis', that is, an irresponsible, wanton, violation and exploitation of the patient's unconscious. I have the impression that these analysts are so sincerely concerned about this danger that they consider as their first duty to advise their non-analytically trained colleagues what they should *not* do.

For instance, it is widely recommended that general practitioners should not try to analyse dreams; the reason being that without proper psycho-analytic training no one can understand the latent contents of a dream, that is, the finer mechanisms of the unconscious. Similarly, no attempt should be made to create conditions which would facilitate the emergence of primitive wishes, forms of experiencing, mental states, or in a word, primitive forms of transference, because to understand their full implications and to deal with them may be beyond the limits of what a non-analyst can do. In consequence, non-analysts should not try to uncover deeply repressed unconscious conflicts or repair basic faults; they ought to be *content with more superficial work*.

Positively, the psycho-analyst educators recommend to their trainees: (i) to arrange for their patients 'formal' psychotherapeutic sessions, preferably in a face-to-face situation; (ii) to encourage free associations; and (iii) to follow the associations with as little interference as possible—and still work *more superficially*.

To compensate for this last restriction the analysts offer: (i) that if necessary we psycho-analysts will be ready to help with our superior knowledge; and (ii) another offer, which is not too bad but not always helpful for the handling of the concrete situation in medical practice, but of which we analysts know a great deal: lectures on the structure of the personality based on our ideas about the development of infantile sexuality and infantile object relationships; on psychopathology; and on some aspects of psychodynamics. So much so that this sort of thinking and therapy came to be called 'dynamically oriented'—I am rather uncertain whether to our credit.

Our next task will be to examine how far these technical recommendations are justified. All our technical measures—and even our most hostile critics must admit that the psycho-analytic technique is perhaps the most reliable and the best validated of all psychotherapeutic techniques—have been developed and validated in and for the psycho-analytic situation. This is an artificial situation created by us which is so important that we insist, unanimously, that every new generation of psycho-analysts must learn analysis in this situation. An immense literature has accumulated about its significance, its various aspects, and its various 'parameters'.

In consequence I can restrict my discussion to those of its characteristics which will be important for my train of thought. First, the psycho-analytic situation is an exclusively two-person setting. Any third person, any external disturbance, is kept out of it as far as possible. Second, the influence of the analyst's real personality is restricted in it, again as far as possible; the analyst is trained to remain steady and unchanging whatever may happen, allowing or even inducing the patient to absorb the analyst into his internal fantasy life — which is called 'primitive transference'. Third, the analyst interferes as little as possible with the patient's free associations — the policy of the 'well polished mirror'—but follows them wherever they may lead.

In spite of this enormous freedom, right from the start a fairly rigid discipline is imposed on the patient with regard to time and space. There can be hardly any physical contact between the patient and his analyst. If at all possible the patient should try to remain for the whole analysis lying on the couch. Both the length of the sessions and their frequency are prescribed by the analyst; the patient himself has hardly any say in them. Even Alexander and French, perhaps the most revolutionary reformists, advise that the analyst—if he thinks fit—should vary the length and frequency of the sessions but should hardly ever allow the patient to do so on his own.

All these arrangements serve the over-riding aim that all communications between patient and analyst should happen, as far as humanly possible, in words.

All our well-tried and well-proven techniques have two inherent aims: (a) to establish and preserve the analytical situation, and (b) to enable the patient to become aware of his internal experiences while in this situation, then to translate them into words, and finally to communicate them to us. *A priori*, it is not at all certain whether a technique which works well in our artificial analytic setting will automatically prove useful under a different set of conditions. That is why the

closer the connexion between any particular technical measure and the analytical situation, the more cautious we should be in recommending it for other settings in medicine, for instance, the setting of the general practitioner. In what follows I shall discuss only the setting of the family doctor. The specialists' setting differs from that of the family doctor in more than one respect. In consequence, the ideas to be presented will not be entirely valid for their case.

In contrast to the analyst, a general practitioner is the doctor of the whole family. Some practitioners, in England for instance, do not accept split off members of a family. As a matter of course, the doctor maintains a close therapeutic relationship with every member of the family, the intensity of which varies with the member's personality and with the urgency of his complaints, but it is hardly ever an exclusively two-person relationship. If a particular member of the family has some complaints, worries, or is 'ill', the relationship between him and the doctor becomes for a period more intense, more intimate, and he gets special attention. At the 'end of the illness', however, this special attention is automatically withdrawn and given to another member of the family, and so on. Further, it is important to bear in mind that the members of the family are bound together by the ties of original object relationship, not by transference; that is, they are linked to one another by love, hate, and jealousy, by domination and submission, by compliance, rebellion, and identification, and so on.

The doctor, as a matter of course, is in constant physical contact with his patient's body: he counts the pulse, takes the blood pressure, percusses the chest, listens to the heart sounds, palpates the abdomen, looks into the various orifices of the body, and may even inspect and touch the most hidden erotogenic zones. In addition he uses all sorts of instruments to look inside the patient's body, such as endoscopy and X-rays, and has his methods to analyse the patient's blood, excreta, and secretions. And finally, he may prescribe magic pills and potions, injections and suppositories, etc.; and even the most sceptical among us must admit that some of these drugs have a potent pharmacological effect over and above what the patient attributes to them in his fantasies.

To show the limits of our analytical knowledge may I point out that, for instance, we analysts have not yet studied the art of how to combine the real effects of the drugs with the fantasies that they stimulate in our patients so as to achieve a safe and reliable therapeutic result. Neither do we know much about how and when to examine the patient's body, or about the real art of maintaining an on-going therapeutic relationship with all the members of a family, etc.

To sum up, we may say that the general practitioner's setting—though containing many elements of fantasy—is much nearer to reality than the psycho-analytical situation. In order that he should be able to cope with the problems inherent in his professional world the general practitioner needs a psychotherapeutic technique which, we must admit, will be considerably different from ours. Although his techniques will use a good deal of our findings, they will *not* be either a superficial or a watered down form of psycho-analytic technique.

Illustrative Case

If we accept any responsibility for training non-psycho-analysts in psychotherapy of any sort the first thing that we must realize is that we will have to train them in something of which we have much less knowledge than of analytic technique. Training doctors thus changes from teaching selected bits of our knowledge and skill to a research project for finding out what is needed by doctors if they want to do psychotherapy, and to working out together with them the answers to their needs.

To show what I mean, I wish to report a general practitioner's case, which, I am afraid will be somewhat complex; first, because it is a report about a multi-person problem and second, because I have to report several vignettes to demonstrate the development that took place.

The case was reported to a general practitioners' seminar which was at that time about a month old. The doctor was called out at 6 a.m. by Mr Q because his daughter, Leslie, aged 4, had a severe attack of asthma. The doctor, who knew the family well, went immediately, gave the child an adrenalin injection and watched her breathing to recover. Mrs Q then asked him to come to the next room, where she started to complain about her severe abdominal pain and threatened to faint. The doctor suggested that she should lie down on the sofa and went back to the child.

To describe these somewhat complex cases, we use in our seminars two concepts: 'traditional diagnosis', and 'overall diagnosis'. The traditional diagnosis is fairly simple in this case. Leslie is just developing her asthma. The attacks started a few months ago, and until recently the doctor hesitated to call them asthma. About three weeks ago Leslie had her first hospital admission when the registrar mentioned this word in front of Mrs Q. Mrs Q is suffering from functional or hysterical abdominal pains, complicated by chronic constipation.

Now the pointers to an overall diagnosis. The doctor described the couple as aggressive, somewhat paranoid neurotics. Mr Q used to be a long-distance fireman on the railways who recently, at the instigation of his wife, was detailed for local duties. As often happens with somewhat paranoid women, Mrs Q found her confinement an ordeal and since then has dreaded even the thought of pregnancy. She has taken on a full time job which means that Leslie has to spend considerable time either with neighbours or with the cleaning woman. Mother and daughter have been on the doctor's list for about two and a half years. Mr Q uses another doctor, always an important sign, suggesting considerable strain in the family. Right from the start Mrs Q has been complaining of severe constipation and pains. In fact her constipation goes back for about ten years, ever since she moved from her native Ireland to London. The doctor diagnosed it as a functional disease due to some unspecified emotional problem. Mrs Q insisted that it was organic and demanded specialist examinations which the doctor thought wiser to refuse. Instead he offered psychotherapeutic help which was indignantly rejected. In fact, both husband and wife told the doctor, practically in so many words, to mind his own business. It was on this basis that a hostile, argumentative, and mistrusting relationship developed between the Q family and their doctor.

The doctors in the seminar took up the various problems of this case with great interest. Some of them identified themselves with the 'firm' attitude. Others uttered grave warnings about the possibility of a Hirschsprung's disease and advocated acceding to the patient's request for a specialist examination and so on. This sort of erudite pathological discussion offers some respite from the strains caused by the constant preoccupation with psychological implications. When this was realized—with some help by the psychiatrist—the group began to get to grips with the possible causes of the definitely hostile atmosphere between the family and their doctor. Gradually it was worked out that perhaps the policy of 'firmness', the feeling of irritation openly admitted by the doctor, and the general atmosphere of hostility may be some of the symptoms of the patient's illness. To describe this finding we established a maxim that if the doctor feels anything when attending to his patient he should on no account act upon his feelings, but should stop and examine them as a possible symptom of his patient's illness. In this case, the doctor's having these feelings would mean that the patient was stimulating and provoking them and the doctor may be a—perhaps willing — victim who cannot help responding to his patient in this manner.

The reporting doctor happened to be a most conscientious and logical man so he had to accept this interpretation, so to speak, on approval. Under this pressure he decided to change his attitude towards the whole family. First he agreed with the hospital that he would take over from them Leslie's follow-up. Then he offered a 'long interview' to Mrs Q, during which he inquired sincerely about the state of her bowels, and although he remained convinced that the complaints were functional, he offered to send her to a specialist for a check-up. She accepted this offer with pleasure, and the doctor then wrote a letter of referral and handed it to her.

In response to this changed attitude, further details were spontaneously disclosed by Mrs Q. The doctor learned that her father was a friendly, very peaceful man, while her mother was a bossy, dominating woman. When the doctor interjected, 'Somewhat like you?', the patient smiled and continued that her mother left her father and came to live next to the patient which resulted in quarrels and a rather strained atmosphere. The doctor then asked if all this anger and quarrelling may have had some effect on Leslie's asthma, whereupon the patient answered, 'Perhaps', and departed in a friendly mood.

Two months later, Mrs Q's case was brought up again. After the interview the doctor took a fortnight's holiday, but learned on his return that Mrs Q had not yet seen the specialist although the letter of referral was in her purse. In spite of it her abdominal pains disappeared and her bowels functioned every day.

This definitely amounted to a magic cure, especially if one takes into account that it happened after more than two years of unpleasant haggling. I wish to stress that the doctor did not give up his diagnosis; Mrs Q knew that the doctor still thought that the pains were hysterical. The only difference was that the doctor treated her differently, that is, instead of imposing his opinion on her he tried to *understand* her problems and difficulties.

Remarkably the doctor stopped here. He did not inquire any further nor try to understand nor interpret what happened. Instead he switched the interview to a discussion of the mother/child relationship. He learned that Leslie's asthma started in the new flat. Leslie was quite well while the family lived in a somewhat dilapidated house from which they were moved by the local authority to a rent-assisted new flat. Further, Leslie did not have any attacks when she was allowed to play out with the other children, but when she had to stay at home with her mother she responded with two or three attacks a week.

It is fair to say that the atmosphere has now changed considerably. Instead of quarrelling and arguing, doctor and patient are now working together with the production of quite impressive material.

At long last Mrs Q decided to see the specialist who did the usual tests, including barium meal and follow through, none of which produced any positive findings. In consequence she was told that there was 'nothing wrong' with her, she must accept that her bowels move only every three to five days. The only thing she can do is to take some laxative, and the specialist prescribed some for her. As a result, the constipation returned in its old force.

Of course, what the specialist told her was absolutely correct and sensible—that is, as far as his diagnosis went—and this is what we call traditional diagnosis. What he did not do was to bother about the overall diagnosis. In consequence his sensible prescription and advice proved as futile as our general practitioner's equally sensible policy of 'firmness'. In a woman like Mrs Q, a treatment of this kind creates first anger, contempt and resentment, leading to a worsening of her symptoms and proving thereby that the 'sensible' specialist and general practitioner were bad, perhaps even stupid, doctors. If this sequence of events is not recognized by the doctor, his reaction will be irritation which then inevitably leads to a vicious circle of chronic hostility.

During the seminar in which all this was discussed, we also heard that a few days previously the doctor was called out at seven in the evening to see Leslie who had another bad attack. He gave her a quick-acting spasmolytic and then, having in mind the approaching night, thought it advisable to add as a prophylactic—both in his own and in the family's interest—a long-acting aminophyllin suppository. He fished one out from his bag, handed it to Mrs Q and asked her to administer it. A very noisy scene followed between a furiously fighting 4-year-old child and a mother who was absolutely incapable of controlling her. At the end, since the doctor has always been on most friendly terms with Leslie, he took the suppository from Mrs Q and administered it without any

trouble. Leslie soon calmed down, the doctor tucked her back in bed, kissed her goodnight, and left. A few hours later he heard on the telephone that Leslie was sleeping peacefully.

I wish to add here the discussion as it developed in the seminar after the report. The doctor himself admitted that he was fully aware that it was his decision to change his attitude that had brought about the changed atmosphere between himself and the family and this was most welcome to him. However, he was now afraid that he might be 'sucked in'. As he explained, he realized now that the whole family Q was, so to speak, starved for kindness and affection, and he saw the danger that after they had discovered that they could get something of it from their doctor, they might have to demand more and more.

A woman doctor in the seminar replied that she saw no need for alarm at all. Mrs Q saw, perhaps for the first time in her life, what affectionate handling was. Now she would be able to identify herself with the model demonstrated by her doctor. A male doctor, a rather cautious man, somewhat older than the reporter, was very critical. According to him Mrs Q was definitely a deprived child who simply could not help but respond to any show of affection by envious competition, which would force her to demand more affection for herself and would be expressed by her developing more psychosomatic or conversion symptoms.

Another male doctor called our attention to Mr Q, who witnessed the whole performance. He could foresee complications from Mr Q since, as the case history suggests, he did not receive much love or affection from his wife—as is shown by her fear of pregnancy and her insistence on having a full time job. It was to be expected that his wish for affection might lead to some vague illnesses.

And lastly there was the problem of Leslie's reaction. How would it influence her development—now in the full oedipal phase—that her doctor-friend took the suppository from her mother, inserted it himself, which had a beautiful soothing effect, then tucked her in and kissed her goodnight. The doctor certainly must appear to her as a great magician, or a knight in shining armour, saving a little damsel from hell.

Last but not least, let us suppose that the news will spread in the practice that this doctor is prepared to go to this length with his patients; it is very possible that a number of his patients will expect something of this sort from him. What can he do to avoid being 'sucked in'?

I have no answer to any of these questions. After having admitted my ignorance can I now turn the table and ask whether we as psycho-analysts can answer anything definite to these questions? My contention is that apart from having some erudite but rather vague ideas about the possible psychopathology of the whole family we cannot make any definite predictions.

For instance, we cannot predict whether Mrs Q will identify herself with the kind doctor and will become a better, more affectionate mother; or whether she will become angry, jealous and contemptuous; or whether she will develop more and more psychosomatic or conversion symptoms, a kind of overdemanding, addiction-like state. Equally we cannot predict whether Mr Q will preserve his indifferent but somewhat paranoid, shadowy existence, or whether—stimulated by his witnessing the doctor's performance—he will develop some shadowy illnesses in search of some affection. Or, turning to Leslie, we cannot indicate whether her attacks will become worse so that she may get more suppositories, or whether she will be cured by the 'great magician' as long as he will tuck her in and kiss her goodnight from time to time; whether her hostility to her mother and to any other woman will increase so that she can prove that only men are worth anything, and so on, and so on. Of course, we have still less idea as to how the doctor should modify his 'treatment' of the girl or of any other member of the family so as to avoid or even prevent any undesirable developments.

Instead of answering these vital questions, we can indulge in erudite lectures on the psychopathology and psychodynamics of the family Q, but—as we have seen—so can the doctors.

True, our lectures will be more erudite and somewhat more to the point since we know much more, but their relevance for the handling of the concrete situation will not be much greater.

Discussion

To sum up, I propose that we analysts should not do what we know is objectionable. We should not educate anyone to do a watered down form of analysis. We should not try to give advice about a complicated, multi-person situation on the basis of what we have learned from our patients in an exclusively two-person relationship, as the psycho-analytic situation is. We should not talk generalities about psychopathology and psychodynamics instead of concentrating our attention on the concrete case in the here-and-now situation.

The question arises then: what can we do? My answer is contained in the case history reported here. We should concentrate our attention on what we know a great deal about and which we can directly observe during the report, and this is the doctor's countertransference to his patient. There are several synonyms for describing the same phenomenon. It may be called the doctor's contributions to the developing doctor-patient relationship; the doctor's individual ways of practising medicine; the doctor's emotions; or the doctor's apostolic function.

Like all countertransference, that of the general practitioner is partly conscious, partly unconscious. In consequence, its effects are often utterly different from what the doctor intended them to be. This is our real field. Moreover, here there is no absolute need for finding out from the doctor's report what the exact external facts of the case were, which would be essential for a proper psychopathological or psychodynamic assessment. The way the doctor reports about his patient with all the holes and folds in the history, with all the omissions, second thoughts, later additions and corrections, etc., including the sequence in which these are revealed, all tells a tale—similar to the manifest context of a dream—familiar and fairly easily intelligible to us psycho-analysts. The tale is, of course, about the doctor's emotional involvement, his countertransference.

Here we are at home and we can use openly and sincerely our special knowledge and skill and can demonstrate their usefulness in understanding complex human relationships. We can do all these in a straightforward way without any subterfuge, prevarication, or false superiority. Moreover, in general medical practice the doctor is a party to the reality situation, with his countertransference as a most important ingredient of it. If he can change his countertrans-ference to make it therapeutically more effective, the whole situation must change fairly rapidly—as happened in our reported case.

Here a note of warning. The technique of interpretation in the setting of the training seminar is of course different both from the technique of analytic interpretation conditioned by the setting of the analytic situation and from the technique of group interpretation which is conditioned by the setting of the therapeutic group.

The chief difference perhaps is that in the two therapeutic situations the aim of the interpretation is to uncover some content of the unconscious, for instance, the motivation for a particular form of behaviour. This of necessity tends to create an inequality between therapist and his patient and stimulates thereby the emergence and transference of primitive, childish emotions. In the setting of our training seminars one of our main considerations is to preserve the dignity, the independence, and the mature responsibility of the participating doctors without which they cannot function as full members of the research team. Our interpretations, therefore, are hardly ever concerned with the hidden motivation of the doctor's therapeutic behaviour, a sphere which we have come to call his 'private transference'. This remains untouched in the same way as his private life. What we are concerned with is his 'public transference', that is, the part of his professional work that by his reporting and by his participation in the discussion has become known to all members of the seminar. And even here our aim is first and foremost to enable him to make discoveries on his own,

and we therefore use direct interpretations very sparingly. The best moments for making independent discoveries are when most members of the seminar are openly roused by a report and do not mind disclosing that they are emotionally involved. These moments give welcome opportunities for several members to become aware of their individual forms of involvement. The variety of the responses highlights by contrast each doctor's individual response. The seminar discussion after the last report is a good example of this sort of work.

Bearing all this in mind, let us examine what was and what was not done in the case reported. For an analyst it would not have been too difficult to link up: (a) the doctor's contributions to the hostile atmosphere as it existed at the beginning of the period; (b) his unwillingness—after the miraculous cure and after the relapse—to enquire further into Mrs Q's bowel problems and his readiness to turn to the mother-child relationship instead; (c) his choice of a suppository and eventually administering it himself; and (d) his fear of being 'sucked in'. Very likely even a beginner among us would be able to trot out a few sensible interpretations, and it is quite likely that most of them would be more or less correct.

But, may we ask, what would the result be? If the particular interpretation were not to the point, its effect would be some irritation, and hardly more. If, on the other hand, the interpretation were correct, the doctor would feel embarrassed, perhaps ashamed, with a probable great increase in his resistance. This could lead to some splitting in the group, some of the members siding with the 'clever' analyst and the others with the unfairly treated doctor. And lastly, interpretations of this kind would work against the spirit of the research team. They would increase the inequality between the psychiatrists and the general practitioners, leading to the establishment of the dangerous therapist-patient — or teacher-pupil — relationship.

Instead of this, what happened in the group was this: the doctor was helped to discover for himself that his 'firmness', that is, his way of practising medicine, was the result of an interplay between the patient and himself, was in fact a symptom of his patient's illness which brought forth a reaction (countertransference) from him. He had been aware for some time that his 'firmness' led to undesirable therapeutic results. His new discovery, therefore, increased the burden of his therapeutic responsibility. Of course, he could have denied the whole connexion, but in this case he decided to *experiment* with new attitudes.

What was not touched upon was the question of what were his personal motives in reacting in this manner, that is, in practising medicine in this way. We call this field the doctor's 'private countertransference', which we hardly ever touch; and contrast with it the doctor's 'public countertransference' with which we continuously work. In our case I decided not to intervene when the doctor reported that after the miraculous cure he dropped the topic of Mrs Q's abdominal complaints and turned to the mother-child relationship. The reason was that I thought it might stir up the doctor's private countertransference. Possibly, if the group had not been so young, that is, had had more experience in detecting—and working with—this sort of problem, I would have decided differently.

And lastly, after the remarkable admission of the doctor's fear of being 'sucked in', noticing the emotional tension in the group I decided not to intervene. As it turned out, it gave the members a fruitful opportunity to become aware of their own individual involvement, to verbalize it, and thereby bring out the various aspects of possible doctor-patient relationships and their consequences. In addition the preoccupations in the doctors' minds well demonstrated the many individual ways of practising medicine; that is, the many forms of countertransference, the immense force of conviction behind each of these individual forms, and also the largely unconscious motives of all this variety.

In this way, I think, the presenting doctor was helped to realize more fully what his individual way was in contrast to the other ways voiced in the discussion; and also the largely unconscious motives for *his* ways. I hope that this opened new possibilities for him to choose other ways and

drove home that it was his responsibility to choose a way which was therapeutically more effective. From another angle, instead of being lectured to or taught, he was induced to experiment and to discover on his own and at his own peril. At the same time he was allowed to choose what he felt was congenial to him; but he was made to feel that it was *his opportunity as well as his responsibility to choose well*.

There is one important hazard in all this work, and I wish to end by emphasizing it. The analyst who accepts the role of a leader of a research team instead of that of an educator must be prepared that the doctors will soon discover that the phenomenon of countertransference is general. It is not only the participating general practitioners but also the group leader-psycho-analyst who has his own individual ways: of understanding the case reports, of highlighting certain aspects and not others, of giving certain interpretations and not others, etc. All these are expressions of his countertransference which can be understood and interpreted in so many words. And, of course, they will make use of this discovery at the expense of their leader.

This must not only be accepted but *encouraged*, otherwise an inhibited atmosphere will develop which is inimical to any real freedom and progress. What is still worse, a bad form of medicine will be demonstrated, that is: how *not* to behave, how *not* to treat a patient. On the other hand, if the leader can take criticism, can accept that he too has an apostolic function, that is countertransference, and is willing to learn from his group, real psychotherapy is demonstrated in the here-and-now situation to the great liberation of practically all of the participants.

This is a highly important point for the future because if the doctors can liberate themselves from their rigid countertransference patterns, they can go back to their practices having learned how to observe better, how to report more reliably. And with that our real research into what does happen and what may happen in general practice may start with a much improved team.

It is very likely that the proper study of the multi-person relationships and transferences as they exist in general practice will yield data as important for the study of personality as has the study of the two-person relationship in the analytic situation. Until now, however, we have not had any reliable teams of observers in this field.

True, we know that the multi-body problem in general has baffled for centuries both the astronomers and the theoretical physicists, but they were able to produce some very useful and highly precise solutions of various special problems. Let us hope that if we can train our general practitioners to become sensitive observers and reliable reporters a great step will be made in understanding both the personality of the individual and the structure of that most important unit, the family.

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