NEUROTIC REPETITION AND GENERAL PRACTITIONER PSYCHOTHERAPY

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My nerves are bad tonight. Yes, bad. Stay with me.
Speak to me. Why do you never speak. Speak.
What are you thinking of? What thinking? What?
I never know what you are thinking. Think.
T. S. Eliot. The Waste Land.

From the foetus recapitulating phylogeny, to the recurrent seasons, repetition plays a prominent role in human affairs, small and large.

Repetition is correspondingly important in medicine. The psychosomatic diseases have a characteristic repetitive quality, and in psychiatry it is well established that patients, in Freud's phrase, " suffer from reminiscences."

Neurotic behaviour has two important aspects. First, it serves to defend against intolerable situations but, on the other hand, it has a negative or even destructive aspect, producing the symptoms which the patient either talks about, or acts out, in appropriate circumstances, over and over again. As the individual is unconscious of much of the conflict, he is unable to discuss it or, even if it is demonstrated to him, to recognize it clearly without his emotional involvement. Nevertheless, neurotic behaviour is a communication from the patient, which can be utilized to bring to his conscious attention, conflicts previously repressed.

The family doctor and his patients develop a relationship which gives ample opportunity for the observation of neurotic repetitions of behaviour. The patients have erected a defence system, and they conceal from the doctor and from themselves that their symptoms represent the cost of defence. The analogy to disarmament problems amongst nations is striking—a method of defence is needed, and yet the cost is increasingly prohibitive, and damaging to more healthy aspects of development. This situation leads to the well recognized fact that neurotic patients are " difficult " or, to put it bluntly, that they tend to frustrate their doctor's attempts to cure

them. They may do this in either an unpleasant way by failing appointments or ignoring instructions or by outright bad temper: or they may achieve the same end with the greatest of courtesy by concealing information or misleading him in some other way.

The difficulties brought about by this situation are unfortunately complicated by the doctor's own wish to be successful, and his consequent reaction when he realizes that his patient is frustrating him. In physical illnesses, patient and doctor face each other with some hopes of mutual gratification. In neurosis, the defensive aspect of illness actively defies success, and tries to prevent it. Clearly, neurotic patients demand from the family doctor an attitude quite different to that based upon the assumption that the patient wishes to get well, without reservations. For example, in the ordinary way if a patient misses an appointment, he may feel that as the patient is not going to co-operate, it is not much use wasting time—there are plenty of other patients who do need his time and attention. But in neurosis the family doctor can only help if he is willing to persevere with patients apparently reluctant to help themselves. Indeed, the parallel with the emotions stirred up in parents by " naughty " children—feelings of anger, boredom, frustration (leavened by remorse)—is so marked that it is no surprise to find that the neurotic patient retains a strong impression of having been a " difficult " or " problem " child. The patient tends to repeat his difficult behaviour, which has its origins in childhood problems, with the family doctor who in many ways plays an authoritative or parental role. The family doctor, is chosen by the patient personally, in contrast to many other workers in the social services, including hospital consultants. The family doctor examines and touches and shows concern about bodily functions, like a parent. It is true also that in some cases the family doctor has access to the whole family, but it is salutary to remember that many neurotic patients come from homes where communication between the parents has become impaired—a condition reproduced when more than one doctor attends the family.

The foregoing may be summarized as follows: neurotic patients are suffering from unresolved problems with origins in infancy, problems of which they are to a great extent unconscious. A mental defensive system is elaborated which exerts a toll of undesirable symptoms. When the patient comes to the family doctor, wishing to have the symptoms removed, he finds himself repeating infantile problems with the family doctor playing the parental role. In this situation the doctor is in a good position to observe the defensive system at work, and may help to bring it to the patients conscious attention. Under these conditions, the patient's actions or behaviour

are regarded as a communication, of unconscious, or unverbalized, emotions.

In this way, not only can a " specimen " of the repetitive pattern be " sampled ", and a diagnosis arrived at, but the patient can be given insight—the unconscious made conscious and diagnosis and therapy proceed hand in hand.

The case histories which follow, illustrate this theme and have been chosen not for their curiosity value, but because they are common. Discussions with other family doctors at the seminars in psychotherapy for general practitioners at the Tavistock Clinic frequently revolve round these problems.

The first two cases concern the failure to keep and the cancellation of appointments, unambiguous indications that the patients' expectations of success are small.

Case 1. A young, married man, physically healthy, complained of headaches and feelings of tension. At our first long interview he spoke freely about his marriage problems, mainly about the fact that he became uncontrollably angry when his wife crossed him in any domestic matter. He also spoke of his great contempt for his father, whom he considered to be ignorant and a boor. He was late for his next appointment, and then spoke mainly of his philosophy of life (which was depressingly adolescent). He also became curious about me and doubtful of my ability to help him. He wanted to know whether I was married, or had any special training in psychotherapy—he thought doctors in general (" Not you of course, doctor ") were mainly concerned to remain " one up " on their patients. In other words, he was beginning to repeat with me his own difficulties with his father.

He was late for the next appointment and failed to keep the next two I offered him. A year later he came to see me with an injury, and I took the opportunity to resume our conversation. It transpired that much of his resentment against his father was concerned with the problems of acquisition of knowledge about sexual matters. The repetition of his curiosity about my affairs was then seen by both of us in this context. We resumed our interviews for a while, but he found it very difficult to believe that I could help him, although he was paradoxically grateful for my interest. We agreed to stop and await further developments. The next development in fact came from the father, who sought my advice about certain legal difficulties he was in about his possibly bigamous marriage many years ago, and the illegitimacy of his children. The infantile situation of my patient was clearly at the root of his present problems, both with wife and doctor.

It is obviously important to consider what was achieved in this case from a therapeutic point of view and as with so many aspects of psychological medicine, assessment is not easy. In the first place, the original complaint of headache and tension has not been repeated. Secondly, on the wife's testimony a limited amount of insight into his emotional problems was achieved. They both get on much better now. Thirdly, the case is not closed—as a family doctor, I have established a relationship with the patient that enables him to return when he is ready.

Case 2. A 30 year old bachelor complained of recurrent vomiting attacks shown by x ray to be due to duodenal ulcer with pyloric stenosis. He had been advised to have a gastrectomy, but he himself thought his symptoms had a major

psychogenic component. He was a new patient and from the history at the first interview it was obvious that he had had a very traumatic childhood and that he was indeed suffering from a neurosis. I formed the opinion that a trial of psychotherapy was suitable. We agreed to meet again the following week. Two days before he was due, he rang to say that he had changed his mind, and had decided to go ahead with the gastrectomy. I asked him to keep his appointment with me nevertheless. At this second interview, we discussed his behaviour as a repetition of his infantile feelings of disappointment and hopes not realized with his father and stepmother. Having passed this hurdle therapy continued. Within a few weeks, his vomiting abated and he began to regain his lost weight, but he soon began to feel that he was a problem case for me, and that if he again began to vomit he would be a great disappointment to me. This was very much a repetition of one of his problems with his father whose suicide a few years ago he in part attributed to to his own lack of co-operation. In due course, he became conscious of and was able to talk about matters that had previously been communicated only by actions—feelings that he was a messy, awkward individual, and the cause of disapproval and rejection in others.

Case 3. A young, married woman risked suicide by swallowing a quantity of barbiturate tablets. When she had recovered from the effects, I asked her to come and see me, by appointment, to discuss her problems. When she came she brought her two year old toddler with her. Throughout our attempts at conversation, the child wandered round the room, picking up objects, dropping them, and punctuating the proceedings with outbursts of crying. At the next interview she agreed to come alone, and we discussed her marital problems, in which the child figured prominently.

For example there were difficulties with mother-in-law on whom she depended to care for the child while she was at work. Accommodation shortage meant that there were many sleepless nights, when the baby cried and was taken into the parents bed, interfering with both social and sexual intercourse. We then discussed the way in which the same pattern had been repeated with me, with the child this time coming between patient and doctor, instead of husband and wife. This led to further discussion of the fact that her marital situation was really a repetition of childhood problems, when as the eldest girl, and because of her mothers chronic ill health, she found herself for the first time in a triangular situation with herself as the child coming between parents.

Case 4. A middle aged, married woman complained of asthma from the age of about 14 and blackouts for the past 4 years. More recently, her attacks had seemed to be some type of fit, but thorough investigation at a neurological hospital failed to discover any organic cause. She returned to see me and asked what could be done to help her. I suggested that we meet at weekly intervals to discuss the psychological aspects of her problems. At the first few interviews she spoke freely of her history. She was the second eldest of a large family, and had always been very reserved in contrast to her elder sister whose rebellious escapades were severely punished. She made no mention of her present relationship with her husband, and in fact had the greatest difficulty in recalling anything remotely connected with her sexual development. When I commented on this, she told me that her frigidity, and her husband's relative impotence were a source of great irritation to her. She failed to attend the next interview, because of an attack of asthma and giddiness that developed on the day of our appointment.

Subsequent interviews confirmed that although she came to see me and expressed gratitude for my interest, she had great difficulty in allowing anything we discussed to "sink in "—a problem she also experienced with her husband's penis. She had all her life refused to be consciously aware of the conflict in her attitude to her parents who discouraged sexuality in the children, and yet were obviously sexually active themselves.

This patient eventually stopped attending regularly at her own request. Her physical condition has improved a good deal, and the feelings of desperation for something to be done have been replaced by the understanding that when and if she wishes to discuss her problems further, the opportunity is there.

Case 5. A young, unmarried man complained of dizzy attacks, and uncom-

fortable feeling that people were looking at him and laughing. At a long interview, he spoke monosyllabically, so that the interview became a series of questions and unsatisfying answers. From my previous acquaintance with his family I knew that he lived with a stepfather and his mother, his own father having divorced the mother when my patient was about five. There was still a certain amount of tension in the household and the mother was a regular consumer of sleeping tablets. My patient seemed to know very little about all this, and nothing at all about his father. As he was going, however, he stopped at the door, and said, showing animation for the first time, " What do you really think about me? Do you think this talking is going to do any good? Are my symptoms really connected with things that happened so long ago? " I replied that he seemed to have a problem about curiosity. In the first place, he had been frustrating my curiosity about himself, and secondly he had only shown his own curiosity when the interview was really over, and he was going through the door!

He accepted this with a smile, and at our next interview he spoke more freely about his father. He had seen him last about 15 years ago, although he understood that he still lived not far away. When his father was mentioned at home, it was in derisive terms; perhaps a mutual acquaintance would report on having caught sight of him and this was the cause of scoffing and laughter. He agreed that he had never been given much information about his father and admitted that he did sometimes wish to know more. I pointed out to him that when I questioned him he took over the role of the snubbing parent and kept me in the dark, and that, further, he unconsciously identified himself with his father, the one who was laughed at and derided.

We met again on one or two occasions only, and he reported feeling better, and we agreed to wait and see how he got on.

My last case illustrates the difficulties that arise when the doctor starts to " act out " and the destructive effect on therapy that this produces.

Case 6. A middle aged, married woman suffered from attacks of nocturnal dyspnoea, and feelings of depression. At one point, she was admitted to hospital and discharged a few days later as a hysteric. No psychiatric investigations were made or advised. However, when I questioned her, she fairly readily recounted her story for the first time since the events occurred.

When in her early adolescence she had witnessed the suicide of her father by cutting his throat. Although the mother subsequently remarried, and was living, apparently happily nearby, the patient was troubled at a conscious level, by her ambivalant feelings towards her. She felt that in some way her mother was responsible for her father's death. Intellectually, she understood that this was hardly the whole story but, nevertheless, it had always made relations with her mother (apparently happy) difficult.

Talking about these things for the first time was both a relief for the patient (she lost her physical symptoms) and a strain. She repeated her childhood instinct to turn to her mother for comfort. Her mother's reaction was to come straight to me and complain that I was upsetting her daughter, and that she felt that I ought to discontinue treatment. I agreed and informed the patient, although she herself was willing to continue.

Discussion of what had happened at a seminar at the Tavistock Clinic followed. I then understood that I had stopped treatment for the mother's sake, and because of personal fears when faced with anxiety. Thus fortified, I resumed treatment, and therapy continued successfully. The incident had illuminated the personality of each of the three persons involved—a middle aged woman acting out her dependance on her mother, an elderly woman acting out her intolerance of "difficult" behaviour in her child, and a family doctor acting

out his fear when faced with an anxious woman.

Conclusion

I have attempted to put on paper some of the difficulties which neurotic patients, in spite of themselves and their conscious desire to be relieved, put in the way of successful treatment. I have described these in terms of the repetition of infantile problems of disappointment, failure, distress, and so on. Teleologically, the patient is perhaps only attempting by repeated efforts, both to solve emotional problems and to protect himself from their consequences. If the doctor has the ability not to get lost himself, together they may make use of the repetition to bring unconscious motives to consciousness.

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Mental Health in Tudor Times

" There is no man the which have any of the kinds of madness but they ought to be kept in safeguard, for divers inconvenience that may fall, as it appeared of late days of a lunatic man named Michell, the which went many years at liberty, and at last he did kill his wife, his wife's sister and his own self. Wherefore I do advertise every man the which is mad, or lunatic, or frantic or demoniac, to be kept in safe guard in some close house or chamber, where there is little light. And that he have a keeper, the which the mad man do fear. And see that the mad man have no knife, nor shears, nor other edge tool, nor that he have no girdle, except it be a weak list of cloth (to prevent) hurting or killing him self. Also the chamber or the house that the mad man is in, let there be no painted cloths, nor painted walls, nor pictures of man nor woman, or fowl or beast; for such things maketh them full of fantasies. Let the mad person's head be shaven once a month: let them drink no wine, nor strong ale, nor strong beer, but moderate drink; and let them have three times in a day warm suppings and a little warm meat. And use few words to them, except it be for reprehension or gentle reformation, if they have any wit or perseverance to understand what reprehension or reformation is."

Andrew Boorde's *The Dyetary of Health.*