Special Section (continued)

Consuming Passions: Groups for Women with Eating Problems

Inge Hudson and Sheila Ritchie
with Clare Brennan and Deirdre Sutton-Smith

This is an account of time-limited focal group-analytic therapy for women with bulimia and compulsive eating problems in an all-women context at the Women's Therapy Centre, London. Eating problems are understood within the context of the early mother–daughter relationship and there is an account of how these dynamics are played out within the groups. The authors describe their understanding of transference and countertransference phenomena and the use of metaphors to achieve a process of translation from the concrete language of food, eating and the body to the language of feelings and relationships. They demonstrate how homogeneous groups for these women provide the opportunity for them to see their difficulties reflected in others, thereby enabling them to make the link between their relationship with food and the body and their internalized objects. Throughout the article there is an attempt to locate the work within a social context.

Key words: bulimia, compulsive eating, eating problem, focal therapy, translation, women

Introduction

The Women's Therapy Centre, London has been in operation for twenty years and groups for women with eating problems have been in demand from the beginning. Many women who come to the Centre have read *Fat is a Feminist Issue*, by Susie Orbach (1978)

This paper is a slightly expanded version of a paper presented at the 10th European symposium in Group Analysis, Copenhagen, 1996.

Group Analysis (SAGE Publications, London, Thousand Oaks, CA and New Delhi), Vol. 32 (1999), 37–51 0533-3164[1999/03]32:1;37–51;007175

finding that its powerful message gives a voice to their feelings. What often resonates is the recognition that the roots of their problems around food and eating lie in how they have been socialized as women, starting with their early relationship with their mothers.[1]

In this article we present an account of time-limited group-analytic therapy for women with bulimia and compulsive eating problems at the Women's Therapy Centre. We will be drawing on our experience of running short-term groups lasting from 10–12 weeks to one year.

The aim of our groups, as Foulkes (Foulkes and Anthony, 1957) would have put it, is one of translation: to translate the autistic language of food, eating and the body into a communicable language which can be understood — the language of feelings and relationships.

We shall begin with an example. In the first session of a group, after an initial anxious silence, there was talk about diets that group members had tried, their favourite binge foods and past treatments. The conductor spoke about the fear there was in the group of leaving the food outside and bringing their hunger and expectation in. A bulimic woman said:

> If I brought my hunger in here, I wouldn't just gobble up everything in this room but I would have to go on right down the corridor until there wasn't anything left of the Women's Therapy Centre.

This initial anxiety of one group member speaks for a large number of women who have dealt with their desire and hunger by splitting it off from the more rational and adult aspects of their personality, to a point where it feels devouring, out of control and destructive. We would like to show how such fears of destruction can be translated into a hunger which is capable of being experienced and satisfied.

What all women with eating problems have in common is that they are using food and the body in very concrete ways to cope with emotional distress and a sense of emotional emptiness. Their symptoms reflect their longing to fill this emptiness as well as their fear of experiencing it and thinking about it. We suggest that the roots of their difficulty lie in their disturbed relationship with their mother at a very early pre-verbal level.

Joyce McDougall's (1986: 66) description of the addict as still

seeking the breast-mother of early infancy in the external world because there is little or no identification with an *internal* caretaking mother seems very relevant. She describes how the addictive object (food) is in the first instance experienced as 'good' and even as 'vital to the subject's well-being', yet once absorbed the addictive substance is usually experienced as 'bad' and destructive.

Women with eating problems feel that their neediness and hunger cannot be tolerated. They believe that their needs and feelings must be bad, dangerous and too much for anyone, and their symptoms represent a desperate attempt to keep them hidden and under control because they are afraid of expressing them within the context of real human relationships.

When we speak about eating problems this is, in a sense, a misnomer, for we are actually dealing with problems of the self, a self which is unknown, feared or hated.

Why Groups? And Why Homogeneous Groups?

We will be describing in more detail the experience of women with eating problems of having had mothers who did not adequately mirror their daughters' needs and separate sense of self but, instead, required their daughters to act as mirrors for their own needs or function as containers for their own feelings. These early experiences occur within and are reinforced by the wider social context or cultural mirror.

As Bloom and Kogel (1994: 48) put it: 'Sadly, for women, truly being seen and recognised, which is such a critical piece of healthy development, is too often skin deep. Both historically and currently, women are meant to appear, to reflect, to be mirrors for others, to be containers for others' desires.'

Eating problems are often seen as trivial within the current social climate and dismissed as being due to greed or vanity, so that the real pain, distress and emotional cost behind them is denied. Thus women with eating problems are even further alienated from their own experience.

Groups for women with eating problems provide a setting where previously private experiences can be shared and validated and where common underlying factors can be identified. Homogeneous groups provide the opportunity for women to see their difficulties reflected in others, thereby enabling them to make the link between

symptoms and their underlying meanings, between their relationship with food and their internalized object relationships.

Distinctive Dynamics of Groups for Women with Compulsive Eating Problems and Women with Bulimia

In our clinical work we have been struck by the distinctive dynamics of groups for women with compulsive eating problems and women with bulimia, although we acknowledge that this distinction is something of an over-simplification.

The experience of women with a compulsive eating problem is of having had to act as mirrors for their mothers' needs and of having had mothers who were unable to reflect their daughters' needs and separate sense of self. As a result, they have not been able to separate effectively from their mothers, or, to put it another way, they still experience themselves as merged with their mothers and as not having boundaries or a separate sense of self.

The way that this manifests itself in the groups is that competition and conflict are buried. There is a fear of acknowledging difference and the groups appear symbiotic and merged. It is really difficult for individual group members to be clear about what they want and what they don't want. They can't say 'I'm not hungry, mum' or 'I want this rather than that' and so, in the initial stages of the group, they tend to swallow everything they are given but often without really 'tasting' it, that is, they tend to accept everything that their therapist and others say but without appearing to reflect on it or consider it. They are anxious to please and placate and are eager to reassure the therapist and each other that the group is helpful, whilst hiding any feelings of anger and disappointment.

Coming to the Women's Therapy Centre can be particularly evocative for these women and there is often the hope that the Centre will be the perfect mother who will supply what is needed. In fact, feelings of disappointment are, of course, inevitable and it is very important for the group to provide a space where such feelings can be expressed and tolerated.

Because of their lack of boundaries compulsive eaters feel that whatever is on offer will be insufficient to satisfy them. There is a pressure to fill the available space with words and it is common for there to be very little silence in these groups. There is a fear of silence because talking represents remaining connected while

silence represents separateness and a space where the feelings of emptiness and neediness would have to be experienced.

As children compulsive eaters were in touch with their mothers' unmet needs and they became caretakers for their own mothers. This leads them in later life to adopt the role of carers who project their own unmet needs into others while at the same time feeling more and more empty and needy themselves. In the groups this may be expressed by members feeling very responsible for each other and giving support to others, rather than being able to express their own feelings and needs. A group member may say: 'I feel that you need to take some time today, Yvonne', or 'I don't think that my needs are so important just now. I am wondering if Betty needs some support.'

A group member may say that she feels guilty for having missed a session because she has let others down who needed her to be there, or even because of a sense of responsibility for the therapist who needed the group to be complete, rather than being able to think about her own needs which she feels the group has not met.

While the compulsive eaters are attempting to conceal and control a feeling of being insatiable, the issue for bulimic women is more one of concealing a sense of being bad. As in the case of compulsive eaters there has been a reversal of the mother–child relationship in important ways.

In a healthy mother–baby relationship, it is the role of the mother to provide containment, to take in the baby's emotions, process them and give them back in the form of a response which makes them more manageable. The experience of bulimic women is one of having had mothers who were unable to provide such containment and who, instead, projected their own denied and intolerable feelings of anxiety, rage, fear, murder, etc., into the baby. Bulimic women, having taken in their mother's projections, are therefore concealing a sense of being bad.

On the surface everything is immaculate and perfect but they are painfully aware that this is a false front. In the first meeting of one group, members expressed a sense of amazement to find how 'normal' everyone looked as though they had expected to see in the other group members a reflection of their inner 'bad', 'messy' and chaotic selves.

Bulimic women fear that whatever they take in will be bad and destructive and that their survival depends on getting rid of it. A key dynamic in a group for bulimic women is therefore ambivalence. A

bulimic woman may miss a session or even want to leave the group following a session which has been meaningful to her. She fears keeping anything inside.

There is a tangible fear in these groups of interacting directly with one another, a fear of listening and talking. The fear of listening represents their fear that what is on offer will be inevitably overwhelming and destructive while the fear of talking represents their sense that their own feelings will be too destructive, invasive and overwhelming for others.

By contrast, with compulsive eating groups there may be long and difficult periods of silence in a group for bulimic women. The need to protect others from the potentially destructive effect of what they have to say is a frequent theme. Bulimic women often literally believe that their own real feelings could kill and that therefore words can kill. In a recent group several members said with total conviction: 'If my mother knew what I felt', or 'If my mother knew I was bulimic, it would kill her.'

In the group a member might say that she is worried about the effect of something she has said to another group member: 'it feels so sad but I'm worried about how Jill is feeling now. She was feeling so happy.'

Because bulimic women have had 'indigestible' feelings stuffed into them as children and were overwhelmed, they see their own ordinary feelings as destructive. They need to learn that what they believe to be so appalling and dangerous are actually ordinary human emotions and that the experience of interacting with others and expressing their real feelings does not have disastrous consequences.

Setting these issues within a wider social context, we need to recognize that differences around race and culture may compound the kinds of difficulties we have just described. An injury experienced in the mother–daughter relationship may be further compounded by an experience such as racism where black women experience painful and unprocessed projections from the wider society on the basis of their skin colour, which are then incorporated into the eating problem.

A further example is the way in which a woman may find herself in conflict between her wish to conform to the ideal body image of Western society and her fear of losing touch with aspects of her own family of origin and culture around body image and food. Thus conflicts around food and eating may take into themselves wider

cultural issues around separation and loss, particularly the loss of aspects of one's own identity.

A therapy group can provide the space and containment to enable these women — both compulsive eaters and bulimic women — to experience feelings that previously seemed too dangerous and overwhelming, and to begin to think about them. As separation and individuation are of such crucial importance to both groups of women it is particularly important to work with differences right from the start in these homogeneous groups.

Especially in the early stages of the group, women will express their fears and expectations in the language of the symptom, for example, a longing for emotional relief may be expressed in terms of a desire to lose weight; or anxieties about who else will be in the group may be explored in terms of fat and thin, for example, 'Will there be fat people like me?', or 'Will I be the fattest woman in the group?' Without the language of feelings, anxieties and conflicts are commonly addressed in the group via the body, so that the whole range of feelings can be spoken of concretely, as if they could be quantified in ounces, pounds, inches, or amounts of food. The concerns about 'good' and 'bad' foods to eat also stand for feelings that are split into good and bad, safe and dangerous.

As the group progresses we hope that there will be a shift from the language of the symptom to a language of feelings and relationships. We also hope that there will be a movement from a preoccupation with the symptom by the group to an interest in their relationship with one another.

The Process of Translation in Practice: Use of Metaphor

Food, hunger and being fed are so intimately entwined with our earliest relationship that they are originally experienced as one and the same. As Farrell (1995: 29) puts it: 'Eating originally was about eating mother and not knowing where mother began and baby ended.' It is not surprising therefore that as infants and children move through developmental stages from non-differentiated dependence to increasing autonomy there is usually a clear parallel relationship between the child's experiences of physical and emotional feeding.

A mother who is unable to see her baby daughter as separate from herself will care for her according to her own anxieties and needs rather than being responsive to the needs and preferences of

the baby as a separate individual. This is likely to be true of the way she feeds her baby as well as the way she cares for it emotionally. Many of the women in our groups talk about power struggles around the dinner table at home, of being put on diets at very young ages or being forced to finish food in order to please others rather than themselves. Furthermore as Bloom and Kogel (1994: 40–1) put it: 'Clients' *current* difficulties with food usually hearken back to how they were physically *and* emotionally fed. Thus food has a metaphorical dimension as it contains and expresses developmental and relational issues.'

Working with metaphors of food, eating and body size therefore becomes a powerful tool in the process of translation, helping to make the link between problems of food and eating and internalized emotional relationships.

In our groups we work with these metaphors right from the start as a way of engaging with the women's own language. A difficulty with the lack of structure in a group for compulsive eaters, for example, may be seen as being like the search for a diet and the need for some control from outside, rather than allowing oneself to be aware of one's own feelings and needs. If a woman says: 'When I look in the mirror I feel fat', we may help her to see that fat is not a feeling and explore with her what the fat actually means to her and whether she might be feeling sad, angry or rejected.

We may talk about the way that members make use of the emotional nourishment of the group. If a session of a group for compulsive eaters is filled with incessant talk without any space to think and reflect we may interpret this to be as if the group were bingeing on the emotional food of the group, swallowing without tasting or being able to differentiate what is taken in. We may talk about the fear of stopping to think as being like the fear of stopping to taste and digest the emotional food and allow oneself to be nourished by it, as well as the underlying fear that there will never be enough.

We might see the boundary of the group as the beginning and end of a meal. The women's anxiety that the sessions are not long enough or not frequent enough and the concern about how to cope with the intervals between group sessions may in the case of bulimic women be seen in terms of their difficulty in believing that they can keep the emotional food of the group inside and let themselves be nourished by it. With compulsive eaters it can be understood in terms of their difficulties of facing the hunger between sessions.

One group of compulsive eaters would eat lunch together after the session and this was taken up in the group as bingeing after the meal, of not being able to bear the fact that the food of the group had been taken away. The women in this group were unable to imagine digesting the emotional food of the group or to stop and reflect whether, in fact, it had been enough to enable them to wait until the next session when their emotional hunger would be met again. There was a difficulty in holding in mind the fact that there would be another meal.

As the end of the group approaches bringing with it concerns of how to deal with separation and loss, a common preoccupation in groups for compulsive eaters is: 'What next?' There is often a desire to rush on to another group or another form of therapy. This is taken up in terms of thinking about the next meal while still eating the present one, because of their difficulty in believing that the current one could be sufficient to nourish them and that they might be able to digest it and feel stronger and more independent as a result.

In groups for bulimic women the anxiety is more connected with whether the emotional food of the group can be kept inside without destroying it.

Use of the Countertransference

Working with women who have so little access to an emotional language means that the conductor's countertransference is a particularly important tool in helping her to understand what is happening in the group. It is analogous to the baby's first pre-verbal way of communicating with its mother.

The therapist must then be able to take the further step of using facets of her 'more mature personality system in processing the projection', and then through the therapeutic interaction, making it available for re-internalization (Ogden, 1979: 53).

It is common in a group for compulsive eaters for the therapist to experience herself as not being able to give enough and she may leave the group feeling drained and overwhelmed. She may feel a strong pressure to provide more: in the form of interpretations, structure or advice or to make the perfect or what may even feel like a 'life-saving' interpretation. In groups for bulimic women it is common for the conductor to feel that what she is providing

is somehow wrong or harmful. Another common countertransference feeling is for the conductor to experience herself as marginalized as if she is not there or not needed. This may be a reflection of a defensive omnipotence in this group of women, a feeling that they have to do everything by themselves due to the inadequacy of their early environment. It is important to recognize that these feelings are not a reflection of the therapist's inadequacy or insufficiency but belong to the group, reflecting their fear that there will never be enough or the right kind of emotional food. It is important for the group that the therapist can contain such feelings rather than being overwhelmed or destroyed by them, which is what is feared.

In her countertransference the conductor may be drawn into feelings of numbness, paralysis and speechlessness in the group as though she herself had been bingeing and thinking were no longer possible. She may find herself experiencing strong feelings which are split off and unacknowledged by the group, for example, she may experience powerful feelings of irritation, anger, rage or competitiveness while the group is apparently behaving and speaking in quite a nonchalant and faint way.

The conductor may, through projective identification, experience the despair the group members feel that they will never be able to depend on anything other than food and that they would never be able to take in any emotional nourishment or engage in a real relationship.

In all these cases it is important to use these countertransference feelings as a way of understanding what is going on in the group. Once the feelings have been put into words, communicated and contained, members can begin to use the group and progress.

The Body and the Meaning of 'Fat' and 'Thin' in the Groups

'Living in one's body, like learning to interpret hunger accurately, is something that cannot be taken for granted as it too is a developmental achievement' (Bloom and Kogel, 1994: 46). Winnicott (1965) refers to it as 'indwelling' and it may also be called body/self integration. Women with eating problems are alienated from their bodies which they experience as hiding a needy, angry, messy and chaotic self inside.

Their sense of what is wrong is frequently expressed in the language of fat and thin: 'If only I were thin I would be OK,

acceptable, loved, etc.', or 'If only this thin self were my real self and not just a facade.'

Psychodynamically, dieting and the preoccupation with 'fat' and 'thin' can be understood from the perspective of Fairbairn's (1952) understanding of object-relations theory. His theory gives us a way of understanding the *compulsive* nature of eating problems. The child, having internalized the original failed object relationship, proceeds to split this mental representation into a good but tantalizing object which will eventually fail her and a rejecting object which rejects her entirely.

There is then an inner dialogue where the tantalizing object promises thinness as a route to happiness while the rejecting object provides the inevitable failure and rejection expressed as: 'I am greedy . . . a failure . . . it's all my own fault . . . I'll go on a diet', etc. Fairbairn calls this the 'moral defence' whereby the 'original environmental failure is blamed on the self . . . using the culturally suggested form of the diet' (Gutwill, 1994: 31). This may be preferable to acknowledging that the child had a caregiver who has failed her in important ways. Inadequate though she has been the relationship needs to be preserved at all costs.

Everything is then seen in terms of the original failed relationship and the repeated binge/diet and binge/vomit cycles can be understood as an attempt to gain relief but also to keep alive and reproduce the original internalized object relationship and conflict in order to rework it.

In the group situation as members sit face to face their bodies are often painfully visible. There is probably nothing that they are more conscious of especially in the initial sessions, and there may be nothing which is more difficult to speak about. We hope that the group will provide these women with an experience of acceptance and mirroring which will enable them to experience themselves as inhabiting a body which is actually part of the self and which belongs to them.

We conclude this section with a clinical example which shows how the struggle between 'fat' and 'thin' and the feelings that this polarization came to represent, manifested itself in one particular group. This group consisted of members who had either a compulsive eating or bulimic problem. It was a brief focal group meeting for nine months.

The thinnest woman in this group was a model, quite beautiful and thin. (She consistently dieted to maintain her weight but also

had periods of bingeing.) She was a refugee from a country at war and talked about her struggle to belong but also her pattern of continually putting herself on the outside of the group. War-like imagery entered the material of the group while this woman would be quite subtly overlooked or ignored.

Meanwhile the fattest woman in the group was turned into the 'group patient' with lots of attention focused on her. A session when both the fattest and the thinnest women were absent left the group in a panic. Nobody could understand what was happening. They were overcome by feelings they did not understand. They couldn't say what these feelings were but felt very uncomfortable.

What began to be voiced in this session was the women's feeling that the thinnest woman had no need of the group as she was thin and beautiful, with a figure to be envied, while the fattest woman came to be seen as the most in need of the group and a very visual reminder of the group members' fear that they would put on more weight and get fatter.

The aggressive imagery that continued to come into the material of the group seemed to represent, at an unconscious level, an internal war the women experienced between 'fat' and 'thin'.

In a session quite close to a summer break the fattest woman brought a dream. She was staying in the country in a lodge on the outskirts of a forest. She ventured outside quite tentatively and went into the forest down a path into a little house. She was scared but went in anyway and was pleasantly surprised that the scary figures she had anticipated were more like cartoon figures such as you might get in a fairy tale. She felt relieved that she was no longer frightened and was able to sleep soundly.

While the woman was telling the dream the conductor began to fantasize about the fairy tale Hansel and Gretel and the gingerbread house.

In the session the dream was totally ignored by the other group members. Later in the session the fattest woman became distressed, thinking about her relationship with her mother who had died. The whole group remained in what felt like a punishing, withholding silence. The group regressed to talk about diets and binges as they had done in the initial sessions of the group in order to numb the painful feelings. With the Hansel and Gretel image in mind the conductor made interventions about the impending break and the group's anger towards her for leaving them on their own. Perhaps this was particularly difficult at a time when the group

members were beginning to think about whether the feelings lodged in the body could find a different expression.

A few sessions later a woman who had been quite silent in the group began to express dissatisfaction with the group, that it had not been what she had anticipated and she was angry that she had not lost weight. Then suddenly she felt that she was being unrealistic and felt like she was in a kind of musical. She wanted to burst into song and sing something like 'If I Only Had a Dream', which came to be understood as a reference to the fattest woman's dream.

What began to be worked through in the group was envy of the fattest woman's progress; the fact that her internal objects had become less threatening. However, this recognition put them in a dilemma — for how could they possibly envy a fat woman?

The group were faced with a challenge to the myth they held so dear that 'If only I were thin everything would be alright.' As the thinnest woman talked more about her conflicts, the group were forced to think that even though they envied her body size she did still need the group but not as they had originally assumed — after all why would a thin, beautiful woman need the group, if in their eyes she didn't have any needs and could operate totally independently?

The members began to face the reality of the conflict between the 'thin' and 'fat' aspects of themselves. They could begin to work toward a less polarized way of thinking about the full range of their feelings. The symptom had been translated so that the group could then begin to talk about their pain in terms of 'I feel disappointed or angry' and move away from the pre-verbal language of 'I feel fat' or 'I want to be thin'.

Conclusion

What do we hope that the women in these groups will have gained by the time the group ends?

Our hope is that they will have gained an understanding of the fact that their eating problem is actually a symptom of underlying difficulties in the way they deal with their needs, feelings and relationships, the difference perhaps between saying: 'I am bulimic', 'I am a compulsive eater' or 'I am overweight' and 'I need help with difficulties in my relationships.' The aim is not for the women to identify with labels such as bulimia or compulsive eating

but to move beyond such labels to an experience of themselves as a person.

The groups are time-limited because their main aim is to accomplish this process of translation. If further therapy is needed we feel that this can be more fruitfully provided in a general analytic group.

Finally, it is always important to remember that therapy takes place within the broader context of Western culture which fears and denigrates fat while idealizing thinness. Conductors and clients alike are affected by this culture and the conductor too needs to work through her own issues about food and body size. Otherwise she may either overlook or become over-preoccupied with the symptom.

Note

1. Throughout this paper we use the word 'mother' to mean 'mother or early significant caretaker' and we do so with the recognition that mothering occurs within a particular social context.

References

Bloom, C. and Kogel, L. (1994) 'Tracing Development: The Feeding Experience and the Body' and 'Symbolic Meaning of Food and Body', chs 3 and 4 in C. Bloom, A. Gitter, S. Gutwill, L. Kogel and L. Zaphiropoulos *Eating Problems: A Feminist Psychoanalytic Treatment Model*. New York: Basic Books.

Fairbairn, R. (1952) *Psychoanalytic Studies of the Personality*. London: Routledge and Kegan Paul.

Farrell, E. (1995) *Lost for Words: The Psychoanalysis of Anorexia and Bulimia*. London: Process Press.

Foulkes, S.H. and Anthony, E.J. (1957) *Group Psychotherapy: The Psychoanalytic Approach*. Harmondsworth: Penguin. Reprinted London: Maresfield, 1984.

Gutwill, S. (1994) 'The Diet: Personal Experience, Social Condition, and Industrial Empire', ch. 2 in C. Bloom, A. Gitter, S. Gutwill, L. Kogel and L. Zaphiropoulos *Eating Problems: A Feminist Psychoanalytic Treatment Model*. New York: Basic Books.

Ogden, T. (1979) 'On Projective Identification', *International Journal of Psycho-Analysis* 60: 357–72.

Orbach, S. (1978) *Fat is a Feminist Issue*. New York: Arrow Publications.

McDougall, J. (1986) *Theatres of the Mind: Illusion and Truth on the Psycho-analytic Stage*. London: Free Association Books.

Winnicott, D. (1965) 'Providing for the Child in Health and Crisis', in *The Maturational Processes and the Facilitating Environment*. London: Karnac.

The authors are all members of a weekly supervision group at the Women's Therapy Centre, London and the ideas in this article evolved from discussions

there. Although written by the two main authors the ideas are those of the whole group. The authors are all UKCP-registered psychotherapists involved in group work at the Women's Therapy Centre as well as working in private practice, the NHS and on various training courses. Inge Hudson and Deirdre Sutton-Smith are members of the Institute for Group Analysis, Clare Brennan is a member of the London Centre for Psychotherapy and Sheila Ritchie is a member of the Association for Group and Individual Psychotherapy and a student on the MSc in Group Psychotherapy at the University of Sheffield. *Authors' Address*: The Women's Therapy Centre, 10 Manor Gardens, London N7 6JS, UK.

The Group-Analytic Society (London)

The Society provides an **international network** of meeting points and communication for those involved, or with an interest in, the theory and practice of group analysis in psychotherapy, organizations and social processes.

The activities of the Society include monthly *scientific meetings*, the *May week-end* and *Foulkes Lecture*, a variety of *Workshops* including the annual four/five day *Winter Workshop* and the *Triennial European Symposium*.

The newsletter, *Contexts*, keeps members informed about activities.

The Journal of Group Analysis is included in the membership fee.

Membership details and other information concerning forthcoming events can be obtained from the Administrator, Group-Analytic Society (London), 90 Belsize Lane, London NW3 5BE, UK. Tel: [+44] 0171 794 3116. Fax: [+44] 0171 794 4990. email: groupanalytic.society@virgin.net