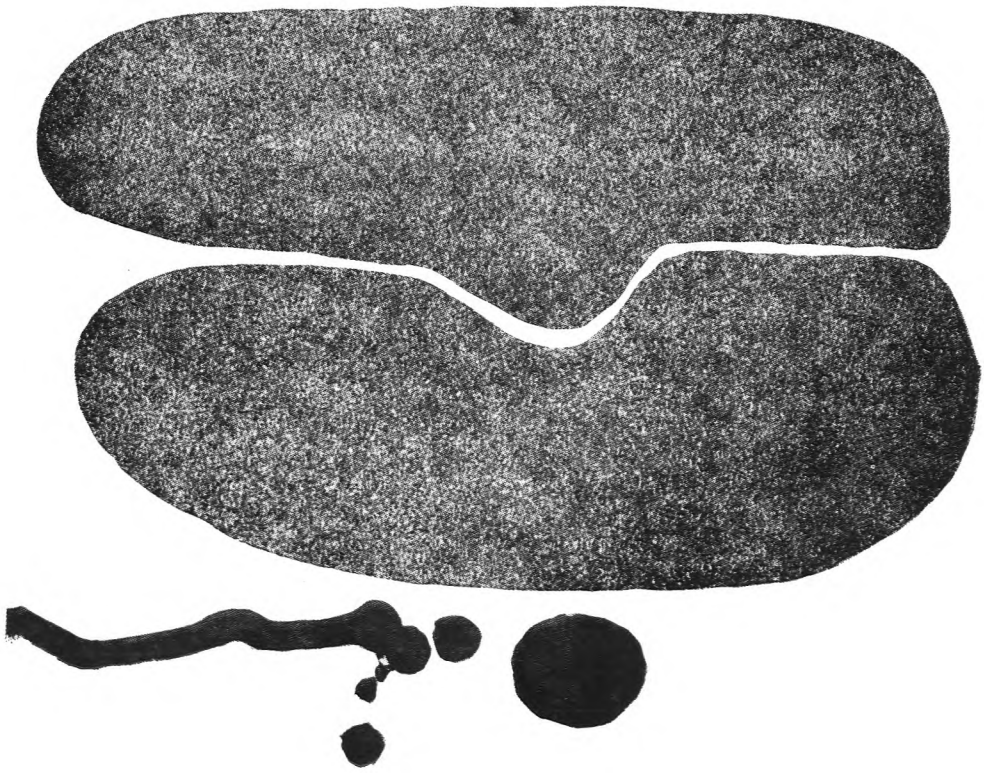
JOURNAL
OF
THE BALINT SOCIETY

1975



Vol. 4

JOURNAL OF THE BALINT SOCIETY

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Editor: Philip Hopkins

Editorial

This year marks the twenty-fifth anniversary of the Balints' first seminars on psychological problems in general practice. One of the chief factors that led many of us to attend them was a growing awareness of the failure of our traditional medical training to prepare us to deal with the huge proportion of our patients presenting with illnesses associated with dis-ease of the mind, rather than disease of the body. And, of course, not a few of the latter were also found to have had preceding emotional dis-ease.

In recent years others, such as Renee Dubos,[1] have suggested that the increasing sickness of our society when linked with the progress of technology is evidence of the failure of medical science. While currently, serious questions are being raised as to the growing dangers of medical science. Ivan Illich,[2] for example, starts his stimulating book, *Nemesis of Medicine*, with the startling allegation that: 'The medical establishment has become a major threat to health'. His wide reference to medical literature goes far to support his view that iatrogenic disease is no longer an unfortunate side effect, but itself is now an illness so that: 'More and more patients are told by their doctors that they have been damaged by previous treatment, which sometimes has been given in life-saving endeavour, and much more often for weight control, hypertension, flu and mosquito bite'.

In keeping with the message of Illich's book, Dr David Taylor[3] concludes his introduction to the published account of a symposium on *Benefits and Risks in Medical Care* with: '. . . it is clear that, in the near future at least, significant improvement in the physical and mental well-being of much of the population will probably depend on the extent health care ceases to be the preserve of narrow professional interest and becomes instead a general social and individual responsibility'.

This is surely what we learned from the Balints, that in order to help our patients to the full we must be prepared to work with them to reach a mutual understanding of their real needs, and as far as possible to avoid all unnecessary technological and unwarranted interference in the process of their healing themselves. We should now be able to demonstrate that patients benefit more, and risk less by this change in our approach, so that its inclusion in the training of future doctors, and the ongoing training of doctors in practice is ensured.

It is with much regret that we must record the deaths of two of the earliest Balintians, Drs A. J. Hawes and I. J. Sachs. Our deeply felt sympathy goes to their families. Obituary notices appear on p. 22.

The Editor would welcome personal views of members, details of new appointments, lectures given and so on, for publication in the Journal.

Lists of publications by members, together with reprints, will be useful for the Society's library.

Manuscripts and communications for publication in the Journal should be forwarded to the Editor.

They should be typewritten on one side of the paper only, with double-spacing and with margins of 4 cm.

References

1. Dubos, Renee. (1959) *Mirage of Health*. London, George Allen and Unwin Ltd.
2. Illich, Ivan. (1975) *Medical Nemesis*. London. Calder and Boyars.
3. Taylor, David. (1974) *Benefits and Risks in Medical Care*. London. Office of Health Economics.

Opening Gambits:

*A Research Project carried out by a Balint Group**

Presented by JAMES CARNE

The group concerned disbanded in July, 1972, at which time we were gaining some insight, as well as a fair amount of interest in the research, but I do not think that even the most optimistic among us would say that we had reached any proven conclusions. In fact we were just about at that point in research where the essence of the problem emerges, so this paper must be incomplete.

This, therefore, cannot hope to be more than an historical survey and introduction, following which I hope there will be discussion and argument.

At first it seemed the most natural thing in the world to use the expression 'gambit' and we thought we knew exactly what we meant by it; but as our work proceeded, it became clear that the very word itself was perjorative. As the expression used in chess it means more than just the opening move. It suggests a move in which the mover is already considering how to outmanouevre his opponent. Again the word opponent suggests conflict between two opposing factors which is not really how we like to think of our dealings with our patients. As the work progressed, however, some of us wondered whether the competitive spirit in the consultation may not sometimes be of greater importance than is often realised.

One thing is clear, perhaps that if the patient initiates the prime move in the consultation, it may well be likened to a gambit in chess. That is, he is trying to manipulate the position so that the doctor can deal effectively with his problem. A greater understanding by the doctor of what this is, allows him to deal with it more effectively. Therefore, a greater understanding by the doctor of what the opening gambit is, must be of great mutual benefit, and help to make the consultation more productive.

Any experienced doctor knows the importance of all this and most would say they are fully aware of the importance of many common opening gambits encountered in practice. We all understand what is meant by the patient who starts by saying he 'won't keep us long', or the lady who says, 'You know I don't normally complain, but . . .'.

Balint Groups have long been aware of the significance of the patient who comes late in order to be the last one with the doctor. His need, apparently, is to have the doctor to himself for the night. It was with this common knowledge that we started the research. We wanted to study at greater depth our own part in the gambit, and examine how our reactions to the patient would influence the outcome of the consultation.

Our group consisted of most of those who had worked with Michael and Enid Balint in their Tuesday afternoon research group since 1965. When Michael died in December, 1970, we were completing our research into the 'Short Interview', from which had arisen the concept of the 'flash'. The book[1], which we all hoped would be written as a final tribute to his memory, was at a stage where only a few more months' work was needed. By October, 1971, the project was almost completed and only the difficulties of publishing remained, but it was agreed that we should continue under the leadership of Enid Balint until July, 1972, which left a hiatus of about nine months for a project.

Study of the transcript of the meeting held on 19th October, 1971, shows that it was Enid who suggested two possible subjects, namely opening gambits, or a study of women who presented with pregnancy. Both seemed to hold our interest, but pregnancy was soon forgotten; officially because some members said they did not provide ante-natal care. But I think it was more likely that with our awareness that the group had only nine months to run, it was too likely that the project would finish as a stillbirth and, like all stillbirths, this would be painful.

Pregnancy having been abandoned, many other suggestions were made, such as 'the pill', contraceptives in general, students' problems, and the common cold. All found short favour, before

*The group consisted of eight general practitioners: James Carne, Max Clyne, Michael Courtenay, Cyril Gill, Philip Hopkins, Aaron Lask, Jack Norell and Stephen Pasmore, together with four associate members: Howard Bacal, Mary Hare, Hayler Holden and Christopher Treves-Brown, under the leadership of Mrs Enid Balint.

being discarded, often for no other reason than a single statement made against them by one or other member.

Of these outsider subjects, the cold was the most popular choice and Jack Norell's cry of 'They'll be better before you find out', went unheeded, until Michael Courtenay brought us back in line by suggesting that Enid's original suggestion sounded the most satisfying to study. It was *not* noted at the time that this was the first instance we had of the importance of an opening gambit bringing us back to its own significance. It was as if everyone became unconsciously aware at that moment of the importance of the opening gambit in alerting the doctor to the patient's needs and hence it was the obvious choice from that moment on.

I was not present at that first meeting, and afterwards tried to change the course of the research by suggesting it was neither of interest nor profitable, but stood no chance once the decision was taken. Perhaps this again is a lesson that once the opening moves have been made by patient and doctor, it is very difficult from that point to alter the course of the consultation history, and hence the importance of its proper understanding from the outset.

Even at this early stage predictions were being made as to the outcome, in the good Michael Balint tradition. Jack Norell stated (as a hypothesis), 'The opening gambit is in some way—if we can only understand it—a clue to the later transaction between doctor and patient'. Philip Hopkins stated (as a statement of fact), 'It is the *doctor's* response to the patient's opening gambit which will influence the whole future of the case'. Both these turned out to be true, but one might ask how much were these results themselves influenced by the group's responses to the original statements, or opening gambits?

Another predictive, and equally accurate, remark made in these early days was made by Dr Hylar Holden, a Psychoanalytic Associate within the group, who said 'The patient's opening gambit will be a reflection of his pre-existing relationship with the doctor'. Again this turned out to be largely borne out by our research.

Having decided on the line of our research, various methods were tried in almost a random way before the final one was established. At the first attempt it was agreed that everyone should report all their patients seen in a specific surgery. After describing each opening gambit and subsequent consultation, it was examined for any possible emerging pattern. This gave a good bird's-eye view of the problem, but did not uncover any specificity. It was therefore suggested that specific case histories should be presented and the first of the morning was chosen. Again this did not seem to satisfy us, and finally patients of personal choice were presented.

During this time, we realised that if there was to be any scientific basis for our work, we would have to present the case histories with some type of standard pattern. Balint-trained doctors will know that this detracts from the emotional satisfaction our seminars tend to supply. In our group, however, we had had hard training from Michael and in consequence knew the importance of this self-discipline. Before starting, therefore, we prepared an 'Initial Interview Form', and naturally enough, since we knew it would later need amending, called it Mark 1. At the same time, and in anticipation of our need when we would come later to follow up our patients, we presented our Mark 1 'Follow Up Form'.

Because of our experience and heart-searching in the previous research on the 'flash', in which we had about eight pilot forms before finalising the one we used, this was not to prove too difficult. Michael Courtenay and Enid Balint very quickly prepared the forms, and in fact both were only amended once, to Mark 2. The main difference between the Marks 1 and 2, was in the area of the importance of non-verbal communication noted by the doctor; for example, the patient's dress, possible silence, manner in which he presented, etc. Having accepted the importance of this within the patient, we realised also the importance of recognising the same non-verbal communication within ourselves.

In other words, it was important to recognise the doctor's feelings in response to the gambit, and for this purpose he had, as it were, to sit outside of his own consultation. This almost impossible task (in some circumstances) became a little more feasible if the doctor kept a mental image of the form. The final form was called Mark 3, but was little more than a tidying up of Mark 2.

At this time, about January, 1972, Enid issued, as a sort of statement of intent, the following memo, which in the words of Stephen Pasmore, put us 'back on course'.

QUESTIONS TO BE ASKED OF RESEARCH GROUP:

1. To what extent does the opening gambit, either by the patient or the doctor, influence the subsequent interview in terms of its climate, or its content, and how can one tell whether it does or not?

2. To what extent does the opening gambit

reflect the patient's attitude to what he wants to get from his doctor at that visit?

3. To what extent does the doctor's response to the patient's opening gambit reflect his attitude to the patient on that occasion; or does it reflect more his own attitude to his practice, to the people waiting in his waiting room, etc, on that occasion?

4. In what way do the doctor's thoughts following the patient's opening gambit relate to his response? For instance a patient might complain about tiredness; the doctor's thought might be 'I haven't time to deal with this at this time'. His observation, however, might show him that the patient does not look well and his actual response might therefore be to examine him. Alternatively, in the same circumstances, from his previous knowledge of the patient, he might not feel the need to examine him physically. Instead he might ask something about his private life, or he might say, 'I haven't got time now, I'd like to see you next week, or this evening.'

This seemed to add some impetus to the project and the group returned to studying a set of reported interviews to see if anything emerged to justify the above assertions. Dr Hylar Holden was asked to assist in this part of the research and, in a surprisingly short space of time, came forward with a classification of categories of opening gambits. Although these were added to as experience increased, they remained throughout a fairly complete set of variations of this theme of opening gambits.

DR HOLDEN'S CATEGORIES OF OPENING GAMBITS:

1. The Physical Symptom: This includes the patient who comes in with any kind of physical symptom. This is probably and traditionally the most common gambit, and certainly the one that first comes to mind when attempting any sort of classification. I think that most patients, and nearly all lay-writers, would assume that this is how a patient presents his problem to the doctor.

2. The Request for a Service: This is usually some particular service that the patient feels he needs and is usually explicitly stated. It implies that the patient knows exactly what he wants and is usually correct. An example might be, 'Doctor, I need an immunisation'. Alternatively the request may suggest the patient knows his own requirement, but care has to be taken. For example, the patient who states he needs his ears syringing may have severe pathology of the ears, or the request for a simple eye-testing examination may often mask an underlying depression. (A more extreme example is the West Indian patient I had some years ago who told me he was on holiday and needed to be circumcised as a requirement before going to America. He meant, of course, vaccinated, and was relieved to hear it! Also included in this group will be those who come merely for a certificate.)

3. Result of Tests: Allied to the above, is that group of patients who have had a test carried out and have come for the result. Their opening gambit will probably be, 'Tell me the result of the test'.

4. The Indirect Symptom: The symptom is presented by someone other than the patient suffering it. A mother bringing a child, or an interpreter with a patient who speaks no English, may be fairly straightforward, but it may be necessary to determine who is the true patient in these circumstances. A spouse presenting is nearly always indicative of some underlying emotional disturbance.

5. The Ready Made Symptom: This is usually the gambit when the patient feels he has a straightforward and simple physical ailment, rarely if he has emotional disturbance, or fears he has serious illness. The patient often adopts a proprietal interest in his illness, for example he will say, 'Doctor, I've got *this* cold'. Or maybe, 'It's *my* psoriasis playing up'.

6. Complaint about Feelings: The obvious and overt approach might be, 'I feel so tired', or 'I feel depressed', but the feeling may not be so easily expressed and might be presented only in an implied way, for instance either of the above may really mean, 'I feel old'.

7. The Social Chatter: This category includes those patients who try to establish a comradeship with the doctor by commencing with social chit-chat. This may be inconsequential, such as chat about the weather, or of more significance, as when the patient talks of more intimate or family matters to the doctor. Presumably this is done as a protective device to prevent the doctor coming too close to the emotions of the patient and by inference, therefore, may be used by the patient in whom this need is greatest.

(I was always made uncomfortable by one patient who started every consultation by asking how my mother was, thus establishing a family relationship; and then more disconcertingly reminding me that she used to push me in my pram when I was a child! I found it almost impossible to establish a productive doctor/patient relationship with her, and I was greatly relieved (for her sake, as much as mine) when she left the area.)

8. The Account of Events: This is the patient who comes in and, without preamble, gives an account of events leading up to the consultation. This may do no more than serve to remind the doctor why the patient is there. In these circumstances it suggests the patient is afraid he had been forgotten by the doctor, as indeed he often has. An example would be, 'You said I should bring him back on Tuesday', or 'Have the solicitors been on to you yet'. An interesting variation of this approach is the patient who assumes you know why he has come, eg 'As you know, I have to have my eyes tested'. Under this category will be the patient who opens with, 'It's no better, Doctor'. 'It' might well refer to a symptom presented to the doctor many years previously. If the doctor is caught out (in other words, he does not remember what the patient has come for), he is liable to feel guilty and over-respond to the patient as a consequence.

9. The News Bearer: This type of patient announces immediately to the doctor the latest state of his health. He will say, 'I'm better'. Sometimes this will be more accurately expressed as, 'I'm better, but . . .'. The news may be announced as a reproach to the doctor, in which case it is likely to be expressed as 'The pills aren't doing me any good'. The mere statement 'I'm no better', may have no sense of reproach at all and should more appropriately be accepted at its face value.

Study of the research shows that one particular doctor had by far the largest number of patients who said 'I'm better'. This led the group to wonder to what extent this reflected the patient's recognition of the doctor's need for his patients to get better. If this is so, it seems likely that other gambits may well also reflect these needs of the doctor as recognised by the patient.

10. Silence: Perhaps this was found more commonly in our research than might be expected, because we tried more consciously not to say anything in order to allow the patient to make an accurate opening gambit. We found that some of us nearly always started our consultations by the doctor being the first to speak. Whether it was only good manners, or conditioning that prevented patients of these doctors saying anything until invited to do so, was difficult to judge. We never satisfactorily discovered, to my mind, just what these groups were trying to convey, but this may be my own prejudice, since I am an inveterate starter of a conversation.

11. Outburst: This group is perhaps related to the above, differing only in their personalities. They are represented by the patient who starts the consultation with a torrent of words almost as he enters the door.

12. Cancer: These were a very real group of patients who either had, or thought they had cancer. They did not present in any one single way, but there was something, almost intangible, about the method of their approach that made us want to include them as a separate group. Perhaps further research might be more revealing.

13. The Relationship Difficulty: Patients who have difficulty in relating in general, are likely to have difficulties in particular in their relationship with their doctor, until this is taken up as part of therapy by the doctor. The underlying message with these patients might be, 'Are you bored with me doctor?', or 'Will you get angry with me like everyone else does?'.

CONCLUSIONS:

The recognition of the opening gambit, and its possible true meaning, is of great relevance at the consultation in question, but is not necessarily of such great import or usefulness as a means of prognosticating about the future conduct of the patient, nor of the outcome of the case.

The patient, while waiting to be seen, has no doubt organised his own thoughts into what he considers the best way of presenting his case so that the doctor will recognise his real needs. This will be at a conscious level, but his unconscious thoughts and needs will obviously colour the presentation. At the presentation of his 'case', the doctor's feelings, moods, needs, etc, will, in turn, determine how he responds, and the resulting consultation will be a result of the interaction between these two factors.

The more objective and professional the doctor can be, the more he will be capable in recognising the patient's needs. At a future consultation, these factors are likely to be somewhat different, for instance the doctor's response might vary as a result of his changed mood at the particular time.

I put forward as a hypothesis for further study that the understanding of the opening gambit is therefore of most importance at the consultation in question, and not of such importance in the overall understanding of the case as a whole.

Because we had to discontinue our research when the group disbanded in July, 1972, we had no real opportunity to study follow-ups at any depth. I have read again the transcripts and made some assumptions. These are my own, and may not reflect the majority feelings within the group.

It is relevant to recount an observation about our work made by a visiting French doctor. He

spent a week sitting with one of our group in his surgery, watching consultation after consultation. The importance and interest of the opening gambit was discussed and, like us, he discovered that the final actions or remarks by the patient before leaving were also of interest and help in understanding the case.

After several days of increasing frustration and anxiety over the British habit of having average consultations lasting no longer than ten minutes, he turned to his English colleague and said, 'You have convinced me, by example, of the importance of the opening gambit: We have discovered the relevance of the closing gambit. Tell me, why do you bother to have the intermediate consultation?'.

Reference

1. *Six Minutes for the Patient* (1973) ed. Enid Balint and J. S. Norell. London, Tavistock Publications.

Based on the paper presented at the Second International Balint Conference, Brussells, May, 1974.

Future Balint Group Leaders

The Council of the Balint Society has accepted the recommendations of the subcommittee on training, which are summarised below:

Selection of potential group leaders, their training and the accreditation of group leaders will be carried out by two panels.

1. The psychoanalyst trainer's panel. Members: Mrs Enid Balint, Dr Tom Main, the president of the Society (ex-officio). This panel will select and accredit trained psychoanalysts as Balint group leaders. They will be called 'Advanced group leaders'.

2. The Balint Society trainer's panel. Members, Mrs Enid Balint, Dr Tom Main, the president of the Society, and three members appointed by the Council of the Society. This panel will select non-analytical doctors, whether general practitioners or others, and accredit them as either Balint Society group leaders, who will lead Balint groups, or Balint Society group co-leaders, who may lead seminars together with another group leader or co-leader.

All group leaders and co-leaders will be required to attend the leaders' workshop.

The panels will be concerned with setting and maintaining standards of selection and training, and establishing principles of accreditation.

The subcommittee's report describes in detail the experience normally needed by potential group leaders.

Further enquiries should be made to the Hon. Secretary.

(These proposals will need to be ratified by the Society. It would be helpful if anyone who has strong views about them would contact the Secretary, so that we can judge how much time to allocate to the discussion at a general meeting.)

Susan Hopkins

At the Brussels Conference.

The Second International Balint Conference: Brussels, May 1974

It may seem presumptuous to try and summarise a conference with such an enormous programme, but as time goes on the wood seems to emerge from the trees with some clarity. I missed the opening speeches due to a strike, but I gather the scene was set by Dr Moreau, who tried to get the assembled company to perform some simple encounter-group exercises, but was not encouraged by Enid Balint to pursue the matter. It was, however, a warning of the shape of things to come. The net had been cast very wide to include yoga, relaxation, bio-energetics, and sophrology (something I never did get to know what it was about).

In the main hall there were great bursts of papers at the beginning of each morning and afternoon sessions, most of them dealing with Balint training ventures of one kind or another. They were translated into four other languages simultaneously with varying skill (and not always helped by delegates leaving their earphones on the seat in front of them at full volume). Even in these sessions some fringe topics appeared. At the end of these sessions there were demonstrations of groups mounted by the French, British, Dutch and Germans. The French and German groups were immediately recognisable as Balint groups with only unimportant cultural differences.

The British seminar was really a revival, under the leadership of Enid Balint, of a research group which met at U.C.H. The members knew each other so well that the demonstration was very irritating to some observers. Indeed one French doctor declared that the patients weren't ill and the method was not truly Balint!

The Dutch group was, however, not a Balint group at all, but an encounter group introduced by a lady who had obviously cast her spell over our Dutch colleagues. What a sad occasion! As I did not find my neighbour pretty enough to pursue the technique, I left half-way through to listen to papers being read in the Library hall. Most of the interesting things actually went on there. Members of our Society, such as Drs Bacal, Carne, Clyne, Norell and Tunnadine, distinguished themselves, and Dr Jean Pasmore set a standard of chairmanship sadly lacking elsewhere throughout the conference.

The task had anyway been made very difficult as the time allowed for a paper had been halved a few weeks before the opening. Not even in the library were we spared from the flight from the doctor/patient relationship work led by the Dutch defection: a Canadian doctor suggested that a video-tape was really quite as useful as a doctor!

But the main issue was raised in the context of the paper by Dr Steel (author of the 'Phenomene Hollondais', which had shown how the Dutch College of General Practitioners had absorbed the Balint method), discussing the difficulties of forming Balint groups outside London. His paper is indeed the major challenge to the Society at present, and the defection of the Dutch to other methods highlights the dangers of trying to undertake too much too quickly with inadequate resources. I am in no doubt that the Dutch fell under their present spell because they had *insufficient good Balint Group leaders.* Now there is a growing demand up and down the country for Balint training, we must remember the lesson we learnt at Brussels.

Michael Courtenay.

The 'Treatment' Aspect of Balint Training

by HOWARD A. BACAL*

I think all of us will agree that the primary aim of our Balint Groups for physicians is to enable doctors to respond more therapeutically to their patients as a whole; and that this is brought about by enhancing their skills in utilising effectively doctor/patient relationship.[1]

The assessment of the degree to which this aim is successful for any particular doctor is a complex and important task involving a host of methodological considerations in outcome research. I am concerned primarily here, though, in *process*, more specifically, process with regard to the doctor. That is, if active membership of a Balint Group results in a beneficial outcome for the doctor in his work with his patient, how does it do this? And how do the beneficial processes affecting the doctor on the one hand and his patient on the other, differ, if they do? Putting this question simply, what happens to the doctor in the Balint Group which enables him to perform a better therapeutic job with his patient? The simple answer, of course, is he undergoes 'training', but one could also ask another question, 'what comprises this training in the Balint Group?' Is the answer a simple one as well?

The classical pedagogic position is that the trainee exposes himself to someone with knowledge and skill, a teacher or tutor, who shares *his* knowledge and skill with the student who in turn assimilates it and develops in the process. I do not have to convince this audience that this is not the essence of the Balint Group. The mutually collaborative aspect of the Balint seminar, whose leader does not misrepresent himself as the omniscient expert, but rather presents himself as the facilitator with particular expertise, is well-known to all of you. The repudiation of the classical teacher/pupil role, and the substitution of this by group collaborative efforts are all hallmarks of the Balint approach.

Still, our central question has hardly been answered. Regardless of whether the group is taken by an expert leader or a democratically collaborative one, how much teaching and learning actually occur in the traditional model? I doubt whether anyone would *totally* exclude this aspect as *an* important feature of the Balint approach. Michael Balint himself certainly did not exclude it, could not exclude it, even as he could not shed his own skin. Indeed, he told me once that if there was one thing that he would like to be remembered by, it would be that he was a 'passionate teacher'.

Let us keep this traditional feature of the Balint training in mind—'cognitive learning' is the modern phrase, although admittedly a bad one—let us keep this feature in mind as we turn to the polar view—so-called 'experiential learning'.

When those who espouse the view that 'learning by experience' is the only way to acquire the wherewithal to do therapeutic work in the psychological area, they are, in effect, talking about personal change, or 'personal growth', to use the currently fashionable phrase. Indeed, I have met a number of doctors who were members of Balint groups who felt that what they were getting out of the seminar was 'psychotherapy, of course, isn't it?' The great questions are, is this true; and if so, has this 'psychotherapy' helped them to be better doctors?

There are a number of others, mostly those who have never had any first-hand experience with the Balint seminar, who lump it together with sensitivity training or even group psychotherapy; and, at the Tavistock Clinic, a number of the seminar leaders have utilised Wilfred Bion's concepts about how a group functions, in such a way which at times made their activity indistinguishable from the way in which those seminar leaders would conduct their regular therapy-groups.

A number of training efforts in the United States have, for some time, leaned heavily on the so-called sensitivity, or encounter group experience.

To summarise so far: the traditional view has it that we acquire psychological skills in patient/orientated medicine by pedagogic techniques which are virtually indistinguishable from those of the standard supervisory procedures. The radical view declares that whenever these skills are in fact acquired, the process which has occurred is virtually indistinguishable from the therapeutic experience which the trainee's patient undergoes. You may well anticipate me here by assuming I will come out with a middle-of-the-road hypothesis about this issue. You would be right, but it is not an easy road to follow. Michael Balint, in his productively provocative way, suggested where we are at in all of this, and at the same time indicated the area for further inquiry. (And he did this long before the polemic arose between the traditional and experiential views of acquiring

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therapeutic skills.) I would like to quote one of his famous aphorisms:

> 'The acquisition of psychotherapeutic skills does not consist only of learning something new: it inevitably also entails a limited, though considerable, change in the doctor's personality.'[1]

The phrase, 'change in the doctor's personality' suggests that some psychotherapy takes place in the Balint group as an integral feature of the doctor's improved performance. But if this is so, it is very important to understand what is meant by psychotherapy here. If, indeed, it refers to psychotherapy in the traditional sense of resolution of personal and interpersonal psychopathology, then are our traditional Balint groups a sufficiently relevant experience for the doctor? Personal psychopathology is not admitted in our groups. The closest we come is what Michael Balint called the tackling of the 'public transference'—those aspects of a doctor's response to his patient which are readily observable to the group members when he discusses his case in the seminar. This includes the way he uses his personality with his patients (ie his style), his scientific convictions (one aspect of which has been termed the doctor's 'apostolic functioning') and his characteristic or automatic reaction patterns to his patients).[1] None of these reveal explicitly the deeper layers of the doctor's personal psychopathology, or of aberrations in his own interpersonal relationships. But, is the internal change which takes place in an individual in successful psychotherapy—change which may well be accompanied by improvement in his ordinary human relationships—is this kind of internal change necessary or even useful to the doctor in improving his ability to carry out therapeutic work with his patients?

For the analyst in training, this is not questioned —certainly not by the analytic institutes. Every candidate must complete a personal analysis as a part of his training. And although it is an analysis which is identical to the analysis of any patient, it is called a 'training analysis'. In practice, however, the only training analysis which deserves the label is that which was developed in the Hungarian Psychoanalytic Institute where at least one of the candidate's cases was supervised by his analyst as the candidate's analysis proceeded. In this procedure, the candidate's therapeutic relationship with his patient, as it was affected by his personality, could be supervised with an immediacy that was not possible in the traditional supervisory procedure. Properly handled, this unusual procedure did not interfere with the analysis of the candidate, and enhanced the supervisory process.

Here was a true wedding of treatment and training for the student; and Michael Balint was a master of this approach. The group seminar method which he developed was in fact a special adaptation of the Hungarian supervisory method where the associations of the group members in relation to the patient under discussion (and the corresponding development of the group process) were used by everyone—not only by the leader—to understand the doctor/patient relationship and to modify it so that it should have a therapeutic effect upon the patient.

It is tempting to conclude that we have now answered our central question, that is, it is in large measure the resolution of personal psychopathology as it affects the doctor's relationship to his patient which helps the doctor member of the Balint Group to be a better therapist, but that the Balint Group does not go far enough since it is a watered-down Hungarian psychoanalytic training. But is it? Apart from the fact that a watered-down anything was anathema to Michael Balint —either watered-down training or watered-down treatment—I would submit that when Balint evolved his group seminar approach as a special adaptation of the Hungarian psychoanalytic supervisory method, he also incorporated in it the special aspect of that method which gave it its unique pedagogic thrust.

In a previous paper which I called 'Balint Groups: Training or Treatment?',[2] I suggested that, indeed, the Balint Group work contained a kind of 'therapeutic aspect'. In this paper I argued that the internal change—this 'limited, though considerable change, in the doctor's personality'—occurs in a limited *area* of his personality; and that this could be termed the 'area of the professional ego' of the physician, in line with Enid Balint's contention that the acquisition of skills in our work is tantamount to changes in the ego.[3] Further, I attempted to define the function of this area of the doctor's personality; that it is where he exercises his capacity to free up and convert enough of his preoccupation and anxiety over personal problems into what we call therapeutic interest or curiosity, so that he is in a *position* to do a good therapeutic job.*

This theoretical hypothesis might account for a diverse number of interesting phenomena, for example, the individual doctor who has had a thorough-going analysis and who is not a very

*A doctor's capacity for change in the area of his professional ego may even constitute a kind of 'basic talent anlage' for learning to do effective therapeutic work.[2]

good psychotherapist (using the word in its generic sense), and, on the other hand, the individual who has never had any formal therapy but who does function as a skilled therapist; and the well-known but curious phenomenon of the doctor who sees and can formulate beautifully the dynamic roots of his or another group member's patient's problem but who, for some time, simply cannot *respond* squarely or effectively to the simplest therapeutic problem of his own patient in these particular areas.

I should like, in addition, to submit the hypothesis that a well conducted Balint group, like a well conducted Hungarian analytic training, effects its 'treatment' in this area of what I have called the 'professional ego' of the physician; and further, that this hypothesis can be tested in the true Balint style—that is, for any particular doctor in relation to any particular patient and his illness. I would like to come back to this later.

Another Balint aphorism deserves closer scrutiny:

> When a doctor feels something when examining or treating his patient, he should not react to those feelings but should stop and examine his feelings as a possible symptom of the patient's illness.'[1]

As you know, the usual criticism of this aphorism is that this is a 'dangerous recommendation'. What about the doctor's personal counter-transference? This should be the doctor's *first* consideration, should it not, and, in any case, in order to assess whether or not the feeling *is* a symptom of the patient's illness, the doctor would have to know himself pretty well, which would require personal psychotherapy—which brings us back more or less to where we started.

However, if the doctor's therapeutic response to his patient is dependent upon proper functioning in the area of his 'professional ego', as I have defined it, a quite different point of view can be offered: although the doctor reacts internally to his patient, the recognition by himself or by the seminar of his internal reactions as this or that bit of personal psychopathology is useless to him. What is useful is that these feelings and thoughts are recognised and dealt with by the doctor, and by the seminar at a level which gives expression to their attachment to curiosity and concern about the patient, that is, activity carried out in the area of what I have called the 'professional ego'. *The treatment aspect of the Balint group could then be practically conceptualised as those activities of the leader and the group which effect a shift in the doctor in the direction of enabling him to use more of himself in the service of his patient.* In this framework, Balint's so-called 'public transference' emerges not as a watered-down private transference, a second best to intensive personal examination of the doctor, but rather as a unique two-body phenomenon—a reflection of functioning in the area of the doctor's professional ego; and the change in this public transference can be used as an index of his progress in the treatment aspect of his Balint training. That is, put to practical use, this theory should enable us to identify more clearly and 'treat' more effectively the recurring problems which seminar members have in responding therapeutically to their patients. It should also enable us to assess more definitively the effects of our efforts with any particular doctor.

To give you an example of what I mean: Dr E is an intelligent, conscientious young general practitioner who had just completed his first year in a Balint group in which he participated actively. Many of the cases he presented were women in whom uro-genital and rectal complaints figured more or less prominently, and in whom the likelihood of problems in the area of sexuality was highly suggestive. However, until recently, Dr E seemed almost completely unable to elicit any of the sexual difficulties he suspected—which information he actually went after through careful detailed questioning of these patients. In addition, he often found himself ordering test after test and sometimes using consultant after consultant in order to rule out organic illness, the significance of which he doubted, even if positive results were to have turned up. When pressed by the seminar about his puzzling behaviour, he frankly admitted that he was really quite as puzzled as they were; and it was noticeable at these times that he tended to block and forget material which involved interaction between himself and his patient.

It is not possible to discuss here the details of these cases of Dr E, but the material of the seminar transcripts suggested the following hypothesis: that whenever Dr E was faced with women who had problems relating to strong feelings of ambivalence towards men—sexual and/or affective—he could not respond to them by using himself therapeutically in the context of the doctor/patient relationship. Instead, he reacted to his anxiety and uncertainty in these situations either by avoiding the patient's emotional difficulties and pursuing fruitless organic investigations; or he would, counterphobically, dive in too deeply in a way which likely frightened these women off. Put in another way, he reacted by unconsciously attempting to gratify the patient's ambivalent wishes, which resulted in his getting

caught up in an identification with her which was therapeutically unworkable.

This hypothesis can then be used as a guide to specific work which must be done in the seminar on this doctor's public transference in relation to these kinds of patients. And one can then make a prediction that if this work is carried out properly, a respectable training objective will be achieved—simply that this doctor will begin to respond to these patients in such a way that they can share with him more openly and honestly their distress and frustration related to sexually ambivalent feelings towards men. In fact, the evidence so far indicates that Dr E is already beginning to move in this direction.

What all of this means, essentially, is that we tease out for each doctor the *specific* elements of the famous 'doing a Smith' or whoever, and can address ourselves directly and more intensively to the modification of these elements, with what could be predicted will be more beneficial training results for the individual seminar members.

Now, none of this involves psychotherapy for the doctor in the traditional sense, but it could well be described as an intensive 'treatment' of the doctor's functioning in the area of his professional ego, the aim of which is to effect a shift in him in the direction of becoming able to use more of himself in the service of his patient.

In addition, with the base-line data obtained, the assessment of the degree to which the doctor has changed in these respects can be evaluated over time, both during and after his membership in the seminar.

References

1. Balint, M. (1964) *The Doctor, His Patient and the Illness*. 2nd ed. New York, International Universities Press.
2. Bacal, H. (1972) Balint groups: training or treatment? *Psychatry in Medicine*, 3:373.
3. Balint, E. (1967) Training as an impetus to ego development. Psychoanal Forum 2:55.

This paper was read at the Second International Balint Conference, Brussels, May, 1974.

Opinion from Canada

Patient-Centred Medicine, edited by Philip Hopkins

'. . . this book should be read by all residents in family practice and it would certainly be a good book to have on the reading list of senior medical students interested in family practice. Any family physician who feels he is not getting through to his patients' psychological problems and needs, would benefit from reading it. It opens a new area of practice and points the way to resource data in its extensive bibliography.'

Canadian Family Physician, July, 1973.

Patient-Centred Medicine, the anthology of papers from the First International Balint Conference is now available at a special price of £2.50 (including postage and packing) to readers of this journal.

Please send your order with cheque payable to: The Balint Society, 249 Haverstock Hill, London NW3 4PS.

MICHAEL BALINT'S PUBLICATIONS 1924-1973

BACTERIOLOGY, CHEMISTRY

1924 Eine jedemetrische Bestimmung des Natriums (with M. Petew). Biochem Z 145:242
—— Eine jedemetrische Mikrobestimmung des Natriums. Berlin, Inaugural Dissertation
—— Shortened version. Biochem Z 150:424
—— Ein Beweis der Konstanz der /H+/ der lebenden Bakterienzelle. Biochem Z 152:246
—— Eine Mikromethode zur Bestimmung von organischen Substanzen (with P. Ruszesinsky). Biochem 152:92
1925 Wassereteffionenkonzentration und Elektropie. Biochem Z 165:465
1926 In Hungarian. Gyógyászat 66:82
—— Gepuffertes Wasser für die Romanowsky-Giemsa Färbung. Klin Wschr, No 4
—— Hydrogenionconcentratie és electropia II (Concentration of the hydrogen-ions and electropy II). Gyógyászat 66:611

MEDICINE, PYCHOANALYSIS

1925 Perversie vagy hysteriás tünet? (Perversion or a hysteric symptom?) Gyógyászat 65:1104
1926 A pszichoterapiákról a gyakorló orvos számára (On the psychotherapies for the general practitioner). Terapia (Budapest), No 5
1927 Reprinted. Terapia (Bratislava) 6:1
1926 Testintünetek psychogenesise es psychotherapiája (Psychotherapy and psychogenesis of physical symptoms). Gyógyászat 66:310
—— Psychoanalyse und klinische Medizin. Z Klin Med 103:628
—— In Hungarian. Gyógyászat 66:439
1927 I. P. Pavlov. Gyógyászat 67:964
1930 As orvosi praxis válságs (The crisis of medical practice). Gyógyászat, Vol 70
—— Zur Kritik der Libidometrie nach Bernfeld und Feitelberg (with P. Caillag). Image 17:410
1932 Psychosexuelle Parallelen zum biogenetischen Grundgesetz. Image 18:14
1933 Az érselemátvitelröl (On transference of emotions). Gyógyászet, Vol 73
—— As öregedés lalki problémái (Mental problems of old age). Gyógyászat, Vol 73
—— Zwei Notizen über die erotische Komponente der Ichtrieve. Int Z Psychoanal 19:428
1934 Charakteranalyse and Neubeginn. Int Z Psa 20
1933 In Hungarian. Budapest, Lélekalemzési Tanulmanyok
1934 Dr Sándor Ferenczi as a psycho-analyst. Indian J Psychiat 9:19
—— In Hungarian. Gyógyászat 74:312
—— Die Onanieabgewöhnungskampf in der Pubertät. Z Psychoanal Pädagogik 8:374
1935 A contribution on fetishism. Int J Psycho-Anal 16:481
1937 In German. Int Z Psychoanal 23:23
1936 The final goal of psycho-analytic treatment. Int J Psycho-Anal 17:206
1935 In German. Int Z Psychoanal 21:525
1936 Zur Kritik der Lehre von den prägenitalen Organisationen der Libido. Int Z Psychoanal 21:525
1938 Eros and Aphrodite. Int J Psycho-Anal 19:190
1936 In German. Int Z Psychoanal 22:453
1937 A contribution to the psychology of mentruation. Psychoanal Quart 6:346
—— Early developmental stages of the ego: primary object-love. Int J Psycho-Anal 30:265
—— In German. Image 23:270
—— Contributions on psycho-analysis to the Hungarian encyclopedias:
Uj Lexikon, Vols I-IV, Budapest
Uj Idök Lexikona, Vols I, XII, Budapest
1939 On transference and counter-transference (with Alice Balint). Int J Psycho-Anal 20:223
1942 Strength of the ego and ego-pedagogy. Psychoanal Quart 11:87
1939 In German. Int Z Psychoanal 24:417
1942 Reality testing during schizophrenic hallucinations. Brit J Med Psych 19:201
1945 Individual differences of behaviour in early infancy. Manchester, M.Sc. thesis
1948 In abridged form. J Genet Psychol 73:57
—— On genital love. Int J Psycho-Anal 29:34
—— On the psycho-analytic training system. Int J Psycho-Anal 29:163
—— On Szondi's 'Schicksalanalyse' and 'Triebdiagnostik'. Int J Psycho-Anal 29:240
1949 Dr Sándor Ferenczi. Int J Psycho-Anal 30:215
1950 Changing therapeutical aims and techniques in psycho-analysis. Int J Psycho-Anal 31:117
1951 Reprinted in the Yearbook of Psycho-Analysis
1950 On the termination of analysis. Int J Psycho-Anal 31:196
1951 The problem of discipline. The New Era 32:104
1952 In French. Rev Franç Psychoanal
1951 On punishing offenders, Psychoanalysis and Culture. New York, International Universities Press
1952 New beginning and the paranoid and the depressive syndromes. Int J Psycho-Anal 33:214
—— On love and hate. Int J Psycho-Anal 33:355
—— In German. Psyche 6:19
—— Notes on the dissolution of object representation in modern art. J Aesthetics and Art Crit 10:323
—— General concepts and theory of psycho-analytic therapy (with Sydney Tarachow). Ann Surv Psychoanal 1:227
—— Primary Love and Psycho-Analytic Technique. London, Hogarth Press, International Psycho-Analytical Library
—— American edition: New York, Liveright Publishing

1953 Edited: The Psycho-Analysis of the Nursery, by Alice Balint. London, Routledge and Kegan Paul
1954 American edition under the title 'The Early Years of Life'. New York, Basic Books
—— Training general practitioners in psychotherapy. Brit Med J 1:115
—— Abridged version. Brit J Med Psychol 27:37
1955 In German. Psyche 6:IX
1956 In French. Psychanalyse, Paris 2:221
1954 Analytic training and training analysis. Int J Psycho-Anal 35:157
—— In German. Psyche 7:77
—— Géza Róheim: an obituary. Int J Psycho-Anal 35:434
1955 Notes on parapsychology and parapsychological healing. Int J Psycho-Anal 36:31
—— The doctor, his patient and the illness. Lancet 1:683
—— Also in Samiksa 9:173
—— Abstract of above in B.P.S. Bulletin No 26, May:54
—— Friendly expanses—horrid empty spaces. Int J Psycho-Anal 36:225
—— Dynamics of training in groups for psychotherapy (with Enid Balint). Brit J Med Psychol 28:135
—— Edited: Final Contributions to the Problems and Methods of Psycho-Analysis by Sándor Ferenczi. London, Hogarth Press International Psycho-Analytical Library
American edition. New York, Basic Books
1956 Domiciliary consultation in psychiatric practice (letter). Lancet 2:1389
—— Pleasure, object and libido: some reflexions on Fairbairn's modifications of psychoanalytic theory. Brit J Med Psychol Vol XXIX, Part 2
—— Sex and society. Address to the Universities of Heidelberg and Frankfurt during the Freud Centenary Celebrations
1957 In German. Frankfurter Beiträge zur Soziologie, Band 6:127
1956 Pleasure, object and libido: some reflexions on Fairbairn's modifications of psychoanalytic theory. Brit J Med B.M.A., Brighton. Brit Med J 2:235
1957 Abridged version. Brit Med J 1:156
1956 Edited: Perversions (with Sandor Lorand). New York, Random House
—— Perversions and genitality, Perversions. New York, Random House
1957 The Doctor, His Patient and the Illness. London, Pitman Medical Publishing Co.
—— American edition. New York, International Universities Press
1960 In German. Stuttgart, Ernst Klett Verlag, Second edition
—— In French. Paris, Presses Universitaires de France
1961 In Hungarian. Budapest, Akadémiai Kiadó
—— In Italian. Milan, Foltrinelli Editore
—— In Spanish. Buenos Aires, Libros Basicos
1957 Problems of Human Pleasure and Behaviour. London, Hogarth Press
—— American edition. New York, Liveright
—— Criticism of Fairbairn's generalization about object relations. Brit J Philos Sci, Vol VII, No 28
—— Contribution to 'Freud in der Gegenwart' in Frankfurt Beiträge zur Soziologie, No 6. Frankfurt, Europäische Verlagsanstalt (contains the German translation of 'Sex and Society', Address to the Universities of Heidelberg and Frankfurt during the Freud Centenary Celebrations, May 1956 and two chapters of 'The Doctor, His Patient and the Illness')
1958 The three areas of the mind: theoretical considerations. Int J Psycho-Anal 39, Part V
1957 In German. Psyche, Vol XI, No 6
1961 In French. Psychoanalyse, Paris, No 6
1957 Training medical students in psychotherapy. Lancet 2:1015
1958 In German. Psyche, Vol 12, No 1
1959 Opening moves in psychotherapy. J Hillside Hosp, Vol 8, Nos 1 and 2
1958 In German. Dtsch Med Wschr, p 2117
—— The concepts of subject and object in psychoanalysis
Brit J Med Psychol 31:83
1959 Thrills and Regressions. London, Hogarth Press
—— American edition. New York, International Universities Press
1960 In German. Stuttgart, Ernst Klett Verlag
—— The doctor's responsibility. Med World, 92:529
1959 In French. Rev Méd Psychosom, No 1
1960 In German. Psyche, Vol 13, No 10
—— The marital problem clinic: a problem child of the F. P. A. Family Planning 9:18
—— Primary narcissism and primary love. Psychoanal Quart 29:6
—— In German. Jb Psychoanal, Band I
—— Training for psychosomatic medicine, Advances in Psychosomatic Medicine. Basel, S. Karger
—— American edition. New York, Robert Brunner
—— The regressed patient and his analyst. Psychiatry, Vol 23, No 3
1961 In German. Psyche, IV: 253
1964 In French. Psychoanalyse, Paris, No 7
1961 The other part of medicine (shortened version of 'The Place of Psychotherapy in Medicine', paper given at Annual Meeting of the Deutsche Gesellschaft für Psychotherapie und Tiefenpsychologie, Wiesbaden, 29th April, 1960). Lancet 1:40
—— In German. Psyche
—— Training of general practitioners and medical students in their role in mental health. Working Paper No 2, Expert Committee on Mental Health, World Health Organization, Geneva

1963 In French. Praxis, 41:1231
1964 Also in French. Rev Struct Evolut Tech, No 87, Paris
1961 The pyramid and the psychotherapeutic relationship (shortened version of above paper). Lancet 2:1051
—— Experiences of a psychiatrist with post-graduate training of general practitioners in groups. Huisartsen Wetenschap, 4de Jaargang, No 5
1963 In German. Medizinische Psychologie in der hausärstlichen Praxis, Band 1. Hippokrates Verlag
1960 Examination by the patient. Excerpta Medica, No 53
1961 In French. Rev Med Psychosom Vol 3, No 2
—— The present and the absent patient (report of a symposium on emotional disorders in general practice held in Torre Abbey, Torquay, 6th May, 1961). Supplement, J Coll Gen Practitioners, Vol IV, No 4
—— Psychotherapeutic Techniques in Medicine (with Enid Balint). London, Tavistock Publications
1962 American edition. Springfield, Illinois, Charles C Thomas
—— In German. Stuttgart, Klett
1966 In Spanish. Siglo XII Editores S.A.
1961 Foreword to 'Night Calls', by Max B. Clyne. London, Tavistock Publications (pp ix-x)
1962 American edition. Springfield, Illinois, Charles C Thomas
1964 In German. Stuttgart, Klett
1962 Foreword: Virgin Wives, by Leonard J. Friedman. London, Tavistock Publications, pp vii-x
—— American edition. Springfield, Illinois, Charles C Thomas
1963 In German. Stuttgart, Klett
1962 Ein Zwischenfall: Bericht über eine nichtverbale analytische Intervention. Jb Psychoanal 2:161
—— The theory of the parent-infant relationship (contribution to a symposium). Int J Psycho-Anal 43:251
1963 The younger sister and prince charming. Int J Psycho-Anal 44:226
—— The malignant and the benign forms of regression. Bull Ass Psycho-Anal Med, Vol 3, No 2
1964 Introduction: Training in Psychosomatic Medicine. Basel and New York, S. Karger
—— Contribution: Psychiatric Education, edited by D. L. Davies and M. Shepherd. London, Pitman Medical Publications
—— Entretien avec les Drs. M. Balint et P. M. Turquet. Rev Med Psychosom, No 4
—— Understanding the patient. Praxis, No 28
—— In French. In La Formation Psychologique des Médecins, edited by R. Kourilsky, J. A.
—— Gendrot, E. Raimbault. Paris, Librairie Maloise
1965 Also in Medical World 102:192
—— Also in Abbottempo, Book 2
—— In French. Rev Méd Psychosom, Tome 7, 2:197
—— In German. Medizinischer Monatsspiegel, Heft 5
1964 The Doctor, His Patient and the Illness. 2nd enlarged and revised edition. London, Pitman Medical Publishing
—— 2nd American edition, New York, International Universities Press
1965 In Dutch. Antwerp, Aula Boeken
—— In German. Stuttgart, E. Klett
1966 In French. Paris, Editions Payot
1964 Preface to the 2nd edition of Sándor Ferenczi. Bern, Hans Huber, Bausteine zur Psychoanalyse
—— Two-way telephone system for seminars using post office trunk lines. Lancet 2:1293
1965 The benign and the malignant forms of regression, New Perspectives in Psycho-Analysis. Edited by G. K. Daniels. New York, Grune & Stratton
—— Primary Love and Psychoanalytic Technique. 2nd enlarged and revised edition. London, Hogarth Press
—— American edition. New York, Liveright
1966 In German. Stuttgart, E. Klett
1965 Secondary frigidity (with Ian Hector). Med World 102:108
—— Whole person medicine. New Soc, No 131
—— The doctor's therapeutic function. Lancest 1:1177
—— Book review: The Wild Analyst, by Carl M. and Sylvia Grossman. New Soc, No 144
—— Az orvos gyógyító szerepének fejlödesmenete (The development of the doctor's therapeutic role). Orvosi Hetilap, Budapest 106:1345
—— Foreword: Marriage and First Pregnancy, by Esher R. Goshen-Gottstein. London, Tavistock Publications
1966 Preface: One Man's Practice, by Ray S. Greco, with Rex A. Pittenger. London, Tavistock Publications
—— Philadelphia, Lippincott
—— Psycho-analysis and medical practice. Int J Psycho-Anal 47
—— Zur Klink psychosomatischer Erkrankungen. Helv Med Acta 32:374
—— A Study of Doctors (with Enid Balint, Robert Gosling and Peter Hildebrand). London, Tavistock Publications
—— American edition. Philadelphia, Lippincott
—— La psychothérapie par des non-psychiatres (with Enid Balint). Rev Méd Psychosom 8:71
—— Perversion und Genitalität (Translation of Perversions and genitality). Psyche 10:520
—— The drug 'doctor', Medical Care. Edited by W. R. Scott and E. H. Volkart. New York, John Wiley & Sons
—— Le Médecin, son Malade et la Maladie. Paris, Payot
—— Techniques Psychothérapeutiques en Médecine (with Enid Balint). Paris, Payot
—— Foreword: Psychoanalyse der frühen Lebensjahre, by Alice Balint. Munich/Basel, Ernst Reinhardt Verlag
—— Foreword: Asthma, Attitude and Milieu, by Aaron Lask. London, Tavistock Publications
—— Die Urformen der Liebe und die Technik der Psychoanalyse (German translation, Primary Love and Psychoanalytic Technique). 2nd edition. Stuttgart, Huber Klett
—— Die technischen Experimente Sándor Ferenczis. Psyche XX:904-25
1967 Médecine psychosomatique: valeur des séminaires associants l'enseignement et la recherche. Méd Hyg XXV:139
—— Book Review: Doctors and Patients, by Mark Hodson. New Soc,

1967 Sándor Ferenczi's technical experiments, Psychoanalytic Techniques. Edited by Benjamin B. Wolman. New York, Basic Books
—— The Doctor, His Patient and the Illness (Japanese translation by Professor Yujiro Ikemi). Tokyo.
—— Il lavoro di gruppo, La Psicoterapia in Italia. Edited by P. F. Galli. Milan, La Formazione degli Psichiatri, Centro Studi di Psicoterapia Clinica
—— Philobatism and ocnophilia, Motivation in Play, in Games and Sport. Edited by R. Slovenko and J. A. Knight. Springfield, Illinois, Charles C Thomas, pp 243-7
—— Book review: Personality and Arousal, by C. S. Claridge. New Soc, p 642
—— Book review: Psycho-Analytic Pioneers, edited by Franz Alexander, Samuel Eisenstein and Martin Grotjahn. Psycho-Anal Forum 2, 4:373
1968 Preface to S. Ferenczi, Oeuvres Complètes, 1:1908. Paris, Payot
—— The Doctor, His Patient and the Illness. Paperback edition. London, Pitman Medical Publications
—— Qu'est-ce que la médecine générale et que pourrait-elle être? Méd et Hyg 26:124
—— Preface: Sexual Discord in Marriage, by Michael Courtenay. London, Tavistock Publications
—— The Basic Fault: Therapeutic Aspects of Regression. London, Tavistock Publications
—— Psychoanalyse et pratique médicale. Rev Med Psychosom, p 243
—— Letter to the Editor. Int J Psycho-Anal 49:99
—— Die Struktur der Training-cum-Research Gruppen und deren Auswirkungen auf die Medizin (The structure of the training-cum-research reminars and their effect on medicine). Jb Psychoanal V: 125-46. Bern and Stuttgart, Verlag Hans Huber
—— Medicine and psychosomatic medicine: new possibilities in training and practice. Comprehens Psychiat 9:267
—— Erfahrungen mit Ausbildungs- und Forschungs-Seminaren. Psyche, Vol XXII, Heft 9
—— The structure of the training-cum-research seminars and its implications for medicine. Proceedings of the Seventh APA Colloquium for Postgraduate Teaching of Psychiatry, New Orleans, pp 5-18
1969 Book Review: Beyond the Therapeutic Community, by Maxwell Jones. Brit Med J 2:304
—— Editorial (with B. Luban-Plozza). Méd Hyg, Vol 27, No 857
—— Thoughts on the problem of the membership of the society. President's News Bull, 13:3
—— Les séminaires de formation et recherche: leurs structures et leurs implications en médecine. Extrait de la Rev Med Psychosom, No 4
—— Book review: Sex and Society in Sweden, by Birgitta Linner. Brit Med J 2:564
—— The problem of membership: the next steps. President's News Bull, No 14
—— The structure of the training-cum-research seminars: its implications for medicine. J Roy Coll Gen Practit 17:201
Pädiatre und Psychotherapie in der ärztlichen Praxis, Handbuch der Kinderpsychotherapie. Edited by Gerd Biermann. Munich, Ernst Reinhardt Verlag
—— Unterrichtung von Medizinstudenten in patientzentrierter Medizin (with Dorothea H. Ball and Mary L. Hare). Psyche XXIII:532
—— Die Urformen der Liebe und die Technik der Psychoanalyse. Paperback edition. Frankfurt, S. Fischer Verlag
—— Training medical students in patient-centred medicine (with Dorothea H. Ball and Mary L. Hare). Comprehens Psychiat 10:249
—— The discussions in the scientific meetings of our society. President's New Bull, No 16
Book review: The Hostage Seekers: A Study of Childless and Adopting Couples, by Michael Humphrey. Brit Med J, 4:218
—— Trauma and object relationship. Int J Psycho-Anal 50:429
1970 Preface: Sándor Ferenczi. Psychoanalyse, Vol. II. Paris, Payot
—— La genèse de mes idées. Gaz Méd France 77:457
—— Der Arzt, sein Patient und die Krankheit. Pocket edition. Frankfurt am Main, S. Fischer Verlag
—— Teaching patient-centred medicine (with Dorothea Ball and Mary Hare). Synapse: J Edinburgh Med School 20:17
—— Repeat prescription patients: are they an identifiable group? Psychiat in Med 1:3
—— Edited and prefaced: Sándor Ferenczi: Schriften zur Psychoanalyse (Papers on Psychoanalysis). Vol 1. Frankfurt, S. Fischer Verlag
—— Formation des étudiants en médecine à la médecine centrée sur le malade (with Dorothea Ball and Mary Hare). Rev Méd Psychosom, Tome 12, No 2
—— Tecniche Psicoterapiche in Medicina (with Enid Balint). Turin, Piccola Biblioteca Einaudi
—— Psychotherapeutische Techniken in der Medizin (with Enid Balint). Paperback edition. Munich, Kindler Verlag
—— Techniques Psychothérapeutiques en Médecine (with Enid Balint). Paperback edition. Paris, Editions Payot
—— Research in psychotherapy and the importance of the findings for psychoanalysis. Rev Méd Psychosom 3:225
—— Treatment or Diagnosis: A Study of Repeat Prescriptions in General Practice (with John Hunt, Dick Joyce, Marshall Marinker and Jasper Woodcock). Mind and Medicine Monographs. London, Tavistock Publications
—— American edition. Philadelphia, Lippincott
1971 Les interruptions de grossesse vécues par le médecin de famille en Grande-Bretagne (with Anne-Marie Sandler). Gaz Méd France, Tome 78, No 4
—— Ichstärke, Ichpädagogik und 'lernen' (1939), Psychoanalyse und Erziehungspraxis. Edited by Johannes Cremerius. Fischer Bücherei, Bücher des Wissens
—— Reserches sur la psychothérapie et importance des résultats pour la psychanalyse. Extrait de la Rev Méd Psychosom No 1
—— The family doctor and patients, secrets. Psychiat in Med 2:98
—— Focal Psychotherapy—An Example of Applied Psychoanalysis (with Enid Balint and Paul H. Ornstein). London, Tavistock Publications
1972 In German.
1973 In Italian.

1972 Recorded Interview, in Patient-Centred Medicine, edited by Philip Hopkins. London, Regional Doctor Publications, p 316
1973 Research in Psychotherapy, Chapter in Six Minutes for the Patient: interactions in general practice consultations. Edited by Enid Balint and J. S. Norell. London, Tavistock Publications, p1

ENID BALINT'S PUBLICATIONS 1943-1973

1943 The Function of the Interpretation in Citizen's Advice Bureau Work—Social Case Work
1950 Report on the Conference held by the Family Discussion Bureaux
1951 Development of Family Discussion Bureau Work Social Case Work
1955 Dynamics of Training in Groups for Psychotherapy (with Michael Balint). Brit J Med Psychol 28:135
1957 Drei Phasen Einer Ubertragungsneurose (Three Phases of a Transference Neurosis). Psyche No 9:526
1959 Training Post-Graduate Students in Social Case Work. Brit J Med Psychol 32:193
—— In German
1961 Psychotherpeutic Techniques in Medicine (with Michael Balint). London, Tavistock Publications.
1962 American Edition
—— In German
1966 In French
—— In Spanish
1970 In French, in paperback
—— In Italian
—— In Japanese
1962 How will this marriage work? Social Work, 19, 4:8
1963 On being empty of oneself. Int J Psychoanal 44:470
1964 Understanding Marital Conflicts. Davidson Clinic Bulletin
1966 Marital Conflicts and their Treatment. Comprehensive Psychiatry, 7, No 5
—— A Study of Doctors (with Michael Balint, Robert Gosling, and Peter Hildebrand). London, Tavistock Publications
—— American Edition
—— In French
—— La Psychotherapie par des non-psychiatres. Rev Méd
—— Psychosom et de Psychol Méd (with Michael Balint) 8:71
1967 A Study of the Doctor/Patient Relationship using Randomly Selected Cases. J Coll Gen Practit 13:163
—— Training as an Impetus to Ego Development. The Psychoanalytic Forum 2:1
1968 Investigating the Possibilities of Patient-Centred Medicine. Proceedings of the Seventh APA Colloquim for Postgraduate Teaching of Psychiatry, New Orleans 39–50
—— Remarks on Freud's Metaphors about the 'Mirror' and the 'Receiver'. Comprehensive Psychiatry 9, No 4:327
—— Unconscious Communications between Husband and Wife. What is Psychoanalysis? Edited by W. G. Joffe. London, Institute of Psychoanalysis
1969 The Possibilities of Patient-Centred Medicine. Roy Coll Gen Practit 17:269
—— Examen des possibilités de la medecine centrée sur la malade. Extrait de la Rev Méd Psychosom et de Psychol Méd No 1
1971 Focal Psychotherapy: An Example of Applied Psychoanalysis (with Paul H. Ornstein and Michael Balint). London, Tavistock Publications
1972 In German
1973 In Italian
1972 Fair Shares and Mutual Concern. Int J Psychoanal 53:61
—— Preface: Psychiatry in Medicine 3, No 4
1973 Technical Problems found in the Analysis of Women by a Woman Analyst: A contribution to the question 'What does a woman want?' Int J Psychoanal 54:195
—— Six Minutes for the Patient (with J. S. Norell). London, Tavistock Publications
—— In German

Help me but don't get too close!

by CYRIL GILL

A psychiatrist wrote me an apology for failing with a patient: 'This man's problem is that he will never make a relationship to a psychiatrist or anyone else'. This was true enough, but the general practitioner, unlike the psychiatrist, is readily available to people who are tied in such knots, and they entangle us repeatedly in their unresolved defences.

The frightened patient who wants our help, but cannot let us too close to his secrets, may come for repeated reassurance such as, 'Tell me I'm not ill, but don't frighten me with investigations'.

More difficult to break through are the many varieties of patient who 'flirt' with us, then cut us down to size, and often have pelvic troubles too.

The demanding patient, 'Help me and I'll suck you dry', usually has teeth somewhere. 'I know you will fail me too.'

Worst of all are the aggressive patients, like the frightening psychotic I mentioned at the beginning. He seems to be ensnaring me with, 'You are a useless doctor, but if you stop trying, I might smash your windows'. Too alarming for interpretations, so I appease him with prescriptions or investigations when he gets demanding. Fortunately there are not many like him. It is easy to forget the patient's interests when they are too demanding or aggressive, but there is not much to lose with an interpretation or two as we defend ourselves.

One thin Anglo-Indian woman came on my list with a large record file. After a while the pattern emerged. She would start by complaining softly about something, which aroused my pity. This would soon fade as she told me, less softly, that what I gave her for something else last time had done no good.

As the list of troubles grew, I would shuffle the notes about and wonder how to get rid of her. Letters from various specialists showed the same pattern: 'Thank you for sending this interesting patient. . . .' Then after a few visits a second letter. 'I don't think she need attend hospital again unless her troubles persist.' And persist they did, until overlaid by something else.

Gradually I learned how friends and employers all failed or rejected her, and this, of course, went back to her earliest childhood in India. I felt I was hurting her as she talked. However she had the ability to see and understand her pattern. 'Help me and I'll show you how beastly you are for failing me.'

Another patient, with an equally thick folder, behaves like a dirty baby, testing everyone to see if they can stand her. She is fat and ugly; she coughs over me; annoys my receptionist; and behaves as though she owned the place. She wastes my time and misses appointments; and has been in hospitals and prison. Her adoptive parents only liked good little girls, and she was horrid. She spins the story out so that I lose the thread, and have to throw her out of the surgery somehow. Yet there is a pathetic appeal about her. She sends me a Christmas card, even if it is grubby and secondhand. She too could see and understand her pattern: 'Can't someone bloody well love me?'

I am sure we all have patients like these two. I know I am an important person for them both. Are they any better for responding to my preference for a particular sort of relationship? Since each of them has accepted a crude interactional diagnosis with me, our relationship has become more mutually tolerable. There is a slight shift from mock battle to honest discussion of personal problems, though there is still a battle. There have been many fewer physical complaints, and no referrals at all.

The thin Anglo-Indian lady took a slow painful trip home for the first time, last summer. She worked on this experience with me revealing her own sense of failure and guilt. One day she said, 'The trouble with me is that I don't belong anywhere'. She cried then, and complained about my receptionist. Then she troubled me twice with a flurry of minor physical complaints, till I got the message and told her she could 'belong' in my surgery without all these complaints. That was too close, and she fled, but she will be back. There is a slight but definite change in her, with more insight into her isolation, reflected in our relationship too.

The fat disruptive girl also comes from somewhere thousands of miles away, but she did not

go home, because her family pays her to stay here. But a relative, over here on business, delayed his return flight to look me over. I got the impression that they could afford to keep her here. I'm on her side.

Recently her parents wrote me that 'Something must be done about her'. Though this was impossible advice, they seemed to accept that I was the one to do it. I gathered from the patient that this letter was a response to some rather angry ones she had written home after our discussions. This was not quite my intention, but as she said herself, 'it was better than being in trouble over here'. However I would not leave her alone with my EC1os. Her love-hate ambivalence is not lessened for being more explicit. Though I am keeping her out of hospitals, physical and mental, and possibly from prison and other troubles, no doubt she would revert if I left her. There is truth in her threat, 'If you ever abandoned me I'd do something terrible'.

This supportive relationship is better than my useless appeasement of the frightening psychotic man, but not so good as the Indian lady, painfully using our relationship for a slight change in herself. There is a temptation to put on an artificial show to appease difficult patients, or get rid of them, and to pretend that we can really cure everybody. Perhaps this is often to protect ourselves rather than the patient.

Personalia

In the absence of any response to repeated requests for news of members' activities, the Editor has felt obliged to produce material to keep this column open.

Michael Munro Hopkins, a son, was born on 14th January, 1975, to Susan, wife of Philip Hopkins.

I am happy to report that during the past year, two volumes of the Journal of the Society have been published by the sterling efforts of the Editors, and it would seem that there is now no reason why there should not be at least one a year from now on, and perhaps expansion can occur. Indeed it is now the International Journal which has fallen on hard times, and we are being asked to support it financially. The Council have not yet had time to consider this problem.

The other main area of endeavour behind the scenes has been on training. The sub-committee on training has met on several occasions and has now recommended a two-tier system of Training Panels to accredit seminar leaders, and has recommended criteria for those leaders, both psychoanalysts and others, to receive accreditation by the Society. These proposals are now ready to be considered by Council.

The need to form Balint Seminars outside London has become pressing, as not only has this been the aim of Council during almost the whole existence of the Society, but we have now had enquiries from the Royal College of General Practitioners to help them by supplying group leaders up and down the country. Quite apart from trying to form Balint Seminars outside London, it would seem that the time is now ripe to consider the many ways in which the Society can contribute to medical education, especially in the early postgraduate phase of training for general practice, now that this phase is becoming the centre of more attention with the mushroom development of Vocational Training Schemes and the like.

The key word is perhaps Whither?, and if the Society does not play its part in the evolution, the result will be that the word will drop an aitch, wither and so die. Those of us who attended the Second International Balint Conference in May, 1974, will appreciate how important this question is, and the present outcome of the daring Dutch experiment in incorporating Balint methods into the College of General Practitioners training has caused much heart-searching in those who were present at what was supposed to be the demonstration of a Balint Group. As I sat in the auditorium I seemed to hear a voice saying, 'Do not adjust your mind, there is a fault with reality'.

Finally, I wish to thank all members of Council for their hard work and personal support during a year which has given me much pleasure and satisfaction. Most particularly I wish to express our gratitude to Stephen Pasmore, who is retiring as Secretary, for his untiring and splendid efforts in getting the wheels of the Society turning from its inception until now; only his close colleagues know how much time and effort he has spent in our service.

M. J. F. Courtenay

There has been a rise in the membership of the Society by 20, making 80 Ordinary Members and 29 Associate Members. He reported on the success of the Second International Balint Congress held in Brussels in May which was attended by 23 members of the Society—many of whom took an active part in the Congress. Drs Bacal, Clune, Courtenay, Morris, Norell, Prudence Tunnadine and Steel read papers, Drs Clyne, Hopkins and Jean Pasmore chaired sessions. Dr Vera Pettitt held a demonstration group; the members of the Tuesday seminar, ie Drs Bacal, Carne, Clyne, Courtenay, Gill, Mary Hare, Hopkins, Lask, Norell and Stephen Pasmore, led by Enid Balint, gave a demonstration seminar. Enid Balint opened the Congress and also gave the closing speech in which she gave an important summary of the main aims of the Balint training. All the members attending felt they had a most interesting and enjoyable week-end. The Third International Balint Congress is to be held in Paris in 1976.

The Secretary emphasised that the most important work of the Society during the previous year had been that of the Steering Committee set up by the Council to discuss the problem of training methods. At their last meeting the Council had approved the sub-committee's proposals to draw up a programme related to:—

(a) The advanced training of psychoanalysts in the Balint trainer methods.
(b) The advanced training of general practitioners and other doctors who would qualify as Balint Society trainers or co-trainers.

The sub-committee had since drawn up a new programme which had been referred to by the President in his report, and which had yet to be submitted to Council. H. S. Pasmore

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Income and Expenditure Account for the Year Ended 31st March, 1974

Secretarial and General Expenses	£30·52	Subscriptions	£440·00
Workshop Expenses	82·98	Workshop Receipts	26·00
A.G.M. Dinner Expenses	39·04	Journal Receipts	1·65
Anglo-French Group Expenses	261·79	Anglo-French Group Receipts	190·77
Hire of Hall and Meeting Expenses	35·40	Interest	64·53
Bank Charges	12·94	Regional Doctor Publication Receipts	196·00
Journal Printing Expenses	175·00	A.G.M. Dinner Reimbursement Receipts	40·38
Publishing Costs Amortisation	200·00	Memorial Dinner Reimbursement Receipts	29·20
Memorial Dinner Provision	29·20		
Surplus for the year	121·66		
	£988·53		£988·53

Balance Sheet as at 31st March, 1974

General Fund		*Cash at Bank*	
1st April, 1973	£911·89	Deposit Account	£780·37
Surplus for the year	121·66	Current Account	50·38
	£1,033·55		£830·75
Memorial Lecture Fund	210·00		
Creditor	29·20	Capitalised Publishing Costs	442·00
	£1,272·75		£1,272·75

In my opinion and to the ons given to me the said accounts give the informa... ... view of the state of the Society's affairs as at 31st March, 1974, and the Income and Expenditure Account gives a true and fair view of the surplus for the year ended that date.

HENRYK DRYSCH,
44 Manor Court Road, W.7.

Past numbers of the Journal of the Balint Society are available at 70 p. (including postage) from:
Mrs. Rogers, 15 Marian Close, Hayes, Middlesex.

The Balint Society motif kindly designed by Mr Victor Pasmore, C.B.E.
Produced by Haverstock Publications, 249 Haverstock Hill, London, for the Balint Society.
Printed by Dorian Printers Ltd., London, W.C.1.