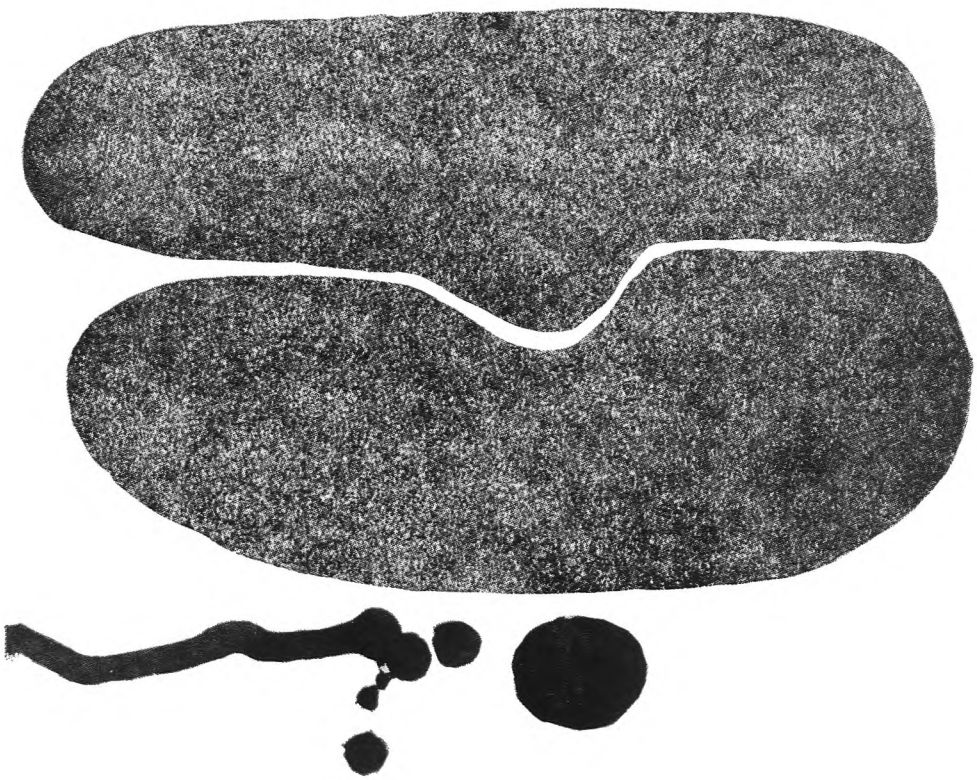
JOURNAL
OF
THE BALINT SOCIETY
1976



Vol. 5

JOURNAL OF THE BALINT SOCIETY

Vol. 5, 1976

Contents *Page*

Editor: Philip Hopkins

Editorial

This issue of our Journal has been regrettably delayed and we apologise to our members and readers. The Editor of the Journal, Philip Hopkins, the first President of the Society, has been seriously ill and has thus been unavoidably prevented from completing the task of preparing the Journal for printing. I am very glad to be able to write that he is very much better now and will soon be able to return to his practice, having already returned to his editorial tasks. Needless to say, the good wishes of his friends and fellow members of the Society have always been with him.

The Society is flourishing with regard to its activities and membership. We had several interesting and fruitful meetings. Professor Marshall Marinker's fascinating Balint Memorial Lecture on *The Academic General Practitioner*, was well attended. Another member of the Society to become an academic general practitioner, is Paul Freeling, who will soon start work as Senior Lecturer in General Practice at St. George's Hospital Medical School in London. Our good wishes accompany him in his new venue. May the storming of the bastions continue!

Our seminar work is also increasing although it cannot yet be said to be 'flourishing', I have. for some five years, been trying out a new venture in seminar work, chiefly because there seemed to be so very few people outside London willing and able to lead Balint Seminars; and also because many doctors (and prospective leaders) found the commitment to attend weekly or fortnightly Balint Seminars a considerable strain. We of the 'Old Guard' had also not found it particularly easy 25 years ago to attend seminars, but then the charisma of Michael Balint and our pioneer enthusiasm made the burden lighter.

By chance, during my visits to various congresses in Germany I found that a large number of doctors there were very keen on attending Balint seminars, but that there were very few, if any, groups or leaders available. I therefore organised weekend seminars (four meetings of two hours each on a Saturday and Sunday every six to eight weeks. The demand for these seminars almost overwhelmed me. I ran seven such seminars, a backbreaking task, greatly to the advantage of BEA and Lufthansa. I later started a similar seminar in Blackburn, Lancashire. The venture, which required a great deal of thought, and redefinition of the Leader's task, seems to have been successful in terms of attendance, persistence of members, and 'customer satisfaction' (not to speak of mine). There may be an opportunity to tell the Balint Society more about this at a meeting or in the Journal.

The Third International Congress of Balint Societies at Paris in May, 1976, promises to provide much of interest. Its theme: *Specific Features of Balint Training*, may sound a little more vague to English than to French ears, but in private and public discussions we shall be able to gauge the progress of seminar training at home and abroad, in addition to savouring the pleasures of Paris. I hope that we shall be able to provide a strong British contingent.

M. B. Clyne

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.

Psychiatric Referral*

M. A. KALENA

(General Practitioner, London)

It has already been shown that the reporting rate of psychiatric illness is greater among 'Psychotherapeutically minded doctors' than among their more 'orthodox' colleagues[1]. In their five year study of psychiatric referral in general practice Hopkins and Cooper[2] attest to the special interest in psychiatry of the referring general practitioner. They found the psychiatric referral rate in the author's practice to be higher than the reported average.

While participating in the field-work for the survey, *Psychiatric Illness in General Practice*[1], I became increasingly interested in the results of my own psychiatric referrals.

Some patients have come for consultation with conscious knowledge of their psychiatric problems, seeking out this particular practice because of my known interest in psychiatry. As a result of this, no useful statistical information could possibly be obtained on general population incidence, etc., from the information gathered and this has not been attempted.

Throughout this paper psychiatric referral is used to mean referral to a qualified doctor practising psychiatry or some branch of psychiatry (e.g. hypnosis), a qualified non-medical psychoanalyst or qualified non-medical child psychoanalyst.

THE PRACTICE

The practice is situated in central London, consisting of National Health Service (NHS) and private patients; the NHS list is small, approximately 1,400 patients who are drawn almost entirely from the immediate vicinity. There is a preponderance of females (approx. 2:1). The patients' occupations range through all the social groups with Secretary being the most common. In addition to the spread of occupations there is a considerable range in age, and a number of different nationalities are represented.

In general the private practice is larger but it is impossible to give any kind of figure. This is because some patients may consult me privately for one particular episode of illness or for some other specific reason, (e.g. contraception) and have another doctor for any other complaints. The area covered by this part of the practice is extremely wide and could be said to include the whole of Greater London. As in the NHS practice there is a preponderance of females. As they are paying patients they tend to be mainly in social classes I, II and III but this also is generally true of the NHS practice because of the area. All patients are seen by appointment.

The main difference to be observed between the two groups of patients with regard to this present paper is the matter of selection. As already intimated some private patients come with overt psychiatric complaints having previous knowledge of my interest in the subject. They are often sent by established patients of the practice who have already been helped with their psychological problems by me.

There is an appreciable area of overlap between the NHS and private groups and NHS patients who move away from the area and may become private patients, and local patients who may consult me privately initially, and not being able to afford to continue doing so and may then be transferred to the NHS list.

METHOD

A record was kept of all psychiatric referrals made in the practice from January 1st to December 31st 1967, and these have been followed up as far as possible by personal observation and questioning of the patients still in the practice, and by writing and telephoning for specific information, where it was required, to the psychiatrist concerned. The information has been brought up to date as far as possible to the end of 1972 and so represents a true five-year follow-up. A total of 51 patients underwent 56 referrals, and factors recorded as far as possible for every

Figure 1

Factors Noted

Age, sex and marital state and occupation.
Previous psychiatric treatment—including GP psychotherapy.
Reason for present referral.
Relevant medical condition at time of referral.
Relevant psychological or social factors.
Whether patient was private or NHS in the practice or the referral.
The psychiatric opinion obtained.
Kind of treatment obtained.
Duration of treatment.
Reason for stopping treatment.
Results obtained from treatment—patient's own assessment as well as the doctor's assessment.
Any further follow-up information.

*This paper was read at the Annual General Meeting, 14 May 1975.

referral are shown in Figure 1; the class of patients in Figure 2; and the age and sex distribution in Figure 3. The marital status is shown in Figure 4; and social class in Figure 5, using the official classification of occupations.[3]

Figure 2
Class of Patients in Practice

		In Practice			
		NHS		Private	
		Female	Male	Female	Male
In referral	NHS	8	3	6	1
	Treatment Private	11	1	21	5
Total	56	19	4	27	6

Figure 3
Age and Sex

Age	5–10	15–20	20–25	25–30	30–35	35–40	50–55	65–75
Male	3	0	0	1	2	7	0	1
Female	1	6	8	11	5	1	1	1
Totals	4	6	8	12	7	8	1	2

Figure 4
Marital Status

	Married	Single	Other
Females	14	25	3
Males	3	4	2

Figure 5
Social Class

Social Class	I	5
Social Class	II	26
Social Class	III	13
Social Class	IV	4
Social Class	V	2
Not known		1
		51

(For women the husband's occupation was noted, and for the children the father's occupation.)

CLASSIFICATION OF PATIENTS IN SURVEY

Nineteen NHS female patients were referred to eight NHS psychiatrists and 11 in private practice. Four NHS male patients were referred to three NHS psychiatrists and one in private practice.

Twenty-seven private female patients were referred to six NHS psychiatrists and twenty-one in private practice. Six male private patients were referred to one NHS psychiatrist and five in private practice. (See Figure 2).

A total of ten male patients appears in Figure 2 because one male child patient was referred first for NHS assessment, then placed in psychoanalysis as a private patient.

Two NHS patients are included in this survey who were seen during the year by a psychiatrist without having been referred by me.

Of the total of fifty-one patients, four were referred a second time becuase of problems with the first psychiatrist, and these were private patients.

The ratio of male to female patients in both NHS and private groups correspond very well; otherwise the numbers are too small to yield any useful data, and little further reference will be made to whether a patient is NHS or private, except in the analysis of the final results.

PREVIOUS PSYCHIATRIC TREATMENT

(*i*) *As an inpatient:* Four patients had previously been admitted to hospital for psychiatric treatment. Of these, two were undoubtedly psychotic and required further inpatient therapy which was obtained. The third had had several mental hospital admissions and had been given at least one course of electroconvulsive therapy (ECT) but when seen showed no signs of being psychotic. However, she had problems of identification with her own mother who was also very disturbed. All her treatment had been with male psychiatrists and this led me to refer her to a woman psychoanalyst with whom she has done very well. The fourth had been treated as an inpatient for depression in a hospital abroad.

(*ii*) *Drug therapy as outpatient:* There were two patients: One had been treated by me and the hospital physician for recurrent somatic complaints for which no organic cause could be found, and only latterly had obvious delusions appeared. The other patient had suffered from depression when she was pregnant on a previous occasion, when she found out that the man by whom she was pregnant and had expected to marry, was already married. She had been given drug therapy and had the baby adopted. She was again pregnant and still unmarried.

(*iii*) *Psychotherapy from psychiatrist:* There were six patients, two of whom had had group therapy, the rest individual therapy.

(*iv*) *General practitioner psychotherapy:* Since all patients referred required at least one long session with the general practitioner for the purpose of taking a psychiatric history, this group comprises those who had two or more long sessions. The number of general practitioner

sessions per patient varied from two to twenty-four.

The patients fall into two main groups: (A) those whose psychotherapy immediately preceded the referral and (B) those whose long sessions had been some time before the referral.

(A) There were eighteen in this group, but though their long sessions with the general practitioner immediately preceded referral there was a spectrum from the patient who had 14 sessions over 11 years, to one who had four sessions in one month immediately preceeding referral. This range includes one patient who had 12 sessions over two years and another with seven sessions over seven months. One of the private patients who had presented with overt psychological problems had 24 sessions over six months preceeding referral — ie formal psychotherapy by the general practitioner.*

(B) Three patients had an interval between their long sessions with the general praatitioner and their being referred to a psychiatrist. The intervals were of 1, 2 and 2½ years respectively.

It is of interest that one of the two patients who were seen by a psychiatrist without being referred by me had had several brief sessions over the preceeding year when emotional problems had been discussed, but only one long session had occurred just prior to her being seen by the psychiatrist to whom she was sent by a friend.

There were three patients in this group who had previously had treatment from a psychiatrist. They were each given a number of general practitioner sessions before being referred during this survey.

(*v*) In a 'group' on her own is the patient whose previous therapy had been termination of pregnancy on psychiatric grounds on the advice of the hospital psychiatrist in the previous year. In the course of our consultations prior to referral to hospital for the termination, her psychiatric problems had been discussed and the need for therapy had been pointed out. The patient returned after the termination to have this arranged.

(*vi*) Sixteen patients had no psychotherapy of any kind prior to referral.

REASONS FOR REFERRAL

It will be seen in Figure 6 that the main cause for referral was depression, with unwanted pregnancies second. The depression group contained one of the patients not referred by me who was admitted to hospital as an emergency after taking an overdose because he was depressed by two cancers and a ureterostomy.

The third largest group is labelled 'other'. These ten patients form virtually 20% of the total but have no relation to each other. They include such varied diagnoses as phobic anxiety, intense jealousy, difficulty in concentrating, anxiety hysteria, night terrors in a child, learning difficulty in a child, a depressive personality disorder with alcoholism, and finally a patient who was referred to a hypnotist in an attempt to help her to give up smoking—needless to say without success.

Figure 6
Reasons for Referral

Reasons for Referral	Male	Female	Total
Depression	3	11	14
Unwanted pregnancy		12	12
Psychosomatic	2	4	6
Psychosexual		5	5
Psychosis		2	2
Unsatisfactory pattern of relationships		2	2
Other	4	6	10
Total	9	42	51

The psychosomatic group consisted of two asthmatics (one male, one female), one female with depressive symptoms related to diarrhoea for which no cause could be found: another female with lassitude related to a variety of somatic complaints mainly abdominal for which no cause could be found: and a fourth, a female child with enuresis. The remaining male in the group was a child with a stutter and a lisp.

The psychosexual group were all female. One patient was complaining about lack of orgasm—however the female psychiatrist who saw her thought that the husband was more disturbed than the presenting patient. As he did not accept her invitation to attend, nothing came of the matter and shortly afterwards they moved away. Another of this group complained of lack of orgasm but also expressed an unwillingness for intercourse with her husband. She attended the psychiatrist once only. A further patient who was married complained of frigidity with her boy friend. Lack of sexual interest in her husband was expressed by a fourth patient who also attended once only. The last patient in this group attended with a fear of not being able to consummate a

*This patient came as a result of advice from two of my patients who were her friends, and who had both had some help with emotional problems.

sexual relationship though at the time of referral she did not have one to consummate. It is of interest that her treatment was considered successful at the time. She subsequently made the longed-for relationship satisfactorily.

Two female patients presented with psychosis, one was a schizophrenic with delusions, and the other a depressive with a schizoid element.

Two female patients presented with unsatisfactory patterns of relationships, one with her boyfriends, either made her intensely unhappy or vice-versa, and the other with her mother. This latter was the second of the two patients not referred by me who found her psychotherapist through an old family friend. It is interesting that this patient's father had died when she was eleven years old. She felt her mother who was a very successful woman did not approve of her. At one of her first consultations she had told me she was attending group therapeutic activities which she was keeping secret from mother, and clearly treated me in a similar way.

The treatment obtained and its duration are summarised in Figures 7 and 8; each group is here considered separately.

Figure 7
Treatment Obtained as Result of Referral

		No. of Referrals
1	Individual analytic psychotherapy	23
2	Termination of pregnancy	10
3	Non-analytic therapy	7
4	Treatment advised but not taken up	5
5	Psychoanalysis	3
6	No therapy advised	3
7	Assessment Only	2
8	Group psychotherapy	1
9	Termination of pregnancy advised but Patient changed her mind	1
10	Patient did not attend	1
	Total	56

Figure 8
Duration of Treatment

One month or less	8	16-18 months	4
3-4 months	3	2 years	1
6 months	3	3 years	1
9 months	1	Still in treatment	1
1 year	1		

INDIVIDUAL ANALYTIC PSYCHOTHERAPY

The 22 patients in this group were involved in 23 referrals. The duration of therapy varied considerably as shown in Figure 8.

In the eight referrals where therapy lasted one month or less there were three who attended for one session only and three who attended for two. Another patient, a child, was seen first, followed by the parents, but they defaulted after three sessions; subsequently there proved to be a considerable problem in the marriage. Another patient terminated three-times-a-week therapy after three weeks. One patient attended two successive psychiatrists for two sessions each, these latter patients are further discussed under 'Reasons for stopping treatment.' One patient ended treatment after only four weekly sessions. She was one of those with psychosexual problems and she and the therapist considered the treatment successful. So just under one third of the group of seven patients ended treatment within a month unsuccessfully.

In the three patients whose therapy spaced over 3—4 months, one had 4 or 5 sessions during this time, one was seen once weekly and the third twice-weekly.

Of the three patients whose therapy continued for six months, one was seen once a week, one three times a week and the third was treated as an inpatient.

The patient who attended for nine months is reported to have done so irregularly—she was the girl who had previously had a termination of pregnancy.

The patient treated for a year was the only one in this group who was given anti-depressive drugs as an inpatient for part of her treatment.

The 16–18 months group consisted of two at once a week, and one at two to three times a week.

One patient, an adolescent, was treated for two years with appreciable benefit.

The patient treated for three years was seen once a week, also with benefit.

The patient still in therapy started off at three times a week and continues at once a week now.

TERMINATION OF PREGNANCY

This study began in 1967, the year of the Abortion Reform Act. Of the ten pregnancies terminated, three of the patients were married, six were single, and one was living with her boy friend. The latter patient proved an exception. The opinion obtained from the psychiatrist was that the pregnancy should *not* be terminated. This was based on her not having used contraception and her being unsure of her feminine role. The patient promptly went elsewhere and obtained a termination before returning to my care. One of the married patients who already had four children, was sterilized at the same time as the termination on the advice of a psychiatrist who gave her psychotherapy before and after the event.

One patient who sought termination changed

her mind when it was offered. She came to see me recently to report she has no regrets.

It is convenient to consider here (though she is obviously not included in the total of patients who were treated by termination), one other patient who was seeking termination for whom it was not advised by the psychiatrist. The way she was referred to the practice was questionable – namely by a chemist that I did not know and about whom the patient seemed vague. Secondly, another doctor had told her she was pregnant. She had a complicated religious and ethnic background and the psychiatrist felt that to terminate her was tantamount to the doctors confirming her worst fears, namely that she was not a proper woman. I have not heard from her since.

It is interesting to consider this group of patients in relation to their marital status and age. Of the 'single' and 'other status' women, all save one (36 years of age) were less than 28 years old; while the married patients were all 28 years old or more. This concurs with the observation of Lambert[4] that it is young single girls and older married women who seek termination. However, the single girls in this group were rather older than those seen at the Pregnancy Advisory Centre reported by Lambert. The sample also differs in that only two of the four married women in my group had existing children.

NON-ANALYTIC THERAPY

There are six patients in this group. One was referred twice, making a total of three treated as outpatients, and four as inpatients.

In the outpatient group there is one female who was first referred to a psychoanalyst with whom she did not get on and is included in the group 'Treatment advised but not taken up'. She was then referred to a non-analytic psychiatrist who treated her with 'forceful psychotherapy' and drugs over about ten months. The other two patients were psychotic. One was referred to outpatients, treated with drugs and subsequently admitted for 6 weeks; she died early in 1972. The other was given ECT and drugs as an outpatient, and was subsequently referred to another psychiatrist (who had treated her previously) and given more ECT as an inpatient – she too is now dead.

Of the other two patients in the inpatient group, one was admitted to hospital for 10 days. The other patient was one of those not referred by me and has already been mentioned. He had taken as overdose because of his depression at having cancer and was admitted to hospital by ambulance as an emergency. During his stay he was seen by the psychiatrist.

TREATMENT ADVISED BUT NOT TAKEN UP

There were five patients in this group. The first was a German speaking girl working here as a domestic who returned home. Two more of the group had a consultation but did not follow it up with therapy. One of these was a child suffering from enuresis whose mother thought she had enough character 'to get out of it herself?' The other patient was complaining of lack of sexual interest in her husband and subsequently left him.

The remaining two patients in this group went into treatment with other psychiatrists, one very shortly after the first referral; as a result she was given non-analytic psychotherapy. (The first referral was to a psychoanalyst). The other patient, a woman also referred to a psychoanalyst, was referred by him to a psychiatric social worker for psychotherapy, and was so disappointed at not being treated by the consultant that she refused to go. In 1970 this patient at her own request was referred again for psychotherapy but was considered unsuitable. She subsequently had more drug therapy from a third psychiatrist.

PSYCHOANALYSIS

Of the three patients in this group, one was an alcoholic who attended approximately 14 sessions over two months and then terminated the treatment. The second patient was a female who entered analysis after advice from a previous psychiatrist. She stayed in analysis for one year. Neither of these patients appeared to benefit from their therapy.

The third patient was a child. The consultant psychiatrist considered he needed both remedial teaching and psychoanalysis both of which were started with considerable benefit. The analysis was carried out by a non-medical psychoanalyst and terminated towards the end of 1972, some special teaching is continuing.

NO THERAPY ADVISED

Of the three patients in this group, the first was not considered by the consultant psychiatrist to be ill enough to require treatment, though he reported that her problem of a neurotic relationship with her boy friend was clearly related to her idealised relationship with her dominating father. However, the patient herself did not want treatment when she arrived at the consultation so it was not advised.

The second patient had a psychosexual problem, but the consultant considered from her account of the situation that her husband was more in need of treatment than the presenting

patient. As mentioned above the family left the area shortly after.

The third patient was referred because two years of twice weekly psychotherapy had failed to produce any improvement. The consultant psychologist to whom she was referred thought she might be paranoid and that only supportive therapy was indicated.

ASSESSMENT ONLY

There were two of these patients. One already mentioned was advised to have psychoanalysis and went into treatment. The second had a psychosomatic disorder and was advised to have analytic psychotherapy with another therapist, but never took it up. (This patient is considered separately from the treatment advised but not taken up group because at the consultation it was never considered that he should have therapy with that particular psychiatrist).

GROUP PSYCHOTHERAPY

The only patient who had group psychotherapy attended for eight months. She had severe asthma, congenital heart and lung abnormalities and problems related to her illegitimacy.

PATIENT DID NOT ATTEND

This patient rang me in great distress on the morning of the day of her consultation to say she was too frightened to go and asked for permission not to go. I left it to her to decide and she did not attend. She continues in her same situation taking tranquillizers and hypnotics from time to time.

REASONS FOR STOPPING TREATMENT AND RESULTS

(**A**) **Individual analytic psychotherapy** – total of 23 patients.

(*i*) *Treatment successful:* There were seven patients in this group ie nearly one third of the total.

(*ii*) *Partly successful:* By this is meant that therapist and patient agreed together to accept a limited success. There were four patients. Two of them were due to move from London – in one case it was the patient, and in the other, the therapist who left. The third patient was in a close relationship with a much older man and it was clear to patient and therapist that further therapy might have disturbed the relationship. One patient still in therapy is included here as she is so much better.

(*iii*) *Patient rejected therapist:* There were four episodes of this, two involving the same patient – her reasons were different in each case. She felt the first therapist was too cold and clinical, the second was not medically qualified and therefore she would have been unable to claim on her health insurance. The second patient in this group found the therapist to be interfering too much in his life. The third felt the female therapist was repeating her interpretations and she did not want to hear them, she also is included in the financial group as she gave this as another reason for stopping.

(*iv*) *Patient rejected therapy:* There were six patients in this group, including a child whose parents rejected the therapy. One patient wrote to say she had become engaged and her fiancé objected to her continuing therapy. Two patients attended one session each and rejected the idea of continuing. One of these was too disturbed for the therapist to elucidate what was really going on; the other denied having any problems – the therapist thought this was due to her being frightened of approaching her drives and being unable to control them. The fifth patient in this group stopped therapy after attending three times a week for three weeks because she said she could not afford to continue; but the therapist felt she stopped because she was very much afraid of what therapy would reveal about herself. The last patient rejected the therapy and the therapist and asked to be referred to a non-analytic psychiatrist, with whom her treatment proved relatively successful.

(*v*) *Financial:* This group includes the two mentioned above in groups (iii) and (iv), and one other patient, a married woman whose husband defaulted in paying the fees.

(*vi*) One patient was referred for psychoanalysis to a different doctor from her initial consultations. She appears again in group C below.

(*vii*) One patient was seen for assessment only. He had asthma, and further analytic psychotherapy was advised but not taken up.

(**B**) **Non-analytic therapy:** There were five patients in this group involved in six referrals. One was depressed, admitted to a mental hospital and discharged when improved. One patient was from group (iv) above after rejecting analytic therapy and the therapist, as already mentioned; the treatment from this referral was relatively effective and was terminated when she improved. Another patient already mentioned was the one who was seen by the hospital psychiatrist after being admitted following his taking an overdose. He has since died of the organic illness about which he was depressed. Another of the patients involved in two referrals failed to respond to the treatment of either, and subsequently has committed suicide. The last patient in the group was psychotic and has died.

(C) Psychoanalysis: Of the three patients in this group, one (an alcoholic) rejected the therapy, the second rejected the therapist after one year of intensive analysis; she has continued with psychotherapy with two psychiatrists since, and the third, a child, has now come to the end of a full analysis with apparent considerable success, but continues remedial therapy.

(D) Group psychotherapy: The one patient in this category told me that her treatment was ended by the group disbanding. However, the psychoanalyst in charge of the group wrote to say that she had been the victim of group viciousness and presumably driven to leave.

FINAL RESULTS

The figures shown in Figure 9 have been arrived at by using all the information at my disposal, and finally the results are classified according to whether treatment was private or under the NHS are shown in Figure 10.

Figure 9
Final Results

Not known	Improved	Unchanged	Worse	Dead	Still in Therapy	Total
7	24	15	0	4	1	51

Figure 10
Results Classified According to Whether Treatment was Private or NHS

Not known		Improved		Unchanged		Dead		Still in therapy	
PP	NHS	PP	NHS	PP	NHS	PP	NHS	PP	NHS
5	4	16 (8)	7 (7)	10	6	2	2	2	0

It is often asserted that patients who pay for psychotherapeutic treatment are more likely to benefit than those who do not, as they have a stronger motive to recover and therefore terminate the treatment. The results were threrefore classified according to whether the referral was as a private or NHS patient. In the case of patients twice referred, the second referral was the one considered if it differed from the first, where the second referral was for the actual treatment.

On the face of it there appears to be an overwhelming preponderance of improved patients in the private sector of treatment. However, this group includes no less than eight patients whose pregnancies terminated after private psychiatric consultation. The NHS group under 'Improved' also includes one pregnancy patient – but she was not terminated. If the terminated pregnancy patients are removed from the two groups under the heading 'Improved', the figures become 8 private patients and 7 NHS patients. Clearly there is no appreciable difference between these results.

In the 'Unchanged group' the private patients outnumber the NHS patients by 10 to 6.

It appears that in this survey there is no evidence for the value of payment in psychotherapeutic treatment. However, it is important to consider that a high proportion of the patients in the practice, both NHS and private, might be more highly motivated in therapy than the average because they have accepted the approach of the doctor which has already been described earlier in this paper.

DISCUSSION

In terms of geography and population this cannot be considered a typical general practice. Many of the factors in the practice itself have already been considered. The outstanding feature not yet mentioned, but which has become increasingly obvious throughout this paper is the unique choice of referral possibilities in London.

First, there is the large number of teaching hospitals each with its psychiatric department, as well as the specialised psychiatric hospitals like The Maudsley and The Cassel, and such outpatient facilities as The Tavistock Clinic and The Paddington Day Hospital.

For children there are the numerous Child Guidance Clinics and also the Child Guidance Training Centre. For more intensive therapy there is the Hampstead Clinic of Child Therapy and the London Clinic of Psychoanalysis, the latter catering both for adults and children. This list is by no means exhaustive, but the existence of so many institutions means the presence in London of a large number of highly trained personnel, many of whom also practise privately.

This array of specialised psychiatric services is unequalled in Britain. It enables us to find some kind of adequate therapy for most of our patients. Nevertheless, the amount of individual analytically orientated psychotherapy available in the NHS is far from sufficient, and that is one reason why so many NHS patients were referred for private therapy they often could scarcely afford.

Even in London there are many patients who are not referred, and in the provinces the proportion must be even higher. Many more patients receive general practitioner psychotherapy alone

than are referred. It was this consideration that led me to examine whether or not the patients having had previous psychotherapy from the general practitioner made any difference to the outcome of the therapy with the psychiatrist.

All the various kinds of therapy obtained are here considered together, but the patients attending only for termination of an unwanted pregnancy are not included.

Of the ten failures, six (60%) had had general practitioner psychotherapy, and four had not. Of the fourteen successes, eight (57%) had general practitioner psychotherapy and six did not.

So in this group of patients referred to psychiatrists the outcome of that referral apparently was not affected by whether they had previously had general practitioner psychotherapy or not. However, in the information collected for this survey, there is no indication of the many patients who had been given general practioner psychotherapy in the practice during this period with such benefit that there was no need for referral to a psychiatrist. Furthermore, as the information recorded was specifically related to the psychiatric referral, it would not be possible at this stage to define which of the patients referred were able to come to referral only as a result of the preceeding general practitioner psychotherapy.

The process of general practitioner psychotherapy in the widest sense is practised by every general practitioner to a greater or lesser degree depending on his own knowledge, understanding and insight, and is used with nearly all patients.

The definition of general practitioner psychotherapy for the purposes of this paper has been confined to those patients who were given specific long sessions (45 mins. each) to talk about their problems.

The wider practice of psychotherapy includes a whole spectrum of exchanges between doctor and patient. It embraces such processes as discussion as well as the relevant aspects of the doctor/patient relationship (transference). These and other processes in turn increase the patient's insight and the doctor's understanding of the patient and his problems. Sometimes our understanding can help us to help or cure the patient; sometimes it is not enough. The striving for that understanding is one of the most rewarding processes in the practice of medicine – whether it be seen in terms of increasing our understanding of physical illness, psychiatric disturbance or psychosomatic disorder.

It is clear from this paper that sometimes all our endeavours may not be able to help the patient, but it will not stop us from continuing to try, especially when so many are helped.

The basic problem for the general practitioner remains. Until an offer of help has actually been made to the patient it may be impossible to tell how he will react. Both the offer of help and the patient's reaction to that offer require time for the doctor and patient to understand each other. It is this process of mutual understanding that is the essence of general practitioner psychotherapy. Some but not all of us will continue to seek that understanding though we may not always achieve it.

Except in psychotic patients, something of this mutual understanding must be reached before a satisfactory psychiatric referral can be made. Even then it may be necessary to warn the patient about the different approaches they can expect from the psychiatrist, who will of necessity be less reassuring or comforting than the family doctor who may have been known to the patient for many years and seen him through a number of physical and emotional episodes in his life. It will be one such episode or a series of episodes that leads to referral to the psychiatrist. It will be clear from this paper that the preparation of the patient for this referral is far more time-consuming and difficult than referral to any other kind of specialist, and the outcome more uncertain.

There is one other important aspect of this survey that has not been mentioned, though it might have come under Reasons for referral. That is what the author's own motives were in making the referral – eg. whether the patient had become too difficult to continue treating him in the setting of general practice, whether the patient had become tiresome, etc. This aspect of the referrals was not noted at the time and it would be impossible to unravel it now.

Perhaps future research can help us to clarify these factors, and also to differentiate between those patients who are going to benefit from psychiatric referral and those who are not.

References

1. Shepherd, M., Cooper, B., Brown, A. C., and Kalton, G., (1966) *Psychiatric Illness in General Practice*. Oxford University Press.
2. Hopkins, P. and Cooper, B.(1969) Psychiatric referral from a general practice. *Brit. J. Psychiat.* 115; 1163.
3. *Classification of Occupations* (1966) HMSO.
4. Lambert, J. (1971). *Brit. med. J.*, 4: 156.

On Establishing an Ongoing Seminar for the Investigation of Doctor/Patient Relationships

Presented by Dr J L Skinner, Dr D L F Dunleavy and Dr John Foster on behalf of a Seminar which was launched at the end of September 1973, in Nottingham.*
The experience of this Seminar was described at the third meeting of the Balint Society's 1974–5 programme on 11 March 1975.

INTRODUCTION by J L SKINNER,

General practitioner in Ilkeston, Derbyshire and Part-time Lecturer in General Practice at the University of Nottingham Medical School.

The purpose of this paper is to describe the Nottingham experience in achieving the original broad objective of establishing a method to emphasise the need, and to teach the understanding of whole-patient-centred medicine to medical students and others, so that others may learn from our mistakes and experience.

General practice remains an art within the framework of which modern scientific principles are applied. Computerised and high technology medicine can possibly deal satisfactorily with disease entities but fortunately or unfortunately, depending on one's orientation, many people are uncategorisable and their problems uncodable. Classical disease syndromes are found sometimes in practice and always in text books, and doctors may be at a loss when confronted by some aspects of the human predicament against the the back-cloth of which illness occurs.

Discussion of patient-centred medicine and the whole man at undergraduate level is useful but, lacking immediacy can appear academic. Once working in the community, much assumes a different perspective but by then the opportunity to discuss patient interactions may not be available.

A letter was written to a recommended member of the Balint Society seeking advice on the establishment of Balint-type seminars. This was acknowledged in courteous terms[1] and followed by helpful and encouraging advice[2] from the then president of the Balint Society.

Since it was clear that much discussion would have to take place between the author and those in a position to facilitate or support the proposed seminar, a discussion document was prepared. It had the following content:

Proposed seminar for the investigation of doctor/patient relationships.

EDUCATIONAL OBJECTIVES:

To study and discuss:

1. Emotional and relationship problems in general medicine in general, and general practice in particular.
2. Attitudes of doctors.
3. Doctor/patient relationships.
4. Application of a single psychotherapeutic method in general practice.

BEHAVIOURAL CHANGES ANTICIPATED:

1. An increased awareness of the emotional component of disease in general practice.
2. An increased awareness of the central side of the doctor/patient relationship in the diagnosis and management of illness in practice.

METHOD:

1. Seminars would be established.
2. Interested general practitioners, general physicians and psychiatrists would be invited to attend.
3. Co-leaders and resource personnel with experience in the leadership of groups with similar objectives would be recruited.

THE GROUP SIZE:

1. Optimum size thought to be 9 members.
2. Limits for viability thought to be 7 and 12.

FREQUENCY OF MEETINGS:

1. Optimum thought to be weekly with long breaks during the Easter, Summer and Christmas vacations.

**Members of the Seminar were Drs Margaret Colley, John Foster, Alan Gray, Jean Madeley, Jim Nelson, Bridget Shevlin, John Skinner, Tony Turner, and David Wilkie: Leader, Dr D L F Dunleavy.*

2. Forty meetings annually thought to be satisfactory.
3. Alternatively meetings could be held fortnightly.
4. It was felt unlikely that the objectives would be attainable if the meetings were convened less frequently.

TIME AND PLACE OF MEETINGS – to be decided.

DURATION OF SEMINAR – 2 years.

If the demand exceeded the optimum for the establishment of one seminar, two could be arranged. Should it be shown that a demand does in fact exist in the Nottingham area for a seminar of this type, prior application would be made to the Area Director of Postgraduate Studies for approval under section 63. It was explained that membership of a Seminar implied a commitment, and that time was a serious constraint. It was further emphasised that the teaching of basic psychiatry was not a primary objective of the group.

The document now formed a firm basis for discussion. At this stage the problem areas appeared to be:

1. *The time commitment:*
   It was felt that those colleagues most likely to attend may have already committed themselves in other areas of local undergraduates and postgraduate teaching.
2. *Evaluation:*
   This concept induced considerable anxiety in a number of colleagues with whom it was discussed.
3. *The personal intrusion criticism:*
   'You cannot expect to take your general practitioner colleagues to the psychiatric outpatients with you'.
4. *The 'I know it all' syndrome:*
   'It is quite unnecessary to attend a Seminar in order to know, learn or understand what is going on in terms of the doctor/patient relationship'.

The Department of Psychiatry of Nottingham University had been approached in March, 1973 and interest had been expressed in the objectives of the proposed seminar. A passing similarity was noted between the known objectives of the Balint Society and those under discussion in this paper. A request was made to the Department for a Group Leader and at a subsequent Department meeting Dr D Dunleavy, Lecturer in Psychiatry, showed interest, was available and had had experience of similar groups. Dr Dunleavy was assigned the point of contact within the Department for this project. The history and background were discussed extensively by telephone, and Dr Skinner and Dr Dunleavy met in May 1973 when the decision was made to restrict seminar membership to interested general practitioners. The proposal to include general physicians and psychiatrists was therefore withdrawn.

Much discussion took place concerning objectives and the view was expressed that perhaps the seminar should have one educational objective namely 'To study the doctor/patient relationship' rather than the four listed in the discussion document, but the four objectives were retained.

The method of recruitment and approval under Section 63 by the Postgraduate Dean were designated the two problems. At a subsequent meeting in the Department of Psychiatry, the policy was established that although they supported the project they did not wish to be involved in either recruitment or the seminar's organisation.

A suitable letter was now sent to the Area Director of Postgraduate studies enclosing a copy of the protocols and formally seeking Section 63 approval. Approval was forthcoming but the frequency of the meetings was noted with 'some apprehension'. The letter of approval clearly saw the seminar as 'a psychiatric seminar for general practitioners' rather than as one which had the objectives outlined in the discussion document.

Having now obtained the support of the Regional Director of Postgraduate Studies the resources of the Postgraduate Medical Education Centre at the City Hospital, Nottingham became available in the form of:
Secretarial help; a designated tutorial room; coffee and biscuits; fund for payment of lecturers; guest speakers etc.

Recruitment

This proved one of the most difficult problems. Up to this point there was no proof of a local need for the establishment of this seminar. It would NOT be acceptable to convene the seminar by personal invitation since section 63 approval implies that all general practitioners in the Area have had an equal opportunity of attending. It was not felt necessary to screen potential members in any way or to exclude two or more applicants from the same practice.

The market was eventually 'tested' by distributing a recruitment letter with a tear-off application form with a copy of the revised discussion document to every general practitioner on the lists of the Derbyshire and Nottinghamshire Executive Councils. The Clerks kindly did this free of charge. The result of this first recruitment letter was awaited with interest and is shown Table 1.

Many colleagues continued to see the seminar as a forum for the discussion of personal emotional problems ie. as a therapeutic, rather than task orientated group, or as a device for didactic teaching in basic psychiatry. These ideas were not subject to rational discussion. Respondents to this first recruitment letter were asked to rank order four tentative times for the first and subsequent meetings. Thursday was mentioned most frequently. Of the 17 respondents 8 attended the first meeting with the designated leader, and the Seminar was launched on 28 September, 1973.

Table 1. 1st Recruitment Drive August 1973

780 Information Sheets Distributed	
Derbyshire Executive Council 400	Nottinghamshire Executive Council 380
3 responded (0.75 %)	14 responded (3.9 %)
3 indicated they would attend first meeting (0.75 %)	6 indicated they would attend first meeting (1.6 %)
3 actually attended first meeting (0.75 %)	5 actually attended first meeting (1.3 %)
3 are attending 2nd Academic Year (0.75 %)	3 are attending 2nd Academic Year (0.80 %)

Relationship with Area Director and Associate Dean of Postgraduate Studies

We have been aware throughout the first year that this seminar, seen in terms of postgraduate education was different in size, educational objectives and duration from any other situation receiving section 63 approval within the remit of the Area Director. Considerable pressure has been put on us to maintain attendance at the highest possible level. Further information concerning this seminar has been requested so that its financial implications could be discussed with the DHSS.

During the summer of 1974 a discussion wss held with the Area Director of Postgraduate Studies in order to establish the likelihood of approval under Section 63 for a second parallel seminar. It was agreed that approval would be forthcoming if the demand could be shown to exist.

The Second Seminar

The market for the establishment of the second seminar was established in a manner similar to that for the first one ie. distribution of 780 information sheets identical to those used in 1973. Again, this was undertaken at nil expense by the adminstrators of the Derbyshire and Nottinghamshire Family Practitioner Committees. Table 2 summarises the response to this second recruitment drive.

Table 2. 2nd Recruitment Drive October 1974

780 Information Sheets Distributed	
Derbyshire F.P.C. 400	Nottinghamshire F.P.C. 380
5 responded (1.25 %)	6 responded (1.6 %)
1 indicated intention to attend first meeting (0.25 %)	2 indicated intention to attend first meeting (0.5 %)
1 actually attended (0.25 %)	2 actually attended (0.5 %)

This second seminar was approved and convened under the leadership of Dr Mark Aveline a recently appointed consultant psychotherapist but proved only marginally viable due to the smallness of the number. At this time (January 1975) the members of the original seminar were informed that their leader (Dr Dunleavy) had been appointed to a senior academic post in the North East. The twin crisis of a viable and leaderless group being paralleled by a non-viable but 'led' one were solved by the application of common sense. Thus, the new group was convened in mid February, 1975 under the leadership of Dr Mark Aveline as co-leader was introduced. During January 1975 a structured recording card was introduced. This is similar to and based upon the Courtney Mark 9[3] with deletion of reference to specific research interests. An innovation is that our record card fits the standard Medical Record Envelope.

Characteristics of Members of the Present Group

It is not known in what way the nine members of the definitive group are different from either those colleagues who applied for information and did not ultimately join, or those who

received the same information sheet in the two recruitment drives but did not seek further information. Table 3 lists some characteristics of those who constitute the present seminar.

Table 3

Identity No.	Sex	Year of qualification	Medical School	Ethnic origin
1	F	1948	St. Andrews	Caucasian
2	M	1960	Sheffield	Caucasian
3	M	1950	Westminster	Caucasian
4	M	1949	Belfast	Caucasian
5	F	1963	Edinburgh	Caucasian
6	M	1952	Birmingham	Caucasian
7	M	1970	Glasgow	Caucasian
8	M	1948	London	Caucasian
9	F	1971	London	Caucasian

Discussion

Many questions are raised by our Nottingham experience in establishing an ongoing seminar for the study of doctor/patient relationships. It is clearly possible for this to be organised without the resources of the Balint Society and yet with objectives totally in accordance with their own. The low response rate in two consecutive recruitment drives is in contradiction to the apparent interest which is said to exist in the general medical practitioner population.

Those who have attended this seminar are unanimous in their opinion that their patients have benefitted and yet formal evaluation has been meticulously avoided. It is felt that seminars of this type should be approved under Section 63.

Difficulties have arisen due to the small numbers and the inappropriateness of publishing a programme as seminar methodology relies heavily upon case presentation. The extent to which thinking in this seminar has been influenced by prior knowledge of the works of Michael Balint is unknown and is probably irrelevant. The meaning of the concept of Balint to those who did not meet him is not without interest. The fear is expressed that the criticism of cult could detract from the objectives undoubtedly shared, not only by the Nottingham seminar but also by the Balint Society.

Conclusion

This paper describes the Nottingham experience in establishing an ongoing Seminar for the study of doctor/patient relationships. It describes difficulties and suggests that sensitive areas worthy of tighter definition and research might be:

a. Evaluation.
b. Criteria for Section 63 approval.
c. Relationship with the Balint Society.
d. Reasons for low response rate.
e. Discrepancy between apparent and real demand.
f. Characteristics of those who join this type of seminar.

References

1. Lask, A. Personal communication.
2. Courtenay, M. Personal communication.
3. Balint, E., and Norell, J.S. (eds.) (1973). *Six Minutes for the Patient.* London, Tavistock.

EXPERIENCE of the GROUP LEADER

by D L F DUNLEAVY

Formerly Lecturer in Pychiatry at the Nottingham University Medical School; now Senior Lecturer in Psychological Medicine, The Royal Victoria Infirmary, Newcastle.

At the outset I was confronted by three difficulties in describing my experience with our seminar in Nottingham. The first problem is that it is still developing, and it would be premature to talk about a number of things at this time. The second problem is that I relinquished leadership three weeks ago on taking up my new post in Newcastle. The third difficulty, however, looms much larger, and those of you who have been members of a seminar will understand my problem. We have developed a very close group-identity and at an emotional level it is almost like betraying a trust when one comes to talk about ourselves to outsiders. There is a part of me which does not wish to share our experience with others, and a feeling of guilt was hovering in the background while I prepared this paper. I have, I hope, successfully resolved some of this conflict, and would now like to describe my personal experiences in three ways. First of all I would like to say how I personally came to have an interest in this type of work; secondly, what I felt I had to offer; and thirdly, to share some of the seminar experiences.

My involvement

I had been intrigued for some time by Erikson's writings on developmental and accidental life crises. He talks of the time when one becomes engaged, when one marries, the first day one's children go to school, etc., as normal developmental life crises. Accidental life crises would be the death of a loved one, one's divorce, possibly a car accident, or a period of severe sickness. At these times of crisis the individual is likely to fray at the edges a little. He is much more vulnerable to other stresses impinging upon him, and the probability of decompensation increases with the number of things he has to cope with at this time.

However, although there is a potential for destructiveness at these times, there is also a potential for growth. This idea became linked in my mind with Caplan's work on crisis consultation. His idea, basically, is that minimal intervention at these times can be of major benefit to the individual. I always remember one of his encapsulated statements which I feel I should have framed on the wall of my office. He claims that 'excellence is the enemy of the good'. I understand him to mean by this that we should be prepared to do a little even where we realise much more is called for. If we could do this little amount of work at times of crisis our efforts would be rewarded to a much greater extent.

As a psychiatrist, I am also aware that we deal with only a small percentage of the psychological disturbance which exists at any one time in the population. In fact, it has been shown that referral to psychiatric agencies is very idiosyncratic, and it is very hard to tease out why one person ends up seeing a psychiatrist, and another does not, although both may have the same symptomatology. We are also much more removed from people, while the general practitioner is on the spot. Unfortunately he is all too often literally on the spot! If he could be trained to be more psychologically aware of current life stresses and how they act on the individual, his intervention at these times of crisis would hopefully be more effective. The Balint type of seminar seemed to me to be the best medium for developing this expertise.

What did I have to offer?

I had been involved in therapeutic groups in Edinburgh over a four-year period. For two and a half years of this time I had been supervised in a group by Dr J D Sutherland, who has been a great influence on my orientation. He has been concerned for some time that psychiatrists may not be involved where they are most needed. He feels that we should act as consultants to the people who are performing caretaker functions in society. In other words, we should be talking about their case work with general practitioners, social workers, and other community workers. There is no doubt that there is a great demand for this form of consultation from people who work in the community, and also from their clients. The latter often speak through the bulletin of the National

Association of Mental Health, 'Mind', and what they have to say makes alarming reading. Psychiatrists, because of their field of work, should have an expertise in this form of consultation, but unfortunately it is true to say that many of them do not.

As an academic, I am also interested in small-group teaching and, fortunately, much of the undergraduate teaching in Nottingham occurs on the small group-seminar principle. Dr Skinner has described how he was interested in starting a seminar in Nottingham (p. 18), and I felt that I might be able to act as a resource person for this group. It was fortunate for me that I happened to be in the right place at the right time, as the intended seminar combined my interest in teaching and doctor/patient interactions.

Personal experience of the group

I will discuss this under two broad headings: firstly general problems that remained with me throughout the seminar's duration and secondly, specific problems that arose at different stages in the development of the group.

General problems

a. Isolation

The first thing I would like to comment on, in my personal experience of the group, was the experience of isolation. I did not have a co-leader, and in retrospect this was clearly a mistake. There were many occasions when I did not know what was going on, and on other occasions so much was happening that it was impossible for one individual to absorb it all. It is very necessary to have some sort of sounding-board where one can discuss one's ideas, or possibly have one's own feelings reflected back. Most writers on group work talk of the absolute necessity for ongoing supervision and consultation. This is one of the problems, of course, of any type of work in the psychotherapeutic field outside London. There are few people with whom one can discuss one's involvement, and I grasped avidly at any opportunity for discussion when I met friends who were involved in psychotherapy.

b. Anxiety

I had realised from my experience in therapeutic groups that the leader often feels anxious about his abilities. This of course may be a very realistic appraisal of one's own talents, but one also becomes very much involved in group processes. When the group is in a despondent stage one becomes 'infected' with feelings of hopelessness. One doubts one's own ability and questions whether one has the skill to deal with particular situations which are being presented. One feels that here are people who are giving up their valuable time and are eager to learn, and one has nothing to impart to them. Fortunately my natural buoyancy reasserted itself at these times, but there were occasions when I went to the group with reluctance, or went home biting my nails. It is not very pleasant having your identity threatened, and here again, discussion would have been helpful.

Specific problems to the Group

a. Name

This caused a great deal of frustration in the initial stages of the seminar, and illustrates once again some of the bureaucratic nonsense to which Dr Skinner has already alluded. We were billed on the noticeboard in the Postgraduate Centre as '*Psychiatric Tutorial*'. This annoyed me considerably as I did not feel that my function in the seminar was in any way connected with teaching psychiatry. Neither did I feel that I was going to teach psychotherapy directly. I was interested only in looking at the doctor/patient relationship as it was expressed in ordinary, everyday general practice, and I had been at great pains to spell this out in the prospectus which was distributed before we established the seminar.

After some exchanges, we thought we had arrived at another, more appropriate title, ie. '*The General Practitioner Group*'; however, we were eventually billed, to my chagrin, as '*The Psychiatric Group*'. At this stage we gave up. At least if nobody else seemed to appreciate our purpose we, in the seminar, felt that we shared a common ideal.

b. Tape Recorder Incident

Research work has shown that recall of group meetings is very fallible, and quite significant incidents are often forgotten and possibly repressed by the leaders. Having a poor memory I decided to tape-record the seminar to facilitate my own thoughts about the group afterwards. Unfortunately, I did not take a tape-recorder to the first meeting, but brought one along to the second meeting and left it on a side table, and discussed recording the seminar with the members who were already in the room. As luck would have it, there were two late-comers, one of whom had had previous experience of seminars.

Without any disrespect to other members of the seminar, she was the most experienced member in psychodynamics. When this individual noticed the tape-recorder, paranoia became rampant, and there was a heated, irrational discussion. I eventually capitulated and said that I would not record the seminar. This was my first serious mistake – she had made a successful bid for leadership of the seminar, and was colluded with in this by the rest of the participants. I was shown up by this event as having clay feet, and this, allied to my youthful appearance had, I feel, retarded the development of the seminar for a considerable period of time.

c. Attempt to Become a Therapeutic Group

Michael Balint has described in his writings the drive which was shown on many occasions in his seminars to turn them into therapy sessions. Although I had an intellectual appreciation of this, I did not anticipate that this impulse could be so strong. On several occasions in the first trimester members expressed a wish to discuss some of their personal difficulties, and I was met with great hostility by the other members of the group when I forcibly intervened and stated that this was not one of the aims of the group. I had to reiterate on a number of occasions that we were going to discuss cases in the group, and this was our only function.

Dr Skinner, in one of our private conversations, spoke about the function of a referee. If he is to function effectively he must stamp his personality on the game in the first few minutes. This principle applies also in a group situation. The leader and the participants must establish the norms of the group in its early phase. In dealing with the tape-recorder incident I failed to be sufficiently positive, but in stating the manner in which the group was to function I was quite adamant. Often we seem to become so preoccupied with internal reality that we do not deal sufficiently firmly with external reality when it intrudes, and there are some situations where one has to put one's foot down.

d. Visit of Dr M J Courtney

Most groups have a natural evolution. The initial phase is one of questioning and establishment of group norms. However, this is followed by a period of unquestioning belief in the omnipotence of the group's experience and existence. This is a period of unbounded optimism, when all problems are going to be solved by the magic of 'groupness'. Inevitably reality reasserts itself after a varying period of time, and there is a decline in group morale, with loss of confidence in the group itself and in the leader. There is a great deal of questioning as to whether the group is of any use, and the group itself is pervaded by a lack of direction and hopelessness. This period characterised the third term of our group, and it was interesting that at this time when the group had lost confidence in me as a leader, an invitation was extended to Dr Courtney to come to visit us. His visit happened to coincide with the last meeting of the first year of our group.

The meeting itself was memorable for the activity of the group. They were more animated than I had seen them for many months, and were on their best behaviour in order to show our visitor how much they had gained from the group experience. He gave his 'apostolic benediction' to us, saying that he had felt very much at home, and that we seemed to be following Michael Balint's principles to the letter. There was a post-group rendezvous at the home of one of the members, and the evening could only be described as manic. Great optimism for the future of the group was expressed, and we all went off on summer holidays with the feeling that confidence in the group itself had been restored.

e. The Case Material

I was unprepared for the sort of material that members brought to the group; I had expected we would discuss ordinary, everyday exchanges in the surgery. However, with monotonous regularity, case after case with severe personality disturbance was produced. Readers will be aware of the YAVIS type of patient, ie., the young, attractive, verbal, intelligent, and successful patient. If you have to select a patient for psychotherapy the nearer you approach that ideal the more successful will be the outcome. All the cases I heard about seemed to be non-YAVIS and conformed more to the stereotype of the patient that a skilled psychotherapist would have difficulty in managing.

I am a great believer in the principle of preserving oneself, as it is only in this way that one can be of benefit to other people. Attempting to take on too many insuperable problems would tax the already strained timetables of general practitioners, even if it did not strain them emotionally.

J. Group Identity

The group has, as expected, developed its own form of communication and culture over a period of time. Initially we seemed such a heterogeneous group and it was difficult to see how we would ever get to know each other. We have now shared many experiences, and it is noticeable when we get together that one stimulus word or phrase will unleash a variety of emotions and recollections. In a relatively short period of time we became very cohesive and the group bond is now so firm that the original seven members of the group are here tonight!

SUMMARY

In conclusion I would like to say that I have found this a personally maturing and very rewarding experience. It has emphasised for me the difference between community and hospital practice. I have been frequently amazed at the difficult type of patient that the general practitioner has had to continue seeing, as he cannot pass the buck! I feel that this type of seminar helps enormously in understanding and tolerating the emotional demands which are made in the doctor/patient relationship. I hope we have achieved that in Nottingham, but only time will tell.

On Being a Member of the Seminar

by John Foster,
General practitioner in Nottingham

This short contribution is a personal offering, and makes no attempt to be representative of the views of the group.

I think that motivation is an interesting factor, especially as I am sure that members joined for differing reasons. To digress for a few minutes this is the sort of problem I found myself facing.

Some ten years ago, I joined a small two-and-a-half man practice in a small industrial town in the East Midlands, with less than four thousand patients. It was an old established practice with only three doctors in the last seventy years having worked there. I soon got to know people, there was too much night work and too many unnecessary visits, but communications were good. I saw my partners daily, I knew what was going on. Our eldest partner, a paternal autocrat of the best benign quality, told me the history of everyone, and what he did not know, our equally long serving single receptionist soon filled me in on.

After a couple of years he died; we took in another young man, annexed an adjacent isolated practice, expanded the premises to their limit at some expense – and we were set up. Another local doctor died and his partner wished to join us and amalgamate the practices – it seemed to be to everyone's advantage to cut down the night and the weekend work – we were four and pressed, so we became five. We had a main and two branch Surgeries. We now, due to the inscrutable workings of the Ministry, became a Group II underdoctored area. We were pressed, not only for man power, but also space – we needed another doctor and got one – now we were six.

We worked a thoroughly democratic rota in three Surgeries, but space now forced us to operate shift type surgeries – it had all been an honest attempt to solve the problems facing us but, alas, ominous cracks started to appear. I was now only seeing my partners as we changed surgeries – our little rest room was also a surgery – arranging meetings became more difficult – eg. only for five months a year are we all there – holidays became a nightmare because we all had children of school age. The number of patients was well over sixteen thousand – it is so difficult to rember who people are when one is faced with a hospital report 'x' months after the original referral.In spite of all efforts we were, as I suppose most general practitioners are, relentlessly caught in the five minute hop – medicine at the gallop!

The truth of the matter was that I had beaome isolated in my own practice, the very thing that I had helped to create. We had solved one problem and created another, possibly worse. It was not that I did not get on with my partners, it was that we had lost touch, the old 'cozyness' had gone.

This is where the suggestion of a seminar seemed to offer me some help in the awful lack of communication that had grown up arond me. I was delighted when it was obvious we would have the chance to attend one at a reasonable distance. I do not quite know what I expected, but I got more than my money's worth.

We first met in September 1973, and looking around at the time, I thought this is either going to be real and helpful, or it will fold in a few weeks – I could not see a group of us 'hard

bitten' experienced general practitioners buying anything but the real thing.

It is odd looking back now at the suspicion and muted aggression that characterised our first meetings. The leader first got it in the neck, and I remember the aggression was mine — he was a little younger than most of us, and even worse, not a general practitioner. He may have winced inside, but outside he never flinched – he kept his cool and earned our respect week by week as he made his demands clear in his own quiet way.

My own feeling is that I used the seminar to work out my own feelings of anger and frustration, particularly about the confused state of general practice today, and no doubt lots of other personal hang-ups; the difficulties I have with middle-aged, dominant conservative women, is very well known within the seminar.

At first, I think some of us wanted to talk about ourselves and our difficulties, but on this our leader could not be moved, even when he was not there on a few occasions he had made us swear a solemn oath. It became obvious that by the type of patient we discussed, and the way we described them, we were saying plenty about ourselves – and when the other members of the group pointed them out, they were embarrassingly obvious.

But much to my surprise, as the months went by we did not break up – my aggression did not break up the group; far from it, they coped very well with it – I found that I was soon able to listen to them – and it became obvious we were beginning to help each other. No longer the reserve, we knew our problems better, and the group understood – we were beginning to enjoy ourselves, even though it was still painful.

I have always been sceptical of the type of education which relies on the lecture principle to pass on information, and so much of what is offered in postgraduate education seems to be of this type; no matter how good the lecturers are, I fail to see how it involves anything but the most superficial involvement and comittment of the audience. Dr Johnson in his time commented with some amazement on the popularity of the lecture. He would no doubt have agreed with the definition, if he did not say it, that it is a way of transferring knowledge from the notes of the lecturer to the notes of the student, by-passing the minds of both in the process. In my experience, I have always found medicine committed to the one-way approach – the traditional student/teacher set up – but here at last I think I can say I have found a real live two-way communication without any superimposed structure.

My great criticism of postgraduate education was that although the problems dealt with were real and expertly explained, they were always what someone else thought were my problems – up until this seminar I did not seem to have the opportunity to explain to anyone how I saw the problem – indeed the problem was not the theory concerned with Mrs Bloggs' illness, it was Mrs Bloggs herself and the effect she had on me

As the seminar progressed, it was obvious we were getting better at understanding each other – perhaps I thought there might be a time when I would see what was happening between the patient and myself before the seminar so painfully pointed it out to me. Although my appreciation and understanding of what has happened in the relationship improved, my anticipation has not; my inability to see what is coming is so marked it must be a gift!

It is interesting to see how, in the past, people have excused or explained their actions and irrational behaviour before we had our present psychologically orientated vocabulary. There is one point in the *Iliad* where Achilles nearly ruins the whole of the Greek effort by an argument with Agamemnon over (would you believe it?) a fair maiden named Briseis. Eventually, on the very eve of disaster, he decides to forget the quarrel and join in the war so, without blinking an eyelid, he stands in front of the leaders and says that none of it was his fault, Atè blinded him. Everyone agrees he is not to blame and all is forgotten. Now I found that Atè was a daughter of Zeus, and one with the nasty unpleasant habit of blinding men to their motives, and preventing them from seeing what is really going on. Well, I have news for Homer, this lady has not ceased her activities, she practises them frequently in my surgery!

This I take to be one of the greatest benefits of the seminar, that the more I understand of peoples' motives, the more tolerant I become of them, although I cannot help them any more as a result of that knowledge. I think a lot of the credit for this must go to our leader who managed us well and unobtrusively – christened by us as Desmond – what's really going on here Dunleavy?

If I had to put into words the essential value

of the seminars to explain it and its benefits to an outsider, I should find this a difficult task. At first I thought this would be fairly easy to do, but I have found myself in the position of the poet who was asked by his King to describe God in his essential being. He asked for a day to think it over before he answered; at the end of that he asked for two more days, then a week, then a month longer. The King expressed surprise at the delay, and the poet explained 'you see the more I think about it, the more confu ing it becomes'. It is easy to cover ignorance in words, but it seems to me the benefit is easier to experience than to explain. It is best described by the words of our patients, when they recover and ascribe this to our medicine. 'It did me a power of good', they say; that is what I feel about the seminar. Here is an odd Freudian touch which gives some indication of its importance to me.

At the end of the summer term last year, in fact during the evening of the last meeting, much to my surprise I started bleeding from an acute duodenal ulcer. It is odd how doctors face their own illnesses, but I reacted in a way typical of doctors, I ignored it, continued with my planned sailing holiday on the Lakes, only to be brought back at high speed by my evercoping wife, put into hospital and topped up with blood.

Incidentally I have often, as I am sure we all have, been thanked by patients for being kind to them – a compliment I have never really understood. In the interminable night of illness, a big smiling West Indian male nurse taught me what it is all about. Now I know why kindness is the international currency of human beings – what an experience it is to be vulnerable, dependant and ill. However, the point of the digression is that obviously I recovered, and in six weeks I returned to work, just in time for the first meeting of the seminar in the Autumn term, not having missed anything – a feat that our leader had to acknowledge bordered on the heroic. What a complicated thing the aetiology of one's own illness is, everybody else's is so much simpler – was it the aspirins I took for a headache because I had run out of my usual analgesic? Why had I run out of them, or was it the strain on me, or my anger and depression – my family history – or just Saturn in conjunction with Mars? I do not know.

The latest point I have noticed is how in the seminar a lot of non-verbal communication has been taking place, we have had much more theatricals than at first. I have seen one of our group nearly dancing with delight on his chair when he realised I was behaving in the same way as he had been the week before in a similar situation. We have enlarged our vocabulary – that is a talk in itself, but I do like terms like the big-bang case, the fire-cracker – we have added the veronica and the three card trick.

Now our original group has ended, or rather phoenix-like has been rekindled into a larger seminar with different leaders, we have new experiences to look forward to.

I have seen the seminar as the string quartet of medical education – sensitive, but none the less overwhelming at times, in spite of its apparent docility. Not for us the brilliant showing off of technical capability belonging to the solo pianist, nor the grand statements of the full orchestra which almost submerge our individuality but, like the intensely dependent responses of the small group of musicians, we construct and discover an inner reality.

I cannot be very unusual as a general practitioner, and I cannot believe that there are not many more general practitioners who would find a seminar of help in dealing with their relationships with their patients. I am made aware of how vulnerable a general practitioner can be in an apparently well set up situation, and how his traditional position can be undermined in a changing society. There seems to me no doubt, that once one is aware of patients' real problems, dealing with these requires help for the doctor to manage his own problems. If in medicine we do not learn to use these group-situations, we shall soon become aware of how we lag behind other disciplines.

Considering so many of us in medicine spend such a large portion of our time in relationship with people, it seems to me surprising that as students we had no training in this area. This gives me an opportunity to say my own personal thank you to the late Dr Michael Balint for taking the trouble and interest to listen to the problem 'according to me'. I think the message from the provinces is definitely 'come over to Macedonia and help us'.

Well I know that I have not found the holy grail – I realise we are only a small cog in a large machine, but none the less important for that. If you saw that production of Laing's *Knots* by the splendid Actors Company, you will remember at the end a solitary figure looks into a pool of isolated light on the stage, 'What are you looking for' asks the second figure, 'a key' says the first. – 'There is no key there', says the second; 'True', the first replies, 'but at least there is light here'.

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